

Assessing for the Future:

**HIV Health Care and Community Needs among Latino, Gay, Bisexual
and Transgender Individuals in the Twin Cities Area**

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Produced by:

Latino Commission on AIDS

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Office of Minority Health Resource Center

“Hace a la gente más cómoda. Entiende nuestra cultura. El idioma es importante. Entienden más nuestras raíces.”

(They make people comfortable. They understand our culture. Language is important. They understand our roots.)

“Tienen estigma, se espantan, lo señalan como alguien que no deben tocar y excluir. Para los latinos es lo peor.”

(There is stigma, people scare themselves, they signal [someone with HIV] as someone that should be excluded and not touched. For Latinos it is the worst.)

“[West Side Clinic] fue como una casa la que me abrió las puertas y me hizo sentir como un miembro de la familia. Me sacó adelante.”

(West Side was like a home that opened up its doors to me and made me feel like a member of the family. They kept me going.)

“Hay latinos que viven en la calle y son VIH positivos.”

(There are Latinos who live on the streets and are HIV positive.)

- Interviewee Quotations

EXECUTIVE SUMMARY

Latino gay, bisexual and other men who have sex with men experience a disproportionate burden of the HIV/AIDS epidemic (CDC, 2011). Within Minnesota, 82% of new HIV infections in 2013 occurred in the Twin Cities Metro Area (Minneapolis, St. Paul and surrounding suburbs) (Minnesota Department of Health, 2013). Overall, male-to-male sex continues to be the greatest transmission risk (Minnesota Department of Health, 2013). One in four new HIV infections are among foreign-born individuals; while Hispanics account for only 5% of the Minnesota population, they make up 9% of the new HIV infections (Minnesota Department of Health, 2013).

The Office of Minority Health Resource Center and the Hennepin County Human Services and Public Health Department requested that The Latino Commission on AIDS (the Commission) conduct a rapid community assessment. The findings from this assessment will be used to guide improvements in HIV prevention, treatment and supportive services for Latino gay, bisexual and men who have sex with men in the Twin Cities metro area. Through individual interviews with members of this community, the assessment aimed to gain insights on how to provide culturally appropriate services, increase access to and retention in health care, and decrease barriers to health care. The assessment was designed to inform the development of the Latino Men Sexual Health Summit on HIV for Latino Gay, Bisexual and other Men who have Sex with Men (the Summit), as well as spur targeted action among Summit participants.

The Commission conducted 22 interviews with Latino gay or bisexual men, and transgender women (Latino GBT); 13 of which were living with HIV/AIDS. Interviews focused on the following: experiences as a Latino gay/bisexual man or transgender woman living in Minnesota; access to medical information and care, especially HIV-related; prohibitive and facilitating factors for access to health services; and recommendations for improving health and well-being for Latino gay, bisexual and transgender individuals in the area.

Qualitative analysis revealed findings in five areas: the social context, health care context, structural barriers to health care, factors facilitating access to care, and overall community needs.

In terms of the social context, interviewees described stable social support and at the same time a fragmented sense of the Latino gay community and the Latino HIV-positive community; in particular, transgender individuals reported more experiences of stigma than gay or bisexual men. Most interviewees were “out of the closet” to friends, family, colleagues and doctors, however many did not share their HIV status beyond a few friends and/or family.

In terms of the health care context, interviewees reported high satisfaction with medical care they received, quick linkage to care among those living with HIV, and overall good relationships with doctors.

Structural barriers to health were largely due to issues around accessibility, such as education around where to get services as a person without documents, where to get services in general, high costs and challenges around getting insurance. Other structural barriers included English-only services and programs and a lack of services tailored to Latinos specifically.

The assessment identified several factors that facilitated access to health care and included: linguistic and cultural competency; knowledgeable and empathetic bedside manner; patient navigation services to help with referrals and insurance; “one stop shop” models where one can receive multiple services, reducing both stigma and inconvenience; and that being HIV positive afforded some increased access to health care through programs such as Ryan White.

Specific community needs of the Latino GBT population were: 1) developing HIV awareness campaigns to combat stigma; 2) refining outreach approaches; 3) increasing education around PrEP and PEP; 4) building community cohesion through group discussions and resource sharing; 5) creating a physical meeting space; and 6) recruiting or training more doctors specializing in HIV.

Using these assessment findings, specific recommendations were developed that focus on HIV Education, Cultural Competency, Addressing Holistic Needs of the Latino GBT Community, and HIV Care and Treatment.

In terms of HIV education, recommendations stemmed from specific suggestions by interviewees and common themes around community development. These recommendations include: developing an HIV prevention social marketing campaign geared towards Latino GBT individuals, enhancing outreach methods through a Health Promoter model, considering community level evidence-based interventions and expanding outreach and education locations to non-traditional settings and social media.

Cultural competency came up as both a facilitator and barrier that individuals face when accessing health care. There is a definite need for recruiting more Spanish speaking and bi-cultural staff in health care settings, as well as developing more Spanish-language educational material.

In line with previous research on Latino gay and bisexual immigrants (Vega, et al., 2012), findings from this assessment suggest a widespread need to address the holistic needs of Latino GBT individuals. This can include implementing discussion groups, developing a community mobilization strategy and continuing to bring in additional voices into an ongoing assessment cycle to address the needs of those not seeking care.

In terms of HIV care and treatment findings suggest a need to scale up high-touch care practices for clients, emphasizing personal connections and holistic health needs. To address gaps in knowing where and how to get services, consider implementing a social marketing campaign specifically around access to care and treatment marketed in non-clinic settings. As findings suggest high satisfaction at specific healthcare organizations, provide opportunities for mentorship and capacity building, including how to replicate a “one stop shop” model.

As with all community assessments, it is important to examine information from multiple sources as we create strategies and actions to address needs and enhance resources and strengths. These findings and recommendations are meant to be a starting point for such action and a model for continued understanding of the experiences and needs of Latino GBT individuals.

RESUMEN EJECUTIVO

Los latinos homosexuales, bisexuales, y los hombres que tienen relaciones sexuales con otros hombres experimentan una carga desproporcionada con relación a la epidemia del VIH/SIDA (CDC, 2011). En Minnesota, durante el 2013, el 82% de las infecciones nuevas con VIH ocurrieron en el área metropolitana de las Ciudades Gemelas (Minneapolis, St. Paul y suburbios circundantes) (Minnesota Department of Health, 2013). En general el mayor riesgo de transmisión para el VIH continua siendo el sexo entre hombres (Minnesota Health, 2013). Una de cada cuatro infecciones nuevas por causa del VIH se reportan en individuos nacidos en el extranjero; y aunque los Hispanos solo representan el 5% de la población en Minnesota, estos constituyen el 9% de nuevas infecciones de VIH (Minnesota Department of Health, 2013).

La oficina del “Centro de Recursos para la Salud de las Minorías” (Minority Health Resource Center) y la oficina de “Servicios Humanos y el Departamento de Salud Pública del Condado de Hennepin” (Hennepin County Human Services and Public Health Department) solicitaron que la Comisión Latina Sobre el SIDA (la Comisión) llevara a cabo una evaluación comunitaria rápida. Los resultados de la evaluación serán usados como guía para mejorar la prevención del VIH, el tratamiento y servicios de apoyo para Latinos gay, bisexuales, y hombres que tienen sexo con otros hombres en el área metropolitana de las Ciudades Gemelas. Las entrevistas individuales con miembros de esta comunidad tenían como propósito adquirir un mayor conocimiento de cómo proveer servicios culturalmente apropiados, aumentar el acceso y retención en cuidado de salud, y reducir las barreras al cuidado de salud. La evaluación fue diseñada para informar el desarrollo de la Cumbre de Salud Sexual de Hombres Latinos sobre el VIH para Latinos Gay, Bisexual y los Hombres que tienen sexo con Hombres (La Cumbre), además de incitar acción enfocada entre los participantes de la Cumbre.

La Comisión llevó a cabo 22 entrevistas con Latinos gay o bisexuales y mujeres transgénero (Latino GBT); 13 de ellos/as que viven con VIH/SIDA. Las entrevistas se enfocaron en los siguientes puntos: Sus experiencias como Latinos gay/bisexuales o mujeres transgénero viviendo en Minnesota; el acceso a información médica y cuidado, especialmente relacionado con el VIH; los factores prohibitivos y los facilitadores al acceso de servicios de salud, y recomendaciones para mejorar la salud y bienestar para los Latinos gay, bisexuales, e individuos transgénero en el área.

Un análisis cualitativo arrojó resultados en cinco áreas principales: el contexto social, el contexto de cuidado de salud, barreras estructurales del cuidado de salud, factores facilitando el acceso de cuidado, y las necesidades de la comunidad.

En términos del contexto social, los entrevistados describieron tener un apoyo estable social pero al mismo tiempo un sentido fragmentado de la comunidad gay Latina y de la comunidad VIH positiva Latina; en particular, individuos transgénero reportaron más experiencias de estigma que los hombres gay o bisexuales. Mucho de los entrevistados habían “salido del closet” a sus amigos, familia, colegas y doctores, sin embargo muchos de ellos no han compartido su estatus de VIH mas allá de algunos amigos y/o familiares.

En términos del contexto de cuidado de salud, los entrevistados reportaron altos niveles de satisfacción con la asistencia médica que reciben, ser conectados con atención médica rápidamente entre los que están viviendo con VIH, y en general una buena relación con los doctores.

Las barreras estructurales de salud en gran parte se identificaron con la falta de accesibilidad, por ejemplo; educación sobre donde ir a recibir servicios para personas sin documentos, donde recibir servicios en general, los altos costos y retos para obtener seguro de salud. Otras barreras estructurales incluían servicios y programas en inglés solamente y la falta de servicios diseñados específicamente para Latinos.

La evaluación identificó varios factores que facilitaron el acceso al cuidado de salud y estos incluyen: la competencia cultural y lingüística; el conocimiento y trato empático hacia los pacientes; acceso a servicios de navegador de pacientes para ayudar con los referidos y seguro médico; modelos de “ventanilla única” donde pueden recibirse servicios múltiples, reduciendo así el estigma e inconveniencia a la vez; y que un diagnóstico positivo al VIH facilitaba un aumento de acceso a cuidado de salud por programas como Ryan White.

Los entrevistados compartieron necesidades específicas de la comunidad Latina GBT, particularmente sobre: 1) el desarrollo de campañas de concientización de VIH para combatir el estigma; 2) mejorar el alcance comunitario para hacerlo más estratégico; 3) aumentar la educación sobre PrEP y PEP; 4) construir cohesión comunitaria a través de conversaciones en grupos y compartir de recursos; 5) crear un espacio físico para reuniones; y 6) reclutar o entrenar más doctores especializados en VIH.

Usando los resultados de la evaluación, recomendaciones específicas fueron desarrolladas y que se enfocan en la Educación de VIH, la Competencia Cultural, Afrontar las Necesidades Holísticas de la comunidad Latina GBT, y el Cuidado y Tratamiento del VIH.

En términos de educación sobre el VIH, las recomendaciones vinieron de sugerencias específicas de los entrevistados y temas comunes alrededor del desarrollo comunitario. Estas recomendaciones incluyen: desarrollar una campaña de mercadeo social para la prevención del VIH dirigida a individuos Latinos GBT, aumentar los métodos de alcance a través del modelo “Promotor de Salud” considerando intervenciones basadas en evidencia (EBIs) de nivel comunitario y ampliar el alcance comunitario e intervenciones educativas a lugares no tradicionales y redes sociales.

La competencia cultural resaltó como un facilitador y una barrera que los individuos enfrentan cuando acceden el cuidado de salud. Definitivamente hay una necesidad de reclutar a más Hispanoparlantes y personal bi-cultural en ámbitos del cuidado de salud, al igual que desarrollar más material educativo en español.

De acuerdo con investigaciones previas sobre Latinos inmigrantes gay y bisexuales (Vega, et al., 2012), los resultados de esta evaluación sugieren que hay una amplia necesidad de abordar las necesidades holísticas de los individuos Latinos GBT. Esto puede incluir implementar grupos de discusión, desarrollar una estrategia de movilización comunitaria y continuar trayendo voces adicionales a la evaluación en curso para abordar las necesidades de aquellos que no están buscando tratamiento.

En términos de cuidado y tratamiento para el VIH los resultados implican la necesidad de aumentar la atención de alto contacto para los clientes, enfatizando conexiones personales y las necesidades holísticas de salud. Para abordar el desconocimiento acerca de cuándo y cómo recibir servicios, se debe considerar la implementación de una campaña de mercadeo social dirigida específicamente al acceso a cuidado y tratamiento médico en entornos que no sean clínicos. Como los resultados implican alta satisfacción con organizaciones específicas de salud, se deben proveer oportunidades para que estas den apoyo y fortalecimiento de capacidad a otras, incluyendo ideas de cómo replicar un modelo de “ventanilla única” (one stop shops).

Como en todas las evaluaciones comunitarias, es importante examinar la información de múltiples fuentes mientras creamos estrategias y medidas para abordar las necesidades y mejorar los recursos y fortalezas. Estos resultados y recomendaciones proponen ser solo un punto de comienzo para tales medidas y un modelo para seguir entendiendo las experiencias y necesidades de los individuos Latinos GBT.

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INTRODUCTION

Latino gay, bisexual and other men who have sex with men experience a disproportionate burden of the HIV/AIDS epidemic (CDC, 2011). Within Minnesota, 82% of new HIV infections in 2013 occurred in the Twin Cities Metro Area (Minneapolis, St. Paul and surrounding suburbs) (Minnesota Department of Health, 2013). Overall, male-to-male sex continues to be the greatest transmission risk (Minnesota Department of Health, 2013). One in four new HIV infections are among foreign-born individuals; while Hispanics account for only 5% of the Minnesota population, they make up 9% of the new HIV infections (Minnesota Department of Health, 2013).

In the spring of 2014, the Latino Commission on AIDS (LCOA) was contacted to perform a community needs assessment for Hennepin County in Minnesota. The main goal of this exercise was to improve HIV prevention, treatment, and supportive services for Latino gay or bisexual men and transgender women (Latino GBT) in Hennepin County. Through interviews with this target population, LCOA was tasked to collect insights on:

- How to provide culturally appropriate services for Latino GBT, including consideration of race, ethnicity, gender and sexual identity
- How to increase access to and retention in health care for this population
- How to decrease barriers to health care for this population

The assessment was designed to inform the development of the Latino Men Sexual Health Summit on HIV for Latino Gay, Bisexual and other Men who have Sex with Men (the Summit), as well as spur targeted action among Summit participants. Post-Summit, an Epilogue will be developed summarizing the Summit, key strategies and action steps moving forward.

METHODOLOGY

“If the researchers goal is to understand the meaning people... make of their experiences, then interviewing provides a necessary, if not always completely sufficient avenue of inquiry”

– Irving Seidman, Interviewing in Qualitative Research

Through a group process, the Latino Gay/Bi MSM Summit Planning Group decided on a qualitative interview methodology for this assessment. Qualitative methods have been shown to be useful in understanding individual and community trajectories in health (Boeri, Harbry & Gibson, 2009; Vega, Speildenner & Tang, 2012). A semi-structured interview was used, which allowed interviewers to explore similar themes across interviews, but also enabled participants to steer

the conversation in ways that were relevant to their experiences. While we asked key questions across all participants, using a semi-structured method is useful for allowing interviewees to identify topics that *they* feel are important, rather than only responding to pre-determined topics of interest (Cohen and Crabtree, 2006). Using this research approach, not all interviewees were asked the same questions. As this project was focused on identifying the needs of the community using a small sample, a semi-structured interview was the method of choice.

A total of 22 interviews were conducted during May and June of 2014. Of these interviews, 15 were done in person at the Hennepin County Health Department building, while seven interviews were conducted over the phone. Interviewees were recruited through the Latino Gay/Bi MSM (men who have sex with men) Summit Planning Group. Selection criteria included that interviewees were Latino, identified as gay, bisexual or transgender, and over 18 years of age. Interviewees were provided with a \$40 gift card to Target as a token of appreciation for their participation. Inherent in this non-random sample methodology (meaning that participants were selected based on whether they were interested, available and connected to the Planning Group in some way), findings do not generalize to the broader Latino GBT population in the area. However, this approach provides a useful foundation for considerations of how to alter service provision. Two LCOA staff members conducted all interviews in Spanish, one conducting the interview and another taking the notes. Interviews focused on the following topics:

- Participants' experience as a Latino gay or bisexual man or transgender woman living in Minnesota;
- Participants' access to medical information and care, especially HIV prevention and/or treatment;
- Prohibitive and facilitating factors for participants' access to health care
- Recommendations for improving health services for the target population in the area

Using qualitative analysis software (QDA Miner Lite), interview notes were systematically analyzed for themes by the Community Programs Evaluation Manager. The analysis resulted in five themes: the social context, health care context, structural barriers to health care, factors facilitating access to care, and community needs.

FINDINGS

Interviewee Demographic Profile

There were twenty Latino men interviewed, 19 of whom identified as gay, and one of whom identified as bisexual. The sample also included two transgender Latina women. The sample included 13 interviewees who reported an HIV positive status, eight who reported a negative status, and one who reported not knowing their HIV status. All interviewees had been living in the United States for a minimum of seven years, with many interviewees having lived in the US for 10 years or longer. The majority of participants had lived in other states prior to coming to Minnesota, often in larger cities such as Las Vegas, New York and Los Angeles. Moving to Minnesota was thus rooted in knowing people or other details about the state.

While most interviewees were open about their sexual orientation, many of those living with HIV do not disclose their status, only sharing with a few close friends or family.

Social Context

Social context is a key consideration in developing appropriate HIV prevention, stigma reduction and health access strategies that reflect the realities of the social environment that people live in. Several questions were used to assess social context, specifically those around openness and disclosure of one's sexual identity and HIV status, as well as those around community cohesion.

Interviewees reported an ability to openly express their gay sexual identity in the Twin Cities region. Many interviewees mentioned that their ability to openly express their sexual orientation in their home country was different, citing Minnesota as strikingly more accepting. However, transgender interviewees reported experiencing significant stigma due to their gender identity. One woman mentioned that she was not allowed entry into a bar because of her gender identity. This notion was echoed by one other participant who remarked that there is more stigma against transgender and bisexual individuals in the Twin Cities area, compared to gay or bisexual men.

In terms of disclosure, most interviewees reported being fairly open about their sexual orientation, disclosing to friends, family members and work colleagues. Additionally, the vast majority of interviewees reported disclosing their sexual orientation to their doctor, recognizing that communicating this information could have an important bearing on an accurate health diagnosis. Specifically, interviewees felt that knowing a patient's sexual orientation it allows the doctor to offer appropriate tests, such as pap smear to test for anal cancer; additionally

interviewees viewed doctors as health professionals and did not expect disclosure to impact their healthcare negatively. In contrast to sexual orientation disclosure patterns, most interviewees only disclose their HIV-positive status to a few close friends or family members.

Most interviewees mentioned that they have a social support network in place locally, whether friends or family; a few mentioned that they were fairly alone without stable connections. A few interviewees mentioned that they don't normally associate with other Latinos, and that they don't necessarily feel part of a Latino community.

This notion of a fragmented community was repeated in various ways. While participants recognized an existing Latino community and an existing Gay community, there were widely varying views on whether or not a Gay Latino community exists and whether an HIV-positive Latino community exists. In some cases, participants reported that while these communities may exist, they are themselves not involved members.

Along these lines, interviewees characterized the LatinoGBT community in sometimes contradictory ways. As seen in *Figure 1* below, when asked what three words they would use to describe the gay/bisexual/MSM Latino community in Minnesota, some respondents selected words such as "open," while others selected "discreet." Others selected "union" while some selected "fragmented" and "conflicted." Many words such as "gossipy" and "individualized" seem to convey a sense of distrust, and phrases such as "don't take prevention seriously" and "they don't have information" highlights a need for more resources to be devoted to the community.

Figure 1: Three Words to Describe the LatinoGBT Community



Health Care Context

The health care context, or how people experience the health care system in Minnesota, is also important when planning strategic programming and campaigns. Understanding the reality of how people access, experience and relate to health care and health care providers can help prioritize initiatives and create realistic strategies to increase engagement in the health care system. Here we summarize client satisfaction with medical care and case management services, where people receive services, doctor-patient relationships and discrimination.

Where did interviewees access healthcare?

- ✓ West Side Clinic
- ✓ Red Door
- ✓ HCMC
- ✓ Aliveness Project
- ✓ Park Nicollet
- ✓ CLUES
- ✓ Family Medical Center
- ✓ Parkside Clinic
- ✓ Regions Hospital
- ✓ Cuarto 111
- ✓ Ramsey Hospital
- ✓ Minute Clinics

Are there any places that you expected to see but do not?

Overall, interviewees reported being very satisfied with the medical care they receive. Specifically, when HIV-positive individuals were asked if they feel that their current health care is working well for them, 100% responded in the affirmative (12 out of 12; one individual was not asked). The most frequently mentioned health care sites were the West Side Clinic and Red Door Clinic; participants reported high levels of satisfaction with the care they receive in both places. One participant relayed that he was impressed with the care he was given when being linked to services after an HIV diagnosis. *“Fue la mayor atención que me han dado... Me sentí privilegiado de tener una clínica que hace tanto.”* (It was the best care that I’ve received. I felt privileged to have a clinic that does so much). Clients also cited the following locations as places where they access health care: Hennepin County Medical Center, Aliveness Project, Park Nicollet Health Services, Comunidades Latinas Unidas en Servicio (CLUES), Family Medical Center, Parkside Clinic, Regions Hospital, Cuarto 111, Ramsey Hospital and minute clinics in pharmacies.

For clients who were HIV-positive, in the vast majority of cases they were linked to care very quickly. The one exception to this was one client who remarked that he waited for two years to seek services because learning about his HIV status was so traumatizing, that he was not able to immediately accept and cope with his status. There was also one example of an individual who noted that he fell out of care after being linked. He explained that when there was a state government shut down, his insurance was canceled; after one and a half years, the interviewee

visited a hospital and described how the doctors assessed his medication situation and was given HIV medication the next day.

We also heard many instances of HIV-positive clients seeing their case managers on an as-needed basis. The six interviewees who answered our question with a specific figure relayed that they typically see their case manager 2-4 times per year. This reflects that clients are able to live fairly independently but do reach out for help when they need it. When speaking of his case manager, one client said *“When I need him, I leave a message and he’s there for me.”* (Cuando lo necesito, le dejo mensaje y está ahí para mí.) Clients also reported that they receive comprehensive support from case managers. One interviewee mentioned that when he needs any kind of help, including tickets for the bus, his case manager connects him with these resources. *“Se involucra en todo no solo VIH-mi vida social etc... Siento que es mi terapeuta.”* ([My case manager] is involved in everything, not just HIV-my social life, et cetera... I feel that he is my therapist).

We also heard from the majority of interviewees that they have overall good relationships with their doctors. For example, no one reported that they felt they had to choose between their Latino or GBT identity when selecting a medical provider that focuses on Latinos or the LGBT population. All participants reported that they felt comfortable talking to their doctors about any topic. Additionally, when asked if interviewees had been mistreated by a medical provider, 81% of respondents indicated that they had not been mistreated (17 out of 21). A few exceptions to this were when two HIV positive clients reported that they were denied dental services due to their HIV status. In one other case, an HIV positive client reported that he was treated as “difficult to treat” in an instance when his regular doctor was unavailable, and he went to a walk-in clinic. When he disclosed his HIV status, they made him feel uncomfortable. They attended to his medical needs well, but they exaggerated that they didn’t have experience treating patients with HIV. *“Me intimidaron.”* (They intimidated me.) The last person who felt mistreated said that he visited a private hospital in Dakota County, and relayed that the staff were not sensitive and referred him to services in Hennepin County. It was not made clear what staff were not sensitive about.

Also, noteworthy is that one transgender woman mentioned that if she were to feel discriminated against, there is a group of gay doctors that she knows she can go to at the Hennepin County Medical Center. It is a positive sign that this participant could identify supporting resources in the case of being mistreated.

Structural Barriers to Health Care

Of primary concern to this project was the question of what barriers do people experience when accessing health care. **In terms of health care accessibility, we saw that immigration status was a significant barrier.** While a majority of interviewees (55%) noted that immigration status impacts access to health care for themselves or for others in the Latino community, those who mentioned it specifically relayed that they felt this barrier was important. For those undocumented, thinking that they were ineligible for services or fear of deportation when accessing care was a concern. One interviewee expressed the following:

“La preocupación más grande es cuando no tienes documentos. Siempre se ha vivido con la amenaza de que la gente que no tiene documentos no va a recibir tratamiento, pero siempre es una amenaza y no ha pasado nada.” (The biggest worry is when you don’t have documents. There’s always a threat that people without documents won’t receive treatment, but it’s always just a threat and that doesn’t actually happen.)

The perceived thought of not being eligible for care because of immigration status is something that prevents other Latinos from accessing care, even when they *are* eligible to receive care. One interviewee stated that 99.9% of Latinos who don’t access care refrain from doing so because they think they won’t receive services. This sentiment was echoed by another interviewee:

“Tienen las opciones pero las personas no tienen la información de que pueden ir a recibir servicios sin Seguro Social. Se dejan morir por no tener la información ni buscarla.” (People have options but don’t have the information that they can receive services without a social security card. They let themselves die because they don’t have the information and don’t even look for it.)

The idea that people don’t know that they have health care options regardless of their immigration status was a theme that was echoed again and again. We also heard that many times that Latinos don’t access health care due to the fear of being deported when or after attempting to access care.

What are the main barriers to getting health care?

- *Immigration Status*
- *Knowing where to go*
- *Cost*
- *Insurance*
- *Language*
- *Lack of cultural-specific programs*

From the perspective of interviewees, **many Latinos don't know where to access services**. One interviewee stated that many people are so fearful that they don't look for services. "Sé que mucha gente latina que no está legal en el país tiene mucho miedo de buscar ayuda. Mucha gente no busca." (I know that many Latino people that aren't legal in this country have a lot of fear of looking for help (for health care). Many people don't look for help.) A few interviewees mentioned that other Latinos don't know about the West Side Clinic, a health setting which offers services to all clients regardless of immigration status, and includes Spanish-speaking

"Hay gente que se siente mucho mas cómoda hablando español."

(There are people who feel much more comfortable speaking in Spanish.)

staff. Additionally, one interviewee mentioned that for those individuals living in Dakota County, people think that they are not eligible to get services in Hennepin County because of where they live.

Importantly, cost and inability to get insurance can also be prohibitive factors to accessing health care. One interviewee remarked that making prepayments is expensive for those without insurance. When asked how health services could be better, he stated that the \$100

prepayment should be eliminated and instead have a payment program based on salary. Another interviewee stated, "Para que yo puede tener la seguridad, si no fuese positiva, sería difícil. Para Latinos ir al hospital es caro." (Having insurance would be hard for me if I wasn't positive... for Latinos going to the hospital is expensive.) Additionally, when asked if one's immigration status impacts their access to health care another participant remarked in the affirmative, stating: "No puedes ir a todos los lugares porque tienes que llevar el seguro médico. Si no tienes seguro médico hay que pagar mucho," (You can't go to all of the places because you have to have health insurance. If you don't have health insurance you have to pay a lot.)

Interviewees also cited a lack of services and programs targeted to Latinos, or English-only services as a challenge. For example, one interviewee described needing more social service sites where staff "speak your language and share your culture". Another interviewee remarked that there are not programs specifically for Latinos. When asked if he would like there to be programs specifically for Latinos, he answered in the affirmative. "Si ayudaría a acceder servicios...Hay gente que se siente mucho mas cómoda hablando español." (Yes, it would help people access services. There are people who feel much more comfortable speaking in Spanish.) Similarly, another interviewee remarked that language is a big barrier against disseminating information about HIV.

Furthermore, another participant remarked that services could be improved if there was more access to information in Spanish. He continued: "Que este escrita clara y sin errores, no

traducciones en google translate. Que provean respeto cultural, en buena forma y apropiada." ([Information] should be written clearly and without errors, not using translations in Google translate. That [health service providers] provide cultural respect, in an appropriate manner.)

In terms of a need for specific programming, one interviewee stated, *"Hay programas (de información), pero no a las chicas Latinas. No hay oportunidad para la comunidad gay Latina. Tiene aspecto de un estado libre, pero no hay programas."* (There are programs but not for [transgender] Latinas. There aren't opportunities for the gay Latino community. This area has an image of being a free state, a gay-friendly city but there aren't programs.) Another interviewee relayed that there is not a place to help the Latino community with the problem of drugs.

Facilitating Factors to Access Health Care

Equally important to identifying barriers to care is identifying what helps people get access to care. Throughout interviews we noticed that participants mentioned several factors that they appreciated when receiving health care. In many interviews, we heard that having **staff who speak Spanish and are culturally competent** is a facilitating factor to accessing health care. When asked how other Latinos living with HIV access services, one respondent highlighted that language and cultural understanding are very important in accessing care.

"La mayoría está con la clínica. Hace a la gente más cómoda. Entiende nuestra cultura. El idioma es importante. Entienden más nuestras raíces...Siempre me siento muy comfortable. Dan confianza, se siente conectado a La Clínica. Es la diferencia entre una enfermera latina y una enfermera blanca." (The majority [of Latinos accessing HIV services] are with the West Side Clinic. They make people comfortable. They understand our culture. Language is important. They understand our roots...I always feel very comfortable. They generate trust. People feel connected to the West Side Clinic. There's a difference between a white nurse and a Latina nurse.)

Furthermore, this interviewee also highlighted the importance of cultural competence when asked what makes a good medical provider.

"Que sea multi-cultural. Una cosa es que tú hables español, pero también hay que entender todas las diferentes culturas de todos los países que hablan español. Yo no soy de México pero me insulta cuando alguien le pregunta de comida mexicana." (Being multi-cultural; one thing is speaking Spanish, but you also have to understand the different cultures of all of the countries that speak Spanish. I'm not from Mexico, it insults me when someone asks me about Mexican food.)

Staff who are not only knowledgeable but also provide empathetic, emotional support when delivering care is an additional factor that interviewees focused on. One interviewee reported that he usually goes to West Side Clinic to receive services and highlighted the emotional connection he feels to this health care site. He commented,

“[West Side Clinic] fue como una casa la que me abrió las puertas y me hizo sentir como un miembro de la familia. Me sacó adelante.” (West Side was like a home that opened up its doors to me and made me feel like a member of the family. They kept me going.)

Additionally, when asked who is their principal source of support, while the majority of respondents pointed to friends or family, one respondent replied that he receives emotional support primarily at the West Side Clinic. Furthermore, another interviewee pointed to her case manager as an important resource, stating that “he has been a very good support. I think of him more as a friend.” These respondents highlight the need to address not just the health and medical concerns of patients, but the emotional needs as well.

Participants’ descriptions of what make a good medical provider support this notion of a desire for informed and attentive care. *Figure 2* below provides a visual representation of responses to this question. Larger words signify responses that were more frequent. Attentiveness to the client and being knowledgeable are the two most frequently cited qualities; many responses such as “make you feel at home,” and “help you in every way possible,” speak to a desire for a comforting and empathetic delivery of care.

Figure 2. What Makes a Good Medical Provider?



Health care providers who are able to go above and beyond, addressing the comprehensive needs of clients are appreciated highly. When asked where he goes to receive medical care, one respondent answered that he goes to the West Side Clinic, stating “[*West Side Clinic*] es donde está mi salvación.” (West Side Clinic is my salvation.) This respondent highlighted that he highly valued the support he received in terms of the clinic helping him pay his insurance. Another client reported that she appreciated the comprehensive help she receives. “*Me dieron ayuda muy buena. Me ayudaron psicológicamente-la terapia, todo.*” (They gave me very good help. They helped me psychologically, with therapy, everything.) Many HIV-positive clients also welcomed the comprehensive care that they receive from their case managers, including the ability to help them navigate the health care system, referring them to places they can go to meet both their health and non-health care needs.

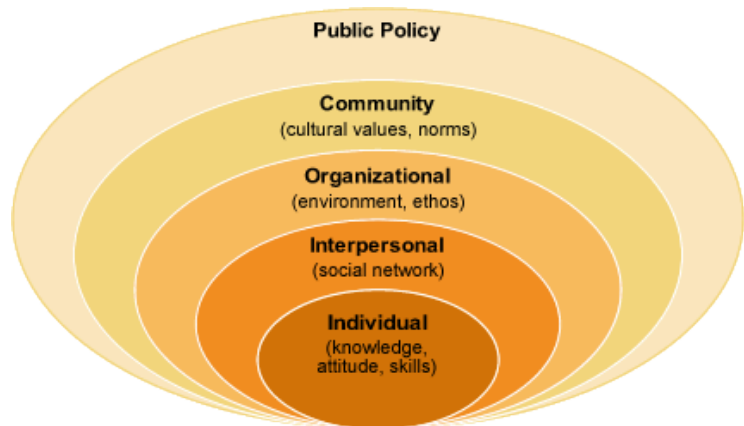
Additionally, interviewees preferred visiting “one stop shop” health settings where multiple services are offered to reduce stigma. For HIV-positive clients who were receiving HIV services, respondents mentioned that they appreciated the degree of anonymity offered when visiting a health site with multiple services. One respondent mentioned, “*Tú siempre vas ahí y todo el mundo está ahí y nadie sabe porque tú vas.*” (You always go there and everyone is there, and no one knows why you are there.) Another respondent echoed this preference. He indicated that he usually attends West Side Clinic to receive medical services and emphasized the comprehensive services received there, as well as the lack of signs indicating that HIV services are offered.

“Mi familia se atiende ahí. Primero te atienden y luego preguntan por seguridad. Mucho del personal es latino...No hay letreros que identifiquen se presentan como pacientes de la clínica 7.” (My whole family goes here. First they service you and later ask for your insurance. Many of the staff is Latino... There aren’t signs that indicate that where you’re going is for HIV services [Clinica 7].)

Finally, **being HIV-positive was a facilitating factor to health care.** All interviewees who were HIV-positive reported that they were able to access comprehensive health care-not just HIV services-regardless of their immigration status. One person mentioned that prior to having been diagnosed with HIV, she thought that she wasn’t eligible to access services. As described previously, immigration status was a barrier to accessing health care for interviewees. However, due to the resources available to HIV-positive individuals, this barrier does not apply to this specific population. Additionally, interviewees living with HIV/AIDS described the change in priorities after an HIV diagnosis: healthcare becomes more of a priority.

Community Needs

A common theory used in public health and social science is the ecological theory (Bronfenbrenner, 1977) which emphasizes the importance of not only the context immediately around the individual, but that also of the community and larger society (see the figure below). Throughout the interviews, participants noted various specific needs on more of a community level, as opposed to their individual needs. These primarily revolved around addressing stigma, getting prevention information out to the community more broadly, community development in the Latino Gay community and HIV-positive Latino Community, and needing more medical professionals that know about HIV.



A resounding need throughout the interviews included the call to address HIV/AIDS stigma, and increase HIV awareness and prevention education in the Latino community. Many interviewees referred to a large amount of stigma and misinformation which they felt was highly present in the Latino community. One participant remarked that in the Latino community, *“tienen estigma, se espantan, lo señalan como alguien que no deben tocar y excluir. Eso no se ve en los anglos. Para los latinos es lo peor.”* (There is stigma, people scare themselves, they signal [someone with HIV] as someone that should be excluded and not touched. You don’t see this in the Anglo community. For Latinos it is the worst.) Another

While perceptions of HIV in the Latino community have improved, it is still taboo to disclose one’s HIV status to the larger community

interviewee highlighted the lack of information in the Latino community, and also said that those with HIV are looked down on and rejected. In a slightly different vein, one interviewee mentioned that Latinos already living with HIV are in need of more information in terms of resources and places they can go for help.

Another interviewee relayed that family members reject those who are HIV positive, stating *“hay latinos que viven en la calle y son HIV-positivos.”* (There are Latinos who live on the streets and are HIV positive.) In particular, one participant suggested that an aggressive campaign is needed in order to better educate the Latino community. He mentioned that in Mexico City, where he is originally from, they have an effective city-wide campaign including large signs, television commercials, and a 24 hour hotline.

A few respondents mentioned that over time, the perception of HIV within the Latino community has somewhat improved. One person mentioned that now HIV is talked about in a more positive manner than before. Similarly, another interviewee remarked that before the condition was very “*satanizado*,” or demonized, and that over time people’s perceptions have become more humane. However, in spite of this improvement, this person also relayed that people infected with HIV don’t share this information with the larger Latino community—a sentiment that we heard echoed throughout the interviews. It is still taboo to disclose one’s HIV status to the larger community.

Additionally, interviewees mentioned a need for more information about prevention methods within the Latino GBT community. One respondent remarked that the Latino MSM community doesn’t take prevention seriously. Another respondent mentioned a need for a different approach to prevention outreach. He remarked that currently, outreach that is done in bars doesn’t provide an opportunity for giving out information, that it’s focused only on testing. Another interviewee remarked that a bar is not the right place for outreach efforts because people aren’t in the right state of mind to absorb the information they might be getting. We asked interviewees if they had heard of PrEP (Pre-exposure prophylaxis) or PEP (Post-exposure prophylaxis) as HIV prevention options. The vast majority of interviewees had not, and could potentially benefit from learning about these treatments.

We also noticed a lack of community cohesion among interviewees. We asked whether there was currently a Gay community, a Latino community, a Gay Latino community or a Gay HIV- positive Latino community. We heard widely varying responses in terms of whether these communities exist from interviewees. Along these lines, many interviewees who had been in a discussion group for HIV positive individuals mentioned that they missed this opportunity. One person noted that without the group it is hard to share resources and benefit from others’ lived experiences.

The vast majority of interviewees had not heard of PrEP or PEP. There is a lack of understanding of the concept “Treatment as Prevention”

“Hay demasiada información... Muchos van a diferentes lugares pero sin los grupos de apoyo no se comparte la info.” (There’s too much information... Many people go to different places but without the support groups information isn’t shared.)

Similarly, another interviewee noted a demand for different types of support groups for the Latino population so that they can express themselves, talk about their experiences, and share

where to get services. Having a physical meeting space was also important to interviewees; a few people highlighted that in particular, meeting in informal locations and inviting settings is desired.

Finally, a few interviewees mentioned needing more doctors specializing in HIV. In some cases they felt that their options were limited and that they would like to see a medical provider more frequently if possible.

SUMMARY

Overall, interview participants were satisfied with the health care they were receiving in the Twin Cities metro area. Interviewees underscored Spanish speaking and culturally competent staff, and health providers who are knowledgeable, provide empathetic care, and go above and beyond as elements currently in place in some local health care settings that enable them to have a positive health care experience. Participants also expressed a preference for health settings that provide anonymity for clients accessing HIV services. In addition to factors that help to promote health care utilization, interviewees identified several elements which act as elements that hinder access to health services. These challenges included immigration status, an uninformed understanding of the local landscape of care and available options, and health care costs and access to insurance. Challenges described also revealed a need for more Latino-focused programming in addition to other community needs including HIV awareness within the broad Latino community, prevention education within the Latino GBT community, increased community cohesion and support groups. In an effort to address these needs and help sustain and expand on successful strategies in service provision to the Latino GBT population, a host of recommendations may be considered.

RECOMMENDATIONS

Taking into account the findings above, we acknowledge there are many avenues available to address the needs of the community. In order to facilitate identifying such strategies and actions, we have identified four main areas of recommendations that could serve as a foundation for action planning to improve services for the Latino GBT population in the Twin Cities area: HIV education, cultural competency, addressing holistic needs, and HIV care and treatment. Below, we summarize these recommendations; those with a star (*) indicate resources and strategies that were specifically suggested by interviewees.

In terms of HIV education and stigma reduction, recommendations stemmed from specific suggestions by interviewees and common themes, particularly around community development.

- Implement an HIV prevention and anti-stigma social marketing campaign geared towards Latinos*
 - Messaging should be simple and clear*
 - Outreach locations may include*
 - Lavender, Vida Y Sabor magazines*
 - Lake Street*
 - Non-hospital setting including churches, bathrooms, commercial centers, bars such as The Saloon.*
 - Social media sites
 - TV or radio spot—Canal 13 for TV; Radio Rey, La Que Buena for radio*
- Enhance HIV prevention outreach methods
 - Develop and train a cohort of Health Promoters, a model familiar in many Latin American countries. This model emphasizes training community members to be the key deliverers of health related messages. *
 - To skillfully educate the target population and health providers
 - Consider who are community insiders that people know and trust; recruit these people to be Health Promoters.
 - Include education about PrEP and PEP, as they knowledge of these biomedical interventions is relatively low.
- For specific HIV prevention interventions, consider the use of community-level interventions such as Mpowerment, Popular Opinion Leader, and Community Promise. This takes into consideration that people want to receive information from culturally appropriate individuals, such as peers. As some implement these types of interventions, they can provide an avenue for leadership development for emerging leaders in the community. More information about these interventions and how to adapt them can be found at effectiveinterventions.org.

Cultural competency came up as both a facilitator (high competency) and barrier (low competency) that individuals face when accessing health care.

- Recruit more Spanish-speaking staff to serve in health care settings, develop more Spanish language materials*
- Develop Health Promoters skills to teach health professionals around key cultural competency practices
- Use the West Side Clinic as a “promising practice” model. It is clear from the participants that there are a lot of strategies at this clinic that keep individuals engaged in care. As

part of the National HIV/AIDS Strategy and CDC's High Impact Prevention is around "scaling up," this clinic may serve as a model for scaling up effective services with Latino gay, bisexual and transgender individuals

- To do this, consider scheduling observations at the clinic and meetings with staff in various roles to understand areas for replicability.

In line with previous research on Latino gay and bisexual immigrants (Vega, et al., 2012), findings from this assessment suggest a widespread need to **address the holistic needs** of Latino GBT individuals.

- Implement discussion groups for HIV positive individuals, and for Latino men who have sex with men (MSM)*
- Develop and execute a community mobilization strategy. Participants were clear in their desire for more spaces for Latino gay community development.
 - Possibly utilize the LUKA Principle as a guide (see Appendix for more information)
 - An acronym for Leadership, Unity, Knowledge, Action, the LUKA Principle recognizes the importance of local leadership in uniting communities and focuses on the need to collect information to inform actions
- As part of sustainable community mobilization, continue and expand on the admirable needs assessment activities done thus far to gain a full picture of target population needs
 - Consider implementing follow up surveys with those who are not seeking care

In terms of **HIV care and treatment**, findings suggest a need to scale up high-touch care practices for clients, emphasizing personal connections and holistic health needs. This builds on the high level of satisfaction among those already receiving care.

- Create and implement a Latino Health Care Access social marketing campaign for those currently not in health care. While most of those interviewed were receiving care, interviewees reported varying barriers to care, one of which is around knowledge of where to go and who is eligible.
 - Focus on clarifying who is eligible for services and where Latinos can go to get services, particularly for those without papers
- Scale up "high-touch" care practices for clients; this involves:
 - Developing close relationship with clients, touching base often
 - Emphasizing personal connections and attention to all health needs
- Provide mentorship or capacity building on service provision for HIV positive patients for providers who don't specialize in HIV. Interviewees indicated being very satisfied with the services that they receive, but that there is a need for developing provider

competency around providing services to those living with HIV, particularly those outside of the typical networks of care. What systems can support developing this knowledge, skill and competency in the larger healthcare system?

- Replicate the one stop shop model for accessing multiple services, protecting patient anonymity. Assess where and when this is feasible, knowing that it is a service that is valued by those interviewed.

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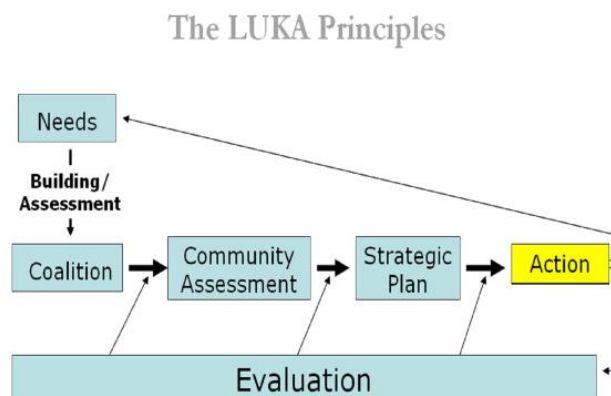
APPENDIX

The LUKA Principle: An Introduction

The **LUKA Principle** brings into focus important elements that have been identified by stakeholders as necessary in building a cohesive front to undertake the issue of health disparities: Leadership, Unity, Knowledge and Action. Within the United States, health disparities are often the result of multiple overlapping issues (not just individual beliefs or actions). Race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location all contribute to an individual's ability to achieve good health.

The model grew out of the *Commission's* experiences building the capacity of organizations in states that serve an emerging Latino community, as well as engaging community members to lead community mobilization efforts in their areas. It recognizes the importance of local, grassroots leadership in uniting communities and forming effective coalitions dedicated to improving living conditions and to addressing the HIV/AIDS epidemic and changing policy environment. The model also focuses on the need to systematically collect data to enhance and continuously update leaders' and coalitions' knowledge of the community, in order to inform actions. As such, the **LUKA Principle** is an iterative process of gathering information, engaging leaders, and taking actions to advocate for services and policies in working to reduce the impact of HIV/AIDS on the community.

The Figure below presents a visual representation of the model. **Leaders** build upon the initial identified needs, to bring together a coalition in **Unity**, this unified group then engage in a community assessment to gather in-depth **Knowledge**. The actors involved then formulate **Actions** based on the information. Once that process is complete, the coalition reassesses any changes that have occurred, within the social, political, and economic contexts that affect the population. Following the reassessment, the iterative process begins again, to once more plan actions that, if successful, impact the community's living conditions. As shown in below, evaluation is a key part of each step of the process, with feedback loops established to help the organizers understand whether the action steps are proceeding as planned, and opportunities to assess progress along the way.



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This community assessment was conducted and authored by the HEARD Institute at the Latino Commission on AIDS. To inquire about further our services, contact us:

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Latino Commission on AIDS is a private non-profit organization founded in 1990 in response to the unmet national need for HIV/AIDS prevention and care for Latinos. The Commission's public health mission is to impact the HIV/AIDS epidemic, in the context of addressing health disparities, by spearheading health advocacy, promoting health education, developing and replicating evidence-based programs for PLWHA and high-risk communities, and by building capacity across the public health sector including community-based organizations, health departments, healthcare organizations, and universities. The Commission's unique mission and corresponding model encompasses five service divisions: 1) capacity building assistance; 2) disease prevention and health promotion; 3) access to care (HIV and hepatitis testing, linkages); 4) community mobilization; and 5) research and evaluation.



The HEARD Institute (Hispanic Health Equity: Action Driven Research and Development) amplifies the diverse voices of the Hispanic communities to improve health outcomes through research, evaluation, education and promoting community networks. Our goals are to: increase the amount and quality of research that puts the experience of Latinos at the forefront; heighten the use of analytic and evidence-driven policy and programming; and empower the community to use research as an effective mobilization tool.