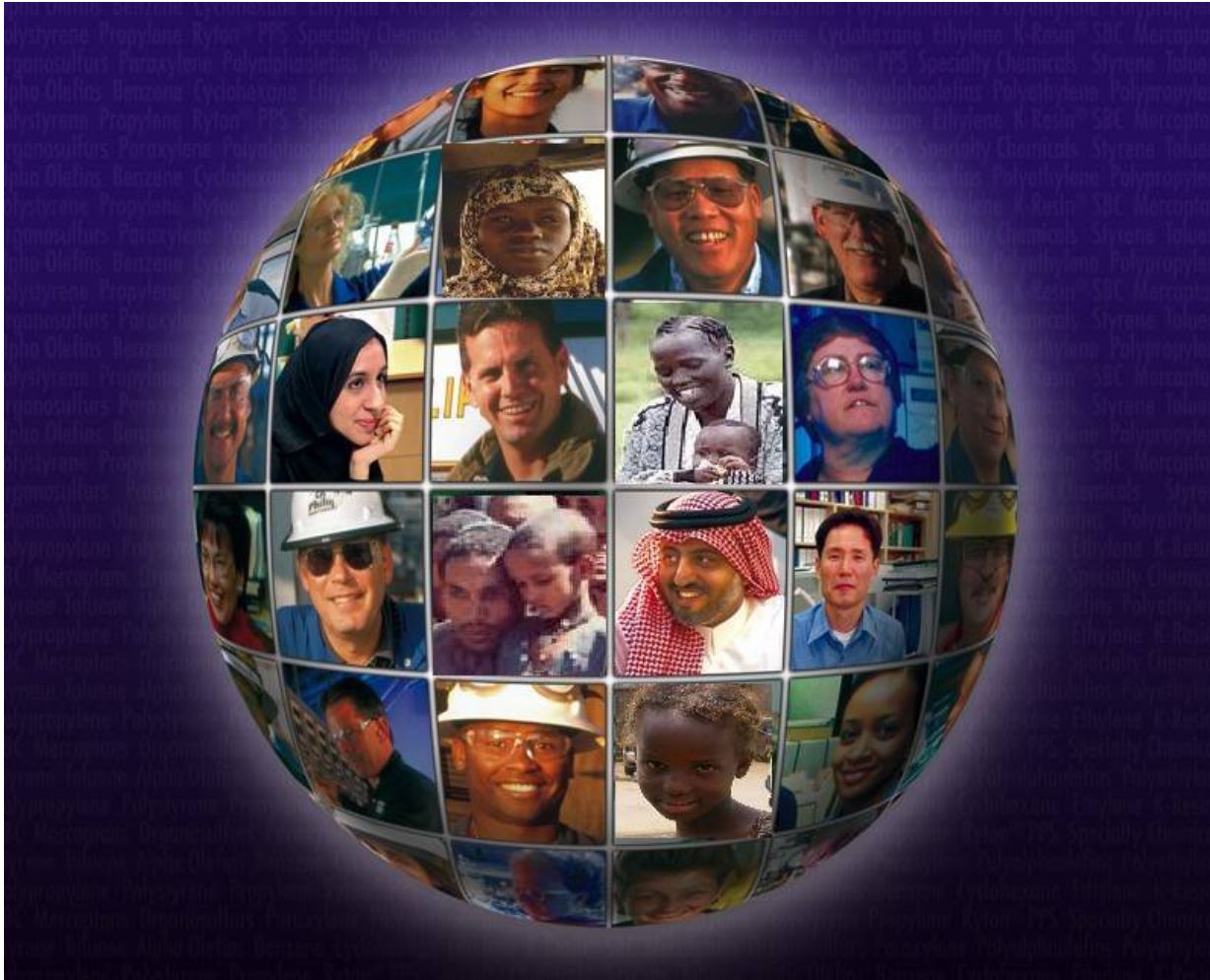


A GROWING CRISIS

**A Funders Response to HIV/AIDS
in the African Community in Minnesota**



From <http://www.cpchem.com/images/PeopleGlobe.jpg>.²³

**Prepared for the community on behalf of
The Jay and Rose Phillips Family Foundation and Otto Bremer Foundation**

by

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A Growing Crisis

Table of Contents

| | |
|--|-------|
| Executive Summary | 2 |
| Introduction | 5 |
| Overview of HIV/AIDS | |
| Global View of HIV/AIDS | 6 |
| HIV/AIDS in Minnesota | 7 |
| HIV/AIDS in the African-Born Communities in Minnesota | 8 |
| Factors Contributing to the Rise of HIV/AIDS Among African-Born Minnesotans | 9 |
| Global Efforts on HIV/AIDS | 11 |
| The ABC Approach | 11 |
| The Taskforce | |
| Work of the Taskforce | 13 |
| Service Matrix | 15 |
| Findings | 22 |
| HIV/AIDS Funding for African Community Organizations | 24 |
| Next Steps | 24 |
| Recommendations | 26 |
| Capacity Building | 26 |
| Program Support | 26 |
| Education and Prevention Support | 27 |
| Advocacy / Public Policy Impact | 27 |
| Conclusion | 28 |
| References | 30 |
| Maps | 31-32 |
| Appendices | |
| Appendix A: Agencies Funded by MDH | 33 |
| Appendix B: Private Funding for HIV/AIDS in Minnesota | 34 |
| Appendix C: Taskforce Members | 35 |
| Appendix D: African World AIDS Day Planning Committee | 36 |

A Growing Crisis

Executive Summary

Background

HIV/AIDS—now the worst pandemic in human history—is a threat to the social and political stability and economic well-being of many nations and the single *most important public health challenge* facing the world today. The Human Immunodeficiency Virus (HIV), the virus that causes Acquired Immune Deficiency Syndrome (AIDS), is mainly transmitted through sexual fluids and unsafe drug-injecting practices, as well as blood, tissues, or breast milk of an infected person. Since the first case of HIV was diagnosed in 1981, the epidemic has killed over 20 million people worldwide; approximately 39 million people were living with the disease at the end of 2004. Of the 3.1 million AIDS deaths that year, over a half million were children.

Despite advances in prevention, care, and support, a viable solution has yet to be found. No cure is available and many people living with HIV are unaware that they are infected. *HIV/AIDS continues to increase around the world*, including the United States, where the incidence of the disease has risen precipitously in some areas.

Access to life-saving medications, not as readily available in developing countries, has contributed to the rise in the number of people living with HIV/AIDS in the U.S. This trend is true in Minnesota as well, where 5,002 people are estimated to be living with the disease, primarily in the seven-county metropolitan area. But while the number of new cases of HIV/AIDS has leveled off in the American-born population, *new cases among foreign-born people have been rising, especially among the African-born.*

HIV/AIDS is increasing at alarming rates among the state's African-born communities. Many African immigrants came to Minnesota to escape war and oppression, only to find new challenges once they arrived. Many believed they left behind the possibility of HIV infection. Unfortunately this is not the case. Less than 1 percent of Minnesota's population is African-born, yet in 2004, 19 percent of newly reported cases of HIV were among African-born individuals. *Actual numbers are likely much higher than reported*, as stigma, ignorance, and fear prevent many people from getting tested. Indeed, many aren't diagnosed until they are quite ill, when they end up in emergency rooms and are discovered to have full-blown AIDS.

About this Report. Over the last couple of years, local foundations began receiving requests from new, grassroots organizations for *funds to educate their African-born immigrant and refugee constituencies about HIV/AIDS prevention*. Program officers from the Otto Bremer Foundation and the Jay and Rose Phillips Family Foundation recognized that their lack of experience in funding HIV/AIDS prevention and in working with African cultures would affect their ability to craft effective funding recommendations. They convened representatives of five community organizations in April 2005; meetings and discussion grew in size and scope over five months, with 23 people eventually participating in a taskforce. The work of the taskforce led to a report, summarized here, presenting background information, findings, and recommendations for Minnesota funders.

A Growing Crisis

Findings

HIV/AIDS in Minnesota's African Communities. Although the HIV infection rate is highest among immigrants from several African countries (the greatest numbers come from, in descending order, Ethiopia, Liberia, Kenya, Cameroon, Uganda, Somalia), the reality is that *all African-born people are at risk*. Females account for 53 percent of HIV/AIDS cases among the African-born, compared to 18 percent among U.S.-born. It is difficult to determine precisely what is causing the increase in HIV/AIDS in Minnesota's African communities because of scant research in the area but some of the contributing factors include:

- Sub-Saharan Africa, where many African-born Minnesotans originated or lived as refugees, is home to 64 percent of the people living with HIV/AIDS in the world.
- The health-screening process for prospective immigrants is not as effective as it could be, and HIV testing is not included in routine refugee health assessments.
- Many African immigrants have not been exposed to HIV/AIDS prevention outreach efforts.
- Some immigrants believe a myth that the disease is left behind once they migrate to the U.S.
- *Cultural, personal, and practical deterrents to testing leave many unaware they are infected.*

Responding to the Epidemic. The taskforce identified the elements necessary for an effective response to the epidemic in Minnesota's African communities. *Prevention and education are key*, and include the need to address the powerful role of stigma. Many would rather die in isolation than seek care and be exposed to the community. Replacing fear with knowledge is critical to winning this battle, as is understanding the *importance of language, culture, and religion*. Additional efforts needed include:

- Developing and promoting HIV testing options;
- Connecting people to services, including funding services for undocumented immigrants;
- Building a supportive environment for infected people;
- Reaching the broader community through outreach campaigns and community spokespeople;
- Providing adequate funding to build the capacity of African community organizations.

HIV/AIDS Services and Funding in Twin Cities African Communities. The taskforce developed a "service matrix," an *overview of current activities, providers, gaps and barriers, opportunities, and funding* for HIV/AIDS prevention and care services in Twin Cities African communities.

The taskforce identified *inadequate funding, especially for African community organizations*, as one barrier. Compared to the approximately \$1.3 million provided by 27 foundations for HIV/AIDS-related work in Minnesota in 2003, African immigrant community organizations received a total of only \$55,000 that year, from 3 foundations, for HIV/AIDS work in their communities. In 2005-06, the Minnesota Department of Health (MDH) provided a total of \$134,311 to African community organizations for HIV/AIDS work. Beginning in July 2006, MDH funding for this work will total approximately \$274,263 per year for two and a half years.

A Growing Crisis

Additional gaps and barriers include stigma, fear, and lack of knowledge; cultural and religious restrictions; lack of comprehensive sex education in schools; and lack of health insurance.

Opportunities include engaging congregations and community and spiritual leaders; developing culturally sensitive education and outreach efforts in appropriate languages; creating an African HIV/AIDS collaborative forum; and better use of public health strategies.

Recommendations and Funding Options for Minnesota Funders

We hope information on the work of the taskforce and the following recommendations are useful to funders in determining whether and *how to respond to the HIV/AIDS crisis in our African communities*. We recommend four categories of support:

- **Capacity building** for existing African community organizations, including efforts to extend services to ethnic communities without formal agencies and to increase the cultural competence of mainstream organizations.
- **Program support** to increase collaboration among community organizations and access to testing, case management, and other services, including services for women, youth, and undocumented and new refugees.
- **Education and prevention**, including developing culturally appropriate health messages and outreach campaigns, and efforts to decrease stigmatization and discrimination.
- **Advocacy and public policy**, including opportunities to affect HIV/AIDS education in the public schools and for new refugees, to increase health care access, and to invest in additional, nongovernmental research.

Copies of the full report are available online at www.phillipsfnd.org or on request from the sponsoring foundations.

A Growing Crisis

Introduction

Over the last couple of years, several local foundations began receiving funding requests from very small, start-up, grassroots organizations serving recent African immigrant and refugee communities in the Twin Cities. The organizations requested funds to educate their constituencies about HIV/AIDS prevention. Most of the requests proposed similar outreach and education activities. Foundation staff were relatively unfamiliar with these communities and the cultural challenges that might prevent such efforts from being effective. The funders also had questions about the viability of these new organizations and their administrative capacity to do an effective job tracking the impact of their efforts and measuring results. In most cases, the funding requests were denied. But they continued to roll in.

At the same time, the Minnesota Department of Health began to identify HIV infection as a growing concern among various risk groups, with the HIV infection rate higher among African-born individuals than in other groups. Less than 1% of Minnesota's total population is African-born, yet in 2004, for example, 19% of the state's 307 newly reported cases of HIV were among African-born individuals. The experience over the last several years has been similar, with 16% of the state's new HIV cases among African-born individuals in 2001 and 21% in both 2002 and 2003. Although both men and women are at high risk for HIV infection, African-born women are experiencing HIV infection at slightly higher rates than men, 53% compared to 47% for men.

As of 2004, there were 521 African-born individuals known to be living with HIV/AIDS in Minnesota. The six countries of origin with the greatest number of cases are, in descending order, Ethiopia, Liberia, Kenya, Cameroon, Uganda, and Somalia. The number of those infected is thought to be much higher than reported, because stigma, ignorance, and fear prevent many people from getting tested. Indeed, many people aren't diagnosed until they are quite ill, when they end up in emergency rooms and are discovered to have full-blown AIDS.

It was against this backdrop that program officers from the Otto Bremer Foundation and the Jay and Rose Phillips Family Foundation recognized that efforts to reach the African communities in Minnesota with HIV/AIDS prevention messages was a growing trend emerging out of the need to address a growing crisis. They also recognized that their lack of experience in funding HIV/AIDS prevention and in working with African cultures would affect their ability to craft funding recommendations that could make a difference, be sustained, and complement existing sources of support. To hear from those who do the work, they convened representatives of five organizations in April 2005, beginning an ongoing dialogue to better understand the situations in these communities and the opportunities where funding could be helpful. Dialogue sessions grew in size and scope over the course of five months.

This report summarizes the findings of these discussions, provides data and other helpful background information on HIV/AIDS and African communities in Minnesota, and offers recommendations for local funders to consider in providing resources to address the growing crisis. This report is not intended to be the final word on this issue, but rather it is an attempt to provide solid information as well as opportunities to engage other funders in tangible ways as we join our African brothers and sisters in this critical work.

A Growing Crisis

Overview of HIV/AIDS

Global View of HIV/AIDS

HIV/AIDS—now the worst pandemic ever experienced in human history—is a threat to the social and political stability and economic well-being of many nations. The Human Immunodeficiency Virus (HIV), the virus that causes Acquired Immune Deficiency Syndrome (AIDS), is mainly transmitted through sexual fluids and unsafe drug-injecting practices, as well as blood, tissues, or breast milk of an infected person. Since the first case of HIV was diagnosed in 1981, the epidemic has killed over 20 million people worldwide. By the end of 2004, the epidemic reached its highest level yet, with approximately 39 million people estimated to be living with HIV/AIDS worldwide.¹ Of the 3.1 million AIDS deaths that year, over a half million were children. HIV is the leading cause of death worldwide among people aged 15-59.

Globally, many people living with HIV are unaware that they are infected. During 2004 alone, an estimated 4.9 million people acquired HIV, including approximately 640,000 children under the age of 15.² The reported number of new HIV cases has been rising in every region, but most new HIV infections and AIDS-related deaths occur in low- and middle-income countries, where 95% of people living with HIV/AIDS reside.^{1,2} The countries of sub-Saharan Africa have been particularly hard hit. There is also increasing concern about the next wave of the epidemic, emerging in parts of Eastern Europe and Asia.

Number of Adults and Children Estimated to be Living with HIV/AIDS in 2004²

| Region | |
|-----------------------------|--------------|
| Sub-Saharan Africa | 25.4 million |
| South/Southeast Asia | 7.1 million |
| Latin America | 1.7 million |
| Eastern Europe/Central Asia | 1.4 million |
| East Asia | 1.1 million |
| North America | 1.0 million |
| Western/Central Europe | 610,000 |
| North Africa/Middle East | 540,000 |
| Caribbean | 440,000 |
| Oceania | 35,000 |

| | |
|---------------------|---------------------|
| Global Total | 39.4 million |
|---------------------|---------------------|

As the figures above indicate, sub-Saharan Africa is, by far, the worst affected region in the world. While approximately 10% of the world's population lives in this region, it is home to 64% (25.4 million) of the people living with HIV/AIDS in the world (39.4 million). Of the estimated 15 million children who have been orphaned by AIDS, having lost one or both parents to the epidemic, 12 million live in sub-Saharan Africa.¹ In 2004, an estimated 3.1 million people in the region became newly infected, while 2.3 million died of AIDS.

A Growing Crisis

Globally, women and girls comprise an increasing proportion of those aged 15-49 living with HIV/AIDS: 47% in 2004 compared to 41% in 1997.² While this trend is occurring in most regions of the world, it has a huge impact on sub-Saharan Africa, where more than half (57%) of adults living with HIV/AIDS are female.¹ A striking 76% of females in the region living with HIV/AIDS are girls and young women aged 15–24 years. Many factors contribute to the apparent gender inequality with respect to HIV. Women's vulnerability to HIV is increased by the gender inequalities in economic and social status as well as lack of access to prevention and care services.² In addition, sexual violence increases the risk of women contracting the disease. Moreover, young women who are sexually active are more susceptible to HIV infection than men.²

HIV/AIDS has spread throughout the world, including the United States, where the incidence of the disease has risen precipitously in some communities. Worldwide, heterosexual sex is the major route of HIV transmission, although risk factors for HIV vary around the world. In many regions, men who have sex with men (MSM), injection drug users (IDU), and sex workers account for significant proportions of infections.² In Africa, the major mode of HIV transmission remains heterosexual sex.

Women's vulnerability to HIV is increased by the gender inequalities in economic and social status as well as lack of access to prevention and care services. In addition, sexual violence increases the risk of women contracting the disease.²

HIV/AIDS in Minnesota

The Center for Disease Control (CDC) estimated that approximately 850,000 to 950,000 people were living with HIV/AIDS in the U.S. by the end of 2004³ (the figures quoted are adjusted to reflect unreported cases). The CDC estimates that about 40,000 people in the U.S. become infected with HIV every year.³ From 1998 to 2003, the number of people living with AIDS increased from approximately 311,205 to 405,926 persons.⁴

While Minnesota is not considered one of the states with high rates of HIV/AIDS, the number of Minnesotans estimated to be living with HIV/AIDS has steadily increased. By the end of 2004, the number of people known to be living with HIV/AIDS in Minnesota was 5,002, a 2.2% increase from 2003 (4,895 persons). Among these cases, 2,835 people were diagnosed with HIV, while 2,167 were diagnosed with AIDS.⁵ The vast majority of these people (87%) live in the Twin Cities seven-county metropolitan area (Hennepin, Ramsey, Anoka, Carver, Dakota, Scott, and Washington counties), though 85% of the counties in Minnesota have people living with HIV/AIDS.⁵

In Minnesota, 78% of people living with HIV/AIDS are male, with 64% of the male cases White, 19% African American, 7% Hispanic, 6% African-born, 1% American Indian, and 1% Asian/Pacific Islander.⁵ In total, 36% of the male population living with HIV/AIDS in Minnesota is non-White, compared to the 12% of the general male population that is non-White.

Gender inequality is evident in the distribution of HIV/AIDS among females of color in Minnesota: 70% of females with HIV/AIDS are non-White, while only 11% of the general female population is non-White.⁵ The specific racial/ethnic profile of the Minnesota female

A Growing Crisis

population living with HIV/AIDS is: 30% White, 33% African American, 25% African-born, 6% Hispanic, 4% American Indian, and 2% Asian/Pacific Islander.⁵

Modes of exposure in Minnesota vary by race and gender. For White males, an estimated 93% of cases are among MSM or MSM/IDU, while for non-White males, 61% of cases are among these groups. Among American Indians, 34% of cases are among MSM/IDU, compared to 30% for African Americans, 17% Hispanic, 11% White, 8% Asian, and 0% African-born. The mode of HIV exposure for females is frequently heterosexual sexual contact.⁵

HIV/AIDS in the African-Born Communities in Minnesota

HIV/AIDS cases have increased significantly among the foreign-born population in Minnesota, specifically among the African-born. Between 1990 and 2004, the number of foreign-born people living with HIV/AIDS increased from 50 to 692, “a twelve fold increase,” according to the Minnesota Department of Health.⁵ It is important to note that this increase took place at the same time that the population of African-born immigrants residing in Minnesota grew at exponential rates.

The profile of foreign-born people living with HIV/AIDS in Minnesota differs from the profile of the U.S.-born living with HIV/AIDS, especially in gender. Among the U.S.-born, females account for 18% of the cases, compared to 53% of cases among the African-born and 42% among Asian-born.⁵ The gender distribution for Minnesotans born in Latin America, the Caribbean, and Europe is parallel to the U.S.-born distribution (18% female).⁵ The following table presents the number of African-born people living with HIV/AIDS in Minnesota by country of birth (see map on page 31.)⁵

Country of Birth for African-Born People Living with HIV/AIDS in Minnesota, 2002–2004

| | <u>2002</u> | <u>2003</u> | <u>2004</u> | | | | | | | | | | |
|---------------------|-------------|-------------|-------------|--|---------------|--|--|-------------|-------------|-------------|-----|-----|-----|
| • <i>Ethiopia*</i> | 81 | 105 | 138 | <table style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="3" style="text-align: center;">Totals</td> </tr> <tr> <td style="text-align: center;"><u>2002</u></td> <td style="text-align: center;"><u>2003</u></td> <td style="text-align: center;"><u>2004</u></td> </tr> <tr> <td style="text-align: center;">335</td> <td style="text-align: center;">419</td> <td style="text-align: center;">521</td> </tr> </table> | Totals | | | <u>2002</u> | <u>2003</u> | <u>2004</u> | 335 | 419 | 521 |
| Totals | | | | | | | | | | | | | |
| <u>2002</u> | <u>2003</u> | <u>2004</u> | | | | | | | | | | | |
| 335 | 419 | 521 | | | | | | | | | | | |
| • <i>Liberia*</i> | 44 | 55 | 72 | | | | | | | | | | |
| • Kenya | 43 | 59 | 67 | | | | | | | | | | |
| • Cameroon | 26 | 31 | 38 | | | | | | | | | | |
| • Uganda | 24 | 25 | 29 | | | | | | | | | | |
| • <i>Somalia*</i> | 18 | 24 | 35 | | | | | | | | | | |
| • (21 other) | 99 | 120 | 142 | | | | | | | | | | |

Italicized countries represent the largest numbers of Africans in the general Minnesota population.

** HIV+ Primary Refugee(s) have relocated to Minnesota from these countries of origin.⁵*

A Growing Crisis

Factors Contributing to the Rise in HIV/AIDS Among African-Born Minnesotans

It is difficult to determine precisely what is causing the alarming increase in HIV/AIDS among African communities in Minnesota, in part because of the scant research in the area.

Nevertheless, it is worth noting some of the possible contributing factors:

1. According to Tracy Sides, HIV/AIDS surveillance coordinator, Minnesota Department of Health, there are many deterrents to testing, leaving many people unaware that they are infected.⁶ And someone who has contracted the disease within three months prior to testing might receive a false negative even though he/she actually has the disease.
2. The sub-Saharan African region where many African-born Minnesotans originated or lived as refugees has high proportions of people living with HIV/AIDS.
3. Some people believe the myth that the disease is left behind once they migrate to the U.S.⁶
4. African community members in Minnesota have not been exposed to the HIV/AIDS education, prevention strategies, and outreach that have been available to the mainstream community for the last 20 years.
5. According to Minnesota African Women's Association (MAWA), some people may have multiple partners and are not practicing safe sex.⁷
6. A number of refugees with positive HIV/AIDS status have resettled in Minnesota. All refugees and immigrants are screened for HIV/AIDS prior to coming to the U.S. and require a special medical waiver to enter this country if they test positive. These waivers are granted, but on a case-by-case basis, and based on circumstances. See chart below.
7. This health screening process is deficient: six months or longer may lapse between the time people are tested and the time they depart to the U.S., creating the possibility of contracting the HIV virus during that period.
8. Once refugees arrive in Minnesota, routine refugee health assessment does not include HIV testing; only those who have symptoms or a medical history of HIV/AIDS are tested.⁶
9. There is limited health education available for people infected with HIV/AIDS and other newly arrived refugees.
10. Lastly, there is no way of telling exactly how many people came to Minnesota with HIV/AIDS versus how many contracted the disease here. What is clear, however, is that the African-born HIV/AIDS cases in Minnesota are increasing at alarming rates.

A Growing Crisis

The following tables show the cumulative number of refugees who arrived in Minnesota with HIV/AIDS positive status from 2000 to August 2005, as well as country of origin, gender, and age group.⁸ Data from the year 2002 is missing from the tables below. Following the 9/11 terrorist attacks and tightened security, the number of refugee arrivals decreased in 2002. Only 1,033 refugees arrived in Minnesota between January and December, 2002, and none were HIV+.⁸

HIV+ Refugees with Special Medical Waiver

| Arrivals | 2000 | 2001 | 2003 | 2004 | 2005* | Total |
|--------------------------|------|------|------|------|-------|-------|
| Total Arrivals | 4013 | 2795 | 2401 | 7345 | 3299 | 19853 |
| Percent (%) | 0.65 | 0.68 | 0.79 | 0.64 | 0.42 | 0.63 |
| Total Waivers (per year) | 26 | 19 | 19 | 47 | 14 | 125 |

Countries of Origin

| Country | 2000 | 2001 | 2003 | 2004 | 2005* | Total |
|--------------|------|------|------|------|-------|----------|
| Burma | | | | | 1 | 1 |
| Eritrea | | | | 1 | | 1 |
| Ethiopia | 17 | 7 | 11 | 20 | 4 | 59 (47%) |
| Liberia | 3 | 4 | 2 | 11 | 4 | 24 (19%) |
| Nigeria | 1 | | | | | 1 |
| Sierra Leone | | 1 | 1 | 1 | | 3 (2%) |
| Somalia | 4 | 6 | | 9 | 3 | 22 (18%) |
| Sudan | 1 | | 5 | 5 | 2 | 13 (10%) |
| Uganda | | 1 | | | | 1 |

Gender

| | 2000 | 2001 | 2003 | 2004 | 2005* | Total |
|--------|------|------|------|------|-------|----------|
| Female | 10 | 9 | 7 | 24 | 6 | 56 (45%) |
| Male | 16 | 10 | 12 | 23 | 8 | 69 (55%) |

Age Groups

| | 2000 | 2001 | 2003 | 2004 | 2005* | Total |
|-------|------|------|------|------|-------|----------|
| 5-14 | 1 | | | | 1 | 2 (2%) |
| 15-24 | 18 | 11 | 8 | 16 | 5 | 58 (46%) |
| 25-44 | 1 | 6 | 7 | 17 | 6 | 37 (30%) |
| 45-64 | 6 | 2 | 4 | 13 | 1 | 26 (21%) |
| 65+ | | | | 1 | 1 | 2 (2%) |

New HIV+ Identified During Health Assessment **

| | 2000 | 2001 | 2003 | 2004 | 2005* | Total |
|------------------|------|------|------|------|-------|-------|
| Total (per year) | | | 1 | 2 | | 3 |
| Cameroon | | | | 1 | | 1 |
| Ethiopia | | | 1 | | | 1 |
| Liberia | | | | 1 | | 1 |

*2005 arrival data through 8/31/05.

**Refugee was either negative during the overseas exam or not screened if under <15 years of age⁸

A Growing Crisis

Global Efforts on HIV/AIDS

The global response to HIV/AIDS has been evolving since the pandemic was discovered in 1981. Some United Nations agencies have jointly sponsored a United Nations Program on HIV/AIDS (UNAIDS), bringing together the efforts of five U.N. agencies and the World Bank.⁹ Over the past few years, the international community has devoted greater attention to HIV/AIDS, leading to several important initiatives, including the United Nations General Assembly Special Session on HIV/AIDS and the Global Fund to Fight AIDS, Tuberculosis, and Malaria. The World Health Organization (WHO), in collaboration with UNAIDS, has started a “3 by 5 Initiative,” pledging that 3 million people in the developing nations receive antiretroviral therapy by the end of 2005.⁹

President George W. Bush has made fighting the international HIV/AIDS epidemic a U.S. priority. The President’s Emergency Plan for AIDS Relief (PEPFAR) is a five-year, \$15 billion strategy, and is the largest commitment ever by a single nation toward an international health initiative.⁹ Through PEPFAR, the U.S. will focus the bulk of the money in new resources in 15 of the most afflicted countries in the world. It will also devote one-third of the funds to ongoing bilateral programs in more than 100 countries, and raise its pledge to the Global Fund to Fight AIDS, Tuberculosis, and Malaria over five years.⁹

Even though global funding for HIV/AIDS has increased over the years, resources still fall short of projected need, and most people living with HIV/AIDS, as well as those at risk for HIV, do not have access to prevention, care, and antiretroviral treatment.

Even though global funding for HIV/AIDS has increased over the years, resources still fall short of projected need, and most people living with HIV/AIDS, as well as those at risk for HIV, do not have access to prevention, care, and antiretroviral treatment. In 2004, global spending on HIV/AIDS was estimated to be \$6.1 billion, but need was much greater. UNAIDS projects that \$12 billion will be needed in 2005 to effectively respond to the HIV/AIDS epidemic in low- and middle-income countries.²

In addition to the efforts noted above, there is a growing impetus to address the global HIV/AIDS crisis, more than at any other time in the course of the epidemic. Over the last decade, there has been a considerable increase in the number and range of non-governmental organizations (NGOs) responding to the multiple challenges presented by HIV/AIDS, especially in developing nations. NGOs undertake HIV/AIDS work, provide education and resources, and integrate HIV/AIDS interventions within other health programming. NGOs also mainstream HIV/AIDS work within development, human rights, and humanitarian programming. There have also been significant changes in the global funding environment, particularly in ensuring that the lessons learned over the past 20 years are used to guide the allocation of resources in scaling up responses to HIV/AIDS.

The ABC Approach

The global community has been using many strategies to combat the HIV/AIDS epidemic. One of the best known methods is the “ABC” approach, which started in Botswana as a slogan in the 1990s: “**A**bstain, **B**e faithful, and **C**ondomise.”¹⁰

A Growing Crisis

The core of the “ABC” method is: The risk can be avoided altogether by avoiding any sexual activities that could cause transmission of HIV (i.e., **Abstain**). The risk can also be reduced, through avoiding sexual intercourse other than with a mutually faithful, uninfected partner (i.e., **Be faithful**) or through the correct and consistent use of condoms (i.e., **Condomise**).¹⁰

Botswana’s use of ABC was not particularly controversial. It was a slogan adopted by the Botswana government as part of a general public AIDS awareness campaign. It was not intended to promote any component parts of ABC or to identify to whom they would be promoted. But other variations of the ABC approach have since emerged that have specific definitions and targets, most notably the approach taken by the U.S.-funded PEPFAR initiative and others adopted by UNAIDS.

The PEPFAR definition of the ABC strategy calls for "population-specific interventions" that emphasize:

- **A**bstinence for youth, including the delay of sexual debut and abstinence until marriage.
- **B**eing tested for HIV and being faithful in marriage and monogamous relationships.
- **C**orrect and consistent use of condoms for those who practice high-risk behaviors.¹¹

Those who practice high-risk behaviors include “prostitutes, sexually active discordant couples [in which one partner is known to have HIV], substance abusers, and others.” The PEPFAR definition does not include the promotion of condoms to young people in general.¹²

For UNAIDS, ABC means:

- **A**bstinence or delaying first sex.
- **B**eing safer by being faithful to one partner or by reducing the number of sexual partners.
- **C**orrect and consistent use of condoms for sexually active young people, couples in which one partner is HIV-positive, sex workers and their clients, and anyone engaging in sexual activity with partners who may have been at risk of HIV exposure.¹³

The ABC approach to HIV prevention was most fully embraced by Uganda. In the late 1980s, when the HIV epidemic was rapidly spreading through the Ugandan population, the government launched an aggressive media campaign involving radio messages, posters, and rallies. The government trained teachers to begin effective HIV and AIDS education, and, most importantly, mobilized community leaders, churches, and indeed the public in general.¹⁴ In addition, the government worked alongside many independent organizations, using different messages to address different groups according to their needs and ability to respond. Thus, Uganda's response was powerful and wide-ranging. PEPFAR claims that Uganda's unique success in reducing its HIV rate is due to the ABC method. However, there is no evidence of the term "ABC" being used in Uganda's campaigns at this time, although they did

In spite of the successful implementation of the ABC approach in various countries, there is still widespread resistance within most African communities to the distribution and use of condoms. This is in large part cultural, due to religious restrictions and the understanding that sexual activity is not discussed openly between genders.

A Growing Crisis

incorporate some elements of abstinence, faithfulness, and condom use.

According to Stella Talisuna, M.D., who is a fellow with the Institute of Public Health and Center for Disease Control HIV/AIDS Fellowship Program, "The ABC approach in Uganda was and still is more than just abstinence and needs to be balanced without any emphasis on one aspect. Neither 'A' nor 'B' nor 'C' on its own can provide the answer to reducing risk of infection that is practical for every member of the population."¹⁴

Moreover, in encouraging public involvement and participation, action was taken to encourage candid discussion of HIV and AIDS, to reduce stigma, to better the status of women, to improve testing facilities, and to provide better treatment and care for those already infected. By using multilateral risk avoidance and risk reduction approaches, Uganda has shown signs of a real decline in HIV infection levels: National prevalence fell from 13% in the early 1990s to 4.1% (2.8–6.6%) by the end of 2003.¹ What appears to have worked in Uganda has been the combination of messages and approaches that have been used, including the widespread promotion and distribution of condoms. During the 1990s, a USAID-funded effort increased condom use from 7% nationwide to over 50% in rural areas and over 85% in urban areas.¹⁵

In spite of the successful implementation of the ABC approach in various countries, there is still widespread resistance within most African communities to the distribution and use of condoms. This is in large part cultural, due to religious restrictions and the understanding that sexual activity is not discussed openly between genders.

Work of the Taskforce

Work of the Taskforce

In April 2005, leaders of some of the state's African community organizations that work with people living with HIV/AIDS, representatives of the Jay and Rose Phillips Family Foundation and the Otto Bremer Foundation, and a consultant began to meet to discuss how best to respond to the rapid spread of HIV/AIDS in Minnesota's African communities. Additional participants included pastors, public service personnel, and representatives of nonprofit organizations that directly or indirectly serve the communities, especially people living with HIV/AIDS. (Participants are listed in Appendix C.) Discussion during four two-hour meetings focused on HIV/AIDS in the African communities in Minnesota, how the foundations can be proactive in addressing the issues, and the gaps facing the communities' organizations.

The discussions identified a number of major issues confronting the African community organizations, including the stigma associated with HIV/AIDS, the challenges facing people living with the disease, the lack of linguistically appropriate and culturally competent services, the need for HIV/AIDS education and outreach activities, and lack of funding for the African community organizations.

The discussions identified a number of major issues confronting the African community organizations, including the stigma associated with HIV/AIDS, the challenges facing people living with the disease, the lack of linguistically appropriate and culturally competent services,

A Growing Crisis

the need for HIV/AIDS education and outreach activities, and lack of funding for the African community organizations. One issue that was difficult to acknowledge and discuss within the group was the fact that HIV/AIDS is mainly transmitted through sexual intercourse. This point must be emphasized because it suggests how difficult it will be for organization leaders who are uncomfortable with the topic to engage in discussions with community members.

Taskforce discussions led to the development of the following service matrix, which identifies service activities for prevention and care of HIV/AIDS, including current providers, gaps and barriers, opportunities, and current funding. After the service matrix was finalized, a report was prepared based on the work of the taskforce, interviews with staff of the Minnesota Department of Health (MDH) and refugee resettlement agencies, and consultant research. The report has been reviewed by a committee comprised of four members of the taskforce and three people who have not previously participated in taskforce meetings: a community organization leader, a religious community leader, and a staff member of a Health Management Organization (HMO). The committee's input has been included in this final report.

A Growing Crisis

Service Matrix HIV/AIDS Services in the African Communities in the Twin Cities

| Service Category | Service Activity | Current Providers (to the best of our knowledge) | Gaps / Barriers | Opportunities | Current Funding |
|-------------------|---------------------------------|---|--|--|---|
| Prevention | General Public Education | <ul style="list-style-type: none"> • African American AIDS Task Force (AAATF) • African Network for Development, Inc. (ANDI) • Confederation of Somali Community in Minnesota (CSCM) • Good Image Family Services • Minnesota AIDS Project (MAP) • PEACE African • Somali Health Project <p>MDH funded 11 continuing agencies (Appendix A)</p> | <ul style="list-style-type: none"> • Stigma • Lack of knowledge • Cultural competence / language • Myths and misconceptions • Newly arrived HIV-positive refugees need prevention education • Taboo to talk about sex and sexuality • Inadequate funding to CBOs • Most CBOs are understaffed, hence time constraint is a factor | <ul style="list-style-type: none"> • Engaging congregations / community / spiritual leaders • Need for more culturally sensitive education and outreach in language appropriate settings • Need to talk about HIV transmission in two ways—through sexual contact and in other ways • Creation of an African HIV/AIDS collaborative forum • Better utilization of known/proven public health strategies | <ul style="list-style-type: none"> • Minnesota Department of Health provided a total of \$134,311 to African immigrant community organizations in 2005-06 (Appendix A) • 3 foundations gave HIV/AIDS grants in 2003 to African immigrant community organizations for a total of \$55,000 (Appendix B) • 27 foundations gave HIV/AIDS-related grants for non-African related work in 2003 for a total of \$1,285,501 (Appendix B) |
| Prevention | Public Policy Work | <ul style="list-style-type: none"> • AAATF • MAP • ANDI | <ul style="list-style-type: none"> • Trend toward abstinence-based education • Lack of comprehensive sex education in schools | <ul style="list-style-type: none"> • Need adequate state funding for prevention programs • Condoms in school with comprehensive sex education • Collaboration with MN Organization on Adolescent Pregnancy Prevention and Parenting (MOAPPP) | |

A Growing Crisis

Service Matrix, continued

| Service Category | Service Activity | Current Providers (to the best of our knowledge) | Gaps / Barriers | Opportunities | Current Funding |
|-------------------|--|---|--|--|-----------------|
| Prevention | One-to-One Outreach / Education | <ul style="list-style-type: none"> • MAP • PEACE African • Sub-Saharan African Youth and Family Services (SAYFSM) • AAATF • Sudanese Women’s Association • Same 11 agencies in Appendix A • Women Light Action Network (WLAN) | <ul style="list-style-type: none"> • Stigma • Lack of knowledge • Myths and misconceptions • Cultural competence / appropriate materials and strategies | <ul style="list-style-type: none"> • Engaging congregational, community, and spiritual leaders • Festivals and other community gatherings | |
| Prevention | Testing | <p>Free/Confidential Sites:</p> <ul style="list-style-type: none"> • AAATF • Access Works • Red Door (Minneapolis) • Room 111 (St. Paul) • MAP • Minneapolis Urban League • SAYFSM • Turning Point • Planned Parenthood <p>Fee-Based Sites:</p> <ul style="list-style-type: none"> • Regions Hospital (St. Paul) • Hennepin County Medical Center (HCMC) (Minneapolis) • Most clinics | <ul style="list-style-type: none"> • Lack of culturally specific sites • Stigma and fear • Lack of knowledge about free sites • Fear of immigration / deportation if test positive • Lack of culturally appropriate counseling • Lack of resources if test positive • Lack of health insurance • Fear of finding out • Lack of knowledge of HIV | <ul style="list-style-type: none"> • Orasure / Ora-Quick testing methods • Use other diseases/ conditions as the inroad • Use newspapers and media to advertise and educate • Create satellite testing sites from clinics • More culturally specific counselors | |

A Growing Crisis

Service Matrix, continued

| Service Category | Service Activity | Current Providers (to the best of our knowledge) | Gaps / Barriers | Opportunities | Current Funding |
|-------------------|--|---|---|---|-----------------|
| Prevention | Youth Education | <ul style="list-style-type: none"> • PEACE African • MAP • Hope International • Red Cross • SAYFSM • MN African Women’s Association (MAWA) • WLAN • Kids Home International • Some mosques/ churches • Project Valentine • MOAPPP • Red Door (YIP) Program • Good Image • East African Health Project • MN International Health Volunteers | <ul style="list-style-type: none"> • Abstinence-based education that won’t teach about condoms and safe sex • Caught between two cultures • Lack of incentives • Lack of positive social / educational activities • Lack of funding • Time – school activities vs. HIV projects | <ul style="list-style-type: none"> • Speakers bureaus • Faith-based groups • Opportunity to work with parents as well • Tying HIV education to other youth activities at CBOs • Mentorship | |
| Prevention | Publications in Various Languages | <ul style="list-style-type: none"> • PEACE African • SAYFSM • Mestawet (newspaper) • MAWA • Project Valentine | <ul style="list-style-type: none"> • Printing costs • Illiteracy • Access to publications • Funding is limited | <ul style="list-style-type: none"> • Skits / dramas • Public access TV • Radio PSAs • Music • Congregational newsletters | |

A Growing Crisis

Service Matrix, continued

| Service Category | Service Activity | Current Providers (to the best of our knowledge) | Gaps / Barriers | Opportunities | Current Funding |
|-------------------|----------------------------|---|--|--|--|
| Prevention | Condom Distribution | <ul style="list-style-type: none"> • AAATF • Africa Solutions • ANDI • Good Image • HCMC • MAP • Project Valentine, Inc. • Red Door and other testing sites • SAYFSM • Zyombi Project | <ul style="list-style-type: none"> • Cultural / religious restrictions • Access • Lack of knowledge re importance of their use • Believing there is a cure • Focusing on a Western agenda to educate rather than focusing on cultural realities • Funding is limited for condoms | <ul style="list-style-type: none"> • Safe sex education • Get condoms closer to community at more convenient access points • Education with faith-based community • Use ABC method (Abstinence, Be faithful, Condoms) • Utilize public events and other gatherings • Distribute at public events • Funds for purchasing condoms | <ul style="list-style-type: none"> • Department of Health |
| Prevention | Train the Trainer | <ul style="list-style-type: none"> • MAP • Minnesota Department of Health • Midwest AIDS Training Center—train providers through consultations, individualized clinician training program, targeted clinic program • Red Cross (certify) | <ul style="list-style-type: none"> • No cultural-specific training • Predominantly volunteer driven | <ul style="list-style-type: none"> • Need full-time staff to support volunteers as trainers • Stipends for volunteers • More fee for service opportunities | <ul style="list-style-type: none"> • Fee for service |

A Growing Crisis

Service Matrix, continued

| Service Category | Service Activity | Current Providers (to the best of our knowledge) | Gaps / Barriers | Opportunities | Current Funding |
|------------------|--|--|---|--|--|
| Care | Ongoing Health Care / Testing | <ul style="list-style-type: none"> • HCMC • Private clinics • Regions Hospital • Clinic 42 (Minneapolis) • Fairview University Hospital • Room 111 (St. Paul) | <ul style="list-style-type: none"> • Having care provider options • Stigma • How to navigate the system • Lack of cultural providers • Lack of interpreters • Service providers' lack of cultural understanding • Clients' lack of knowledge of services • Not enough time to complete appointment | <ul style="list-style-type: none"> • Looking at ways to license doctors from country of origin and fostering services • Collaborate with African community agencies • Taking advantage of inner resourcefulness | <ul style="list-style-type: none"> • Department of Human Services (DHS) • Hennepin County • Medical Assistance • Minnesota Care • Private Insurance |
| Care | Referral to Care Services / Care Advocacy | <ul style="list-style-type: none"> • AAATF • Africa Solutions • ANDI • Good Image • Kono Union • MAP • PEACE African • Project Valentine • SAYFSM • Zyombi Project | <ul style="list-style-type: none"> • Clients' lack of understanding of the referral concept • Inability to follow up to determine if needs are met • Lack of designated office space / staff • Confidentiality concerns • Confusion about donation vs. pay • Lack of knowledge about the referral destination • Mainstream organizations' lack of trust in African agencies to do the work effectively | <ul style="list-style-type: none"> • Collaborations with existing providers • Empower African agencies to have a space for referrals • Build trust | |

A Growing Crisis

Service Matrix, continued

| Service Category | Service Activity | Current Providers (to the best of our knowledge) | Gaps / Barriers | Opportunities | Current Funding |
|-------------------------|----------------------------------|---|---|--|--|
| Care | Case Management | <ul style="list-style-type: none"> • Clinic 42 • HCMC • MAP • SAYFSM • Turning Point • Urban League • Westside Community Health Services | <ul style="list-style-type: none"> • Not enough culturally appropriate case managers (CM) • Lack of gender-specific CMs • CMs have no openings or a long waiting list • CMs are bound by job description • Bouncing around to various services • Cultural misunderstanding of CM • Educating clients • Fragmented CM services | <ul style="list-style-type: none"> • Collaborations with existing providers • Educating people about CM—what is it? who does it? • Someone to provide initial orientation to HIV services after a positive test | <ul style="list-style-type: none"> • DHS |
| Care | Support Groups / Meetings | <ul style="list-style-type: none"> • AAATF • Africa Solutions • African Women’s Wellness Gathering (collaboration) • Community Fitness Today • SAYFSM | <ul style="list-style-type: none"> • Lack of awareness of the existence of support groups • Client expectations too high initially and many end up dropping out • Inadequate funding for cultural-specific support groups | <ul style="list-style-type: none"> • Collaborative possibilities among providers • Congregations could sponsor meetings | <ul style="list-style-type: none"> • DHS, AAATF, MAP, Women & Families Network, Hennepin County |
| Care | Medications Access | <ul style="list-style-type: none"> • AIDS Drug Assistance Program • HCMC | <ul style="list-style-type: none"> • Funding being cut / decreased • Additional co-pays • Lack of understanding of the various programs • Excessive paperwork | <ul style="list-style-type: none"> • Medical Assistance pays for it | <ul style="list-style-type: none"> • Federal government • DHS HIV/AIDS Program |

A Growing Crisis

Service Matrix, continued

| Service Category | Service Activity | Current Providers (to the best of our knowledge) | Gaps / Barriers | Opportunities | Current Funding |
|------------------|--------------------------|---|---|--|-----------------|
| Care | Mental Health Counseling | <ul style="list-style-type: none"> • ANDI • Community University Health Care Center • HCMC • Neighborhood Involvement Program • Regions International Clinic • SAYFSM | <ul style="list-style-type: none"> • Access—people do not know where to go • Stigma | <ul style="list-style-type: none"> • Mental health resource guide for individuals with HIV /AIDS • Connecting people who are HIV positive as mentors to others | |
| Care | Individual Advocacy | <ul style="list-style-type: none"> • AAATF • Africa Solutions • ANDI • MAP • PEACE African • Project Valentine • SAYFSM | <ul style="list-style-type: none"> • Legal status • Financial constraints | <ul style="list-style-type: none"> • Have more people who are positive come out | |
| Care | Interpretative Services | <ul style="list-style-type: none"> • SAYFSM • Hennepin County contracts with a number of agencies | <ul style="list-style-type: none"> • Insufficient number of interpreters • Lack of funding • Concerns about confidentiality | | |
| Care | Transportation | <ul style="list-style-type: none"> • AAATF • HCMC, Regions Hospital (bus cards) • Health Plans • MAP • Project Valentine • SAYFSM • St. Paul Red Cross (St. Paul residents only) | <ul style="list-style-type: none"> • Lack of transportation options • Lack of funding means priority is given for rides to medical appointments • No weekend or evening transportation | <ul style="list-style-type: none"> • Access to other forms of transportation • 31-day bus passes are best | |

A Growing Crisis

Findings

As indicated in the service matrix (above), there is a lot to be done to respond collectively and effectively to HIV/AIDS in the state's African communities. Based on the work of the taskforce, critical elements to consider in addressing this epidemic include prevention/education efforts in a number of ways and forums, support groups, ways to connect people to services, and building a supportive environment for infected people. Stigma is still a significant issue in the community. Many people would rather die in isolation than seek care services and be exposed to the community. Replacing fear with knowledge is critical to winning this battle.

Stigma is still a significant issue in the community. Many people would rather die in isolation than seek care services and be exposed to the community. Replacing fear with knowledge is critical to winning this battle.

Developing HIV testing options is imperative to the community. More efforts must be made to help people get tested and know their status. Services for undocumented immigrants who are HIV positive are under-funded. Additional problems they encounter include limited services, stigma, and, above all, fear of deportation. People who test positive need to know

that there are supportive environments in which they can deal with their status. Building these support networks is critical in dealing with the illness, both individually and communally, and will ultimately address the stigma issue.

In order to reach the broader community, outreach campaigns and the media must be utilized to create awareness. Potential channels include television talk shows, radio, and drama/theater work to get the messages out in appropriate languages. To put a face to the issue, HIV-positive people who are willing to speak frankly to their own ethnic group about their story, whether in public, small groups, or one-on-one, must come forward.

Lack of funding is a key challenge facing African community organizations, affecting their ability to have adequate facilities and staff and to provide needed services. Most organizations are operating on a volunteer basis or by part-time employees. This issue was noted both by the taskforce and by MDH staff interviewed for this project. Both Kip Beardsley, section manager for the STD and HIV section, and Japhet Nyakundi, program services specialist, pointed to the need for capacity building, capital funding, and functional collaborations for African community organizations.¹⁶ However, these tasks are complicated by differences in language, culture, and religion. Ignoring these differences will hinder efforts to serve the affected population and to reduce the number of HIV/AIDS cases in African communities.

Available data indicates that the number of cases of HIV/AIDS in African-born communities in Minnesota is on the rise, which means all Africans are at risk, even if cases of HIV infection remain low for immigrants from specific countries. Between 2002 and 2004, an average 20% of new reported cases of HIV infection were among African-born people. And, as noted above, these infection rates lean slightly more toward women than men at this time. However, many believe that the numbers of people infected are actually much higher than the data indicates, since the majority do not get tested due to stigma, lack of knowledge, or fear of finding out. The study conducted by Minnesota African Women's Association (MAWA) indicates that there are high levels of risky behavior and misinformation among some of the survey respondents.⁷

A Growing Crisis

Aside from state data, independent research is lacking on the impact of the HIV/AIDS epidemic in the African community in Minnesota, making it difficult to conduct in-depth evaluations. In general, however, the six countries of origin with the greatest number of HIV/AIDS cases in Minnesota are, in descending order, Ethiopia, Liberia, Kenya, Cameroon, Uganda, and Somalia. But data from HIV-positive primary refugees resettled in Minnesota gives significant reason to be concerned about the future trends of HIV/AIDS in some of the communities with lower numbers of cases.

Between 2000 and August 2005, 47% of the HIV-positive refugees with special medical waivers resettled in Minnesota were Ethiopians, 19% Liberians, 18% Somalis, and 10% Sudanese.⁸ While Somalia has the lowest number of HIV/AIDS cases in Minnesota among the top six countries of origin, it ranks third in the number of refugees arriving in Minnesota with a previous HIV/AIDS diagnosis. A focus group with Somali community members conducted by Minnesota International Health Volunteers (MIHV) reveals that Somalis do not generally talk about HIV/AIDS because of fear related to isolation and stigmatization from the community.¹⁷ The focus group also highlighted the issue of religion and the belief of participants that an individual acquires the disease if they are “doing bad deeds” or “leaving (their) religion.” Sudan, which is not even on the list of the six countries of origin with the greatest number of Minnesota cases, ranks fourth in the number of refugees arriving in Minnesota with a previous HIV diagnosis.

Given the higher percentages of refugees living with HIV/AIDS, the lack of awareness, prevention, and education, and the fear associated with stigma and isolation, the Somali and Sudanese communities seem to be susceptible to the next wave of the epidemic. The gender profile of refugee data, consistent with the characteristics of the affected population in sub-Saharan Africa, shows that HIV-positive female cases have been increasing. In addition, the most affected age group in this population is 18-24.

Newly resettled refugees living with HIV/AIDS suffer a great deal of rejection once their families find out that they are infected with the disease, according to Ann O’Fallon, refugee health coordinator at the Minnesota Department of Health.¹⁸ These individuals, who are new to Minnesota and might have limited proficiency in English, are isolated, without a support system or the knowledge of where to find necessary resources.¹⁸ The Office of Refugee Resettlement used to fund the International Institute and other resettlement agencies to support people living with HIV/AIDS for six months, but the funding was cut. Now they are treated just like other refugees. After three months, resettlement agency services end and they are left to fend for themselves.¹⁸ According to Shukri Hassan, case worker / medical case manager at the International Institute of Minnesota, nothing materializes in three months, and HIV-positive refugees are put on a waiting list, leaving them without case management support.¹⁹

Further complicating the situation, refugee resettlement agencies differ in whether they inform the refugees’ partners or sponsoring family members of the HIV/AIDS status. The International Institute, for example, informs the partner or family member who sponsored the individual, while some of the other agencies expect the individual to inform his/her partner or family.¹⁸

The lack of linguistically appropriate services is one of the issues the taskforce discussed at length. The need for interpretive services brings its own set of challenges. On one hand, it is an

A Growing Crisis

essential service for people with limited English proficiency in order to communicate with health care / service providers. On the other hand, since some interpreters' breach of patient confidentiality is known in community circles, HIV/AIDS patients may avoid care and treatment altogether rather than face the stigma and isolation associated with having community members know they have HIV/AIDS. Shukri Hassan contacted some of the major hospitals and clinics that serve HIV-positive refugees, requesting that they assign one regular interpreter for each HIV/AIDS patient. However, there was a general lack of understanding related to the stigma associated with HIV/AIDS within the African community, leaving many health care providers reluctant to assign an interpreter.¹⁹

HIV/AIDS Funding for African Community Organizations

In the past, both private foundations and the Minnesota Department of Health funded African agencies that serve African-born populations affected by HIV/AIDS. According to the Minnesota Council on Foundations, in 2003, The Jay and Rose Phillips Family Foundation, Otto Bremer Foundation, and Blue Cross and Blue Shield of Minnesota Foundation gave a total of \$55,000 to African agencies for HIV/AIDS prevention (see Appendix B).²⁰ Also, as shown in Appendix A, MDH continued to fund 11 African agencies to do HIV prevention education in 2005-2006. MDH gave a total of \$134,311, in amounts ranging from \$5,000 to \$17,000 per agency.

Next Steps

In August 2005, the Minnesota Department of Health hosted an information session on community-based HIV prevention at the Minneapolis Community and Technical College. The purpose of the meeting was to share information about the MDH 2006-2008 funding cycle, including:²²

- The community planning process used to prioritize populations at highest risk for HIV
- Populations that will be targeted for HIV prevention programming in 2006-2008
- Additional factors that contribute to HIV risk behaviors that prevention programs will be asked to address
- Proposed levels of funding available for each targeted population
- General information on the request for proposal process and timeline

Community Cooperative Council on HIV/AIDS Prevention (CCCHAP) worked with MDH to streamline the process of prioritization to determine which populations are at highest risk of HIV infections and transmissions. The population categories used for this process are based on the categories predefined by the Center for Disease Control: HIV-Positive Individuals (HIV+), Men Who Have Sex with Men (MSM), High Risk Heterosexuals (HRH), and Injecting Drug Users (IDU).²²

People living with HIV/AIDS in the African communities in Minnesota belong mainly to the High Risk Heterosexuals (HRH) group, and within the HRH group, the African-born population is the highest risk group. Starting July 1, 2006, MDH will allocate a total of approximately \$274,263 per year for two and a half years to African community-based organizations for

A Growing Crisis

prevention efforts through contract-based funding. This is more than twice MDH's current funding commitment to African-born populations in the state of Minnesota. The Request for Proposal (RFP) was announced in October 2005 for funding to start in July 2006. However, MDH staff indicated that most of the ethnic African organizations funded in the past will not receive funds for this round. Most likely, MDH staff indicated, the two to four African community organizations serving the greatest number of HIV/AIDS cases will be funded during the next cycle.

According to Tracy Sides, the Minnesota Department of Health is also working collaboratively with Hennepin County's Health Assessment and Promotion clinic to include HIV/AIDS testing in the refugee routine health assessment. This testing is not mandatory, but will be offered to all sub-Saharan African refugees. The evaluation project is short-term. If 1% or more of the tested population is infected, the routine screening will be continued and formally recommended for all refugees originating from regions where HIV is endemic⁶

A Growing Crisis

Recommendations

This report is intended to highlight the problems associated with the HIV/AIDS epidemic in the African community in Minnesota as well as the struggle faced by the community organizations serving the people living with the disease. The following recommendations for funders are based on analysis of the work of the taskforce, interviews with Minnesota Department of Health and International Institute staff, and additional research. Recommendations are divided into four categories, enabling potential funders to target their resources to an area of specified need. It is critical to note here that there are no quick fixes to effectively address this issue. In order to make a lasting impact, resources will be needed over the long haul to assist the community in building its capacity, designing and implementing culturally appropriate and effective programs and prevention efforts, and impacting policy decisions.

Capacity Building

1. Assist African-led organizations in building organizational development skills including: program development, planning, implementation, program monitoring and evaluation, money management, and resource development. Ultimately this support should help organizations improve the quality and cohesiveness of their work and their accountability to grantmakers and beneficiary communities.
2. Partner with the Minnesota Department of Health to provide capacity building support to the African organizations funded by MDH HIV/AIDS prevention funding to help ensure each organization's success in such areas as staffing, proposal writing, strategic planning, board development, collaboration building, and outcome documentation.
3. Be aware of ethnic communities without formal agencies to serve them. Encourage funded organizations to hire individuals from these communities in order to address community needs, or, perhaps more effectively, provide support to an established organization to collaborate with a less established culturally specific organization to provide needed services.
4. Provide support to existing mainstream service providers to increase their cultural competence to serve these communities and function effectively as partners in fighting the HIV/AIDS epidemic and to hire African staff.

Program Support

1. Provide support to increase access to prevention, care, and support services at both mainstream organizations and culturally specific organizations. In these programs, it is critical that staff represent the culture of the clients and, if possible, the gender as well. Having a female African case manager to work with women, for example, is more important than ensuring that she is from a specific country.
2. Support the development and implementation of a "client navigator" position that helps people who test positive for HIV access and stay connected to services.
3. Fund programs that encourage people to get tested and emphasize the benefits of effective case management, including access to ancillary services such as support groups, transportation, housing, and childcare. This should include efforts to reach and serve undocumented people, who fear recrimination if they are discovered.

A Growing Crisis

4. Invest in HIV/AIDS education and outreach projects specific to women and youth. Ensure these programs are advised and operated by women or young people from these communities. In addition, support programs that are run by and for HIV-positive individuals of African descent.
5. Consider providing funding to religious institutions as part of a collaboration to conduct outreach and educational campaigns. As the center of many communities, religious institutions provide a logical connection to members of targeted communities. This may in fact be where impact is greatest.
6. Assist and work with volunteer refugee resettlement agencies to improve the health and education of newly arrived refugees with HIV/AIDS, including ensuring continuity of medical care, which is critical to maintaining health.
7. Foster greater collaboration among the various community organizations now actively engaged in responding to the HIV/AIDS pandemic. Support efforts to bring people together who are actively working on HIV/AIDS in the African communities to learn from each other and share resources.

Education and Prevention Support

1. Provide funding for awareness campaigns through local community newsletters, television and radio programs, and congregations. This can be accomplished by developing audiovisual materials for HIV/AIDS awareness and education in the native languages of the affected communities, to be shared with international NGOs working in the countries of origin.
2. Provide funding for programs that encourage de-stigmatization and discourage discrimination for those affected by HIV/AIDS. However, cultural considerations must be part of any programmatic approach to educating people because efforts divorced from cultural contexts will not be successful.
3. Provide funding to develop culturally appropriate health messages and educational campaigns that are effective for all generations. One example could be an adapted form of the “ABC” approach that takes cultural realities into account.

Advocacy / Public Policy Impact

1. Identify public policy opportunities to bring about systemic change in HIV/AIDS education in the public school system as part of comprehensive sexuality education.
2. Identify opportunities to affect public policy around issues of health care access, culturally relevant testing and case management services, public funding, and prescription drug access programs. Advocate for HIV education to be offered universally to newly arrived refugees.
3. Invest in nongovernmental HIV/AIDS research where data is either missing or skewed. Alternative forms of data collection and storytelling about individual experiences with HIV/AIDS should be considered, especially as they are more culturally relevant than traditional forms.

A Growing Crisis

Conclusion

The HIV/AIDS epidemic is the single most important challenge facing the global public health community today. Sub-Saharan Africa, home to almost 64% of people living with HIV/AIDS worldwide, is the region with the greatest burden. Although many efforts have been made by the international community to tackle this issue, a viable solution has yet to be found as no cure is currently available. The global community has taken a multifaceted approach to the pandemic to mitigate its impact on social and economic development. To a large extent, these efforts have led to an increase in access to prevention, care, and support services, and significant investments in improving the knowledge base. Yet the spread of HIV/AIDS has been increasing globally.

In the United States, the number of people living with HIV/AIDS has been rising since the pandemic started, due to the increasing access to life-saving medications that are not as readily available in other developing countries. The increase in the prevalence of HIV/AIDS has also affected Minnesota, where 5,002 people are known to be living with the disease, the majority in the seven-country metropolitan area. While the number of new cases of HIV/AIDS has leveled off in the American-born population, cases among foreign-born people have been rising, specifically among the African-born population. Government agencies, nonprofit organizations, and foundations are working hard to fight the HIV/AIDS epidemic in Minnesota, but much more remains to be done in order to win this battle.

Although the HIV infection rate is highest among immigrants from several African countries, all Africans are at risk. Allocation of more financial and human resources, culturally competent and linguistically appropriate services, and massive HIV prevention, education, and outreach efforts are all needed to reach, educate, and provide accurate information to the state's African communities. Strategies that address specific cultural understandings of sexuality and disease are particularly important. When people test positive for HIV or are diagnosed with full-blown AIDS, systems are needed to help these individuals utilize available care services. Practical methods such as the combination of the "ABC" approach and others that have worked in Uganda should be considered. The increasing number of HIV-positive refugees arriving in Minnesota is an indication that the prevalence rates of the disease might be greater than now suspected, and will continue to grow. Therefore, better prevention efforts need to be implemented, as well as intervention efforts to get people tested and into a treatment plan if they test positive.

Many of our African brothers and sisters came to this country to escape war and oppression, only to find new challenges once they arrived. For many, the possibility of HIV infection was something they believed they left behind. However, ignorance about and stigma of HIV have led to increased rates of infection, while the problem has been ignored. Many brave African individuals have fought cultural norms and pressed forward in this fight, and are now seeing the fruits of their labor with increased government funding, public awareness, and nonprofit response.

The local foundation community, however, has not been as responsive. It seems that foundations lack clear direction about how to provide resources that would make a difference, especially given our own lack of cultural understanding about these communities. This report is not intended to endorse any particular community-based organization and its HIV/AIDS-focused

A Growing Crisis

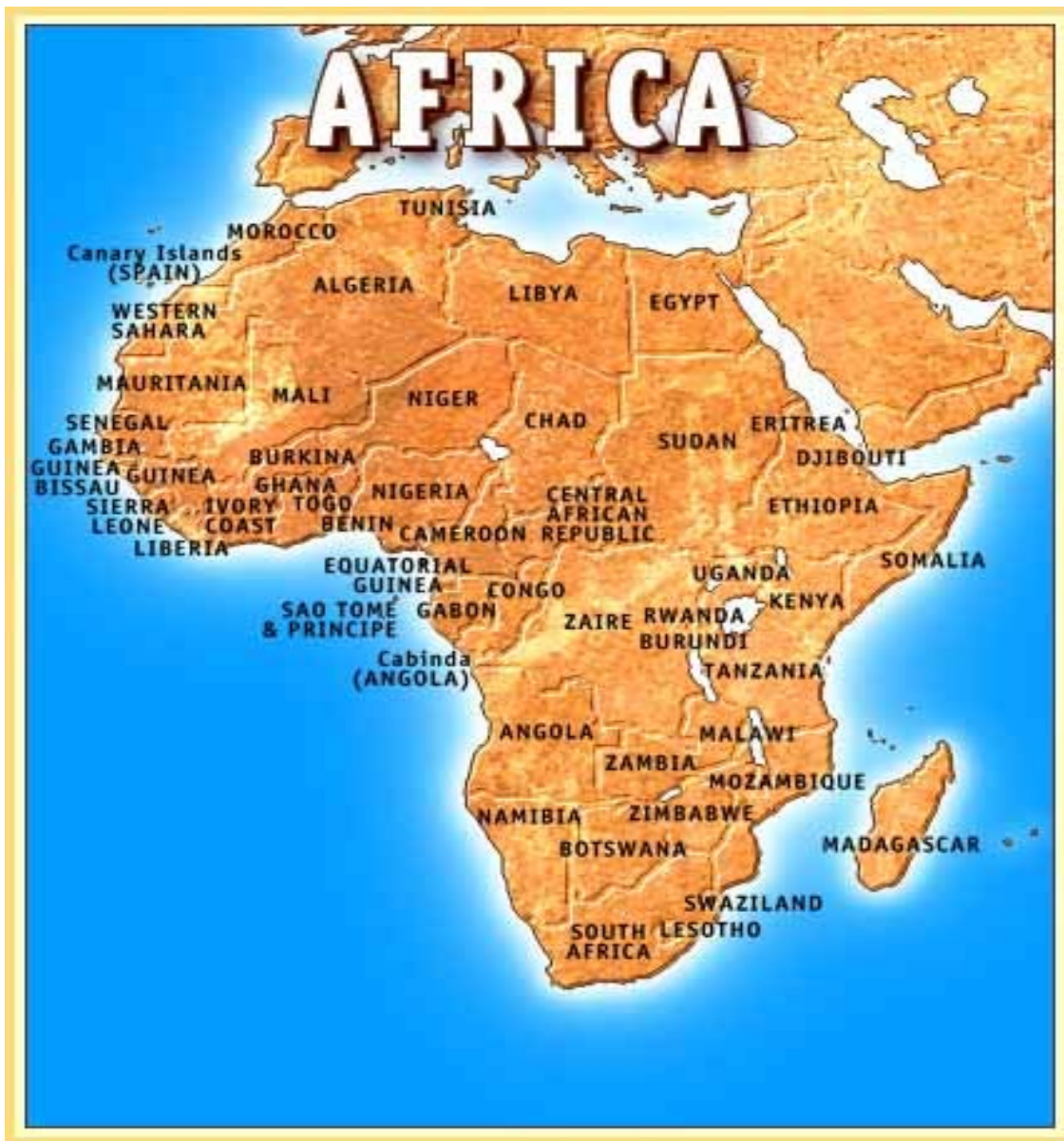
work. Rather, it is intended to provide background information on the epidemic, some basic information about current services available, a summary and analysis of existing needs, and recommendations for funders to consider. It is the hope of the participating foundations that you will consider the information and recommendations as you make funding decisions in this area. If you do not currently provide funding for services in the African communities, we hope this report has encouraged you to join us in this fight.

A Growing Crisis

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A Growing Crisis



Refugees from the following countries to Minnesota²⁰

East Africa:

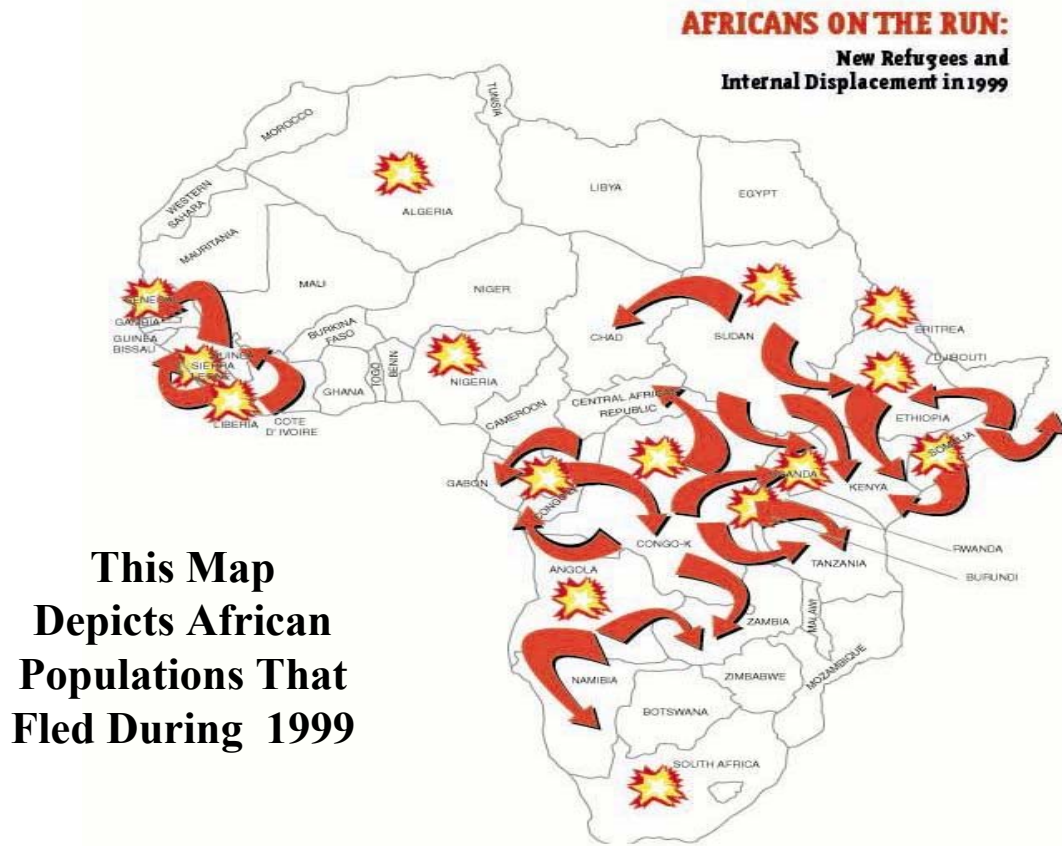
Somalia
Ethiopia
Sudan

West Africa:

Liberia
Sierra Leone
Togo

²² Refugee Health Program, Minnesota Department of Health. (2005). *HIV+ Refugees in Minnesota*. A PowerPoint Presentation received from Ann O'Fallon, Refugee Health Coordinator, Minnesota Department of Health, in September 2005.

A Growing Crisis



²² Refugee Health Program, Minnesota Department of Health. (2005). *HIV+ Refugees in Minnesota*. A PowerPoint presentation received from Ann O'Fallon, Refugee Health Coordinator, Minnesota Department of Health, in September 2005.

A Growing Crisis

Appendix A

Agencies Funded by Minnesota Department of Health, 2005-2006

| Agency | Grant |
|---|------------------|
| 1. African Assistance Program (AAP) (subcontracting Life Line) | \$14,000 |
| 2. Kids Home International (subcontracting American Kenyan Association) | 9,500 |
| 3. Mestawet Ethiopian Newspaper (subcontracting Abyssinian TV) | 17,000 |
| 4. Minnesota African Women's Association (MAWA) | 7,000 |
| 5. Nyagetinge Umoja | 9,500 |
| 6. Oromo Community of Minnesota (OCM) | 5,000 |
| 7. Project Valentine (PV) | 5,000 |
| 8. Somali Community Resettlement Services, Inc. | 7,000 |
| 9. Somali Health Project (SHP) | 6,000 |
| 10. Sub-Saharan African Youth & Family Services in MN (SAYFSM) (subcontracting Wee Care) | 17,000 |
| 11. The Bali Cultural Association–USA, fiscal agent, Zyombi Project | 10,000 |
| 12. Miscellaneous efforts undesignated | <u>27,311</u> |
| Grant Total | \$134,311 |

In 2004, 18 African community organizations were funded by MDH for HIV prevention education in the African community, including the above 11 agencies that have full or partial continuing funds in 2005-2006. Agencies partially funded in 2004 or not funded in 2005-2006 include:

1. African & American Friendship Association for Cooperation & Development (AAFACD)
2. Bloomington Covenant Church – Women Light Action Network (WLAN)
3. Ethiopian Community of Minnesota
4. Kids Home International (Kenyan community HIV prevention education presentation)*
5. Kono Union Minnesota Chapter, Inc. (KUMC) (Sierra Leonean community HIV prevention education presentations)*
6. New American Community Services (NACS)
7. Nyagetinge Umoja (Kenyan community HIV prevention education presentations)*
8. Somali Mai Community of Minnesota (SOMCOM)
9. Victory Chapel United Church of God in Christ, Inc. – Liberian Human Rights & Refugee Welfare Organization (LIHRRWO)

* Numbers 4, 5, and 7 were funded only for six months (January 2005 through June 2005).

A Growing Crisis

Appendix B

Private Funding for HIV/AIDS in Minnesota

In 2003, three foundations funded HIV/AIDS work by African community organizations for a total of \$55,000:

1. The Jay and Rose Phillips Family Foundation
2. Otto Bremer Foundation
3. Blue Cross and Blue Shield of Minnesota Foundation / Blue Cross and Blue Shield of Minnesota

Twenty-eight grantmakers gave HIV/AIDS-related grants in 2003 for a total of \$1,285,501:

1. Ameriprise Financial Inc.
2. Andersen Foundation
3. Andreas Foundation
4. Blue Cross and Blue Shield of Minnesota Foundation / Blue Cross and Blue Shield of Minnesota
5. Otto Bremer Foundation
6. Bush Foundation
7. Charisma Foundation
8. Deluxe Corporation Foundation / Deluxe Corporation
9. Duluth-Superior Area Community Foundation
10. Ecolab Foundation and Corporation
11. General Mills Community Action
12. HRK Foundation
13. Hugh J. Andersen Foundation
14. The Jay and Rose Phillips Family Foundation
15. Mardag Foundation
16. Margaret Rivers Fund
17. Mary Livingston Griggs and Mary Griggs Burke Foundation
18. The McKnight Foundation
19. The Medtronic Foundation
20. The Minneapolis Foundation
21. Ordean Foundation
22. Pax Christi Foundation
23. RBC Dain Rauscher Foundation
24. St. Paul Travelers / St. Paul Travelers Foundation / St. Paul Travelers Connecticut Foundation
25. Target Corporation
26. U.S. Bancorp Foundation
27. Wells Fargo Foundation Minnesota
28. Xcel Energy Foundation

A Growing Crisis

Appendix C

Taskforce Members

The Jay and Rose Phillips Family Foundation and the Otto Bremer Foundation would like to extend our sincerest thanks to the following people who participated in one or more of the four taskforce meetings. Their insights, personal experiences, and willingness to be so open about their communities were invaluable to us in the journey to better understand this growing issue affecting our communities. We also thank their employers for making it possible for them to participate.

| Name | Organization |
|-------------------|--|
| Abba Zerdowit | Ethiopian Orthodox Church |
| Aklog Michiete | Mestawet |
| Alhaji Sogbeh | Kono Dno Union |
| Charity Mentan | African Network for Development, Inc. (ANDI) |
| Charles Koudou | Africa Solutions |
| Dabala Rikitu | PEACE African |
| Dollina Odera | African American AIDS Task Force (AAATF) |
| Dori Makundi | Minnesota AIDS Project (MAP) |
| Elizabeth Namarra | Minnesota Department of Health |
| Emmanuel T. Tatah | Community Member |
| Ephrain Olani | Sub-Saharan African Youth and Family Services (SAYFSM) |
| J. Samuel Smith | PEACE f African |
| Japhet Nyakundi | Minnesota Department of Health |
| Margaret Awasum | Project Valentine |
| Margaret Martin | Sudanese Women's Association (SWA) |
| Megersa Kumbi | American Cancer Society |
| Monica Yugu | Hennepin County Medical Center |
| Moses Fasanya | GIFS |
| Siona L. Nchotu | Zyombi International Project Inc. |

Taskforce Conveners

| | |
|-------------------|---|
| Elsa Vega Perez | Otto Bremer Foundation |
| Kari Suzuki Bardy | Otto Bremer Foundation |
| Patrick Troska | The Jay and Rose Phillips Family Foundation |
| Zainab Hassan | Project Consultant |

A Growing Crisis

Appendix D

African World AIDS Day (AWAD) 2004 Planning Committee

For the first time, in 2004, individuals and groups from a variety of African community and mainstream organizations in Minnesota came together to organize a community-wide event on World AIDS Day, December 1, 2004. The broad representation shows the significant will within these communities to address this issue.

1. Africa Solutions
2. African & American Friendship Association for Cooperative Development
3. African Network for Development, Inc.
4. The African Parents Support Group
5. American Red Cross, Minneapolis Chapter
6. Good Image Family Services
7. HEAL Somali Families of Minnesota
8. Liberian Human Rights & Refugee Welfare Organization
9. Mestawet Ethiopian Newspaper
10. Minnesota African Women's Association
11. Minnesota Department of Health
12. Minnesota Department of Human Services
13. Morning Star Catering Service
14. Neighborhood Involvement Program
15. Nyagetinge Umoja
16. Open Arms of Minnesota
17. Oromo Community of Minnesota, Inc.
18. Planned Parenthood of Minnesota, North Dakota, and South Dakota
19. Project Valentine
20. Somali Community Resettlement Services, Inc.
21. Sub-Saharan African Youth and Family Services
22. Wee Care Family Services
23. Women Light Action Network
24. Zyombi International Project Inc.