HIV Prevention Contractor Kick-Off Meeting Notes

March 5-7, 2013

Crowne Plaza Hotel – 6121 North I-35 Austin, Texas

Co-creating a coordinated, comprehensive, responsive approach to HIV Prevention to reduce the community viral load in Texas

Wednesday 3/6/2013

8:00 AM

Opening words done by Ann Robbins

- Uncertainty

Uplifting to know others have been through the journey I am going through now and we're able to draw meaning from it. This is inspiring.

- German poetry Each indecision brings its own ...what you can do and think you can do...for boldness has magic power and genius
- Each day is uncertain
- Uncertainty creates the need for us
- Community, clients, you live in a world of uncertainty which provides opportunity for many outcomes and the opportunity to steer these outcomes
- Magic power and genius in Uncertainty

Sequestration

- HIV/STD/TB - Funding is discretionary
- Entitlement is not how hard the beneficiary worked - simply means if you meet the qualifications for the program you have to get the service
- HIV/STD and RW and Viral Hepatitis are discretionary funds
- Discretionary funding is dependent upon levels of appropriation from congress
- With Sequester automatic across the board with discretionary spending = Uncertainty
- Cut happens at the federal level (HUDD HERSA)

- Cuts do not necessary translate to an across the board cut for the funds that come to us - We will not do an across the board cut
- When the reduction in funds come to DSHS we will make those decisions
- First our own administration/operations to minimize the impact
- Second guided by the ideas of RFP-science preserve programs and initiatives that we know have the best chance of reducing HIV-availability of medical services preserve this
- Third look at science impact effectiveness and epidemiology to guide decisions
- We will preserve public health infrastructure among the state and surveillance and reduce the number of new HIV infections
- When decisions are made we will not delay in delivering the information to and about how the decisions were made

What is driving the epidemic?

- Focusing on root causes, must acknowledge that there are too many undiagnosed individuals to actually drive down the epidemic.
- Coordinated and comprehensive – one person/group cannot to it all. Need to reframe. The way we think about the world shapes our understanding of the world. What we might see as appropriate or best, we need to think about the relationship btw. you and the state. You are a competitor initially with each other and then you become a grantee. Who we are now is public health "social justice made manifest." Removing the obstacles to good health! Must work on this together. We can't meet our goals unless our neighbor meets their goals.
- Kick-off implies that there are 2 teams on the field with opposing goals. Doesn't seem like the right metaphor. Reimagine football – 1 team on one field with one ball and scoring as many goals as we could together, I can't meet my goals unless you meet your goals. Ann's promise – when looking at your work in partnership with us, let's look at our goals (not specifically contract objectives – although important) – need to reach our goals and not get in the way of accomplishing the work in your community. Reframe

some of the paperwork/documentation – story tellers, sense making units in order to continue to navigate – what comes out of the sense making we choose to tell. Documenting allows others to join in the story we are telling, so that we can share, collectively tell the story, and join together in telling the outcomes. Remember that your documentation is a sacred outcome to help tell the story of your work. You are partners in public health, not competitors.

- Peter Singh: What is needed in the world and what is important to me.
- Eckhart Tolle:

  "When you become comfortable with uncertainty, infinite possibilities open up in your life. It means fear is no longer a dominant factor in what you do and no longer prevents you from taking action to initiate change. The Roman philosopher Tacitus rightly observed that 'the desire for safety stands against every great and noble enterprise.' If uncertainty is unacceptable to you, it turns into fear. If it is perfectly acceptable, it turns into aliveness, alertness and creativity."

Questions:

- How do CBOs, accountable to own agency and state, share with others so that the state sees what we have done? Ann – I think we will have dialogue about how we reconcile individual contracts. Short-sighted to provide negative feedback on the collaboration we are asking for. Will ask something of you today and over the next 5 years – if you have contract objectives in conflict with agency or community, then we need to have a conversation – that is not our goal. It does not help to have squabbling about who gets credit. The contract is a document that is not perfect. If we reach a point that you are not meeting your performance objectives and yet you are working in collaboration to meet a community response, we need to have a different conversation. Complex issues that require thoughtful conversation. The most important thing that you can do in a testing and linkage contract is to have an efficient means of identifying and linking individuals to care. Need to be working on targeted testing and the nature of the targeting is very important. You can still be a member of a partnership. A collective action should move you toward goals in your community.

- Collaboration to maximize impact, medical and non-medical working together – should there be more funding to different types of organizations? Ann agrees explicitly! Prioritize planks in the internal plan then we must reach across the aisle and pull people together, harmonized, one plan, one outcome. It is a recognized goal and is bureaucratic stupidity that it is not.
- Question about Prevention – going back to a community that does not support prevention, doesn't agree – doesn't mesh with what we have been seeing. To me, testing is not prevention, education is prevention. If we test and individuals do not know what causes HIV, then what are we accomplishing? Ann - Need to be doing targeted effective campaigns. Collective action can address a non-supported community, our observations complement each other, they do not conflict with each other. Ann asks DSHS staff to step back to say that focus and values can be different and still complement each other. Individual said there is never a time to test and not educate. Over the next 2 days, Ann will open herself up to hearing what he is saying. The state may not have heard what some are asking for. State is asking for testing for those at the highest risk, if that involves testing and counseling, then that can be a model but not the only model. Let's talk and understand more.
- Individual comment – I would suggest that whether you are gay or straight and live in Texas you are returning to a community that is not supportive. What are you all (DSHS) doing about abstinence which is killing our children? Ann said that the legislature is very specific about what can be done in schools. HIV works with school health, focusing on bullying, YRBS will administer and try again to get sexual orientation on the survey, we support activities focused on young adults – our limitation should not be read as your limitation. We encourage others who have fewer restrictions on their voices. Ann is not trivializing the conversation. Individual - Incumbent upon us to have these discussion with others who – 20 new HIV positives in Travis county in 20 days (18 to 26 year olds).

9:00 AM

MEET DSHS PREVENTION STAFF done by Trish Larwood

Trish - How this meeting will work – let's get up and move around, look around the room, spot someone you do not know, introduce yourself and share one thing that you do in your work that you are not funded for. There will be a variety of activities, reflections, etc. This activity was to get everyone up and around, to use our brains in a different way. The innovation project weaves in different ways to work and think about things. Trish mentioned the intention, attention, action, reflection messages on each table. Pointed to guiding principles and complexity, neuroscience to help change the conversation that we are having with each other and contractors.

9:30 AM

MEET THE CMU-Debbie, Maria and Kendra

10:15

PREVENTION PROGRAM PRINCIPLES done by Jeff Hitt

Who is at risk and regional differences – comprehensive and coordinated response, shared understanding of who is at risk/vulnerable. We need a shared understanding of who is Vulnerable. Vulnerability vs Risk. It is about people, environments and systems. What does this mean for our work?

- Socioecological framework. Not just about individuals.
- Comprehensive, coordinated response – means that we as public health are more than just a purchaser of services, it is about a relationship. It is important for us to understand performance objects, scope, in the context of your organization and the community you work in. We have a joint mission together. It is about how we understand your actions within the context of your community. It happens in a community/regional/local area. We work with people in different ways, we have a mission of capacity building. This is bigger than the scopes of contracts, we are working across the state with very many partners. This group is a special group. Coordinated and comprehensive is focused on community, bigger than individual scopes. What does it mean to have a community goal? 15,000 people living with HIV who do not know it – how do we reduce this number? It takes a coordinated effort, not just through contracts. Have tried to build comprehensive and coordinated into scopes although the

work is outside the scopes as well. Vulnerability can lead us to different explanations about the why. Sometimes risk can take us to individuals. State plan (jurisdictional plan) is how the state plans to carry out this work.

10:35

SHARED UNDERSTANDING OF WHO IS AT RISK & REGIONAL DIFFERENCES done by Jonathan Poe

- Newly diagnosed, deaths and PLWH – many more people living with HIV due to improved treatment.
- New diagnosis rates by race/ethnicity
- New diagnosis rates by sex
- New diagnosis rates by Race/Ethnicity and sex, 2011
- New diagnosis by age group – biggest concern is 15-24 year old age group. AA MSM is driving this number.
- New diagnosis rates by EMA/TGA – Houston and Dallas have the largest rates
- New diagnoses by transmission category – rates going up for MSM
- Austin has highest new diagnoses of MSM. More than half the cases in almost all regions are MSM. Need to determine a denominator to determine rates for MSM (working on this).
- HIV prevalence rate by selected characteristics, 2011 – MSM dramatically higher than any other group.
- By county (MSM) – Dallas, Harris, Bexar are the 3 highest
- By race in Dallas & Harris Co – MSM – one in 5 in Dallas, one in 4 in Harris
- Why do disparities exist? – Individual risk behavior is not the key – sexual networks are smaller, more homogenous and more isolated among AA, a new person introduced to this network has a greater chance of being exposed.
- Question – is state developing tools and materials based on this trend that is being seen (effective, proven ways to reach these communities)? DSHS will be a resource for community mobilization, communities need to respond to the need and DSHS will support this. Communities cannot wait for DSHS. DSHS has done a lot of work in Dallas

and plans to share this information across the state. Esp. issues with testing, how do we replicate best practices? Need to break down cultural competency more than we generally do. DSHS is looking at how to build more capacity to deal with these target populations. Would like to see DSHS do this as we do not have time to do this when we are working on the ground.

- Must be cautious about the focus of advertising campaigns – "Don't talk to black, gay men" was the message that seemed to come out on one campaign. This is not what we wanted. This is why we need to have conversations about the data and really talk about our message before just putting it out there.
- Individual - How do we get this data? What data is valuable to the testing organizations? What events should we participate in? Data is close, still tinkering with how to determine the denominators…
- CDC and others working on new models but hard to account for supportive environment, education, etc.

Individual - There are tried and true methods but can be seen as invasive on people's private life. Targeting partners and testing does avert more infections…

(5) Brief reflection-Liza – on your table, take a minute or so and write down 3 things that stood out to you.

Challenge is how do we translate this to young MSM? What is the best way to do this?

11:05

SOCIO-ECOLOGICAL MODEL & TEXAS HIV PLAN done by Rosa Valdez and Jesse Carter

- Overview of Texas HIV Plan – TX CPG created TX Prevention Plan. National strategy calls for a comprehensive plan for prevention and services. The plan boils down to (Gardner cascade) Public awareness – how do we get non-traditional partners to understand this is part of their work? Need to talk about factors that put populations at higher risk – housing, incarceration, environmental factors that influence the choices that people can and do make. What table do we need to be at in addition to who needs to be at our table?

- Targeted prevention – really understanding who is at risk/vulnerable populations and making sure our resources are targeted to have greatest impact. Scale – how do we scale our interventions up to create broad impact?
    - Really understand who is at risk
    - Who are the vulnerable populations
    - Create activities around these individuals
    - Focus resources where they have their greatest impact
    - Scale: how do we scale this up to reach a broad pop and create a broad impact
    - Find un-diagnosed individuals and link them to care and maintain them in care
    - Diagnosed people get linked into care (within 3 months they are gone and return when they are sick-too late)
    - 1/3 diagnosed in Texas are currently out of care
    - Retention in care over time there is much in and out of care throughout
    - Support services mechanisms need to be present to support and maintain individuals in care

- Full diagnosis – finding those who are infected who do not know they are living with HIV, and linking them to care.
- Successful linkage – getting people who are diagnosed linked into care within 3 months (or else they tend to be gone).
- Support participation in care – keep them in care, sustain them in care, need to make sure the support services are available to maintain them in care.
- Viral suppression – want to drive down viral load in a community. Might not be able to get every individual to a totally decreased viral load but can do this for a community.
- Finding ways to complement activities across staff will help us to expand capacity.
- Socio-ecological Model – framework for plan in Texas. Framework for interaction, for action, and for spreading our work. We do a lot of work with individuals; this individual does not come in for care in a vacuum. They bring individual relationships, community relationships, community (religious, drug using community, geographic, gay, political),

public policy (influence lives and choices) – individuals come in with many influences – all of which effect behavior. DSHS has proposed in RFP that we want to work across the socio-ecological model. Jeff – organizations – health care – 50% of gay men are not out to their doctors – they will not get the services they need. Also look at lack of racially appropriate providers & doctors. Stigma comes in to play as well. Opportunity for intervention and action. Whatever area it is in, it is seeing the opportunity to make changes within different pieces of the model. Jeff – may not have all of the individuals on board that need to be – they could actually be a target for intervention – target individuals who have control and shape the environment (providers, legislators, etc.). Might want to target health care providers, the target does not just have to be the individual at risk or who has HIV. Actions might be different but the process could be the same.

- Plan looks very linear although we have broken it down into individuals, environments, and systems (matrix on the wall). Example: Empowerment – individual level, maybe some environment, targeted. Need to start thinking about who in your community is working in the other domains and at different levels. This tool can also help us to find gaps in a community. Need to see activity across the whole spectrum at multiple levels. Who do we need to talk to, how can we help them and how can they help us? Jeff - Organizations do this already – this is about bringing more intention to this.

1:00 PM

HIV TESTING done by Jeff Hitt

Community forum – talked with Black gay men about their perceptions – they talked about 50% of people infected. That is one in 2 who are infected. Jeff wants us to thing about turning the number around (that is one in 2 who are not infected).

- Testing philosophy – targeted testing. Aiming for 1.2 positivity rates.
- Testing data – we are looking at data for all tests over past 10 years and then looking at data for specific populations. Looked at MSM which has been targeted and identifying more positives. How has focusing on gay men worked out?

- Testing with Black women – effort to focus on Black women has been less successful. Our efforts with heterosexuals need to be more intense to figure out who is at risk. We need to think about how to be more effective. Could rates in Black women actually be decreasing? Nationally, this is happening but DSHS does not have the Texas numbers. 2012 - About 23% of all tests among MSM. 45% among women, about 1/3 among heterosexual men. Rate pretty low among IDUs. Transgender a very small segment of the population.
- Demand for HIV prevention is something we should talk about. May even see test avoidance among high risk populations – still need to work on this issue. Gay community and HIV community have grown apart in some places.
- Where are the positives? 75% of positives were MSM. Of positives, black men and women stand out. Need to figure out balance in testing based on risk. Data in 09, 10 & 11 (lifted requirement for counseling with every test). In 2011, 2/3 of tests were done w/out deep in-depth formal counseling. Positivity rate for those with testing much higher than those w/out testing which is not what we thought would happen. Might need to talk about this a little more since DSHS is only contract that allows testing w/out intense counseling. Intense counseling works but is a very expensive model. Testing needs to be very targeted – needs to be about "positive people know your status," not just "know your status."
- How to mobilize testing and how to handle these situations.
  - Testing without counseling - are you able to separate the large screening events; what are the positivity rate of the individuals going through our programs
  - Documentation of counseling important in reference to refusal resistance etc. document the story(how you approached this and how you are linking the client) different type of counseling document what you are doing not just checking off a box
  - Overall DSHS looks at all the tests administered and overall positivity rate
  - Effectiveness of counseling for negatives is still questioned
  - Counseling is defined in many ways→type of information you give client

- DSHS needs to understand everyone's efforts - this need to be an ongoing conversation. Brandon – Jeff wants DSHS to break this down more, break out big screening efforts (mass testing) from the data to see if it changes anything. Data could be skewed due to the fact that organizations follow positives of rapid testing with intense counseling when doing follow-up test? DSHS might need to do a better job defining the counseling to get a better understanding of what is happening.

1:50PM PRESENTATIONS FROM THE FIELD WITH Q&A

SAAF - Sarice Greenstein – MSM targeted grant.

- Last year 2500 tests, 1300 were among MSM (50% increase). 90% received results, 80% into medical care.
- Onsite testing, more offsite testing with new grant (have a new van w/2 private testing rooms). Take the van to many events.
- New campaign - USE Me – targeted to gay men. Gave out 100,000 condoms last year. This was first time they had dedicated funds for testing and allowed them to do what they knew was best for their program. New DSHS funding allowed them to take it to a new level (including advertising which they were never able to do before).
- Best Practices:
    - Relationships
    - Providing best service that we can (Saturday testing) 10-12 clients
    - Repeat clients 1/3 testing clients are repeat clients
    - Developing relationships and having clients come back
    - Clients remember counselors name etc.
    - Diversity- and the realization of flexibility and relationship building with clients
    - Listening to staff and empowering their thoughts and recommendations
    - Use entire agency
    - Providing comprehensive service

- Google search=HIV testing SA - their website comes up first in SA when HIV testing is entered.
- Focus not just on HIV but on a broader Health basis
- Research on what campaigns work
- Mutually beneficial relationships (educate in your space/provide free condoms to you or your org (bar))
- Referrals from people who have seen us
- "Who is the best counselor?" competition
- Compliments why do you like your test counselor?
- Documenting referrals
- Staff observation
- Ongoing improvement

Resource Center - Ruben Ramirez

- HIV testing, Fuse and United Black Element, Stomp out Syphilis. The relationship with DSHS has been most important piece of implementation of program – DSHS guidance of National AIDS strategy has reinforced and supported our programming. What has impacted programs is that DSHS and Nat'l Strategy have provided general guiding principles which we did not have before. This has helped to create an organizing direction and coordinated response.
- Highlighting populations at greatest risk has been very important. This maybe the only way these individuals found a home/focus.
- Also highlighted that transgendered individuals are at risk. Quoted Obama's statement. Guidance also allows flexibility, making conversation a two-way street, relationship with funders and county health department really makes a difference.
- Encouraging a focus on condom distribution was key. Dallas Co. voted in 2009 to allow condom distribution by county folks. Also, opening the door to a variety of TA opportunities.
- His director wanted everyone to have logic models so everyone was offered a course in this, in addition to grant writing.

- Key factors - Relationships with people, targeted testing,
- 4 corners of your contract (you must do this) – not constrained by this – there is space for innovation, we look to seek innovation within our contract (what can I do within the contract?), ongoing communication w/DSHS and with the community. Find positives anywhere we can find them.

Q&A Moderated by Chris

- Does Sarice get training for her staff? No outside training. Looking into doing syphilis testing. She does not use a silo-ed approach. Staff sometimes needs to do testing.
- How do you track repeat clients? TWOK database. Staff writes "repeat" and how people heard about them.
- What kind of training are you doing for staff? Developed their own training program – give volunteers a 101 training and then they take the van, go out and hand out condoms, etc.
- In-house patients make condom packets for the program.

2:50PM THE NEW ALGORITHM &QA done by Jenny MacFarlane

- Since 1985, first generation antibody test – now have over the counter anti-body test. Who would believe this would happen? Test can now detect virus 10 days after infection. Stigma has changed around HIV testing. Go to Kaiser website for beliefs around testing. Technology as well as attitudes and beliefs around testing has changed. 18% of population living with HIV does not know it. People unaware of their infection are 3.5 times more likely to transmit. Account for up to 54% of new infections.
- Algorithm has not changed since 1989.
- Antibody and antigen test (4^{th} generation) – antigen is what will be detected 1^{st}. The diagnostic algorithm has not advanced with technology.
- 40-90% have symptoms of acute infection (not everyone has symptoms).
- Risk of sexual transmission is greatest during acute infection (early on).
- Discussed all of the new testing. Bottom line – one test does not fit all. Need to decide what is best for each setting and each situation.

4:10 WORKING WITH POSITIVE CLIENTS done by Darriane Martin, Chris Mobley and Amanda Reece

Linkage to care-Chris Mobley – Linking folks to care – different ways to do this. Could have a linkage coordinator (very informal), ARTAS – structured intervention, Peer Navigator program – preparing folks for getting into care. Partnerships very important to help prepare folks for linking to agencies to get them into care. Also can help make referrals based on partnerships.

- DSHS requirement - 85% of folks who you test positive and get results must be linked to care. More focused on outcome than structured intervention.

PWP-Darianne Martin – Once client is linked, now what? Need to remove barriers to care and keeping them interested in care. What makes sense for your community? CRCS, Healthy Relationships, Clear – what works for your population? Be resourceful – look at who is doing what in your community and link into what works for your clients. How do you do those things you are not funded for – need to be creative – do something.

- Ultimate goal is "sustaining participation in HIV related medical care."

Activity-Troika-Amanda, Karalee, Trish, Liza – Toika Consulting Model. Think about a situation, describe to others in your group, and then discuss with each other. (Amanda mentioned that this is a liberating structure.) Break into groups of 3, preferably people who you do not know. Reviewed the Ask, Tell, Problem. Take a minute to think about what challenges you have working with HIV individuals in your community. Go through this activity 3 times so that each person gets to describe a situation.

THURSDAY MARCH 7TH, 2013

8:30 REFLECTIONS done by K.Kaye & Liza Hinojosa

- Using images is important for understanding. KKaye and Jessica reviewed the visual facilitation from the past 2 days.
- Started with Pisces, data, meaning making, coordinated, comprehensive response. Marshmallow activity. Focusing on intention, what do we want to pay attention to, then we take action, what, so what, now what – meaning making.
- Ann's conversation – what is driving the epidemic? Focus on epidemiology, how we think about the world drives our actions, documentation is important (tells the story of

our work and connects us to other people, meaning making), The road to uncertainty can get in the way of boldness. Moving on to epidemiology, who is vulnerable informs how we do a comprehensive, coordinated response. Why/how does this happen? Interplay btw. people, systems & environments. More people living with HIV. Sexual networks, who has not been diagnosed, TX HIV plan, the socioecological model, cultural competency, data, reports, customizable reports will now be available. Where do I fit in the linkage system?

- Troika exercise helped in beginning to form relationships. We need to increase capacity, let state know what you need.
- Algorithm for testing was introduced. Shifted from knowing your status to, everyone who is positive needs to know their status – targeted testing.
- We heard from two programs from the field (SA and Dallas). Importance of dialogue with DSHS, shining a light on the transgendered population. The question is more about, "what can I do?" Not just what I have to do. Testing, different types of tests available. Troika consulting – an opportunity to use cognitive questions to help people come up with their own solutions. Feedback was that people realized, "We are all in the same boat."
- South Africa "Ubtuntu" – "I am what I am because of who we all are." A person with Ubtuntu is: open, available to others, affirming of others, does not feel threatened that others are able and good, based from a proper self-assurance that comes from knowing that he or she belongs in a greater whole and is diminished when others are humiliated or diminished, when others are tortured or oppressed.
- Liza told map story. Focus on sense making, find your own tools. Uncertainty is huge at the moment. Pay attention, reflective practice – use what you have to guide your path. Lifting your vision. There are many paths to a goal. Sometimes it feels safer to talk with people outside of our immediate area – important to create dialogue with others. Share what you have heard at the conference and learned from others.

9:00AM COMMUNITY MOBILIZATION INTRODUCTION done by Ken Ripperger-Suhler

We have been asked to change the game – how are we going to do it? Community mobilization. Believe you can be successful, let go of assumptions, start with new ideas. If you don't look through others eyes, you don't see the whole pie. We realize that some performance objectives won't be met.

- Accept
- Learn from what is going on around you. Build on what is around you. Send Ken an e-mail about what you have learned. We can make sense out of what we see.
- Persist – have to have a fire in your belly to continue forward.
- Fired Up? Ready to go! There is a team behind you and with you. Need to work as a team because the job is hard.
- Social Determinants of Health. So What? Forces keep people in a web of infection (stigma, limited access to resources, poor understanding of sexual health, financial hardships). What are we going to do? Get in the flow –
- Shape the vision – evolving process, community and social change, build support & participation, create a common vision (no one person has the answer, conversations).
- Make the plan – connect your vision with the resources and activities that will get you there. Collect information and continually feed it back into your program.
- Take action – this is a community-wide effort (many different groups) – bring in as many people as you can, sharing the opportunity, and sharing the vision
- Tell the story – document what you do -outcome monitoring, describe what you do – process, outcomes, adjustments – this tells the story to funders, staff, and community.
- Outcome monitoring – identify outcomes – immediate, intermediate, long-term (link outcomes together). Develop – outcome measures – analysis plan.
    - Outcomes may change. Think about the socioecological model as you do planning and evaluation.
    - Prepare for change – community mobilization can be a moving target – this will require determining new outcomes. Wordle – key words – reflect, conversation, innovation.

9:30AM COMMUNITY MOBILIZATION PANEL moderated by Ken Ripperberger-Suhler

San Antonio Task Force - - Sarice Greenstein, Gloria Salinas-Garcia

- Task force gets together once a month – greatest benefit is the relationships that have been formed.
- Have become friends and now know who to call when help/partnerships are needed. There is a lot of opportunity for new mobilization and to work across many agencies who have all different kinds of funders. Great to talk with people who do other things.
- Getting people to the table and asking people what they thought and what they were doing.
- Challenges – broken relationships that have been created over time. Data collection has been a lot of work and not always led to action. What to do with information and can we form relationships to keep moving things forward.

PILLAR - Manuel Sanchez –

- Community mobilization does work. Called by DSHS in 2010, cutting edge, looking for new ways to reach out to MSM community in Laredo.
- Reached out to community with community conversations (sent letters inviting officials to a meeting about men who have sex with men).
- Learned that there were many other issues – bullying, etc.
- Realized that the city did not have near enough mental health providers.
- Ended up forming a non-profit for HIV, mental health, bullying, sexual health issues, suicide related issues. Have been adopted by United Way as part of their family.
- They also do their own fundraising. Bucket Brigade – raised over $5000 in a few hours. Important to follow city ordinances.
- Work with local university to have students who do free counseling. Work with 2 school districts and surrounding counties.
- Public officials have supported this even though they were worried about career images.
- Support groups, teens come to offices, reaching out to many in the community. Critical to success – getting the right people involved.
- Challenges – public officials and churches didn't want talk about HIV, etc. to the public - churches actually let us in, conversations were held

TxBWI – Darriane – excited that DSHS is taking responsibility in helping regions learn, explore and innovate in communities to help Black women. Tired of hearing that Black women's lives are a mess. 7 teams

- Tarrant Co. has worked together to bring volunteers in to collaborate, other cities as well. Continual effort.
- In Tarrant Co., this initiative has brought the awareness into the religious community, has really increased community awareness that has led to a large donation last year. BWI has gotten into schools and the religious community.
- Question – what are the outcomes of these programs? Goal SA– to create collaboration, fill/close gaps, cut down on overlaps, increased capacity by working together.
- BWI – overall goal and objectives not as specific as most grants – looking at the environments and the systems – pushing beyond looking at the individuals. Bringing conversations together to work on systems and environments. Planting seeds that might not be able to be measured until down the road.
- Challenges – evolution of trying to do this, making it meaningful for communities. Balance the work that pays you w/money and the work that changes the environment (these are volunteers).

1:00PM CONDOM DISTRIBUTION done by Darriane Martin

Close your eyes take a few minutes and think about what it will look like 4 years down the road if your condom distribution efforts are successful.

- Discussion at tables. Need effective language for those who have disengaged. Let's have a discussion about what has worked well in other communities – tell us what has worked and give us ideas. We tend to be very penis focused, need to explore female condoms as well. Need to be real about using condoms. Just because you don't use one today doesn't mean you can't use one tomorrow. Would like to see more cultural competence – teach me how to talk with a young MSM or whoever it might be, need to know the language.
- If I'm not funded for this, how can I support this effort?
- Condom Distribution Strategies – want to focus on the socio-ecological levels.
- Generate ideas that can be accomplished at different levels:

- Individual: handing out condoms when they come in for services/testing;
- Organizational:
- Community: Supplies for sex parties; pageant parties,
- Societal: Changing policies to be allowed to place condoms in schools or other institutions where they are prohibited. Dallas Co. changed the policy of letting sex workers hand out condoms, changing laws about being charged with prostitution if you have a certain number of condoms on you.

3 Rounds to generate as many ideas as you can at different levels.

Round 1: Individual and Intrapersonal:

- School district, school policy, school curriculum
- Legislative, Congress, Mayors
- Research impact
- Economic benefit
- TEA, UIL, SHAC, PTA, Elect people to those boards
- Judicial system
- National organizations
- Alliance w/legislation
- Condom lobby group
- Youngsters testifying in front of congress @ condom…
- Parents, siblings, peers
- Sex workers

Round 2: Organization and Community

- ER, Schools, Rec centers, Tattoo shop, Thrift shop, Facebook, Grinder, Social service agency, Happy Meals, DMV, Colleges, fraternities, sororities, Banks, Post office, Tupper ware parties, Avon, Clubs, Bars, Stripper clubs, WIC, pep rally, sporting event, newspaper routes, jails, detention centers, beauty shop, massage parlor, book stores, adult book stores, lingerie shop, dorms, doctor's office, taxis, probation/parole office, liquor store, city bus, gay shops, ICE, hospital boards, sports teams, HR training, nursing homes, plasma centers,

police officers, AA, narcotics anonymous, hotels, grocery stores, barber shops, VA, Urban League, chambers of commerce, truck stops, rest areas, military, GLBT alliance,

- Condom education w/ parolees/community service, drug rehab centers, deadbeat dads, Insurance rates go down w/condom purchase, MSM empowerment programs,

Round 3: Societal/Public Policy

- City officials, movies/documentary, SHACs, city/county ordinances, state statutes, advocacy, testimonials, digital storytelling, political parties, school/university contest, conferences, people affected by HIV, letters to the public, petitions, propositions, media, PSAs, magazines, awareness days, newspaper, bill boards, campaigns, talk shows, twitter/Facebook campaigns, surveys, publications (white paper), proclamations, research, town hall meeting, focus groups, inviting public official to event, past tragedies, quilts

Discussion:

- Look around and see how to integrate these activities into what you do even if you are not funded specifically to do this. How do you get condoms – how do you decide what to purchase? Your clients might prefer a certain type, name recognition, colors, flavors, textures – might need to do some type of fun assessment. Taste testing for lube, condom displays, be creative.
- How are you tracking your distribution efforts? Do you need an excel sheet. Do you need an MOU with other agencies who are working with you to distribute condoms? Can track which condoms different communities like. Need to keep track so that we have data.
- # of distribution sites, number of condoms distributed vs. number you planned to distribute, track populations, what risk category they are in, sexual orientation, what level of distribution are you in – more traditional measures. Can keep process notes as well. Some things might not fall under traditional measurement numbers. How can we do this differently? Might find outcomes you are not looking for that will better help you serve the community. Condoms could actually be a foot in the door. Keep the levels in mind to really think about opportunities to do different things.

- Need to have a system to tell the story.
- Can we get the groups to hand their lists of ideas in so that they can all be documented? Yes
- One group (Dee Jay – Fort Worth) is doing Condom of the Month Club (limited to 250 people) – send a dozen condoms and lubes each month. Then we send you our community health survey to fill out. Then we send you an evaluation on the condom usage. We send a different condom each month; you also get a coupon to come in for free testing. Strategically targeted the distribution.
- AIDS Arms – agreements with different agencies. They provide condoms and lubes and then the organizations distribute them. They also do condom clinics for the agencies, usage, eroticizing condoms, ways to talk about them, series of You Tube videos about eroticizing condoms.

2:15PM

CONDOM DISTRIBUTION ACTIVITY done by Darianne Martin & Trish Larwood

Spend some time developing a campaign around eroticizing using condoms.

Develop a target audience, tone, slogan, picture, song

- Video called Condom Style
- Convert "Call Me Maybe" – to Fxxx Me Maybe and Here's My Condon – I just met you, here's my condom.
- Young men ages 15-25 – Capitalize on interest and fears about sex – Poster Campaign – That's it? You're already done? Wow-that was fast! Tag line: Condoms – Be safe, last longer!
- Black females – Turn off the lights and turn on the heat, check list for a sexy evening including condoms Song –" Turn off the Lights" by Teddy Pendergrass

3:15PM

CLOSING REFLECTIONS done by K. Kaye, Trish Larwood and Liza Hinojosa

- Tie in concepts of things that we have covered on over last couple of days. Remember that DSHS is a resource for everyone, DSHS does not have all the answers, and DSHS wants to work in partnership with the funded agencies.
- Connect with folks in community - how can we shine a bright spot on those things that are working in the community?
- Remember that we relay our passion through our stories; we need to share our stories with others who do not do what we do.
- We need to lift our vision from the details to make sure you are still on track with your vision to minimize new infection and decreasing the community viral load.
- DSHS wants to partner with funders to make sure that they are successful in their communities.
- Jeff – the partnership is a shared mission, DSHS is also engaged in reflective practice and lifting their vision so want to hear back from funders.