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rural areas, where transportation delays are already a problem.

This doomsday scenario need not occur, of course, if public policymakers make a renewed commitment to provide quality health care to all citizens, regardless of ability to pay. It would cost money (lots of money), primarily because technological miracles don't come cheap. The demands our aging population place on elected officials and bureaucrats will determine, to a large degree, the kind of medicine and hospitalization Americans can expect to receive in the future.

Fairness and equity are the keys. Policymakers need to set decent and humane priorities, then live up to their promises.

When they enact a new program such as prospective payment and promise to provide annual cost adjustments, they must do so. When they come out with a new wonder drug such as TPA, they cannot refuse to make it available.

If our leaders make quality affordable healthcare a top public priority . . . if they maintain and strengthen the public-private partnership that exists with non-profit hospitals . . . if they resist the temptation to balance skewed budget priorities on the backs of the less fortunate . . . then we can look forward to continuing America's reputation as the provider of the best health care in the world.

Human Immunodeficiency Virus in Minnesota: Summary of 1988 Statewide HIV Risk Reduction and Disease Prevention Plan

KRISTINE L. MACDONALD, M.D.

The AIDS epidemic continues to grow in Minnesota. As of December 10, 1988, 447 cases of AIDS had been reported to the Minnesota Department of Health (MDH), and 252 Minnesotans had died from AIDS. An effectively implemented risk reduction and disease prevention plan that has broad support and involvement of all segments of the statewide community is essential to reduce the tragic morbidity and mortality caused by this disease in Minnesota. The Commissioner's Task Force on AIDS approved a statewide human immunodeficiency virus (HIV) risk reduction plan in the spring of 1986 (1). The original plan has been updated to incorporate the following objectives for 1988.

Objectives

The ten objectives of the statewide HIV risk reduction plan form a comprehensive and unified approach to preventing the spread of AIDS in Minnesota. The plan objectives are:

1. To study the prevalence and incidence of HIV infection in Minnesota.

2. To study and evaluate knowledge, attitudes, and behavior of persons at risk of acquiring HIV infection.
3. To conduct outreach programs.
4. To conduct programs leading to risk elimination/reduction through behavioral change.
5. To provide adult public education.
6. To provide youth education.
7. To provide professional education to health care providers.
8. To develop a plan for addressing the disproportionate risk of acquiring HIV infection among Minnesota's communities of color.
9. To assist local public health agencies in developing community-based plans for dealing with HIV infection and providing education to their local communities.
10. To evaluate the efficacy of all risk reduction programs.

Study HIV Infection in Minnesota

The MDH will continue to conduct surveillance for AIDS cases and patients with positive test results for HIV infection (repeatedly reactive ELISA with a positive Western blot, positive HIV antigen test, or positive culture for HIV), regardless of symptoms. Ongoing tabulation of seroprevalence rates from the blood banks and the state-sponsored counseling and testing sites can also provide such information. During 1988, the MDH has begun to obtain HIV seroprevalence data from

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patients in a variety of settings in the Twin Cities standard metropolitan statistical area as part of the CDC Family of Surveys. The settings include the following: sexually transmitted disease (STD) clinics, tuberculosis clinics, clinics for women of reproductive age (such as family planning clinics), chemical dependency treatment facilities, a sentinel hospital (inpatients and outpatients) and neonates born in Minnesota. Such data will be used to evaluate the existing HIV surveillance system and to make appropriate recommendations for targeting HIV risk reduction programs.

Study/Evaluate Knowledge, Attitudes, and Behavior

Study and evaluation of knowledge, attitudes and behavior of persons at risk for acquiring HIV infection is a major element of the risk reduction plan. High-risk persons include those likely to be exposed to HIV through sexual contact, and persons who share needles when using intravenous drugs. To obtain these data, persons attending counseling and testing sites, family planning clinics, STD clinics, and chemical dependency treatment facilities can be surveyed. Also, at-risk participants of AIDS education/safer sex programs can be given pre- and post-tests to assess these issues. The MDH has issued a request for proposals to elicit responses for such knowledge, attitudes, and behavioral research.

Outreach Programs

Outreach programs are intended to access high-risk persons so that: 1) they perceive their risk of acquiring HIV, 2) persons who are infected with HIV know ways to limit transmission, and 3) persons who are not infected can remain so. These programs are specifically intended to reach persons who may not be identified through community-based organizations. Outreach programs include the following: media campaigns; third-party contact notification; partner outreach services (a program aimed at helping HIV-infected persons notify their own partners); and follow-up of persons identified to be HIV-infected through physicians' offices, hospitals, clinics, and laboratories (including blood banks). These programs are currently in place and will continue.

Risk Elimination/Reduction

Community-based organizations will conduct programs leading to risk elimination/reduction through behavior change. These programs will be primarily funded by the MDH. Such organizations should provide services to persons at increased risk, such as gay or bisexual men, persons who engage in prostitution, intravenous drug users, persons with hemophilia, and sexual partners of persons at risk. On October 1, 1987, the MDH awarded funding to eight agencies in Minnesota to conduct community-based risk reduction activities. These include: Health Start (high-risk teenagers), Hennepin County Community Health Department (training of correctional facility staff and inmates), Lutheran Social Services (youth in prostitution), the Minneapolis Health Department (women of childbearing years at high risk), the Minnesota Institute for Black Chemical Abuse, the Minnesota AIDS Project, St. Paul Division of Public Health (HIV-antibody negative clients who persistently engage in high risk behaviors), the University of Minnesota Comprehensive Hemophilia Center, and Women Helping Offenders (women in the correctional system). Funding for these agencies is for a 15 month period (October 1987 through December 1988). The MDH has developed two new request for proposal processes to fund additional agencies beginning January 1989. The first is to elicit program responses from these

organizations that best serve youth at risk for HIV infection; the second is to elicit program responses for AIDS prevention/risk reduction programs in communities of color.

The Commissioner of Health has reorganized the Commissioner's Task Force on AIDS to focus on the public health role in promoting behavior change. The initial report of the Task Force will be presented to the Commissioner by the end of 1988.

Adult Public Education

Ongoing adult public education is achieved predominately through media efforts, public lectures and seminars, education in the workplace, and the Minnesota AIDSLINE. Public education is aimed at the prevention of HIV transmission, prevention of "hysteria" related to AIDS, and discrimination against HIV-infected persons. Because some persons engaging in high-risk activities do not have access to information directed at high-risk groups, educational programs for the general public must also contain information about specific risk activities.

Youth Education

Education programs for youth will impact behavior formulation, so young people in the state can be educated to develop healthy behaviors and avoid developing behaviors that put them at risk for acquiring HIV infection. The MDH will continue to work with the Minnesota Department of Education to assure that all Minnesota students know how to protect themselves from becoming infected with HIV. Currently, the MDH is also working to assure that local community health services agencies can respond to the HIV informational needs of school administrators and educators.

Professional Education to Health Care Providers

Professional education is offered through the MDH Disease Control Newsletter and seminars and lectures intended for health care professionals. In addition, the MDH will work with other professional organizations to provide such education, including the Minnesota Medical Association, the Minnesota Nursing Association, the Minnesota Hospital Association, the Minnesota Dental Association, and the Minnesota Chapter of the Association of Practitioners in Infection Control. Professional education should focus on routine HIV risk assessment and, where appropriate, risk reduction counseling. Professional education should also emphasize infection control practices aimed at limiting transmission of HIV to health care providers.

Disproportionate Risk Among Communities of Color

Currently, a disproportionate number of AIDS cases has occurred among Minnesota's communities of color, indicating that such persons are at increased risk of acquiring HIV infection. Therefore, the MDH will assess the level of risk and evaluate HIV antibody seroprevalence in persons of color. In addition, the MDH has issued a request for proposals to develop a survey to gather data on current knowledge, attitudes, and behaviors regarding HIV infection in persons of color. Also, programs aimed at risk reduction and behavior change for communities of color in Minnesota were developed during 1988.

Community-Based Plan Development

The MDH will assist local public health agencies in developing community-based plans for dealing with HIV infection and providing education to their local populations. Eight local public health agencies have received funding

enabling them to develop model community education programs. The MDH is providing training for CHS agencies throughout Minnesota and assisting them in the development of community-based approaches for providing HIV education and services. These approaches need to 1) develop consensus in the community for dealing locally with issues related to HIV infection; 2) provide education to local populations through the use of media, schools, social and religious organizations, and the workplace; 3) assure that adequate services are available to persons infected with HIV and to persons with AIDS.

Program Evaluation

Efficacy of risk elimination/reduction programs can be measured through specific and general outcome, impact, and process objectives outlined by the MDH. Outcome objectives focus on measurable data (i.e., seroprevalence rates in high-risk populations) for Minnesota in 1991. Process objectives identify activities to be conducted by the MDH during the current one-year budget period. Impact objectives specify anticipated results of targeted educational efforts during the corresponding budget period. All such objectives involve timed and measurable outcomes.

Commissioner's Task Force on AIDS

The statewide HIV risk reduction and disease prevention plan was prepared by the Commissioner's Task Force on AIDS. Members of the Task Force from 1985-87 include: Robert Bowman, M.D., St. Paul; Mr. Ed Eberhardt, St. Paul; Mr. Eric Engstrom, Minneapolis; Mr. Morris Floyd, Minneapolis; Robert Kane, M.D., Minneapolis; Aggie Leitheiser, R.N., B.S., Buffalo; Mrs. Lee Luebke, Winona; Michael Moen, M.P.H., Minneapolis; James Nelson, Ph.D., New Brighton; Michael Osterholm, Ph.D., M.P.H., Minneapolis (chairperson); A. Jeanne Pfeiffer, B.S.N., Minneapolis; Herbert Polesky, M.D., Minneapolis; Frank Rhame, M.D., Minneapolis; Rodney Thompson, M.D., Rochester; John Weiser, M.D., Minneapolis; David Williams, M.D., St. Louis Park; Roslyn Yomtovian, M.D., St. Cloud; and Ms. Sue Zuidema, Minneapolis.

Reference

1. MacDonald, K.L., and the Commissioner's Task Force on AIDS. Human Immunodeficiency Virus in Minnesota: Statewide risk reduction and disease prevention plan, *Minnesota Medicine* 1987; 69:467-468.