Ending HIV/AIDS in West Central Minnesota

SUMMARY OF REGIONAL STAKEHOLDER INPUT

July 2018
Prepared by Wilder Research

MINNESOTA

Ending HIV/AIDS in West Central Minnesota

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Minnesota HIV Strategy (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html)

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Adults HIV/AIDS information (https://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/)

Contents

Introduction

The Minnesota Departments of Health (MDH) and Human Services (DHS) convened 15 facilitated workshops around Minnesota to develop tactics for implementing the Minnesota HIV Strategy (the Strategy). The Strategy is a comprehensive plan to end HIV/AIDS. It includes five goals supported by 22 total sub-strategies (strategies) focused on how the goal will be achieved. The Strategy is available here: Minnesota HIV Strategy report (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/reportfeb2018.pdf).

Each facilitated workshop focused on a specific region of the state or high-risk community. Workshop participants included stakeholders and community members with knowledge, connections, and insights about challenges and opportunities to support the success of this strategy. Wilder Research facilitated each workshop, and offered a web survey to individuals who were unable to participate in the workshop.

To ensure geographic representation across Minnesota in this process, feedback was sought through workshops and web surveys in each of eight regions of the state. A facilitated workshop focused on ending HIV/AIDS in the West Central region was planned for April 16, 2018, in Moorhead, Minnesota but was canceled due to low participant registration. This is a summary of the findings from the web survey respondents.

Survey process and participants

Process

The survey asked respondents to identify the three strategies that they feel are most important for their region, to recommend a tactic that addresses each strategy, and to identify barriers to implementing the tactic as well as resources that could support it.

Participants

Eighteen people provided input via the survey. Table 1 shows survey participants' roles or areas of work. Participants could select multiple roles or areas of work.

Table 1. Roles of survey participants

	Survey participants (N=18)	
Role or area of work	**N**	**%**
Advocate for, or member of, high risk population[a]	1	6%
Chemical dependency provider	0	0%
City or county public health or human services professional	4	22%
Faith leader	0	0%
HIV services provider	1	6%
Housing provider	0	0%
Medical provider	3	17%
Mental health provider	0	0%
Social service provider	0	0%
Youth advocate/youth worker	0	0%
Other	4	22%
Prefer not to answer	1	6%
Missing	7	39%

Note. The numbers above may not sum to the total number of participants because each participant was able to select multiple roles.

[a] High-risk populations include men who have sex with men, people who inject drugs, people experiencing homelessness, African-born men and women, African American women, Latina women, and transgender people.

Prioritized strategies

Web survey respondents were asked to identify strategies that they thought were most important for ending HIV/AIDS in the west central region. Each survey respondent could identify up to three strategies they thought were most important. The most commonly selected strategies are shown in Table 2.

Table 2. Prioritized strategies from survey participants

Strategy	N (out of 18)	%
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), syringe services programs, and partner services.	10	56%
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	8	44%
Strategy 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.	6	33%

Note. The strategy numbers (e.g., 1.1) correspond to the numbering system used in the Minnesota HIV Strategy. Only strategies that were selected by at least six people are included in the table; some strategies were prioritized by a smaller number of respondents.

Tactics

Each survey respondent was invited to recommend a tactic that should be used to implement each of the strategies they selected as most important. Table 3 lists the tactics that they recommended.

Table 3. Recommended tactics from survey participants

Prioritized strategies	Recommended tactics
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	▪ Start with giving better information to school-aged children. Not just how to wear a condom, but more [information on] what HIV is, how it is transmitted, prevention, [and] not to be afraid of normal contact. ▪ [Have] public forums, focus groups, [and] events. ▪ [Make] information available like brochures [that can be accessed] on a smart phone [because] the younger generation is very tech savvy. ▪ Include information at all educational levels from elementary to the college. Have professionals or educators in the field trained to relay the information, and possibly certify people to be the educators or professionals.
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as PrEP, PEP, syringe services programs, and partner services.	▪ [Implement] programs for those that are under-insured or that have no insurance so [that] those individuals can be [informed] of available resources and because the medication is so expensive. Indian Health Services is not able to provide needle-exchange services; [they] often have to refer to tribal health [centers], which are only open limited times during the week. This is great for those that live on the reservation, but many of the patients live outside of the reservation. ▪ Do more education in greater Minnesota around the advantages of PrEP, PEP, and syringe exchange programs to increase buy-in. Communities in this area are extremely resistant to "harm reductionist" strategies due to their perceived "counter-intuitive nature." If there is buy-in for programs such as these, then funds and resources can and will follow. There are energized people in the community and local organizations to implement this work, but they cannot do it without proper supports. ▪ All payers should pay 100% of treatment costs for both patient and partner. ▪ Utilize mobile or home-based efforts to better reach rural areas. ▪ Meet people where they are with real-time services and support. Don't wait for them to come to [a] facility. Provide a holistic approach to assess all health risks and provide hands-on case management. ▪ Break down the stigma of obtaining these services. This is a rural, conservative area and the most significant barrier to people obtaining any of these services is cultural. Enlisting churches to help would be a major breakthrough.

Note. The strategy numbers (e.g., 1.1) correspond to the numbering system used in the Minnesota HIV Strategy. Only strategies that were selected by at least six people are included in the table; some strategies were prioritized by a smaller number of respondents. Some respondents did not provide a tactic for their chosen strategies. Some responses that were provided to the question about tactics were non-responsive and thus not included above.

Table 3. Recommended tactics from survey participants (continued)

Prioritized strategies	Recommended tactics
Strategy 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.	▪ Bring a variety of people to the table and educate them - this is the most important piece in addressing issues about HIV stigma, racism and structural discrimination on a systems level. People do not want to discuss the role racism, stigma, and other discrimination/oppression plays in not only "othering" certain communities, but also perpetuating these public health crises. This is mostly because the general community, of both professionals and the public, do not believe that these issues exist in their community unless they are directly impacted by it. This is very dangerous. ▪ Provide information to broader audiences to encourage diversity. ▪ Have pastors and local politicians openly use the term "HIV" to break down the stigma.

Note. The strategy numbers (e.g., 1.1) correspond to the numbering system used in the Minnesota HIV Strategy. Only strategies that were selected by at least six people are included in the table; some strategies were prioritized by a smaller number of respondents. Some respondents did not provide a tactic for their chosen strategies. Some responses that were provided to the question about tactics were non-responsive and thus not included above.

Next steps

Using the information from this summary, as well as other regional and community summaries and a statewide report of synthesized results, the Minnesota HIV Strategy Advisory Board will prioritize a set of tactics to be implemented. In fall 2018, MDH, DHS, and Wilder Research will prepare an implementation plan (including a fiscal analysis which describes the anticipated cost) and an evaluation plan to guide and monitor these efforts.

An updated Minnesota HIV Strategy will be submitted to the Minnesota Legislature by January 1, 2019. The update will include the most current data about the status of HIV/AIDS in Minnesota, information related to the outcomes of the facilitated workshops and web-based survey, the prioritized tactics, and the implementation and evaluation plans.

DHS is creating a new position to coordinate and report on the progress of the implementation and evaluation plans as well as progress in reaching the outcomes and indicators included in the Strategy. As tactics are successfully implemented in coming years, additional tactics will be prioritized and added to the implementation and evaluation plan.

For additional information about developments in the Minnesota HIV Strategy, please visit Minnesota HIV Strategy (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html) or email Health.HIV.Strategy@state.mn.us.