



Volume 11
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SERVING THE COMMUNITY
SINCE 1983

MINNESOTA AIDS PROJECT AIDSLINE BRIEF

A MAP journal providing you with information to strengthen your awareness in the fight against HIV.

BY THE NUMBERS

In 2003, the MAP AIDSLine had a total of 5380 contacts. This number includes not only phone calls, but also email contacts drop-in visits, as well as on-site HIV testing and “Quick Connect” appointments. Of these total contacts, 47% were HIV prevention-related, and 53% were from people living with HIV, their friends and family, or HIV service providers. 22% of all contacts requested information on HIV transmission and risk reduction. 24% of people contacting MAP AIDSLine were interested in learning about HIV testing options. 13% of contacts requested case management information and referrals. 21% requested assistance with finding basic needs such as housing, health insurance and transportation. Ninety people called looking for volunteer opportunities. Of the 5380 people contacting the MAP AIDSLine, 26% found the phone number in the phone book, 22% found the phone number on the Internet, 21% from a social or public health worker, 13% from a publication or brochure, 10% from a friend or family member and 8% from their doctor’s office.

Recently Diagnosed



1400 Park Avenue
Minneapolis, MN 55404

MISSION

Minnesota AIDS Project envisions a world free of AIDS. Our mission is to lead Minnesota's fight to stop HIV and enhance the well being of those affected.

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Readers Notes:

Minnesota statistics reported on the cover in "By The Numbers" are based on data collected by the Minnesota Department of Health.

MAP RATING LEVEL 3:

Children ages 13-17, educators, adults.

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A message from Lorraine Teel, MAP executive director

The Value of One



For years we have heard how valuable it would be to have "one phone number, one place" to contact to get HIV information. It would be nice to have one place for both answers to complex questions and for all of the referral information needed by a newly diagnosed person or a member of their family. As HIV planners have traveled around the state that refrain is heard over and over.

Minnesota AIDS Project (MAP) AIDSLine has filled this need for over 18 years. It is a one-stop shop for basic HIV education, information and referral services and linkage to needed services.

Many callers, especially those who have grown up learning about HIV through school health classes, already know a lot about HIV and transmission; nevertheless, when HIV becomes personal, they call the MAP AIDSLine because they can immediately talk through the risk factors about which they are concerned. The MAP AIDSLine community educators will help the caller assess their risk, and, if an HIV test is needed, explain the testing process and help them find a test site with which they are comfortable.

Other callers are HIV-positive and maybe just moved to Duluth or Moorhead or some other Greater Minnesota location from another state. They may not have any idea of what HIV-related programs and services are available in their area. Because the MAP AIDSLine maintains a database of HIV resources statewide, we can help them find the resources that will be the first steppingstones in developing their personal network of care and support.

Social workers, health educators and teachers are also frequent MAP AIDSLine callers. They may be searching for resources that will assist a client with whom they are working, or looking for age-appropriate learning resources that they can share with students. In addition to the Resource Guide, MAP AIDSLine community educators continually look for brochures, pamphlets and other learning materials that speak to widely diverse audiences.

Last year more than 5,000 people contacted the MAP AIDSLine to assess their personal risk, get connected to needed resources, or find resources to increase their own or others' HIV knowledge. It is reassuring to see how well received this service is and MAP remains dedicated to keeping this a strong and vibrant program.

Give us a call at (612) 373-2437 (AIDS) or 1-800 248-2437 (AIDS) or visit us at our Web site at <http://www.mnaidsproject.org> to check out our on-line resource guide.

The MAP AIDSLine – your one-stop resource for the most up-to-date information about HIV in Minnesota.





In 2002, Minneapolis had the 12th highest syphilis rate in the nation

Syphilis Increase

Among Men who Have Sex with Men (MSM)

Syphilis is one of the longest recognized sexually transmitted infections. Public health targeted syphilis for elimination in 1998. Strides were being made as case numbers were extremely low and treatment remains highly effective. The CDC was making a push to fully eliminate its spread. In fact the national goal is to reduce the primary and secondary stage syphilis cases to 1,000 or fewer and to increase the number of syphilis-free counties in the United States to 90 percent by 2005.

Recently, however, the disease has been making a frightening comeback nationwide, including in Minnesota, and that increase has been seen primarily among men who have sex with men (MSM). In 2002, the City of Minneapolis had the 12th highest syphilis rate in the nation, compared to 30th in 2000. And that trend continued into 2003.

During 2001, Minnesota saw five cases of syphilis among men who have sex with men. That number climbed dramatically to 56 in 2002, and then even further in 2003 with 73 newly reported cases. In 2003, these cases were primarily white men (79 percent), residents of Hennepin County (75 percent), and the average age was 37. And 41 percent of these MSM infected with syphilis were also living with HIV.

Syphilis infection increases a person's risk for HIV as it causes a chancre to form where individuals were exposed, usually in the genital region, which serves as an easy opening for HIV. In many cities around the country, a rise in syphilis rates among men who have sex with men has been suspected as the precursor to a spike in new HIV infections. And as we are now seeing increasing

rates of syphilis among MSM in Minnesota, there is concern that we may soon see an increase in HIV infections.

Learning from how syphilis outbreaks are handled in other cities is critical. During 2004, Patti Constant from the Minnesota Department of Health's STD & HIV Section brought together members from the community, particularly from the "MSM Network" – a network of outreach workers from PrideAlive, the Red Door Clinic, and Clinic 42 – to identify strategies for a campaign about this trend targeting the gay and bisexual men's community.

Informational flyers were created and distributed, advertisements were placed in prominent GLBT publications, the Internet was used to educate men through chat rooms and bulletin boards, and the Red Door Clinic hosted seven weeks of late evening syphilis specific testing hours.

Efforts are underway to continue a public education campaign about syphilis. PrideAlive staff will continue to provide educational materials and information about syphilis during testing and counseling sessions. In addition, Patti Constant and others are working with Internet-based GLBT Web sites to include banners and informational links to syphilis and safer sex information.

Reacting quickly to emerging epidemics is vital in order to preserve the health of queer men.

Health Care **FOR SOME?**



MAP **Believes** **in Health** **Care** **FOR** **ALL**

You may have noticed a new issue included on MAP Public Policy's agenda – adding a universal health care or "Health Care for All" amendment for the Minnesota Constitution. MAP is excited to be joining with the AFL-CIO and other non-profit organizations in this effort. Why "Health Care for All"? According to both the Coalition of Minnesota Unions and the Minnesota Citizens Forum on Health Care Costs, over 90 percent of Minnesotans believe health care should be available to all citizens, regardless of income or employment. Over 75 percent of those polled by both groups believe the government has a responsibility to ensure Minnesotans have quality health care.

While protecting programs such as the federal Ryan White

CARE Act from further budget cuts or defending against cuts in Minnesota's ADAP program are important, the real solution is to ensure that everyone has access to health care.

For the past generation, Minnesota moved forward with a political consensus in support of expanding access to health care for all. In his 2005 State of the State address, the Governor set a new tone by referring to state-funded health care programs as "welfare programs." MAP will work toward giving Minnesotans the opportunity to make it clear, once and for all, that our state is committed to having its elected officials work to ensure access to health care is a basic right, right along with the constitutionally protected right to education and the right to hunt and fish.

WHO WILL PAY **FOR HIV DRUGS**

The Institute of Medicine (IOM), one of the federal government's most prestigious advisory groups on health policy, says that the country's current plan for providing access to life-saving HIV drugs for low-income people is broken. David Holtgrave, director of Emory University's Center for AIDS Research, is a member of the IOM panel of professionals that looked at the federal "ADAP" – AIDS Drug Assistance Program. He and his fellow panelists suggest a new national strategy that guarantees equal access to HIV care for low-income persons throughout the country. Far from being a "pie in the sky" proposal, the IOM report shows there is almost enough money in the current system to achieve this goal. The question is whether there is the political will to make it happen.

Universal, guaranteed access to health care for persons living with HIV is not just good policy in terms of health care access, it is also smart public health. If HIV-positive people are seeing doctors on a regular basis, they are more likely to change and sustain changes in risk behaviors. While maintaining lower viral loads does not eliminate transmission risk, it significantly reduces the risk of transmission in case of exposure. And finally, keeping people in health care is the best path to maintaining adherence and avoiding emergency of drug-resistant strains of the HIV virus.

Holtgrave spoke at the MAP forum on the same day that Governor Pawlenty released his budget for 2006-07. The Governor's budget further reduces public health care available through General Assistance Medical Care and MinnesotaCare. When the Governor led the effort to cut these programs in 2003, approximately 200 low-income people living with HIV lost their health care and had to turn to the state's version of the ADAP program. With no new money available for Minnesota's ADAP program in either the Governor's past budget or the one he recently proposed, HIV advocates expect Minnesota to join the "list of shame" of states that use waiting lists to ration access to HIV drugs and health care.

There is another way. Read a summary of the IOM report on MAP's Web site and check out MAP's Public Policy Home Page to track MAP's work in the legislature to resist further cuts in the state's ADAP program.

What You Can Make Happen at the Minnesota State Capitol

MAP Public Policy continues its tradition of leadership advancing smart and effective policies to stop HIV in Minnesota. The 2005 State Legislative Action Agenda aims to expand access to effective HIV education and prevention, secure access to needed health and social services, ensure fair treatment of persons affected by HIV, and focus resources on the global epidemic in our own backyard.

You can help advance the MAP Action Agenda by joining the MAP Advocates network. Visit the MAP Public Policy Home page on our Web site and sign up to join the MAP Advocates network. You will get a weekly newsletter, the MAP Advocate, your best source for information about what is happening with HIV issues at the State Capitol. We will also keep you informed about the best opportunities to weigh in with your elected leaders.

2005 MAP STATE LEGISLATIVE ACTION AGENDA

EDUCATION & PREVENTION

INCREASE EFFECTIVE HIV PREVENTION & EDUCATION

- Introduce comprehensive sexual health education bill, including request to restore funding for K-12 regional training sites in greater MN and suburban Twin Cities.
- Protect funding for state HIV prevention. Oppose content restrictions that minimize effective use of public dollars.

HEALTH CARE & SOCIAL SERVICES

ENSURE ACCESS TO HEALTH AND SOCIAL SERVICES

- Introduce legislation to protect and expand HIV insurance and drug assistance in Minnesota.
- Protect Minnesota's minors consent law to ensure access to health services for teens.
- Organize grassroots support to guarantee affordable health care for all Minnesotans. Co-sponsor constitutional amendments.

FAIR TREATMENT

ENSURE FAIR TREATMENT OF PEOPLE AFFECTED BY HIV

- Introduce legislation to strengthen HIV confidentiality protections to prevent unauthorized disclosure of HIV status.
- Oppose changes in MN human rights act provisions related to sexual orientation and people with disabilities.
- Oppose mandatory testing in occupational settings.
- Oppose discriminatory impact of medical asset transfer guidelines

GLOBAL IMPACT

RESPONSE TO THE GLOBAL EPIDEMIC IN OUR OWN BACKYARD

- Introduce legislation to increase HIV prevention funding targeting African-born Minnesotans.

■ THE ALIVENESS PROJECT

730 38th St E
Minneapolis MN 55407
Tel: 612-822-7946

Provides a variety of programs and services for the HIV community. Serves lunch Monday through Friday, evening meals Tuesday through Thursday, and a Saturday brunch. Coordinates food shelf. Sponsors regular educational workshops and resource center. Space and/or support provided for several support groups. Positively Alive offers programs for HIV-positive individuals to discuss HIV prevention. Offers life enhancement activities including tickets and social events. Client advocacy assists HIV-positive individuals not in case management. Complimentary therapies include massage, acupuncture and chiropractic care. Offers free veterinarian services. Volunteer speakers bureau offers presentations about HIV. Annual Holiday Basket program delivers gift baskets to HIV-positive Minnesotans each December. Provides reimbursement for complimentary therapy programs at a clinic in Rochester, MN. Call for details. Volunteer opportunities available.

■ CRISIS CONNECTION

PO Box 19550
Minneapolis MN 55419-0550
Tel: 612-379-6363

A phone line offering support to victims/survivors of sexual abuse/assault. Provides advocacy and assistance through medical, law enforcement and legal procedures. Also provides support groups and individual counseling for victims/survivors of sexual abuse/assault, referrals, and education materials in the St. Cloud area.

■ DELAWARE STREET CLINIC

Fairview-University
Medical Center
420 Delaware St
Minneapolis MN 55455
Tel: 612-625-4680 Toll Free:
800-688-5252 x54680

Infectious disease clinic providing HIV treatment and medical care, HIV testing, counseling and consultations. Affiliated with AIDS Clinical Trials Unit at the University of Minnesota. Clinic has ten adult infectious disease physicians and a pediatric infectious disease physician who sees HIV-positive children or children of mothers who are HIV-positive. Another clinic physician specializes in HIV-positive women, including pregnant women. Potential clinic patients for any of the programs at Delaware St. Clinic can schedule a free orientation visit to meet the health care team, see the clinic, learn about programs offered and answer questions about payment, billing, pharmacy services, etc. The orientation visit does not require any registration, and can be arranged as quickly as the day of the call.

■ MAP AIDSLine

1400 Park Ave. S
Minneapolis MN 55404
Tel: 612-373-2437
Toll Free: 800-248-2437

MAP AIDSLine provides phone, web-based and face-to-face services providing answers to questions about HIV including prevention, testing, treatment and general information, as well as information and referral to testing, prevention and service resources statewide. Available for people with HIV, friends, partners, family members, service providers and anyone who wants information or needs assistance accessing community resources. Quick Connect provides short-term assistance to HIV-positive

individuals to assist them in connecting to needed resources such as financial assistance, medication assistance programs, or meal delivery programs. Provides information on HIV services available in the community and helps people connect to HIV case management programs if needed. Contact the MAP AIDSLine to set up a Quick Connect appointment.

■ NEIGHBORHOOD INVOLVEMENT PROGRAM (NIP)

2431 Hennepin Ave. S
Minneapolis MN 55405
Tel: 612-374-4601
(Counseling Center)
Alt. Tel: 612-825-4357
(24-hour Help Line)

The Counseling Center provides free or affordable counseling and support groups for people with HIV. Offers individual, couples and family counseling to persons with HIV and their partners or families. Addresses issues such as depression, anxiety, fear, anger, changes (for example in work, income and health), relationship issues, sexuality, self-acceptance and personal growth.

■ RED DOOR CLINIC

525 Portland Ave
Minneapolis MN 55415
Tel: 612-348-6363 (Clinic)
red.door.clinic@co.
hennepin.mn.us
www.reddoorclinic.org

Clinic provides STD testing and treatment and free blood work and medical evaluation for uninsured persons who are HIV-positive through the Ryan White Short-Term Intervention Program.

■ **ROOM 111**

555 Cedar St. Floor 1
St. Paul MN 55101
Tel: 651-266-1352

Room 111 has a physician on site that specializes in providing care to people who are newly diagnosed with HIV. This physician provides an initial exam, lab work, medical evaluation, and medical referrals for new HIV-positive patients. Provides STD testing and treatment.

■ **RURAL AIDS ACTION NETWORK (RAAN)**

970 Raymond Ave
Suite G-60
Saint Paul MN 55114
Tel: 651-641-6167
Toll Free: 800-966-9735

RAAN assists persons living with, affected by, and at risk for HIV in Greater Minnesota through a network of volunteers and professionals. Offers community meetings in most regions of the state, support groups, speakers, HIV-related referrals and resources, prevention education and volunteer support. Networks frequently include volunteers who provide practical, emotional, and social support to individuals and families living with HIV, including, but not limited to, transportation, errands and companionship.



Minnesota AIDS Project
AIDSLine
612-373-2437
800-248-2437
tty 612-373-2465/888-820-2437
www.mnaidsproject.org



ACTION DAY

BIGGER AND BADDER THAN EVER

Tuesday April 12, 10 am - 2 pm
Minnesota State Capitol Great Hall

STEP RIGHT UP THOSE LONG CAPITOL STEPS

Show those legislators what citizen lobbyists are made of

CHAMPION NEW LEGISLATION TO ENSURE EVERYONE WITH HIV WHO NEEDS HEALTH CARE, GETS HEALTH CARE

View MAD's new All-Star Video starring People You Know!

YOU KNOW YOU GOTTA BE THERE!



SIGN ME UP TODAY! • REGISTER BY APRIL 8TH

EMAIL TO KNELSON@MNAIDSPROJECT.ORG OR REGISTER ONLINE AT WWW.MNAIDSPROJECT.ORG/PUBLICPOLICY



DONATE YOUR CAR
EMAIL: CARS@MNAIDSPROJECT.ORG • 612-373-2407
MINNESOTA AIDS PROJECT

OraQuick Rapid HIV Antibody Test for Oral Fluid



You may have heard on the news that there is a rapid HIV test available: OraQuick Advance HIV-antibody test (OraQuick Advance), yielding results in 20 minutes. Until March 2004 a rapid HIV test could only be performed using a blood specimen from a needle stick or tube of blood. With FDA (Food and Drug Administration) approval last March, a new version of the rapid test is available for use with oral fluid.

Does the oral OraQuick Advance test use saliva?

No. The test is performed using a device to swab around both upper and lower gums. The swab collects small amounts of oral fluid, different from saliva, which may contain HIV antibodies. The swab is placed in a vial that holds developer solution. Within 20 minutes, lines appear in a window of the testing device, indicating whether HIV antibodies are present.

What type of results does this test produce?

First, it's important to remember that it can take up to three months from the time of exposure to HIV for HIV antibodies to appear on a test. This is called the HIV "window period." When the OraQuick Advance test is administered, a person will receive either a "non-reactive" (negative) or "reactive" result. A reactive result is considered only a preliminary positive, and must be confirmed by an additional, more specific test to determine whether or not HIV antibodies are present. There is no rapid confirming test, so indeed this technology allows an individual to learn if they are negative but does not fully tell if someone is positive. A negative result does not need a follow-up test if it was completed at least three months following the last HIV risk.

How accurate is the OraQuick Advance oral fluid test?

Clinical studies showed that the OraQuick oral fluid test correctly identified 99.3 percent of people who were infected with HIV, and 99.8 percent of people who were not infected with HIV.

The swab collects small amounts of oral fluid, different from saliva, which may contain HIV antibodies

What are the advantages of testing oral fluid rather than blood?

The OraQuick Advance oral fluid test provides a reliable and safe alternative for people who are not comfortable getting a blood draw or finger prick. Also, because saliva and oral fluids do not transmit HIV, the oral fluid test presents a much lower risk of exposure to infectious diseases for health care workers. This will allow for more easily performed "field-based" tests, e.g., not in a clinical setting.

Will the test be sold over the counter?

Currently, the use of OraQuick blood and OraQuick Advance oral fluid tests is limited to trained professionals. However, the test may be administered by trained persons in outreach settings, including homes and community environments.

In Minnesota where can people receive the OraQuick Advance oral fluid test?

For more information about clinics in the state of Minnesota that provide the OraQuick test, call the MAP AIDSLine at 612-373-2437 or toll free 1-800-248-2437.

Proof that Good Health Education Works

The risk of HIV infections among newborns has been practically eliminated in the United States. That's the view of public health officials around the country, as reported recently in the *New York Times*. The amazing success in this one aspect of fighting HIV is something to take note of and learn from. The lesson: Provide good health education, make sure screening, counseling and voluntary testing are available to help people learn their HIV status, and ensure access to health care.

Clearly, the availability of antiviral treatment during pregnancy was the key to achieving the drop from 2,000 new cases among newborns a year in 1990 to just a bit more than 200 in 2004. While it is not a "given" that an HIV-positive mother will transmit the virus to her newborn, with no intervention transmission risk is estimated to be 20 to 25 percent. Providing HIV antiviral treatment during pregnancy and birth can virtually eliminate any risk of transmission. But getting there took much more than just HIV testing and providing drugs.

In Minnesota, community-based providers gathered together through MAP's Women and Families Network to make sure that women received information about how they could prevent their newborns from being infected with HIV. Health educators from all of the groups that participated in the network made sure the information got included in their brochures and workshops. Also, HIV-positive women started talking to other HIV-positive women. This combination of efforts by health professionals and well-informed peers was an effective way to make sure women who needed the facts had the facts and could decide if it was time to talk to their health care providers about getting tested for HIV or getting treatment if they were HIV-positive.

Health care providers also played an important role. They were the ones who carefully managed the sensitive process of screening and counseling women to help them make an informed

decision about getting tested and starting antiviral treatments if needed. Again, MAP played an important role in making this happen in Minnesota. In 1997, MAP secured funding from the Minnesota Legislature to allow the Minnesota Department of Health to work with clinics that served women at high risk for HIV and to help those clinics develop policies and procedures for routinely offering screening and voluntary testing. One of the key things learned through this work was that women would voluntarily consent to being tested for HIV if they were given the right information and counseling. We didn't need to go down the road of forced testing in order to get the job done.

Finally, Minnesota has had a long history of providing access to health care. Since many women at higher risk for HIV are also low income, the fact that prenatal health care was readily available in Minnesota, as well as care for their new family after a birth, made all the difference in the world.

One child was reported to have been infected with HIV through pregnancy in Minnesota in 2002. That same year, 23 HIV-positive women were known to deliver babies in Minnesota.

Building upon the success achieved in preventing newborn infections would seem to make sense. The three-pronged approach of health education, helping people learn their HIV status through voluntary testing, and then providing access to health care is exactly what the CDC "Centers for Disease Control and Prevention" recommended as a national prevention strategy in 2000. However, the current administration replaced that strategy in 2003 with a more limited approach that emphasizes testing, and not always in the best way, and education centered on HIV-positive individuals. Ironically, the new plan also calls for special emphasis on bringing down the rate of newborn infections. It seems that what is really needed is to look at the facts and to celebrate what has worked and then get back to doing what works.





Quick Connect Services

For a person living with HIV, the world of medical, social, and supportive services can be confusing to navigate. There are many reasons why people do not access services. Some may not know how or where to begin, or what programs are available to them. Others may be unwilling to seek out services because of the stigma associated with HIV. They may wonder how they will be treated, or what their friends or family would say if they found out they were living with HIV. Some people may not access services because of language barriers or transportation limitations. Minnesota AIDS Project's Quick Connect program can be a simple first step in seeking services. Consider the story of Melinda.

Melinda is 42 years old. She is a single mother living with her three young children in a Twin Cities suburb. She works forty hours a week and has a

part-time job on the week-end. During a routine physical exam, Melinda's doctor asks if she would

like an HIV test. Melinda agrees, although she feels fine, and believes that she is not the type of person who becomes infected with HIV. During the next week while she waits for her test result, Melinda thinks back to a few times in the last year when she may have been at risk for HIV. Though she is worried, she convinces herself that 42-year-old mothers do

not get HIV. Melinda returns for her test result, and is told that she has tested positive for HIV. Melinda is shocked, and barely hears the rest of what the doctor is telling her. She takes the materials the doctor gives her, and goes back to her job to finish the day's work. She feels overwhelmed and doesn't want to deal with any information about her diagnosis.

Two years go by, and Melinda starts to feel run down and sick. She has not been to a doctor since she was told she was HIV-positive. She knows that she should find medical care but doesn't know where to start. Melinda has missed so many days of work due to illness that she has lost her job, her health insurance, and has just received a notice that she will be evicted if she doesn't catch up on rent payments. Melinda feels hopeless and distressed, and looks back to the materials her doctor gave her. She finds a business card for the MAP AIDSLine and decides to call the number.

After listening to Melinda's concerns, a MAP AIDSLine community educator describes the Quick Connect program. Quick Connect appointments are face-to-face informational sessions with a MAP community educator, who addresses a client's immediate needs for services and education. Those who may benefit from an appointment include newly diagnosed, HIV-positive individuals new to Minnesota, or HIV-positive people who have not accessed HIV-related services before. Quick Connect staff can also work effectively with those who have dropped out of service

and now want to find help again. Quick Connect staff can address both short-term needs and long-term services. In Melinda's case, MAP AIDSLine introduced her to HIV

People living in Greater Minnesota can receive Quick Connect services through phone consultation by calling the MAP AIDSLine toll-free number.

services in the Twin Cities, made referrals to appropriate agencies, and answered many of the questions she had about living with HIV. When Melinda left the appointment, she had phone numbers for HIV clinics that see uninsured patients, an appointment with a MAP's benefits counselor to discuss her health insurance coverage, and referrals to housing and financial assistance programs. Melinda understood that her HIV diagnosis was not a death sentence, and that she did have options for health care and HIV medications. She found out there was ongoing support available to her, such as case management, support groups and counseling, and basic needs assistance specifically for people living with HIV. People living in Greater Minnesota can receive Quick Connect services through phone consultation by calling the MAP AIDSLine toll-free number.

Interpreters are available for both office and phone appointments. Quick Connect provides support, education, and connection to HIV services for those in need. Services are just a phone call away. To make an appointment, call 612-373-2437 or toll-free 800-248-2437.





What Does Comprehensive Sexual Health Education Really Mean?

When announcing the appointment of the U.S. Department of Education's new Secretary Margaret Spellings, White House spokespeople noted that promoting abstinence-only education in schools would be among her priorities. Backing up the policy is the administration's renewed budget request to dramatically increase federal funding for abstinence-only education. All this despite the fact there is no research to show this approach to sex education works, and that there is overwhelming research showing that comprehensive sex education does work. Even while the administration was touting its abstinence-only plans, the American Medical Association (AMA) revised its policies on sex education to support "evidence-based programs and oppose federal funding of unproven ones." According to AMA's President-Elect, Dr. J. Edward Hill, "The whole thing has to do with evidence. It's really a scientific issue." That means, "If an abstinence-only program is proven to work, we're extremely supportive of it, and would be supportive of federal funding for programs that work. But we want them to show the evidence that they work." Based on the facts, however, the AMA supports "comprehensive sex-education programs that stress the importance of abstinence... and also teach about contraceptive choices and safer sex."

MAP, working in partnership with the Sex Ed for Life Coalition, will encourage Minnesota's lawmakers to follow the direction of the AMA and make comprehensive sexual health education a basic part of every public school's curriculum. Legislation being introduced has tri-partisan backing from urban, suburban and Greater Minnesota lawmakers, as well as support from advocates on both sides of the divisive reproductive health debate.

There are certain things we know about comprehensive sexual health education. We know that comprehensive programs are most effective in reducing risky behaviors. We know that most parents support comprehensive sexual health education. And we know that few issues get some people's blood boiling more than teaching young people about sex.

The controversy all comes from confusion over that one word – comprehensive – and what it means. Does it mean teaching young people how to protect themselves from sexually transmitted infections, such as HIV, and pregnancy? Absolutely. But what about encouraging young people to be abstinent and teaching refusal skills? It does that, too. Comprehensive is just that – comprehensive. It is about providing young people with medically accurate and current information that is age-appropriate and designed to help them make healthy choices throughout their lifetime. And we know it works in encouraging healthy behavior in young people.

According to Elaine Uzarek, an Apple Valley sexuality education teacher, sexual health education in Minnesota is expected to address an exhaustive list of subjects, including: abstinence education; communication skills; psychological maturation of the teen; relationship knowledge; abuse in relationships; decision-making skills; refusal skills; guidelines for behavior when dating; teen pregnancy; legal, emotional and social impact of intimate sexual behavior as a teen; impact of sexually transmitted infections; reproductive resources; anatomy; care of the reproductive system; and pregnancy prevention methods.

Despite what its critics say, comprehensive sex ed is not about teaching kids how to have sex, or encouraging them to do so. "Saying that sex education causes kids to have sex is like saying the umbrellas cause rain," said James Wagoner of Advocates for Youth. Numerous scientific studies have shown that programs that address both abstinence and contraception are the most effective in encouraging young people to postpone sexual activity and increase contraception use among those who are sexually active.

MAP supports comprehensive sexual health education that is just that – comprehensive. To track Minnesota's success in reversing the national push for abstinence-only education, visit the MAP Public Policy Page on our Web site.

What Was Systems Advocacy & What Happened to It?

Once upon a time those who worked in various “silos” of the social service system felt ill equipped to address HIV. When they discovered one of their clients was HIV-positive, whether in chemical dependency treatment or a homeless shelter, MAP often received a frantic call. Sometimes it was the provider who either didn’t know what to do or was fearful of transmission. Sometimes the comment was made that “wouldn’t it be in the client’s best interest to be in an ‘HIV-only shelter’ or an ‘HIV-only treatment program?’” Or the client was calling to find out what rights they had as the provider had blatantly violated their confidentiality by informing others of the client’s HIV status.



First, here in Minnesota there are no HIV-specific chemical dependency treatment programs, housing shelters, mental health centers and the like.

Frankly, we believe that rather than isolating and further stigmatizing those with HIV, it is the responsibility of these other networks to expand their skill and knowledge base so that those with HIV can receive services just like anyone else. And one critical factor to help them get there is basic HIV education and skill building. Providers understanding confidentiality laws, reporting requirements and the lives of those living with HIV is also central to the ability of HIV-positive people accessing services regardless of their presenting problem.

Thus was born “systems advocacy.” Systems advocacy is the name MAP created to describe its nationally innovative

effort to change at a systems level those barriers and issues, such as housing discrimination, that affect people living with HIV. Systems advocacy resulted from listening to the frustrations of HIV providers who repeatedly encountered the same barriers or inefficiencies in health care, housing and other systems clients depended on for their health and well-being. Some barriers occurred in the HIV system, but often the problem arose when clients accessed or attempted to access housing, chemical dependency treatment, care and service systems for women and their children, or were in the corrections system.

Training and education was the cornerstone of systems advocacy. Other critical components included networking, outreach, research and policy development, needs assessments, and development of information and resources for these providers. These activities all served to increase the capacity of HIV providers and consumers to better understand and negotiate services in non-HIV systems. Likewise we were able to increase the capacity of housing providers, treatment centers, day care centers, schools, jails, and others to understand and effectively meet the needs people living with HIV.

So how did systems advocacy look in practice? Here are a few examples:

A grandmother in a small Minnesota town is a foster parent for a child with HIV. She finds a childcare center she likes and enrolls the child. In a conversation with a childcare center employee, she discloses the child’s HIV status. Within days, she is contacted by the childcare center and told that state law



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requires the center to tell all the parents with children about her grandchild. MAP system advocates and legal staff inform the center that the child poses no direct health threat and the disclosure is not legally necessary and will violate the child's right to privacy. Unfortunately, in this case the center ignored MAP's advice and disclosed to all the parents. The foster parent had to remove the child from the center and find another program to attend. In her next search for a childcare center, she was armed with all the relevant laws about HIV and information on basic HIV risk and transmission. This grandmother and foster parent had the information she needed to find childcare and protect her foster child from further stigma and isolation.

In another example, a patient in a chemical dependency program told her counselor about her HIV status and was told not to talk about it because it could be a problem for the other residents. All residents in the center are required to participate in kitchen duty – including meal preparations, serving meals and washing dishes. This patient was exempted from kitchen duty because of her HIV status. They were afraid that if she cut herself she would expose everyone to HIV. Almost immediately other residents wanted to know why she was getting out of kitchen duty so she eventually began to share her story with other residents. She then found herself being reprimanded by the counselor for disclosing her status and violating her treatment plan. The client completed treatment but eventually told her case manager about the experience and has agreed to tell her story as part of a training session at a statewide conference for treatment professionals.

While this service was in high demand and produced real results for real people, it was often not understood and unfortunately not viewed as a direct-enough service.

As a result this service was eliminated in February 2005 due to a lack of Ryan White funding. While we will continue to fight to gain new sources of revenue, this is a big loss to those who work outside of the HIV-service sector and are hungry for training and skills building. It is short-sighted for planners to cut this type of programming as it only increases the pressure on the already over stretched HIV system to expand its capacity while not holding other providers accountable to expand their ability and knowledge about how to work with those who are HIV-positive.

Despite 20 years of education, the public is still ill informed about HIV, especially about how this virus is and isn't transmitted. As a result there are many inaccuracies and myths that continue throughout the social service network that needlessly create stigma. Systems advocacy worked to reduce this stigma through training that resulted in these systems being more responsive to the needs of people affected by HIV. At a time when there are more people than ever living longer with HIV, a systems level approach is an on-going need.



Some of our systems advocacy work resulted in written reports that are currently available on the MAP Web site. Some resources, however, that we were able to maintain and were utilized statewide by hundreds of providers, such as our affordable housing lists, became outdated soon after the service ended in February and will be removed from the site. We will continue to assess and determine which of our materials and resources we can adapt to ensure their usefulness after systems advocacy is gone. You can find them at www.mn aidsproject.org by clicking on "Living With HIV" and then on "Changing Systems."

Changes in

EVERY PENNY COUNTS EMERGENCY ASSISTANCE

This past year has been a roller coaster for people seeking assistance from MAP's Every Penny Counts Emergency Assistance (EPCEA) program funded through Titles I and II of the Ryan White Care Act.

Historically more than 1,200 individuals per year receive this critical financial support helping them pay for rent, utilities and food. More people than ever sought assistance in April and May of 2004, the start of the program year, and as a result, funds ran dry by August. In fact, during April alone, 620 individuals applied for assistance and requested that 1,240 payments be made on their behalf.

As we look toward the program year that begins April 1, 2005, MAP is making changes that will spread the availability of funds evenly throughout the year and ensure that as many people have access to assistance as possible. With that in mind, the following changes will be in place:

- **Monthly Allotment:** All funds from Title I and Title II of the Ryan White Care Act used for Emergency Assistance will be divided evenly by month so that the same total amount of funding is available each month. This will ensure that there is

the same amount of assistance available in April as in October or February.

- **Lottery System:** The lottery system that began in October 2004 will be continued. All completed written requests that have been received by EPCEA on the first of the month will be placed in a lottery. Requests chosen from the lottery will be filled until the total amount of funding available for the month has been reached. Individuals are notified if their request has been selected in the lottery. If not, they are welcome to submit a request in subsequent months.
- **Amount of Assistance per client:** With the increase in the number of individuals seeking assistance together with what looks to be flat funding, during the 2005-2006 program year, individuals will be eligible for up to \$280 per program year. Applications and program guidelines will be available after March 15, 2005, either by accessing the MAP Web site (www.mnaidsproject.org) or by calling 612-331-7733 or 1-800-565-9028. The on-line application will have the final amount for which individuals will be eligible during the program year.

- **Food Vouchers:** Eligible individuals seeking food assistance may receive up to \$40 of food vouchers once per month.

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- **Greater Minnesota:** Ryan White Title II funds will once again be available for eligible residents of Greater Minnesota (outside the 11-county metro area) for assistance with phone, child care, food and medical care. HOPWA funding will be available for mortgage, rent and utilities other than phone. Contact EPCEA for further information on assistance for residents of Greater Minnesota.
- Once again, these changes will go into effect on April 1, 2005. Final EPCEA guidelines and applications for will be available after March 15, 2005.

EPCEA

612-331-7733 • 800-565-9028

<http://www.mnaidsproject.org/living/map/financial.htm>



A 10-Year Success Story

Access to Sterile Syringes in Minnesota

“What a mistake, giving addicts clean needles, you’re only encouraging them to abuse drugs and commit crimes.”
“Don’t set up that needle exchange in my neighborhood. Who wants a bunch of junkies around to break in to private homes?” “I’ll tell you how to stop AIDS in the addict community – find ‘em all and lock ‘em up.”

Ten years ago these statements represented the sentiment in Minnesota about providing injecting drug users (IDUs) with sterile syringes. This is despite study after study showing that syringe exchange programs and legal purchase programs did not increase rates of addiction and in fact served as a bridge to substance abuse treatment for many. Of course the most compelling reason to provide this service was that these same studies emphatically described how injecting drug users were the “bridge” for HIV infection to travel unchecked into the heterosexual community. This had been demonstrated in city after city not only in the U.S. but also across the world. Rates of HIV amongst injectors varied widely throughout the United States from lows of .1 percent to highs of nearly 50 percent. It was clearly time to act.

Back in 1994, Minnesota law was somewhat vague about the purchase and possession of sterile syringes. While there was no precise law prohibiting such purchase as there were in other states requiring medically ordered prescriptions, in practicality many individuals could not purchase a syringe. Most notably if you were a person of color and the pharmacist or clerk at the store felt you might be a drug user, often the sale would not be completed. Or the clerk would inform you that you’d have to purchase a box of 500 syringes – single ones were not for sale. On the other hand if you were of European heritage and you made up some plausible excuse like needing just one syringe for “a sick aunt who left her syringe home but remembered to bring the insulin,” the sale would go through.

MAP felt strongly that based on the research at the time, a legal syringe exchange program was needed, and would be accepted in Minnesota. At the same time, we needed to clarify state law so that the purchase and possession of a limited number of syringes would clearly also be legal. Those were the approaches taken concurrently and in the long-term interrupted what would have otherwise been a growing population of infected IDUs and their sexual partners.

“I’ll tell you how to stop AIDS in the addict community – find ‘em all and lock ‘em up.”

The success of these strategies stands today. Today with two fully accepted syringe exchange programs in operation (MAP & Access Works) and the laws clarified in 1997 regarding the purchase and possession of syringes, the incidence and prevalence of HIV amongst IDUs in Minnesota remains amongst the lowest in the U.S. Minnesota became only the second state, just after Connecticut, to clarify its laws regarding purchase and possession. We went even further and undertook a program to educate pharmacists statewide about this new initiative. These strategies combined with continued outreach targeting education for IDUs resulted in our success. We continue to build on these initiatives even today as our programs continue their exchanges, education, assessments, treatment referrals and even field-based HIV testing.

MAP is proud of our work in creating better access to syringes in Minnesota. We paid attention to the research back in 1994, acted upon it and as a result saw a decade of slow declines in the rates of IDU-related HIV transmission. This is a success story that can be duplicated not only in other states but also around the world. Combining syringe exchange with legalized access and continued field-based outreach education can work.



Minnesota AIDS Project™

www.mnaidsproject.org

The 2005 HIV Resource Guide

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