Ending HIV/AIDS in Minnesota

FINAL REPORT ON IDENTIFYING TACTICS FOR THE MINNESOTA HIV STRATEGY

July 2018
Prepared by Wilder Research

Ending HIV/AIDS in Minnesota: Final Report on Identifying Tactics for the Minnesota HIV Strategy

Minnesota Department of Health
Infectious Disease Epidemiology, Prevention and Control Division
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-5414
[Minnesota HIV Strategy (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html)](http://www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html)

Minnesota Department of Human Services
Disability Services
P.O. Box 65967
St. Paul, MN 55164-0967
651-431-4300
[Adults HIV/AIDS information (https://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/)](https://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/)

Contents

Acknowledgments

This report would not be possible without the significant contributions of staff members at the Minnesota Department of Health and the Minnesota Department of Human Services who shared their expertise, helped to guide the project, and supported facilitated workshops with regional and community stakeholders, including: Colleen Bjerke, Gayle Caruso, Kathy Chinn, Melissa Conway, Peggy Darrett-Brewer, Jackie Dionne, Alvine Laure Ekame, Sarah Gordon, Krissie Guerard, Chryssie Jones, Beth Kingdon, Dennis London, Esther Mwangi, Japhet Nyakundi, Sharlonda Pierce, Jose Ramirez, Sam Robertson, and Jared Shenk.

We also wish to thank the workshop participants and survey respondents who contributed their time, energy, expertise, and ideas to prioritize strategies and develop tactics for ending HIV in their regions and communities.

The authors of this report are: Anna Granias, Madeleine Hansen, Stephanie Peterson, and Francie Streich.

We are grateful to the many Wilder Research staff who also worked on this study:

Sheila Bell
Jenny Bohlke
Walker Bosch
Jackie Campeau
Jen Collins
Phil Cooper
Amanda Eggers
Dylan Galos
Nicole MartinRogers
Ryan McArdle
Amanda Petersen
Maria Robinson
Denise Rodriguez
Melissa Serafin
Dan Swanson
Azra Thakur
Kerry Walsh

Executive summary

There are approximately 300 new HIV diagnoses made every year in Minnesota. At the end of 2017, 8,789 people were estimated to be living with HIV or AIDS in the state. With the vision of making new HIV diagnoses rare and ensuring that all people living with HIV, and those at high risk of HIV infection, have access to high quality health care and resources, the Minnesota Departments of Health (MDH) and Human Services (DHS), along with the Minnesota HIV Strategy Advisory Board, developed the Minnesota HIV Strategy. The Minnesota HIV Strategy provides a roadmap for coordinating efforts and resources to address HIV and move towards eliminating HIV/AIDS in Minnesota.

The first step recommended in the Minnesota HIV Strategy is to identify and prioritize tactics, which are the detailed ways in which the Minnesota HIV Strategy will be implemented. In order to do this, MDH and DHS contracted with Wilder Research to facilitate a series of regional and community workshops in which a wide array of stakeholders collaborated to develop tactics.

In total, 15 regional and community workshops were conducted around the state. These workshops included a highly facilitated process that helped participants prioritize sub-strategies of the Minnesota HIV Strategy that were most important for their region or community and develop tactics for implementing them. These sub-strategies are described throughout the rest of the report as strategies.

Two of the workshops were unique in their process and content. During the workshop focusing on the African-born community, participants called for a different process to share their feedback. Several participants did not feel that their communities were represented in the Minnesota HIV Strategy and were therefore uncomfortable using it as the starting place for the facilitated conversations. Instead, participants held a set of small group conversations focused on their key concerns. A follow-up meeting was held to review and confirm what they shared. Another workshop consisted of talking circles focused on ending HIV in Native American communities. This workshop took a different form in order to recognize and respect the sovereignty of tribal nations and because the state recognized a need to learn more about the needs and concerns regarding HIV in these communities before work could begin to develop tactics that would meet their needs. Input captured during these two workshops is summarized separately from the other regional and community workshops.

Wilder Research also conducted a web survey to collect input from stakeholders who were unable to participate in the workshops.

Key findings

Regional and community workshop participants most commonly prioritized the following **strategies**:

- Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.
- 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.
- Strategy 3.3: Provide culturally and linguistically appropriate services, as well as gender appropriate and sexual orientation appropriate services in clinical and/or community support settings.
- Strategy 4.4: Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive services.
- Strategy 5.2: Integrate HIV prevention, care and treatment throughout all sectors of government (e.g., health, human services, education), health care systems, and social services.

Regional and community workshop participants most commonly recommended **tactics** that included:

- Developing provider networks to support person-centered care or warm referrals.
- Offering easy to understand or targeted education or outreach.
- Implementing messaging campaigns, PSAs, or ads to increase awareness and understanding of HIV.

Workshop participants indicated that money and funding were the most common **barriers** they expected could impede the implementation of their recommended tactics.

African-born community leaders shared that:

- Authentic engagement with African communities is essential, acknowledging that different communities have different needs, and allowing for multi-directional communication and partnership-building, face-to-face interactions, and ongoing mutual accountability.
- Processes need to be community-driven, community-led, and culturally responsive, engaging community leaders (including faith leaders), existing networks, and community organizations to work toward ending HIV.
- Funding in the African-born community needs to be consistent and ongoing, with an emphasis on making funding and capacity building support accessible to organizations who are already doing this work.
- Stigma is a large barrier in this community, and there is a need for community-driven education and awareness around this issue.

Talking circles focused on HIV in **Native American communities** highlighted that:

- Stigma surrounding HIV is a major problem in Native American communities, which prevents people from getting tested or seeking services.
- There is a shortage of HIV services and resources in Native American communities, and providers who do serve these communities often lack knowledge about HIV prevention and treatment.
- To make progress on ending HIV in Native American communities, several things are needed, including: education, adequate health care services, competent providers, support for basic needs such as housing and transportation, and outreach to increase HIV awareness and promote service utilization.

- To support efforts to end HIV in Native American communities, participants recommended that state agencies should offer more dedication and commitment to this topic in their communities. They also recommended changing and maximizing available funding and resources, collaborating with other state agencies and with smaller organizations, and improving sex education.

Individuals who were unable to participate in the workshops were able to contribute feedback via a web survey. **Web survey participants** most commonly prioritized strategy 1.1, focused on increasing HIV education and awareness for all Minnesotans, and strategy 1.4, focused on increasing availability, access and use of evidence-based interventions that prevent HIV infections. The tactics and barriers they identified are described throughout the report.

Next steps

Using the information from this report, as well as summaries of the detailed input provided for each region and community, 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.

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.

Introduction

In January 2018, the Minnesota Departments of Health (MDH) and Human Services (DHS) and the Minnesota HIV Strategy Advisory Board released the Minnesota HIV Strategy—the first comprehensive plan to end HIV/AIDS in Minnesota. The Minnesota HIV Strategy is a living document that provides a roadmap for coordinating efforts and resources to address HIV and move towards eliminating HIV/AIDS in the state.

The first step recommended in the Minnesota HIV Strategy is to identify and prioritize tactics, which are the detailed ways in which the Minnesota HIV Strategy will be implemented. In order to do this, MDH and DHS contracted with Wilder Research to facilitate a series of regional and community workshops in which a wide array of stakeholders collaborated to prioritize sub-strategies of the Minnesota HIV Strategy and to develop tactics for implementing them. These sub-strategies are described throughout the rest of the report as strategies. Stakeholders who were unable to participate in the workshops were invited to provide input through a web-based survey. This report summarizes the results of the workshops and the web-based survey.

After presenting information about the status of HIV in Minnesota and the Minnesota HIV Strategy, this report summarizes the feedback and ideas from stakeholders around Minnesota, including the strategies they prioritized to meet regional and community needs, and the recommended tactics for implementation.

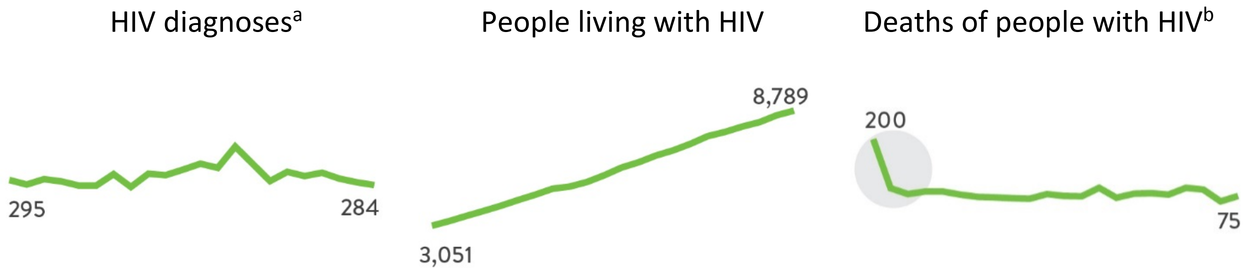
An individual section highlights input from African-born community leaders, because this community called for a different process to capture their thoughts and concerns. An individual section also highlights feedback about HIV in Native American communities. The process was designed differently in order to recognize and respect the sovereignty of tribal nations and because the state recognized a need to learn more about the needs and concerns regarding HIV in these communities before work could begin to develop tactics that would meet their needs. Finally, we share participant reflection and next steps for the Minnesota HIV Strategy.

Detailed information collected from the workshops and survey about specific regions or communities can be found in the population-specific summaries available on the [Minnesota HIV Strategy website (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html)](www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html)

Status of HIV in Minnesota

Since 1996, the number of new HIV diagnoses has remained relatively stable in Minnesota at approximately 300 cases per year (Figure 1). During this same time period, deaths among HIV-positive people in Minnesota has decreased dramatically, with the largest decrease seen between 1996 and 1997 due to the introduction of effective multidrug antiretroviral regimens to treat HIV. As people with HIV are living longer and healthier lives, the number of people living with HIV (PLWH) in Minnesota continues to grow. At the end of 2017, 8,789 people were estimated to be living with HIV or AIDS in Minnesota.

Figure 1. New HIV diagnoses, deaths, and number of people living with HIV in Minnesota by year, 1996-2017



Source. Minnesota Department of Health. (2017). [HIV incidence report, (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html)](www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html), 2017.

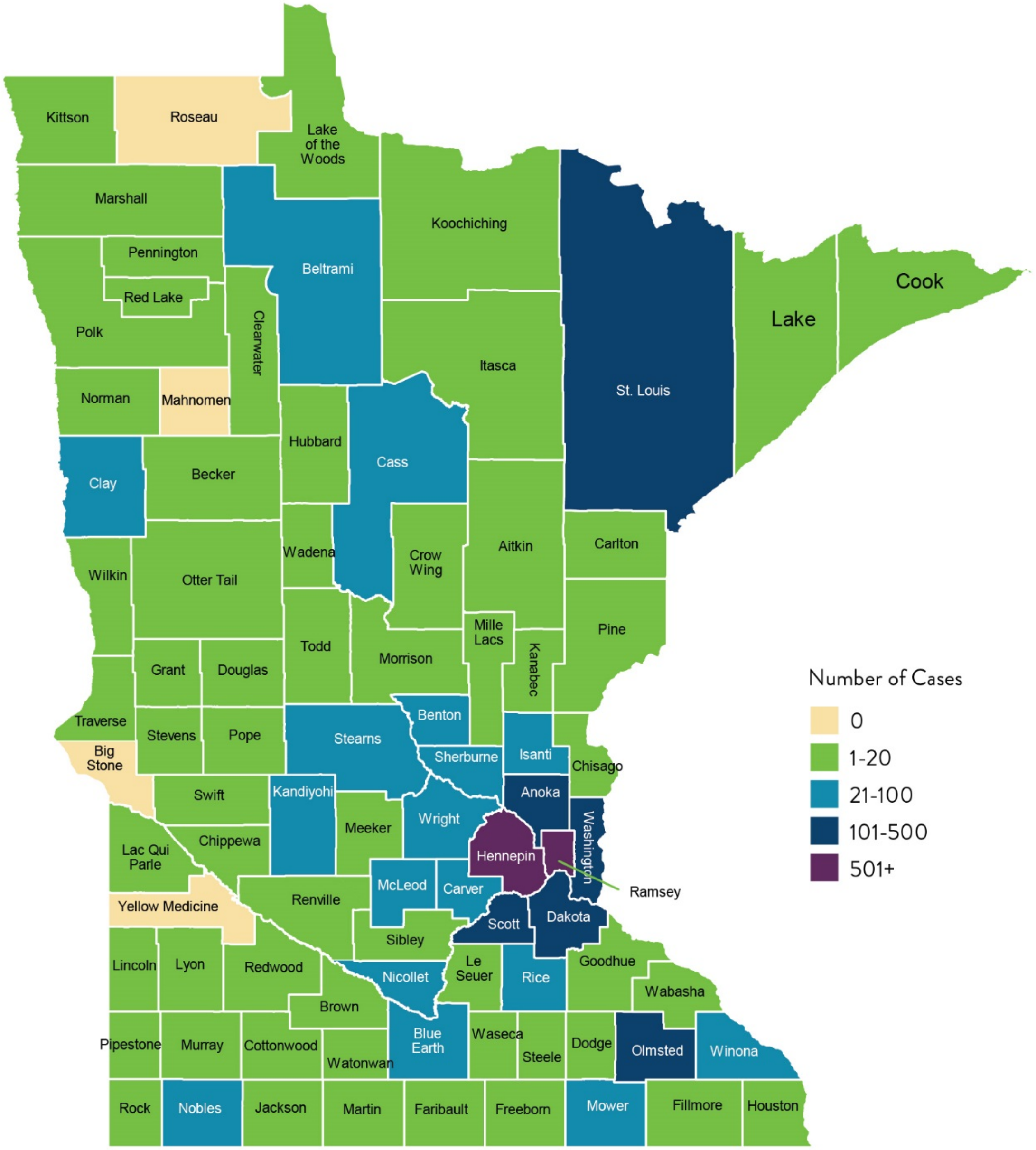
[a] Includes all new cases of HIV infection (both HIV (non-AIDS) and AIDS at first diagnosis) diagnosed within a given calendar year.

[b] Deaths in Minnesota among people with HIV/AIDS, regardless of location of diagnosis and cause.

Geographic distribution

The majority (83 percent) of PLWH reside in the Twin Cities seven-county metropolitan area (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties). Although HIV infection is more common in communities with higher population densities and greater poverty, there are PLWH in 95 percent of counties in Minnesota (Figure 2).

Figure 2. Number of cases of HIV/AIDS in Minnesota by county, 2017



Source. Minnesota Department of Health. (2017). [HIV/AIDS prevalence and mortality report (www.health.state.mn.us/divs/idepc/diseases/hiv/stats/2017/hivprev.pdf)](www.health.state.mn.us/divs/idepc/diseases/hiv/stats/2017/hivprev.pdf), 2017.

Racial and ethnic disparities

There are large disparities in the prevalence of HIV/AIDS across racial and ethnic communities. While white, non-Hispanics account for the greatest number of people living with HIV, the rate of HIV/AIDS is among the lowest in this population (93 per 100,000 persons) (Table 1). The rate of HIV/AIDS among African-born people is more than 13 times greater than the rate among white, non-Hispanic people. The rate among black, non-African-born people is more than 12 times greater. The rates among Hispanic and American Indian people are also higher than the rate among white, non-Hispanic people, while the rate among Asian/Pacific Islanders is slightly lower.

Table 1. Number of cases and rates (per 100,000 persons) of HIV/AIDS in Minnesota by race/ethnicity, 2017

Race/Ethnicity	Number of cases	Percentage of total	Rate per 100,000[a]
White, non-Hispanic	4,119	47%	93
Black, non-African-born	1,885	21%	1,156
Black, African-born[b]	1,368	16%	1,268[c]
Hispanic	852	10%	340
American Indian	113	1%	203
Asian/Pacific Islander	191	2%	88
Other[d]	261	3%	--
Total	**8,789**	**100%**	**165**

Source. Minnesota Department of Health. (2017). HIV/AIDS prevalence and mortality report (http://www.health.state.mn.us/divs/idepc/diseases/hiv/stats/2017/hivprev.pdf), 2017.

[a] 2010 United States Census Data used for rate calculations, except where otherwise specified.

[b] African-born refers to blacks who reported an African country of birth. Non-African-born refers to all other blacks. Rates for black, non-African-born and black, African-born are not comparable to previous years due to an increase in the estimate for black, African-born population.

[c] Based on population estimate of 107,880 (Source: 2014-2016 American Community Survey with additional calculations by the Minnesota State Demographic Center).

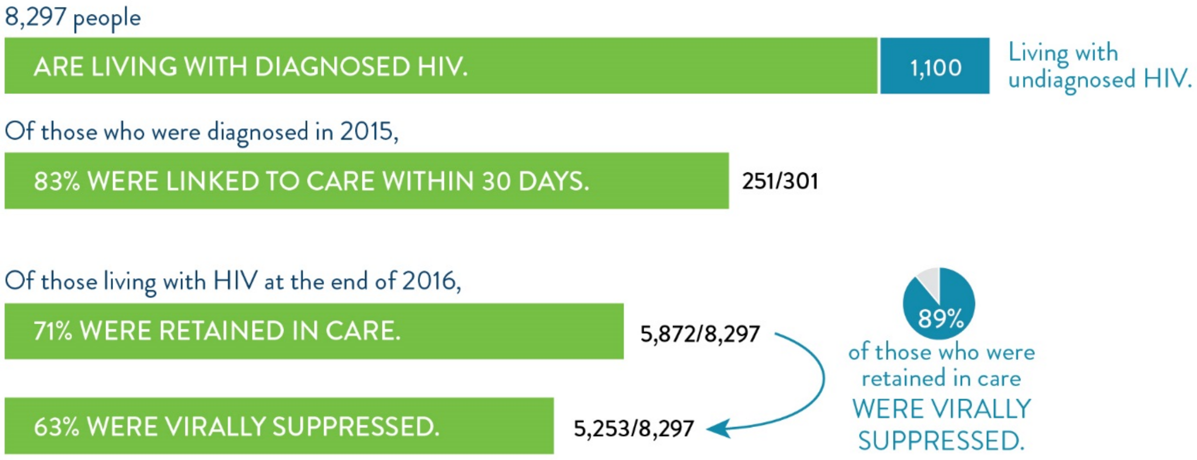
[d] Other includes multi-racial persons and persons with unknown race.

Continuum of care

The HIV continuum of care is a nationally recognized approach to illustrating the stages of HIV medical care for PLWH from initial diagnosis to viral load suppression[1] (Figure 3). Unlike other data in this section, the continuum of care statistics are from 2016 rather than 2017. The continuum of care tells us that:

- **9,397 people were living with HIV** at the end of 2016 including an estimated 1,100 people who were unaware of their status (undiagnosed).
- Of those newly diagnosed in 2015, **83% were linked to care**, meaning they visited a health care provider within 30 days of diagnosis.
- Of those living with diagnosed HIV at the end of 2016, **71% were retained in care**, meaning they had one or more CD4 or viral load test[2] conducted during 2016.
- Of those living with diagnosed HIV at the end of 2016, **63% were virally suppressed**.
- **89% of those retained in care were virally suppressed**.

Figure 3. HIV continuum of care in Minnesota, 2016



Source. Minnesota Department of Health, & Minnesota Department of Human Services. (2018). [Minnesota HIV Strategy (http://www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/reportfeb2018.pdf)](http://www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/reportfeb2018.pdf): A comprehensive plan to end HIV/AIDS.

---

[1] Viral load suppression is the goal of HIV treatment in which an HIV-positive individual achieves a very low or undetectable level of HIV in the body.

[2] CD4 is a blood test that measures how well the immune system is functioning for HIV-positive people and viral load test measures the amount of HIV virus in a person's body.

Minnesota HIV Strategy

Vision of the Minnesota HIV Strategy:

By 2025, Minnesota will be a state where new HIV diagnoses are rare and all people living with HIV and those at high risk of HIV infection will have access to high quality health care and resources they need to live long healthy lives, free from stigma and discrimination.

The Minnesota HIV Strategy provides a roadmap for coordinating efforts and resources to address HIV and move towards eliminating HIV/AIDS in Minnesota. MDH and DHS began developing the Minnesota HIV Strategy in 2016; it subsequently became mandated by legislation in 2017. The Minnesota HIV Strategy includes five goals, each of which is supported by sub-strategies (strategies) focused on how the goal will be achieved.

The goals and strategies are shown in Table 2. For more detail, please see the full Minnesota HIV Strategy (http://www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/reportfeb2018.pdf).

Table 2. Minnesota HIV Strategy: Goals and strategies

Goal	Strategies
Goal 1: Prevent New HIV Infections	**Strategy 1.1:** Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations. **Strategy 1.2:** Increase routine opt-out HIV testing and early intervention services. **Strategy 1.3:** Immediately link newly diagnosed individuals to person-centered HIV care and treatments. **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.
Goal 2: Reduce HIV-related Health Disparities and Promote Health Equity	**Strategy 2.1:** Protect and enhance advancements in health care policies, including Minnesota Health Care Programs expansion, coverage for people with pre-existing conditions, and access to preventative treatments without cost sharing. **Strategy 2.2:** Engage community leaders, non-profit agencies, people living with HIV (PLWH), and other community members to identify and to address barriers that prevent testing and person-centered care. **Strategy 2.3:** Dedicate adequate resources to populations of color hardest hit by HIV to eliminate health inequities. **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.

Table 2. Minnesota HIV Strategy: Goals and strategies (continued)

Goal	Strategy
Goal 3: Increase Retention in Care for People Living with HIV	**Strategy 3.1:** Employ high-impact public health approaches to identify and to re-engage individuals who are out of HIV care and treatment. **Strategy 3.2:** Ensure person-centered strategies that support long-term retention in care. **Strategy 3.3:** Provide culturally and linguistically appropriate services, as well as gender appropriate and sexual orientation appropriate services in clinical and/or community support settings. **Strategy 3.4:** Identify and reduce barriers to accessing mental health and substance use services and care. **Strategy 3.5:** Ensure access to services that meet the basic needs of PLWH.
Goal 4: Ensure Stable Housing for People Living with HIV and Those at High Risk for HIV Infection	**Strategy 4.1:** Identify gaps in affordable housing statewide. **Strategy 4.2:** Build partnerships that increase the supply of safe, affordable housing units for PLWH and those at high risk of HIV infection. **Strategy 4.3:** Ensure that PLWH and those at high risk of HIV infection have access to necessary supports that maintain their housing stability. **Strategy 4.4:** Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive services.
Goal 5: Achieve a More Coordinated Statewide Response to HIV	**Strategy 5.1:** Create a leadership structure that is held accountable for implementing and updating this strategy. This leadership structure will include key stakeholders that this strategy affects, such as government leadership, community-based organizations, PLWH, and Minnesota residents that the HIV epidemic hits hardest. **Strategy 5.2:** Integrate HIV prevention, care and treatment throughout all sectors of government (e.g., health, human services, education), health care systems, and social services. **Strategy 5.3:** Identify, research, and replicate new, effective interventions through partnerships between local public health and state governments, tribal nations, HIV providers, community-based and religious organizations, the University of Minnesota and other academic institutions, research partners, and others. **Strategy 5.4:** Establish policies that encourage an innovative culture and delivery of comprehensive statewide services. An innovative culture includes recognizing that prevention and treatment options evolve and leadership must be willing to respond to new technologies to reduce HIV burden. **Strategy 5.5:** Create effective information sharing partnerships and systems that produce reliable data and that inform decision-making, strategy development, and program accountability.

The Minnesota HIV Strategy's goals align with the stages of the continuum of care discussed earlier and support the achievement of four measurable outcomes mandated in the legislation. These outcomes include:

1. Increase the percentage of individuals living with HIV who know their serostatus[3] to at least 90 percent by 2025.
2. Increase the percentage of individuals diagnosed with HIV who are retained in care to at least 90 percent by 2025.
3. Increase the percentage of individuals diagnosed with HIV who are virally suppressed to at least 90 percent by 2025.
4. Reduce the annual number of new HIV diagnoses by at least 75 percent by 2035, with an interim outcome of reducing the annual number of new HIV diagnoses by at least 25 percent by 2025.

Data collection methods

In order to identify and prioritize tactics for implementing the Minnesota HIV Strategy, Wilder Research conducted a series of facilitated workshops around the state and also implemented a web-based survey. Both the workshops and the survey asked participants to identify the strategies of the Minnesota HIV Strategy that are most important to address in their community or region, then develop tactics for implementing them.

In total, 15 facilitated workshops were conducted around the state. Each facilitated workshop focused on a specific region of the state, to ensure geographic representation, or a high-risk community, to focus on populations experiencing the greatest disparities and need. Across all workshops, 224 people participated, though some individuals participated in multiple workshops so this total number includes some duplicates.

Two of the workshops were unique in their process and content. During the workshop focusing on the African-born community, participants called for a different process to share their feedback. Several participants did not feel that their communities were represented in the Minnesota HIV Strategy and were therefore uncomfortable using it as the starting place for the facilitated conversations. Instead, a set of small group conversations focused on the key concerns of

---

[3] Serostatus is the state of either having or not having detectable antibodies against a specific antigen, as measured by a blood test. For example, HIV seropositive means that a person has detectable HIV antibodies; HIV seronegative means that a person does not have detectable HIV antibodies.

participants and a follow-up meeting was held to review and confirm what was shared. The workshop focused on Native American communities took a different form in order to recognize and respect the sovereignty of tribal nations and because the state recognized a need to learn more about the needs and concerns of these communities before working to prioritize strategies and develop tactics that could meet their needs. Input captured during these two workshops is summarized separately from the other regional and community workshops.

Invitees who were unable to attend the workshops were invited to provide input through the web survey; 124 people completed the survey. Table 3 lists the regions and communities of focus as well as the number of individuals who participated in the workshop or completed the web survey for each.

Table 3. Workshop participants and survey respondents by community or region

	Workshop participants[a] N=224		Survey respondents[b] N=124	
High-risk communities	N	%	N	%
African American people	18	9%	19	15%
African-born people	19	10%	11	9%
Latinx people	13	7%	5	4%
Injection drug users	15	8%	8	6%
Men of color who have sex with men	10	5%	6	5%
Native Americans	24	12%	n/a[c]	
Transgender people	15	8%	2	2%
White men who have sex with men	10	5%	6	5%
Youth	15	8%	10	8%
Regions				
Central region	15	8%	13	10%
Northeast region	21	11%	10	8%
Northwest region	10	5%	15	12%
Southeast region	8	4%	6	5%
Southwest region	11	6%	14	11%
South central region	20	10%	10	8%
West central region	n/a[d]		18	15%

[a] Participants are counted multiple times if they participated in multiple workshops. Staff from MDH, DHS, and Wilder Research also attended each facilitated workshop to present data on HIV in Minnesota, describe the Minnesota HIV Strategy, facilitate activities, answer questions, and take notes during small group discussions. These staff are not included in the table.

[b] The sum of respondents by community and region does not equal the total number of respondents because people could complete the survey multiple times for different communities, yet they are only counted once in the total.

[c] No survey was conducted with a focus on Native Americans. The workshop focused on Native Americans used a different set of guiding questions that did not align with the survey questions.

[d] A workshop was scheduled to take place in Moorhead, Minnesota (the west central region) but was cancelled due to low registration.

Workshop participants most commonly identified as HIV services providers (32 percent), advocates for, or members of, high-risk populations (26 percent), and city or county public health or human services professionals (23 percent). Survey respondents most commonly identified as city or county public health or human services professionals (23 percent). Some individuals who participated in the workshops and who responded to the web survey identified as HIV-positive (9 percent and 4 percent, respectively).

Additional detail about the data collection processes, the workshop participants, and the survey respondents can be found in Appendix A.

Prioritized strategies

Strategies prioritized by workshop participants

The first step in each facilitated workshop was for participants to identify strategies of the overarching Minnesota HIV Strategy that are most important for ending HIV in the community or region of focus. There are 22 strategies contained in the overarching Minnesota HIV Strategy.

Participants worked in small groups to determine the four strategies that they felt were most important. The workshop facilitators did not specify a definition of "important," but instead offered some examples of what it could mean (e.g., the strategy would impact a very large number of people, the strategy would impact a very high-need group of people, the strategy addresses a very critical point of the continuum of care) and instructed participants to use whatever definition they saw fit.

Then, each small group presented their results to the full group. To bring the group to consensus around a set of high priority strategies, participants were given four votes to distribute across any of the strategies proposed by at least one group. The strategies with the largest number of votes advanced to the next stage of the workshop where participants brainstormed potential tactics. Note that the results of these activities, which are described in this section, do not include feedback captured during workshops focused on African-born or Native American communities as those used a different process. Additionally, the results do not include input for the west central region as that workshop was canceled due to low participation. Throughout this discussion, strategies that received the most votes and were focused on for developing tactics are referred to as prioritized strategies.

Table 4 shows the strategies that were most commonly prioritized in the 13 regional and community workshops that followed similar processes. The most commonly prioritized strategies included strategy 1.1, focused on increasing HIV education and awareness for all Minnesotans, and strategy 2.4, focused on reducing HIV-related stigma, systemic racism, and other forms of structural discrimination.

Table 4. Prioritized strategies from facilitated workshops (N=13)

Strategy	N	%
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	7	16%
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.	7	16%
Strategy 3.3: Provide culturally and linguistically appropriate services, as well as gender appropriate and sexual orientation appropriate services in clinical and/or community support settings.	5	11%
Strategy 4.4: Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive services.	5	11%
Strategy 5.2: Integrate HIV prevention, care and treatment throughout all sectors of government (e.g., health, human services, education), health care systems, and social services.	4	9%

Note. Strategies are only listed in this table if they were prioritized in at least four regional or community workshops. The complete frequency of the number of times each strategy was prioritized in a workshop is included in Appendix B.

Participants were invited to offer their rationale for prioritizing specific strategies. Some of the comments provided for the two most commonly selected strategies include:

Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations

> *The first step to creating change is increasing knowledge in the population.*
>
> *HIV has gone by the wayside—people don't talk about it as much. It has become a back-burner issue and needs to be talked about again.*
>
> *This is the first step toward any other strategy.*
>
> *There's no way to get rid of stigma without basic education for all.*

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.

> *Stigma is a big concern—[it] prevents testing and accessing care.*
>
> *Individuals in greater Minnesota still feel very stigmatized.*
>
> *The stigma is difficult in rural areas. [PLWH] are not able to get adequate care because of HIV-related stigma. It would take care of everything if this were addressed.*
>
> *Reducing stigma increases willingness to access services.*
>
> *Stigma isolates people.*
>
> *This is what stops people from getting care.*

Tables 5 and 6 show the strategies that were most commonly prioritized in the workshops focused on high-risk communities (held in the metro area) as compared to those focused on regions in greater Minnesota, respectively. Notably, strategy 2.4, which focuses on stigma, systemic racism, and structural discrimination, was prioritized in all of the metro-area workshops and strategy 1.1, which focuses on HIV education and awareness, was prioritized in all of the greater Minnesota workshops.

Table 5. Prioritized strategies from high-risk community workshops (N=7)

Strategy	N
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.	7
Strategy 3.3: Provide culturally and linguistically appropriate services, as well as gender appropriate and sexual orientation appropriate services in clinical and/or community support settings.	4
Strategy 4.4: Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive services.	4

Table 6. Prioritized strategies from greater Minnesota workshops (N=6)

Strategy	N
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	6
Strategy 5.2: Integrate HIV prevention, care and treatment throughout all sectors of government (e.g., health, human services, education), health care systems, and social services.	4

Note. Strategies are only listed in these tables if they were prioritized in at least four regional or community workshops. The complete frequency of the number of times each strategy was prioritized in a workshop is included in Appendix B.

Strategies prioritized by survey respondents

Survey respondents were asked to choose the three strategies they felt were most important for ending HIV in the community or region for which they were completing the survey. Similar to the workshops, respondents were not given a specific definition of “important,” but were instead offered some examples of what it could mean and instructed to define it however they saw fit. Unlike the workshop data presented earlier, which does not include prioritized strategies for the African-born community or west central region, the survey responses described here do include priorities offered from individuals on behalf of these populations. The survey data do not include responses on behalf of Native American communities because the survey did not align with the questions used in the talking circles.

Across all respondents, each of whom were able to select three strategies per community or region they responded about, the most commonly prioritized strategies are highlighted in Table 7. Notably, strategies 1.1 and 2.4 were also the two most commonly prioritized strategies across all of the workshops.

Table 7. Prioritized strategies from web survey (N=153)

Strategy	N	%
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	59	39%
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.	54	35%
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.	34	22%
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.	31	20%
Strategy 1.3: Immediately link newly diagnosed individuals to person-centered HIV care and treatments.	30	20%
Strategy 2.2: Engage community leaders, non-profit agencies, PLWH, and other community members to identify and to address barriers that prevent testing and person-centered care.	30	20%

Note. Strategies are only listed if they were prioritized by at least 30 respondents. Individual respondents could be counted multiple times if they prioritized the same strategy for multiple communities. The complete frequency of the number of times each strategy was prioritized by survey respondents is included in Appendix B.

Tactics

The second part of each facilitated workshop helped participants to identify tactics for their highest priority strategies (those that received the most votes).

Tactics brainstormed by workshop participants

First, participants worked in small groups, each focused on a specific high-priority strategy, to brainstorm tactics without concern for feasibility or cost. Across all of the workshops and all of the prioritized strategies, participants brainstormed 256 tactics. These tactics were coded to understand their key features and to assess any trends in the types of activities that participants identified. Across all of the tactics, the most common feature was to increase providers' understanding of or competency with HIV prevention, testing, or care (Table 8). This came up in 18 of the brainstormed tactics. Additionally, participants commonly thought of tactics involving easy to understand or targeted education or outreach and implementing messaging campaigns, PSAs, or ads to increase awareness or understanding about HIV.

Table 8. Features of all brainstormed tactics from workshops (N=256)

Tactic feature	N	%
Increase provider understanding or competency regarding HIV prevention, testing, or care.	18	7%
Easy to understand or targeted education or outreach.	17	7%
Messaging campaigns, PSAs, or ads to increase awareness or understanding about HIV.	17	7%
Increase provider understanding or competency regarding cultural or community needs or issues.	12	5%
Research or identify existing resources, curriculum, and/or organizations.	11	4%

Note. Features that were included in 10 or more tactics are listed.

Focusing on strategy 1.1, we see that the three most common features of brainstormed tactics mirror those seen across all tactics regardless of the strategy they were developed for, with the most common feature being to increase provider understanding and competency regarding HIV testing, prevention, and care (Table 9).

Table 9. Features of all tactics from workshops for Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations (N=52)

Tactic feature	N	%
Increase provider understanding or competency regarding HIV prevention, testing, or care.	8	15%
Easy to understand or targeted education or outreach.	7	13%
Messaging campaigns, PSAs, or ads to increase awareness or understanding about HIV.	7	13%
Education or outreach at educational institutions.	6	12%
Community education events, conferences, or classes.	4	8%
Statewide standards for sex education.	4	8%

Note. Features that were included in four or more tactics are listed.

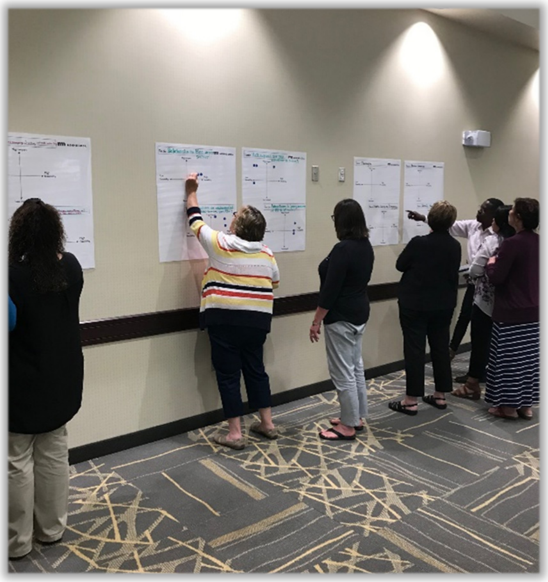
Across all brainstormed tactics for strategy 2.4, we see that the most common features were to implement messaging campaigns, PSAs, or ads to increase awareness or understanding about HIV, or recruit or hire community members as decision-makers, leaders, or liaisons for their communities (Table 10).

Table 10. Features of all tactics from workshops for 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 (N=41)

Tactic feature	N	%
Messaging campaigns, PSAs, or ads to increase awareness or understanding about HIV.	5	12%
Recruit or hire community members as decision-makers, leaders, or community liaisons.	4	10%
Change policies or laws.	3	7%
Increase provider understanding or competency regarding cultural or community needs or issues.	3	7%
Easy to understand or targeted education or outreach.	3	7%

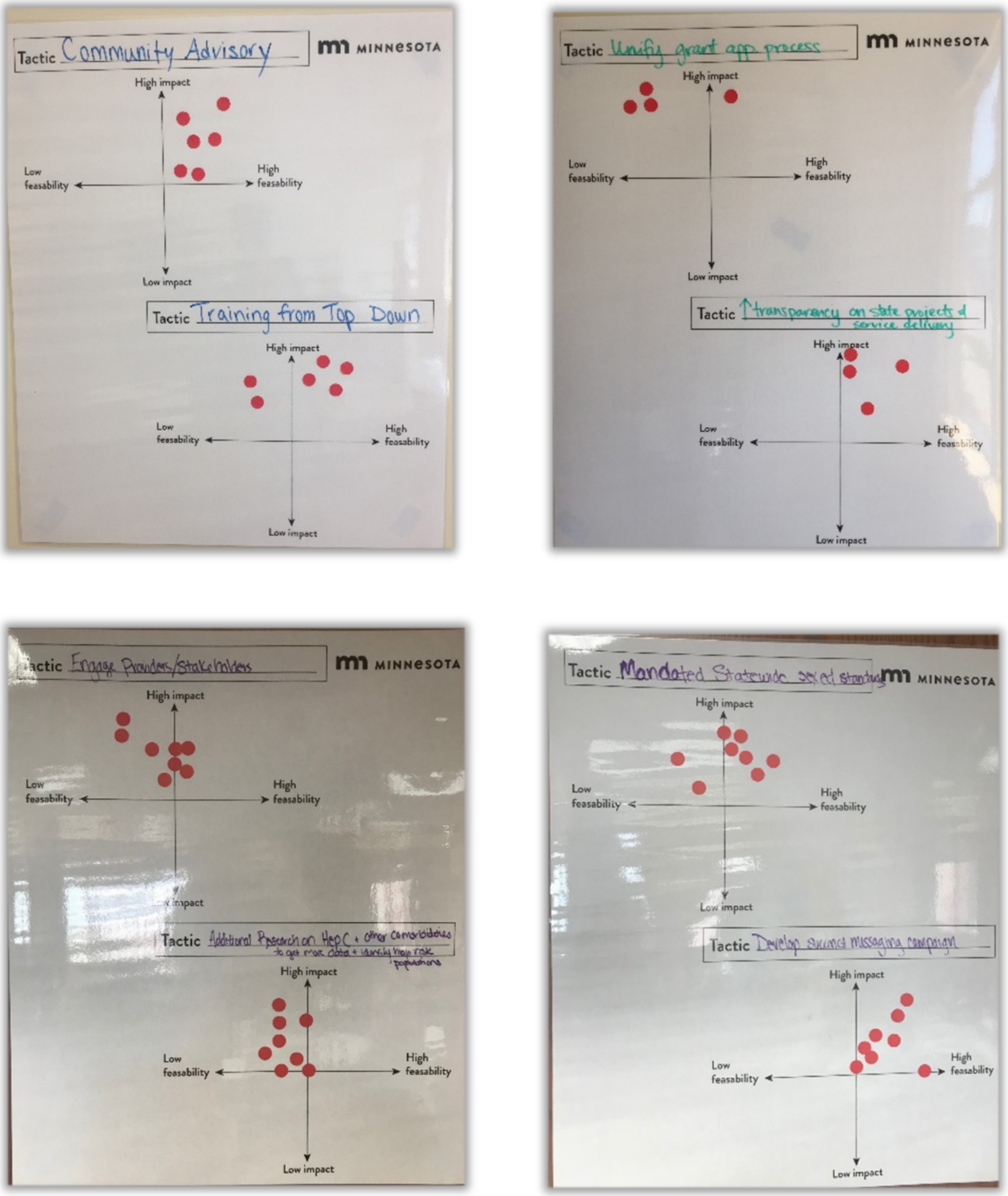
Note. Features that were included in three or more tactics are listed.

Tactics recommended by workshop participants



Next, workshop participants conducted a grid ranking activity in which they ranked their four most preferred tactics in terms of feasibility of implementation and level of impact. Figure 4 shows several examples of the completed grid ranking exercise. Each participant from each group was given one sticker per tactic and was instructed to place their sticker into the appropriate place within the grid based on whether they thought it would be highly feasible or less feasible (e.g., How many resources would be required? How much time would it take?) and the level of impact the tactic would have (e.g., How many people would this help? Would this help individuals with a high level of need?). For example, if a participant thought a tactic would be difficult to implement but doing so would have a high impact on the population in their region, they placed a sticker in the upper left quadrant.

Figure 4. Grid ranking examples



After conducting the grid ranking exercise, participants discussed the trends in their responses and then each small group selected their top two recommended tactics for implementation. Across all regional and community workshops, 83 tactics were recommended for implementation. The most common features of these tactics included:

- Developing provider networks to support person-centered care or warm referrals (6 percent)
- Offering easy to understand or targeted education or outreach (6 percent)
- Implementing messaging campaigns, PSAs, or ads to increase awareness and understanding of HIV (6 percent)

Tables 11 and 12 show the features of the tactics that were recommended for the most commonly prioritized strategies. To increase HIV education and awareness, participants most commonly recommended implementing messaging campaigns, PSAs, or ads. To reduce HIV-related stigma, systemic racism, and other forms of structural discrimination, participants most commonly recommended changing policies, such as decriminalizing possession of syringes and changing HIV disclosure laws, and recruiting or hiring community members as decision-makers, leaders, or community liaisons.

Table 11. Features of tactics recommended in workshops for Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations (N=14)

Tactic feature	N	%
Messaging campaigns, PSAs, or ads to increase awareness or understanding about HIV.	4	29%
Easy to understand or targeted education or outreach.	3	21%
Community education events, conferences, or classes.	2	14%
Statewide standards for sex education.	2	14%
Education or outreach at educational institutions.	2	14%

Note. Features that were included in two or more tactics are listed.

Table 12. Features of tactics recommended in workshops for 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 (N=12)

Tactic feature	N	%
Change policies or laws.	2	17%
Recruit or hire community members as decision-makers, leaders, or community liaisons.	2	17%

Note. Features that were included in two or more tactics are listed.

Barriers

For each of their recommended tactics, workshop participants were invited to document any barriers that might impede implementation of the tactic. The barriers they listed were coded to identify themes. The most commonly identified barrier, across all strategies and tactics, was funding, money, or challenges with funders (Table 13). This was identified as a barrier for 56 percent of the recommended tactics.

Table 13. Barriers identified in workshops (N=80)

Barrier	N	%
Funding or money	45	56%
Lack of expertise, understanding, or education	17	21%
Challenges with appropriate implementation of tactic	16	20%
Time	14	18%
Provider or organization interest, buy in, or energy	14	18%
Policies, rules, or laws	13	16%

Note. Barriers that were identified for 13 or more tactics are listed.

Tactics recommended by survey respondents

Web survey respondents were also invited to identify a tactic they would recommend implementing for their prioritized strategies. Tables 14 and 15 show the most common features of the tactics for the two most commonly prioritized strategies. Similar to the types of tactics recommended for strategy 1.1 among workshop participants, we see that a common recommendation is to implement messaging campaigns, PSAs, or ads to increase awareness or understanding of HIV (24 percent). For strategy 1.4, the most commonly mentioned feature of the tactics was to expand or improve access to syringe services programs (26 percent).

Table 14. Features of tactics from web survey for Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations. (N=34)

Tactic feature	N	%
Messaging campaigns, PSAs, or ads to increase awareness or understanding about HIV.	8	24%
Continuing education, conferences, or other professional development for providers.	6	18%
Community education events, conferences, or classes.	6	18%
Education or outreach at educational institutions.	6	18%
Easy to understand or targeted education or outreach.	5	15%

Note. Features that were included in five or more tactics are listed.

Table 15. Features of tactics from web survey for 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. (N=27)

Tactic feature	N	%
Expand or improve access to syringe services programs	7	26%
Expand or modify insurance coverage or benefits	4	15%
Expand community-based service provision	4	15%
Easy to understand or targeted education or outreach	4	15%

Note. Features that were included in four or more tactics are listed.

Barriers

Web survey respondents were also asked to identify any barriers that might impede the implementation of their recommended tactics. Similar to barriers identified by workshop participants, the most commonly anticipated barrier across all tactics was funding or money (68 percent) (Table 16). Limited staff time or capacity was also noted as a barrier for 43 percent of the recommended tactics. It is important to note that unlike the workshop participants, survey participants were offered a list of barriers to select from along with an “other, specify” option.

Table 16. Barriers identified by survey respondents (N=227)

Barrier	N	%
Funding or money	155	68%
Limited staff time or capacity	97	43%
Limited buy-in from key stakeholders	82	36%
Lack of specific expertise	64	28%
Legal or political challenges	58	26%

Feedback from the African-born workshop

Overarching themes

As previously mentioned, due to participant concerns, the African-born workshop followed a different process than the other workshops and included a subsequent follow-up meeting. While the specific suggestions regarding communication, goals and strategies, and next steps are described in the sections below, several overarching themes emerged across the workshop and follow-up meeting, and were echoed in the web survey. These themes apply to multiple aspects of the Minnesota HIV Strategy and work to end HIV moving forward. These include:

- Authentic engagement with African communities is essential, acknowledging that different communities have different needs, and allowing for multi-directional communication and partnership-building, face-to-face interactions, and ongoing mutual accountability.
- Processes need to be community-driven, community-led, and culturally responsive, engaging community leaders (including faith leaders), existing networks, and community organizations to work toward ending HIV.
- Funding in the African-born community needs to be consistent and ongoing, with an emphasis on making funding and capacity building support accessible to organizations who are already doing this work.
- Stigma is a large barrier in this community, and there is a need for community-driven education and awareness around this issue.

Workshop process

At the beginning of the workshop, participants raised concerns and questions about the workshop's processes and their involvement. Their concerns included:

- Previous community engagement efforts from MDH and DHS were not inclusive of African populations. In particular, participants noted that the Liberian community, one of the largest African populations in Minnesota, was not engaged in the process. In addition, participants pointed out that there is no such thing as one "African-born" community, as each community has its own leadership and communication structures.
- This lack of engagement made it feel as though the Minnesota HIV Strategy was being *done to* the African community, rather than being *done in collaboration with* the community.
- Participants expressed discomfort with repeated requests for information from the community without seeing tangible outcomes or benefits for the community. In particular, participants noted that their communities have had negative experiences with MDH and DHS in this regard.
- Traditional methods of communication from MDH and DHS were ineffective for African-born refugees who cannot read or write, further excluding these portions of the population.
- The HIV Care Continuum data for African-born residents was outdated.

After hearing these concerns, the facilitators decided to deviate from the planned process and capture feedback from participants in a way that was comfortable for them. Ultimately, workshop participants agreed to break into smaller groups to comment on the current Minnesota HIV Strategy and make suggestions to help the Minnesota HIV Strategy better conform to the needs of the African communities that participants represented. In addition, MDH, DHS, and Wilder Research held a follow-up meeting with participants on June 27, 2018 to review what was heard during the initial workshop and invite feedback to ensure their input was accurately captured and described. Web survey feedback from this community was included in the overall web survey analysis.

Suggestions for connection between African-born communities and the state

To address some of their concerns, participants offered suggestions for ways for the state to connect with African-born populations. These include:

- Create opportunities for authentic engagement with African communities. This begins by acknowledging that these communities are not "one size fits all," and that engagement looks different for different tribes. Suggestions for engagement focused primarily on face-to-face dialogue–rather than email and phone—such as focus groups, making connections through community leaders (tribal leadership, religious leaders, etc.), and attending existing meetings or celebrations. Create and grow true relationships and partnerships with the community.
- Acknowledge that African communities have existing infrastructure (for example, tribal groups, women's groups, youth groups) that can and should be used to do this work, rather than developing new groups or using intermediaries.
- Keep the engagement and momentum going by providing sustainable and ongoing resources (funding and staff time). There had been funding, training, and momentum in the past, but policies and funding shifted away from that, disrupting momentum and awareness of HIV.
- Strategies and tactics should be determined by the African community, as they are one of the populations most heavily impacted by HIV/AIDS. The community should be able to drive the process.
- All strategies and tactics should address social determinants of health, which operate differently in African communities than in American or majority communities. African communities have specific social and cultural contexts that need to be addressed throughout the process. It is important to remember that these contexts vary by tribe, geographic community, etc.
- Create conditions for mutual accountability between the state and communities. Acknowledge that this effort is happening in part because the solutions presented to date have not been effective. Work with communities to establish what accountability looks like for the state and for the community.

Feedback on Minnesota HIV Strategy

Feedback from participants on specific goals and strategies included in the Minnesota HIV Strategy is summarized below. This summary only includes the goals and strategies that were brought up by participants during the workshop.

Goal 1: Prevent new HIV infections

Strategy 1.1: *Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.*

- The focus should be on high-risk populations—list this group first in the wording of strategy 1.1.
- Simplify data for people to understand and communicate easily, particularly if they are not as highly educated or don't know the specialized vocabulary/jargon. For example, instead of saying "50 percent," say "1 of every 2 people in this population are affected." Visualize the data with infographics.
- Employ Africans, both within state agencies and in outside capacities, to do the work as instructors; they can blend these educational activities into existing community events.
- Educate community leaders (including faith leaders) on HIV and HIV resources, and then utilize them and existing structures to deliver educational messages to the community. Support this work with funding.
- Diversify educational strategies like combining community leader engagement with social media and community-specific media outlets to deliver messages.
- Provide training for culturally responsive education. For example, for African women, ask them what culturally specific sex/HIV education should look like.
- Education will look different for different African communities.

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.*

- Provide incentives for interventions. For example, provide incentives for every individual tested or provide incentives in more creative ways to save money (raffling, etc.).
- Give resources (particularly funding) to sustain the strategy and the work done in communities.
- Purposefully involve different African communities to lead and do the work for themselves, rather than collecting them into one centralized African organization or entity.
    - Encourage money for implementation within existing initiatives and programming. For example, do not give money for new staff or new rent for a new initiative.
    - Understand that networks already exist within and among African communities—use these networks to do work collaboratively.

Goal 2: Reduce HIV-related health disparities and promote health equity

Strategy 2.2: *Engage community leaders, non-profit agencies, people living with HIV, and other community members to identify and to address barriers that prevent testing and person-centered care.*

- Include and involve faith-based leaders (imams, pastors, etc.), as these leaders are trusted within African communities.
- Support existing structures of leadership and community engagement to find champions within African communities. In addition to faith-based leaders, this includes tribal leaders, women's group leaders, youth group leaders, etc.
- Use grassroots and informal networks to deliver messages as well.

Strategy 2.3: *Dedicate adequate resources to populations of color hardest hit by HIV to eliminate health inequities.*

- Clarify that the primary resource needed is funding: African communities in Minnesota have networks and infrastructure with willing staff to carry out the work, but they need adequate funding to do so.
- Focus on sustainability of these resources; provide ongoing support to sustain momentum, not just build it.
- Dedicate these resources directly to community and organizations within the community, not to intermediary organizations who may then subcontract with community organizations. Acknowledge that there is inherited mistrust of mainstream/intermediary organizations due to the disruption of work that was already being done within African communities.
- Provide capacity building and technical assistance for smaller organizations to grow and better qualify for state funding. Allow smaller organizations to focus on the community-based work while, for example, partnering with a larger organization that can handle tasks such as accounting or administrative work.
- Move away from competitive grant-making processes as these are too complex and prohibitive for smaller organizations. Grant-funding models also pose other challenges in their selection and implementation (e.g., needing to have "evidence-based" approaches that may not work in African communities, proposals for funding graded on writing, grant funding runs out). Consider a cohort model of organizations to create a common agenda with MDH/DHS and have mutual accountability.

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.*

- Stigma is a major factor/barrier to accessing HIV education, care, and prevention. Addressing stigma is the most important factor in the ongoing work. Create urgency in and by the community to bring the issue into focus and reduce stigma.
- Any tactics to address stigma and structural discrimination/systemic racism need to be culturally responsive and community driven—people will listen to those whom they trust.
- Reduce stigma by integrating HIV services with other health services. For example, by providing HIV testing at a “health fair event” with multiple types of testing (blood pressure, blood sugar, etc.), or by providing access to PrEP at the community pharmacy. In both instances, people are able to avoid outing themselves for “going to the [HIV] clinic” or specifically getting HIV testing.
- African-born residents need different strategies than Africans born in the U.S.; strategies need to address continual influx and learning of new people coming from movement back and forth between the U.S./Minnesota and Africa.
- Address care and prevention for undocumented citizens.
- Address the generational nature of the disparities that exist; this includes educational restrictions on who can do the work (for example, requiring a master’s degree for certain positions).

Goal 4: Ensure stable housing for people living with HIV and those at high risk for HIV infection

- Provide subsidies for existing housing (e.g., rent vouchers and transportation supports) so that people can live near their existing communities and where they work; make it a priority to keep families and communities together.

Priorities and approaches for communication

During the follow-up meeting, MDH, DHS, and Wilder sought recommendations about high-priority next steps as well as guidance on the best way to communicate with African-born community leaders and members about next steps and progress on the Minnesota HIV Strategy. Those recommendations are listed below.

High-priority next steps

- Prioritize providing funding and other support to African communities that have the highest incidence and prevalence of HIV here in Minnesota.
- Prioritize reaching out to the “gatekeepers” or champions within the community, such as faith-based leaders and formal and informal group leaders who are committed to their communities and the work of ending HIV/AIDS.
- Prioritize community education with simplified data, working with and providing training and funding support to the community to do this.
- Prioritize providing organizations and leaders within the community with ongoing support and capacity building in order to promote sustainability. Organizations and leaders within the community should be charged with leading the work of ending HIV/AIDS within their community.
- Prioritize working with community to build an idea of what success in this work looks like within the community. Do this instead of imposing benchmarks or guidelines of what success looks like from the state/institutional perspective.

How to communicate with African communities, and vice versa

- Participants expressed a specific desire for this communication to be bi-directional. MDH and DHS should not just communicate with communities, but communities should be able to initiate contact and communication with the state as well. Ensure that there is mutual accountability.
- Begin by bringing leaders from the most impacted African communities and state staff together for face-to-face dialogue.
- Ensure continuity across contact and engagement; in the words of one participant, "It needs to be a continued, ongoing relationship. We can't just jump in and jump out."

HIV in Native American communities

During the talking circles focused on Native American communities, participants discussed their thoughts and concerns about HIV in their communities, the greatest needs and barriers related to ending HIV, and ways that state agencies could support existing or future efforts to end HIV in Native American communities.

When asked about their thoughts or concerns related to HIV in Native communities, key themes were related to the stigma associated with having a positive HIV/AIDS status and a shortage of services and resources for those who are infected or are at risk of infection.

- **Stigma.** Participants in the talking circles described many different types of stigma associated with an HIV/AIDS diagnosis. Stereotypes and stigma are common, particularly related to: injection drug use; opioid addiction; lesbian, gay, bisexual, transgender, and queer (LGBTQ) identities; and cultural beliefs (e.g., anti-Planned Parenthood sentiment in Fargo/ Moorhead). The lack of anonymity in a small, closely-knit community, such as White Earth, makes it difficult for people to be tested or seek services for fear of stigmatization and isolation from their community. In addition to stigma, there is a misperception that HIV/AIDS is a "white man's disease" and is not seen as a disease that impacts Native populations. Lastly, the cultural taboo around discussing sex and sexuality make it difficult to address HIV/AIDS as an issue in Native communities.
- **Lack of services and resources.** Participants described a general lack of providers of HIV/AIDS services and treatment in Native American communities. Furthermore, providers that are located in Native American communities often lack knowledge and information about PrEP and other treatments. There are also limited HIV services, treatment options, and resources in general (e.g., access to PrEP, Narcan, 24-hour access to syringes) and, in particular, there is a lack of appropriate health care for transgender individuals.

Needs of Native American communities

Talking circle participants were asked to describe what would be most needed to end HIV in Native communities. Major themes from their conversations include: education, adequate health care services, competent providers, basic needs such as housing and transportation, and outreach to increase HIV awareness and promote service utilization.

- **Education**. Participants felt that there is a need in Native American communities for early sex education and general health education. Some specific strategies or platforms for sharing information that were suggested include risk reduction programs, counseling services, community forums, educational materials, including basic life skills or strategies throughout education, having drug use educators in schools, and providing effective trainings to address issues related to HIV/AIDS.
- **Adequate health care services**. Health care services need to be offered in a comfortable setting for people living with HIV/AIDS and those at risk for HIV. Convenient clinic hours are important to reduce barriers to accessing services (e.g., open on nights and weekends) and clinics should offer more information on services that are provided. In addition to decreasing these types of barriers, participants talked about the need for culturally appropriate services and for a structural change in the health care system to allow for more time between health care professionals and patients during a medical visit. Lastly, STD testing needs to be normalized and co-occurring issues, such as mental illness, substance abuse, and homelessness, need to be addressed in tandem with HIV prevention, diagnosis, and treatment.
- **Competent providers**. There is a need for providers who are comfortable discussing HIV/AIDS and sexual health. Additionally, there needs to be trust-building between providers and PLWH. PLWH should not be afraid to visit a health care provider for fear of blame or criticism (e.g., for failing to adhere to medication). One group talked about how there needs to be better treatment of patients in general.
- **Basic needs**. There is a need for housing, specifically nurse-staffed apartments for PLWH. Transportation to services, and in particular, access to medical transportation is also needed in rural Native communities.
- **Outreach.** There is a need for culturally specific communication and media strategies to increase awareness, communicate information, and share positive stories from PLWH. Strategies to promote health care services are also needed. Some strategies discussed include implementing universal screening, holding HIV/AIDS testing events, and using HIV rapid test kits. Participants also felt that people would benefit from less wait time between medical appointments and targeted outreach on reservations. Lastly, because of the associated stigma, it’s important that HIV services not be targeted towards people in a way that would indicate that they have a positive status.
- **Data.** When discussing both their concerns about HIV in Native American communities and what is needed to address it, participants discussed the data about incidence and prevalence of HIV in their communities. They expressed concern that the data was inaccurate or incomplete (e.g., data under counted HIV cases) and did not reflect the reality of HIV/AIDS in Native American communities. The fidelity with which the data is being collected and reported to the state was of concern. They noted that accurate data was needed to make progress on ending HIV in Native communities.

Barriers

Talking circle participants identified two key barriers Native American communities are facing to address HIV/AIDS: inadequate health care services and a shortage of funding and resources.

- **Inadequate health care services**. Participants shared that key barriers to addressing HIV/AIDS in their communities include frequent provider turnover and a lack of cultural competence among providers. Additionally, there is a lack of providers who belong to the LGBTQ community, which is a hindrance for some who would like to seek health care services, but do not feel comfortable because they don't have a provider they feel can relate to them.
- **Inadequate funding/resources**. Participants said that there is a lack of funding due to low numbers of those infected with HIV/AIDS in Native American communities and that resources that do exist are largely for testing rather than treatment. Specifically, it was noted that Indian Health Services is underfunded and that decisions about funding are made at the federal level, rather than the tribal level. In general, there is not enough time nor resources allocated to the topic of HIV/AIDS in Native American communities.

Suggestions for how the state can support efforts

When discussing how state agencies can support efforts to end HIV/AIDS in Native American communities, participants mentioned that, in general, there needs to be more dedication and commitment from state government on the topic of HIV/AIDS in Native American communities. Additionally, they commonly spoke about changing available funding and resources, collaboration with other state agencies and with smaller organizations, and improving sex education.

- **Funding and resources.** Participants indicated that the state should provide more funding in general and also work to maximize available resources. Specific funding needs included funding for a teen clinic, day care services for women with children, and disposable needle drop boxes (in public bathrooms, government centers, parks). There is also a need for support for newer and smaller organizations. Specifically, grant applications should be easier and more accessible to people without grant writing experience. Tribal nations could also use help leveraging national funds, such as from the Substance Abuse and Mental Health Services Administration (SAMHSA), for harm reduction and syringe exchange, in addition to treatment and overdose prevention.
- **Collaboration.** Participants said that more collaboration between state agencies and tribes would be beneficial to efforts in tribal nations around HIV/AIDS. It was specifically noted that the state could be instrumental in assisting tribes to identify how HIV testing data is being collected in clinics on reservations. Additionally, one group thought it would be supportive to have state agencies willing to partner and collaborate with smaller organizations.
- **Education.** There is a need for support to improve sex education to be more comprehensive and to increase condom availability.

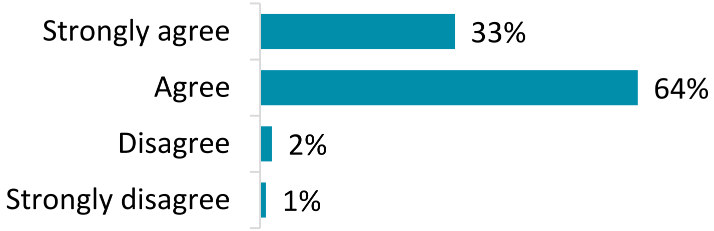
Participant reflections

At the end of each facilitated workshop, participants were invited to complete an evaluation questionnaire that asked for their feedback on several elements of the workshop. A total of 159 evaluations were completed, though some individuals may have completed multiple if they participated in multiple workshops. In general, participants provided positive feedback about the workshops.

Confidence in tactics

Most of the participants (97 percent) felt confident that the tactics they developed would help to end HIV/AIDS in their community or region of interest (Figure 5).

Figure 5. Workshop evaluation: I am confident that the tactics we developed will help to end HIV/AIDS for our community or region of interest. (N=131)

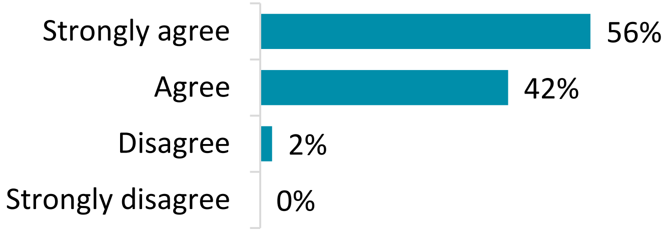


Note. This question was only included in the evaluation at 11 of the 13 workshops.

Feedback on workshops

Participants overwhelmingly felt the workshop was a good use of time for them (98 percent), with the majority of participants (56 percent) strongly agreeing that it was (Figure 6).

Figure 6. Workshop evaluation: Overall, today was a good use of time for me. (N=156)



When asked about the most valuable component of the workshop, participants most commonly indicated brainstorming or sharing common interests, concerns, or strategies and networking or meeting new people (Table 17).

Table 17. Workshop evaluation: What was the most valuable component of today's meeting? (N=137)

Meeting component	N	%
Brainstorming or sharing common interests, concerns, or strategies	32	23%
Networking or meeting new people	28	20%
Small group discussions (general)	24	18%
Learning more about the Minnesota HIV Strategy or status of HIV/AIDS in Minnesota	20	15%
Regional or community interaction, collaboration, or partnerships	16	12%

When asked about what was missing from the workshop, participants most commonly indicated that a specific type of participant, such as additional community members, medical providers and health professionals, and others stakeholders, was missing (41 percent of 98 responses). Many respondents, however, said that nothing was missing (17 percent). Ten percent of respondents wanted more data, community-specific data, or further disaggregated data.

Next steps

Using the information from this report, as well as summaries of the detailed input provided for each region and community, 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.

At the end of the workshop and survey, participants were able to sign up to stay involved with, or support future work on, their recommended tactics if they are selected for the Minnesota HIV Strategy. Participants were also able to indicate other organizations or individuals who were unable to attend but should be included if the tactic moves forward. MDH and DHS will reach out to these individuals to request further input on or assistance with the tactic, as appropriate.

Lastly, workshop participants were encouraged to stay in touch with individuals they met during the workshop. They were invited to move forward with any promising tactics they identified that could be implemented with existing resources.

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.

Appendices

Appendix A: Details about the data collection methods

Facilitated workshops

Each facilitated workshop focused on a specific region of the state, to ensure geographic representation, or a high-risk community, to focus on populations experiencing the greatest disparities and need. In total, 15 workshops were conducted. Table A1 lists the regions and communities for the workshops as well as the date and location of each.

Each workshop was intended to include participants with knowledge, connections, and insights about challenges to and opportunities for ending HIV/AIDS. The goal was to have a broad array of perspectives. MDH identified the initial lists of invitees by accessing information on organization websites and by seeking recommendations from colleagues such as DHS staff, the Minnesota HIV Strategy Advisory Board, field epidemiologists, and public health nurses. The invitation list expanded as, for example, providers distributed the invitations to their networks. A unique invitation list was developed for each regional workshop, while a combined invitation list was developed for all of the workshops focused on high-risk communities held in the metro area. Individuals on the latter list were able to opt in to multiple workshops based on the communities for which they had particular interest or expertise.

Table A1 shows the number of participants at each workshop. Across all workshops, 224 people participated, though some individuals did participate in multiple workshops so this total number includes some duplicates. The number of participants in each workshop ranged from 8 to 24.

Table A1. Facilitated workshop populations of focus, participants, locations, and dates

Workshop region or community	Workshop participants[a] N=224		Location	Date
	N	%		
High-risk communities				
African American people	18	9%	Minneapolis, MN	May 24, 2018
African-born people	19	10%	Minneapolis, MN	April 26, 2018
Latinx people	13	7%	St. Paul, MN	May 10, 2018
Injection drug users	15	8%	Minneapolis, MN	May 29, 2018
MSM of color	10	5%	Minneapolis, MN	May 3, 2018
Native Americans	24	12%	White Earth Reservation (Mahnomen, MN)	April 30, 2018
Transgender people	15	8%	Minneapolis, MN	May 16, 2018
White MSM	10	5%	St. Paul, MN	May 17, 2018
Youth	15	8%	Minneapolis, MN	April 19, 2018
Regions				
Central region	15	8%	St. Cloud, MN	May 22, 2018
Northeast region	21	11%	Duluth, MN	May 7, 2018
Northwest region	10	5%	Bemidji, MN	May 23, 2018
Southeast region	8	4%	Rochester, MN	May 14, 2018
Southwest region	11	6%	Worthington, MN	June 6, 2018
South central region	20	10%	Mankato, MN	May 31, 2018
West central region	n/a[b]			

[a] Participants are counted multiple times if they participated in multiple workshops. Staff from MDH, DHS, and Wilder Research also attended each facilitated workshop to present data on HIV in Minnesota, describe the Minnesota HIV Strategy, facilitate activities, answer questions, and take notes during small group discussions. These staff are not included in the table.

[b] A workshop was scheduled to take place in Moorhead, Minnesota (the west central region) but was cancelled due to low registration.

Table A2 displays the self-identified roles or areas of work that the workshop participants provided during pre-registration. Each participant could select multiple roles. The greatest share of participants identified as HIV services providers (32 percent). Many participants also identified as advocates for, or members of, high-risk populations (26 percent) and city or county public health or human services professionals (23 percent).

Table A2. Role or area of work identified by workshop participants (N=200)

Role/area of work	N	%
Advocate for, or member of, high-risk population[a]	51	26%
Chemical dependency provider	8	4%
City or county public health or human services professional	45	23%
HIV services provider	64	32%
Medical provider	13	7%
Mental health provider	13	7%
Social service provider	38	19%
Youth advocate/youth worker	13	7%
Other	40	20%
Unspecified or not pre-registered	27	14%

Note. Participants could select multiple roles. Participants are counted multiple times if they participated in multiple workshops. Staff from MDH, DHS, and Wilder Research also attended each facilitated workshop to present data on HIV in Minnesota, describe the Minnesota HIV Strategy, facilitate activities, answer questions, and take notes during small group discussions. These staff are not included in the table. The 24 participants of the workshop focused on Native Americans are not included here because pre-registration was not conducted for this workshop.

[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.

An anonymous feedback questionnaire was offered at the end of each workshop. This also included questions about HIV status and demographics. According to this questionnaire, 9 percent of participants identified as HIV-positive (Figure A1). The majority of participants identified as white or Caucasian (Table A3). Eighteen percent of participants identified as black or African American and 8 percent identified as Hispanic or Latinx.

Figure A1. HIV Status of workshop participants (N=159)

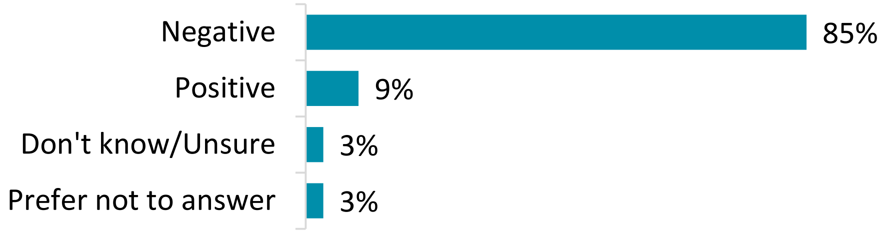


Table A3. Race/ethnicity of workshop participants (N=159)

Race/ethnicity	N	%
African born	8	5%
American Indian	6	4%
Asian, including Southeast Asian and Pacific Islanders	5	3%
Black or African American	29	18%
Hispanic or Latinx	12	8%
White or Caucasian	109	69%
Another race or ethnic group	1	1%
Prefer not to answer	0	0%

Note. Respondents were able to select multiple races or ethnicities.

Workshop process

Wilder Research staff facilitated and managed the logistics for each of the workshops with support from MDH and DHS staff. Each workshop began with a presentation by MDH and DHS about the incidence (number of new cases) and prevalence (number of new and existing cases) of HIV in Minnesota, a description of the Minnesota HIV Strategy, and a review of themes identified during a needs assessment MDH conducted in 2017. The remainder of the workshop consisted of facilitated activities, led by Wilder Research, which helped participants to:

- Prioritize strategies that are most important for ending HIV/AIDS in their region or community
- Develop tactics that would support implementation of high priority strategies

Throughout the workshop, note-takers documented participants' insights and ideas. At the end of each workshop, MDH and DHS offered closing remarks and participants were invited to complete an evaluation questionnaire about the workshop.

Two of the workshops had a different process. The workshop focusing on African-born communities also followed a different process in response to concerns and questions raised by the participants during the beginning of the workshop. Participants expressed discomfort in proceeding with the facilitated process as planned—many participants did not feel that their communities were represented in the Minnesota HIV Strategy and were therefore uncomfortable using it as the starting place for the facilitated conversations. Instead, participants engaged in a set of small group conversations to further share their concerns, provide feedback on elements of the Minnesota HIV Strategy, and offer suggestions about how state agencies could better engage with African communities. A follow-up meeting was also held with participants from the workshop to review what was captured and ensure that it accurately reflected their input. Participants were also invited to identify high priority next steps and recommend approaches for communication between African communities and state agencies. Feedback captured during this workshop, and the follow-up meeting, is summarized separately from the other regional and community workshops to honor the concerns expressed by participants about the Minnesota HIV Strategy and to reflect the different process through which they shared input.

The workshop focusing on Native American communities was conducted as a series of talking circles, held in conjunction with the annual White Earth Harm Reduction Summit. Outreach before and during the conference was conducted by MDH to invite individuals who are tribal leaders, providers who work with Native Americans, and members of Native American communities. A different process was used for this workshop for a couple of reasons. First, the process was designed to recognize and respect the sovereignty of tribal nations and to support initial conversations about how state agencies could support or collaborate with tribal nations and Native American communities to end HIV. Additionally, limited feedback had been received from Native American community members during the earlier needs assessment process that informed the development of the Minnesota HIV Strategy. As such, the conversation needed to focus more on the needs and barriers faced in their communities before focus could be shifted to appropriate tactics for ending HIV in their communities.

Workshop participants included individuals who identify as Native Americans, medical providers, and advocates for or members of high-risk populations. Participants also included at least one person identifying as each of the following: faith or spiritual leader, chemical dependency provider, youth worker, and city or county human services or public health official. Additionally, one elected tribal official participated. Feedback captured during this workshop is summarized separately from the other regional and community workshops because it is based on a different set of guiding questions.

Web-based survey

Individuals who were unable to participate in the in-person workshops were able to contribute via a web-based survey. Similar to the workshops, the survey collected information about high-priority strategies for each region of the state and several high-risk communities. It also asked for recommended tactics to implement the high priority strategies as well as barriers to implementing the tactics and potential resources that could support implementation.

Respondents

An invitation to take the web survey was sent to all individuals who were invited to participate in the workshops but did not attend. Twin Cities metropolitan-area invitees were invited to complete the survey for any of the high-risk communities that they had interest and expertise in but for which they didn't participate in the workshop. Similar to the workshops, individuals were able to provide feedback for as many or as few of the communities they wanted as long as they had not already participated in the workshop. A total of 124 people took the survey, some of which completed the survey for multiple high-risk communities of interest. Table A4 shows the number of survey respondents for each region and high-risk community. The number of respondents for each community ranged from 2 to 19.

Table A4. Survey respondents by community and region (N=124)

Workshop community or region	N	%
High-risk communities		
African American people	19	15%
African-born people	11	9%
Latinx people	5	4%
Injection drug users	8	6%
MSM of color	6	5%
Transgender people	2	2%
White MSM	6	5%
Youth	10	8%
Regions		
Central region	13	10%
Northeast region	10	8%
Northwest region	15	12%
Southeast region	6	5%
Southwest region	14	11%
South central region	10	8%
West central region	18	15%

Note. The sum of respondents by community and region does not equal the total number of respondents because people could complete the survey multiple times for different communities. Some individuals completed the survey for a high-risk community even though they attended the workshop – these individual’s responses are not included in this table or in the report because their feedback was already captured during the workshop. No survey was conducted with a focus on Native Americans because earlier-stage input from tribal nations and Native Americans was needed before tactics could be developed.

Table A5 shows the roles or areas of work identified by survey respondents; respondents were allowed to select as many roles as applied. Among respondents who identified their roles or areas of work, the largest share identified as city or county public health or human services professionals (23 percent).

Table A5. Roles or areas of work identified by survey respondents (N=124)

Role/area of work	N	%
Advocate for, or member of, high-risk population[a]	10	8%
Chemical dependency provider	2	2%
City or county public health or human services professional	28	23%
Faith leader	2	2%
HIV services provider	5	4%
Housing provider	3	2%
Medical provider	10	8%
Mental health provider	5	4%
Social service provider	6	5%
Youth advocate/youth worker	4	3%
Other	21	17%
Prefer not to answer	3	2%
Missing/No response	47	38%

Note. This includes all respondents who provided at least one prioritized strategy in the survey for one or more regions or high-risk communities. If an individual completed the survey multiple times for multiple communities, they are only counted in the table once. Participants could select multiple roles. Some individuals completed the survey for a high-risk community even though they attended the workshop – these individual's responses are not included in this table or in the report because their feedback was already captured during the workshop.

[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.

The web survey also included a set of anonymous questions about HIV status and demographic information. Approximately half of the survey respondents chose to answer these questions. Among those who did, 4 percent identified as HIV-positive (Figure A2). Eighty-four percent identified as white or Caucasian, and 6 percent identified as black or African American (Table A6).

Figure A2. HIV status of web survey respondents (N=67)

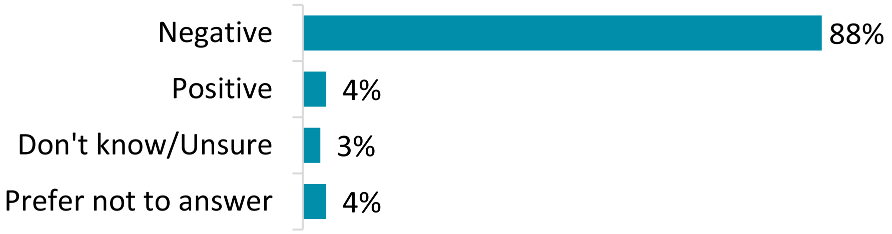


Table A6. Race/ethnicity of web survey respondents (N=67)

	N	%
African born	4	6%
American Indian	1	1%
Asian, including SE Asian and Pacific Islander	1	1%
Black or African American	4	6%
Hispanic or Latinx	2	3%
White or Caucasian	56	84%
Another race or ethnic group	1	1%
Prefer not to answer	2	3%

Note. Respondents were able to select multiple races or ethnicities.

Appendix B: Additional tables

Table B1. Complete frequency of prioritized strategies from workshops (N=13)

Strategy	N	%
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	7	16%
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.	7	16%
Strategy 3.3: Provide culturally and linguistically appropriate services, as well as gender appropriate and sexual orientation appropriate services in clinical and/or community support settings.	5	11%
Strategy 4.4: Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive services.	5	11%
Strategy 5.2: Integrate HIV prevention, care and treatment throughout all sectors of government (e.g., health, human services, education), health care systems, and social services.	4	9%
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.	3	7%
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.	3	7%
Strategy 5.3: Identify, research, and replicate new, effective interventions through partnerships between local public health and state governments, tribal nations, HIV providers, community-based and religious organizations, the University of Minnesota and other academic institutions, research partners, and others.	2	4%

Note. Workshops focused on the African born and Native American communities are not included in this table because they followed a different process.

Table B1. Complete frequency of prioritized strategies from workshops (N=13) (continued)

Strategy	N	%
Goal 5: Achieve a More Coordinated Statewide Response to HIV [a]	1	2%
Strategy 1.2: Increase routine opt-out HIV testing and early intervention services.	1	2%
Strategy 1.3: Immediately link newly diagnosed individuals to person-centered HIV care and treatments.	1	2%
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.	1	2%
Strategy 2.2: Engage community leaders, non-profit agencies, PLWH, and other community members to identify and to address barriers that prevent testing and person-centered care	1	2%
Strategy 3.1: Employ high-impact public health approaches to identify and to re-engage individuals who are out of HIV care and treatment.	1	2%
Strategy 4.2: Build partnerships that increase the supply of safe, affordable housing units for PLWH and those at high risk of HIV infection.	1	2%
Strategy 4.3: Ensure that PLWH and those at high risk of HIV infection have access to necessary supports that maintain their housing stability.	1	2%
Strategy 5.4: Establish policies that encourage an innovative culture and delivery of comprehensive statewide services. An innovative culture includes recognizing that prevention and treatment options evolve and leadership must be willing to respond to new technologies to reduce HIV burden.	1	2%

Note. Workshops focused on the African born and Native American communities are not included in this table because they followed a different process.

[a] One group chose to prioritize a goal from the Minnesota HIV Strategy rather than a strategy.

Table B2. Complete frequency of prioritized strategies from high-risk community workshops (N=7)

Strategy	N	%
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.	7	28%
Strategy 3.3: Provide culturally and linguistically appropriate services, as well as gender appropriate and sexual orientation appropriate services in clinical and/or community support settings.	4	16%
Strategy 4.4: Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive services.	4	16%
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	1	4%
Strategy 1.2: Increase routine opt-out HIV testing and early intervention services.	1	4%
Strategy 1.3: Immediately link newly diagnosed individuals to person-centered HIV care and treatments.	1	4%
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.	1	4%
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.	1	4%
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.	1	4%
Strategy 4.3: Ensure that PLWH and those at high risk of HIV infection have access to necessary supports that maintain their housing stability.	1	4%
Goal 5: Achieve a More Coordinated Statewide Response to HIV[a]	1	4%
Strategy 5.3: Identify, research, and replicate new, effective interventions through partnerships between local public health and state governments, tribal nations, HIV providers, community-based and religious organizations, the University of Minnesota and other academic institutions, research partners, and others.	1	4%
Strategy 5.4: Establish policies that encourage an innovative culture and delivery of comprehensive statewide services. An innovative culture includes recognizing that prevention and treatment options evolve and leadership must be willing to respond to new technologies to reduce HIV burden.	1	4%

Note. Workshops focused on the African born and Native American communities are not included in this table because they followed a different process.

[a] One group chose to prioritize a goal from the Minnesota HIV Strategy rather than a strategy.

Table B3. Complete frequency of prioritized strategies from greater Minnesota workshops (N=6)

Strategy	N	%
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	6	30%
Strategy 5.2: Integrate HIV prevention, care and treatment throughout all sectors of government (e.g., health, human services, education), health care systems, and social services.	4	20%
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.	2	10%
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.	2	10%
Strategy 2.2: Engage community leaders, non-profit agencies, PLWH, and other community members to identify and to address barriers that prevent testing and person-centered care	1	5%
Strategy 3.1: Employ high-impact public health approaches to identify and to re-engage individuals who are out of HIV care and treatment.	1	5%
Strategy 3.3: Provide culturally and linguistically appropriate services, as well as gender appropriate and sexual orientation appropriate services in clinical and/or community support settings.	1	5%
Strategy 4.2: Build partnerships that increase the supply of safe, affordable housing units for PLWH and those at high risk of HIV infection.	1	5%
Strategy 4.4: Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive services.	1	5%
Strategy 5.3: Identify, research, and replicate new, effective interventions through partnerships between local public health and state governments, tribal nations, HIV providers, community-based and religious organizations, the University of Minnesota and other academic institutions, research partners, and others.	1	5%

Table B4. Complete frequency of prioritized strategies from web survey (N=153)

Strategy	N	%
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	59	39%
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.	54	35%
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.	34	22%
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.	31	20%
Strategy 1.3: Immediately link newly diagnosed individuals to person-centered HIV care and treatments.	30	20%

Note. Individual respondents could be counted multiple times if they prioritized the same strategy for multiple communities.

Table B4. Complete frequency of prioritized strategies from web survey (N=153) (continued)

Strategy	N	%
Strategy 2.2: Engage community leaders, non-profit agencies, PLWH, and other community members to identify and to address barriers that prevent testing and person-centered care.	30	20%
Strategy 2.1: Protect and enhance advancements in health care policies, including Minnesota Health Care Programs expansion, coverage for people with pre-existing conditions, and access to preventative treatments without cost sharing.	29	19%
Strategy 2.3: Dedicate adequate resources to populations of color hardest hit by HIV to eliminate health inequities.	27	18%
Strategy 3.3: Provide culturally and linguistically appropriate services, as well as gender appropriate and sexual orientation appropriate services in clinical and/or community support settings.	25	16%
Strategy 5.2: Integrate HIV prevention, care and treatment throughout all sectors of government (e.g., health, human services, education), health care systems, and social services.	22	14%
Strategy 1.2: Increase routine opt-out HIV testing and early intervention services.	15	10%
Strategy 3.5: Ensure access to services that meet the basic needs of PLWH.	13	8%
Strategy 4.4: Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive services.	13	8%
Strategy 3.1: Employ high-impact public health approaches to identify and to re-engage individuals who are out of HIV care and treatment.	11	7%
Strategy 4.1: Identify gaps in affordable housing statewide.	11	7%
Strategy 5.4: Establish policies that encourage an innovative culture and delivery of comprehensive statewide services. An innovative culture includes recognizing that prevention and treatment options evolve and leadership must be willing to respond to new technologies to reduce HIV burden.	11	7%
Strategy 4.2: Build partnerships that increase the supply of safe, affordable housing units for PLWH and those at high risk of HIV infection.	9	6%
Strategy 4.3: Ensure that PLWH and those at high risk of HIV infection have access to necessary supports that maintain their housing stability.	7	5%
Strategy 5.1: Create a leadership structure that is held accountable for implementing and updating this strategy. This leadership structure will include key stakeholders that this strategy affects, such as government leadership, community-based organizations, PLWH, and Minnesota residents that the HIV epidemic hits hardest.	7	5%
Strategy 5.3: Identify, research, and replicate new, effective interventions through partnerships between local public health and state governments, tribal nations, HIV providers, community-based and religious organizations, the University of Minnesota and other academic institutions, research partners, and others.	7	5%
Strategy 3.2: Ensure person-centered strategies that support long-term retention in care.	5	3%
Strategy 5.5: Create effective information sharing partnerships and systems that produce reliable data and that inform decision-making, strategy development, and program accountability.	4	3%

Note. Individual respondents could be counted multiple times if they prioritized the same strategy for multiple communities.