Chapter 16

Targeted Populations

"No intelligent person can fail to recognize that we, as a nation, have the best health and medical care facilities in the world. Yet, in our population there are some minority groups whose health is sorely neglected. These are: the aged with their chronic degenerative diseases and the accompanying health, social, economic, educational, recreational, and housing problems; the disabled who need both treatment and rehabilitation; and the mentally ill who need not only treatment and rehabilitation but frequently a helping hand from a neighbor to maintain their place in society."[1356]

Dr. Robert Barr, 1954

Throughout its history, the Minnesota Health Department has targeted populations having or being at greater risk for health problems. Targeted populations have included American Indians, migrant workers, pregnant women and mothers, refugees, juveniles, the elderly – any concentrated group at greater risk for increased mortality or morbidity.

American Indians

Some of the department's earliest targeted interventions were directed at the American Indian population.

In 1950, there were an estimated 13,000 American Indians in Minnesota. The average age at death was 41.4 years, compared with 63 years for the population as a whole. [1357]

In 1951, the five leading causes of death among American Indians were accidents (15.9 percent of total deaths), heart disease (12.6 percent), pneumonia and influenza (9.9 percent), tuberculosis (7.9 percent) and intra-cranial vascular lesions (7.3 percent). By comparison, the leading causes of death for the general population were heart disease (36.1 percent of total deaths), cancer (16.1 percent), vascular lesions (13.4 percent), accidents (6.5 percent), and general arteriosclerosis (2.6 percent). The American Indian population was disproportionately affected with dysentery, trachoma, poor nutrition and tooth decay. Diabetes was common, but cancer was not.[1358]

For many years the greatest health problem of American Indians in Minnesota was tuberculosis, but considerable improvements had been made by 1949. There were 18

[1356] MDH, *Minnesota's Health,* Vol. 9, No. 5, May 1955, p. 2.
[1357] MDH, *Minnesota's Health,* Vol. VII, No. 8, September 1953, pp. 1-2.
[1358] MDH, *Minnesota's Health,* Vol. IV, No. 7, July 1950, pp. 1-5.

deaths from tuberculosis in 1948, compared to 64 in 1936.[1359] For early detection of tuberculosis cases, when treatment could still be successful, the department visited reservations with a mobile x-ray unit. A 1950 article in the department's newsletter noted that if tuberculosis was to be wiped out among American Indians, they needed better nutrition, frequent x-rays to detect cases early, adequate sanatorium facilities, and segregation of infected individuals. [1360] Beginning in April 1950, outpatient clinics were held at the Red Lake Hospital and other hospitals. Tuberculosis case registries were established at the Chippewa health unit in the Red Lake, Cass and White Earth areas. [1361]

The year 1953 was a milestone year in American Indian health in Minnesota. It was the first time there were no recorded deaths from tuberculosis. While the average life span of American Indians was about 20 years less than the average life span of the general population, headway was being made. An infant mortality rate of 89.1 per 1,000 live births in 1944 dropped to 41.5 in 1954.[1362]

In addition to tuberculosis, health improvements were made in trachoma and other conditions and diseases, but American Indians' health still lagged behind the general population. In 1956, the mortality rate for all diseases in Minnesota was 34 per 100,000 people. For the American Indian population it was almost three times as great at 105.3 per 100,000. The American Indian death rate of 33.2 per 1,000 live births in 1956 compared to 21 per 1,000 for the general population. [1363] Underlying causes for poor health were cited as poor nutrition, inadequate housing, lack of proper sanitation and low economic status.[1364]

It was often difficult for American Indians to find adequate employment. At a board meeting in February 1950, members asked about employment and forms of assistance for American Indians in Minnesota. Dr. Percy Watson, local health services division director, responded:

> I think there is one misunderstanding, generally. The Indians received only $25.00 per capita in 15 years. They do get out of jobs in the winter and they need someone to help find jobs for them. The Welfare Department this year is trying very much to give them jobs and not to give them handouts.[1365]

The primary challenges to preventing and treating diseases among American Indians were scattered populations, impassable roads during bad weather, lack of equipment, and the scarcity of trained American Indian personnel. There were no American Indian doctors on Minnesota Indian reservations. Public health nurses became very important in improving the health of American Indians in Minnesota.

[1359] MDH, *Minnesota's Health,* Vol. VIII, No. 6, June 1949, pp.1-2.
[1360] MDH, *Minnesota's Health,* Vol. IV, No. 7, July 1950, pp. 1-5.
[1361] MDH, *Minnesota's Health,* Vol. V, No. 4, April 1952, pp. 1-2.
[1362] MDH, *Minnesota's Health,* Vol. 9, No. 6, June-July 1955, pp. 1-4.
[1363] MDH, *Minnesota's Health,* Vol. 12, No. 2, February 1958, p. 3.
[1364] MDH, *Minnesota's Health,* Vol. 9, No. 6, June-July 1955, pp. 1-4.
[1365] BOH, *Minutes,* February 14, 1950, MHS, p. 73.

Dr. Albert Chesley, executive officer and board secretary, said: "Putting public health nurses in to the field was the most important move made in relation to Indian health."[1366] Several public health nurses from the department worked with American Indians for many years and developed close friendships. Often they worked in primitive conditions. The weekly clinic at Onigum was held in a dilapidated building where there was no running water and no artificial light.[1367]

Miss Adele Northrup worked as a public health nurse with American Indians until her retirement in 1951. She worked for the department a total of 23 years, the last 15 on the White Earth reservation. On retirement, an educator who knew her well described her work:

> She ministered to the physically, spiritually, and emotionally ill people of her area. Every part of community life was of interest to her. She was the fully occupied person who could always be depended upon to do more when the best interests of the community were involved. Her compensations cumulate from her exemplary, devoted service to the Chippewa people whom she has served so well in these past fifteen years.[1368]

Mrs. Mary Stolze succeeded her.

Herbert Bosch's philosophy, stated below, is one that has been respected by public health workers in Minnesota. Minnesota was the first state to use American Indian nurses to serve the American Indian population. In an effort to reach out to all populations, the department hired two Chippewa nurses again in 1938 to work with the American Indian population.[1369] These nurses, trained in the 1920s, knew the language and made a significant difference in improving the health of American Indians.

"I believe that in attempting to help human beings with their problems one must have knowledge of their cultural patterns so that any suggestions that are made will not violate these patterns."[1370]

Herbert Bosch, State Board of Health Vice President, 1960

With the support of the Soroptimist Club, Minnesota continued the tradition of using American Indian nurses. In 1949, Beverley Estey and Louise Webster completed their nursing degrees.[1371] Shirley Ann Barney, a nurse from Sawyer, Minnesota; was the first American Indian to receive a scholarship for dental hygiene. The scholarship was awarded by the Department of Education through the office of Roy Larson, assistant

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1367 MDH, *Minnesota's Health,* Vol. VII, No. 8, September 1953, pp. 1-2.

1368 MDH, *Minnesota/s Health,* Vol. V, No. 6, June 1951, p. 3.

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1370 MDH, *Minnesota's Health,* Vol.14, No. 4, April 1960, p. 3.

1371 MDH, *Minnesota's Health,* Vol. VIII, No. 6, June 1949, pp. 1-2.

director of Indian schools in Minnesota, with assistance from the Health Department's dental health division.[1372]

One of the department's leading epidemiologists, Herman Kleinman, M.D., chief of the chronic disease section, worked closely with the American Indian population. It was on a reservation where he first met Dr. Chesley, another person who regularly made visits and befriended this population. Dr. Kleinman was convinced the key to improvement in American Indian health was preventive medicine.[1373] As an epidemiologist, Dr. Kleinman conducted research of infectious hepatitis and acute Bright's disease among the Chippewa Indians. In 1950 they gave Dr. Kleinman a special name, "Shining Sky."[1374]

Four American Indian hospitals operated in the state in 1955: White Earth, Cass Lake, Red Lake and Cloquet.[1375] Dr. Albert Chesley was influential in the passage of Public Health Law 568 by the 83rd Congress. This law transferred hospital and health facilities for American Indians from the Bureau of Indian Affairs to the U.S. Public Health Service effective July 1, 1955. This change allowed better coordination of public health programs, with a resulting improvement in American Indian health. Two Minnesotans sponsored the Act: Sen. Edward J. Thye and Rep. Walter H. Judd, M.D. Dr. Chesley chaired the Indian affairs committee of the conference of state and territorial health officers and spearheaded the change.[1376]

In 1957, federal legislation authorized the U.S. Public Health Service to help construct new or remodel old hospitals that were used by American Indians. The state's legislative interim commission on Indians contacted members of Congress to try to persuade them to use the Public Health Service money for building hospitals in Minnesota that were used by American Indians and the general population. They thought using existing community hospitals, rather than building separate hospital facilities for the Indians, was a more efficient use of resources and better integrated the population. In September 1957, Dr. Robert Barr, executive officer and board secretary, along with Ray Lappegaard, deputy commissioner of Public Welfare; Cyrus Magnusson, the governor's representative; five Minnesota state senators and five state representatives gathered in Washington, D.C. to meet with officials of the Public Health Service to advocate for the hospitals and garner support for other health issues concerning the Minnesota American Indian population.[1377]

Another initiative of Dr. Barr's was support for legislation which would help build safe water supplies and sewage systems in areas where American Indians were densely settled. In the late 1950s, gastrointestinal infections were a serious problem with American Indians all over the country. [1378]

[1372] MDH, *Minnesota's Health,* Vol. V, No. 9, September 1951, p. 3.
[1373] MDH, *Minnesota's Health,* Vol. 18, No. 3, March 1964, p. 1.
[1374] MDH, *Minnesota's Health,* Vol. 9, No. 10, December 1955, p. 4.
[1375] MDH, *Minnesota's Health,* Vol. 9, No. 6, June-July 1955, pp. 1-4.
[1376] MDH, *Minnesota's Health,* Vol. 8, No. 9, October 1954, p. 2.
[1377] BOH, *Minutes,* July 30, 1957, MHS, p. 127.
[1378] BOH, *Minutes,* January 13, 1959, MHS, p. 13.

The department worked with many others in trying to improve the health of American Indians. Other agencies and groups included the Public Health Service, Bureau of Indian Affairs, Chippewa Tribal Council, the state departments of Welfare and Education, the U.S. Indian Health Service, state and local voluntary health agencies, nursing and educational groups, church organizations that maintained the mission schools, and mission workers. They worked together with American Indians and other members of their communities, but there was concern that the help provided was preventing them from developing their own leadership skills.

On January 4, 1975, Congress enacted Public Law 93-638 Title I, the Indian Self-Determination Act and Education Assistance Act. On the belief that previous programs for American Indians had served to retard the progress of the Indian communities by depriving them of their ability to develop leadership skills, this act was intended to assure maximum participation in all federal services. [1379]

Migrant Workers

In the 1950s almost 5,000 migrant workers came to Minnesota each year to help with seasonal farm work. This work included sugar beet thinning and hoeing, asparagus transplanting, hoeing and snapping; vegetable hoeing and harvesting; cucumber picking; and potato and sugar beet harvesting.

Migrant workers were economically disadvantaged. While the median income of all U.S. households in 1956 was $4,783, the average income of migrant workers was $2,256. Their income was low and their health problems were high. Migrant workers had high infant mortality rates, suffered from nutritional deficiencies, diarrheal diseases and communicable diseases. Living conditions were often not good. In 1961 a public health nurse visited a migrant family of nine who had three children ill with whooping cough and found them living in a house where the only heat came from the top burners of a gas cook stove. The only bed coverings were two blankets, given by a neighbor. Another family of 18 lived in two rooms, and the children slept on concrete floors. [1380]

The board decided it needed to become more involved in the health care of this transient population. When it was discussed at a board meeting in 1950, they questioned whether or not it was appropriate:

> Dr. Ruth Boynton: "I wonder if we would be in difficulty if we interfered in the field of migrant labor and not in some other fields. There are poor conditions in some other fields, I am sure. I think it is something we would have to think through very carefully and . . .of all the different groups."
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> Dr. Dean Fleming: "Our approach has always been on things that are of a public nature. To protect the public. If a private individual does something that affects the public we feel we have a responsibility. If it is a matter between private individuals then we feel it isn't so much our

[1379] P.L. 93-638 (25USC450) Title I, enacted January 4, 1975.
[1380] MDH, *Minnesota's Health,* Vol. 15, No. 7, August-September 1961, p. 6.

responsibility but local authorities. That same sort of wheedling out of a situation applies for all these agencies." [1381]

The counties with the largest migrant worker populations were Clay, Faribault, Freeborn, Kandiyohi, Marshall, Norman, Polk, Redwood, Renville, Sibley and Steele.[1382] Many migrant workers lived in migrant labor camps. Some camps, such as the ones in the Red River Valley, were equipped with refrigerators. Others, however, did not meet state regulations. Beginning in 1958, the department began inspecting the state's 230 migrant camps. Due to a shortage of personnel, however, it was difficult to follow up on the 1,345 violations that were found between 1958 and 1961.[1383]

A survey of all but six of the 823 migrant labor camps in the state was conducted in 1963. The camps varied considerably, ranging from one-room cottages to abandoned farmhouses to specially constructed facilities. Only 23 percent complied with regulations. Major deficiencies were unscreened windows, inadequate sewage disposal and unsafe water supplies.[1384]

State agencies and local groups worked together to offer educational classes for adults and organized activities for migrant workers' children. They conducted food and clothing drives and provided better medical and health services. Migrant worker families did not usually have medical records. To address this, in 1961, the department provided all migrants entering the state with a personal health record card. [1385]

Limited use was made of the personal health record. Public health nurses and sanitarians reported the head of the family usually determined whether a member of the family was ill or not and what should be done about it. Nurses found a basic obstacle to good health, in many cases, was the lack of information. Sometimes a demonstration, such as the correct method of garbage disposal, was all that was needed to change behaviors.[1386]

In 1959, at the request of the governor's migrant workers committee, the department produced an English-Spanish recipe book for use by volunteers conducting food preparation classes for the migrant workers and for migrant mothers. The book contained 22 recipes selected based on cultural eating habits, facilities and availability of food. "Libro de Recetas" took into account limited income and facilities.[1387] The department also translated a pamphlet, "Getting Your Child Ready for School," into Spanish.[1388]

[1381] BOH, *Minutes,* December 21, 1950, MHS, p. 556.
[1382] MDH, *Minnesota's Health,* Vol. 17, No. 4, April 1963, p. 3.
[1383] MDH, *Minnesota's Health,* Vol. 15, No. 7, August-September 1961, p. 6.
[1384] MDH, *Minnesota's Health,* Vol. 18, No. 1, January 1964, p. 1.
[1385] MDH, *Minnesota's Health,* Vol. 15, No. 7, August-September 1961, p. 6.
[1386] MDH, *Minnesota's Health,* Vol. 19, No. 4, April 1965, pp. 1-4.
[1387] BOH, *Minutes,* August 11, 1959, MHS, p. 210.
[1388] MDH, *Minnesota's Health,* Vol. 15, No. 7, August-September 1961, pp. 4-5.

While these measures helped, the Department newsletter noted that:

> ***"...in order to achieve better health, migrants need more than measures aimed directly at disease prevention and control. They need better general education, opportunities for vocational training, adequate housing, and more opportunities for permanent employment."***[1389]

Two one-year grants from the U.S. Public Health Service in 1964 expanded health services to migrant workers. The grants, totaling $42,110, were used to employ several public health nurses to work with migrant families and to expand and complete the survey of migrant housing. The public health nurse provided health counseling and nursing care. The nurses were assigned to District VII, the Fergus Falls office, but they moved with migrants around the state. Co-directors of the project were D. S. Fleming, M.D. and William Harrison, MD.[1390]

During 1964, seven public health nurses made 304 camp visits and 436 visits to individual families of migrant workers. A total of 175 persons received counseling on specific problems and 149 were put in touch with physicians and other community resources. That year, each camp was visited and inspected by a sanitarian. One public health nurse reported visiting a 10-month-old baby with diarrhea, high fever, and lung congestion. Both parents were out in the field, leaving their 10-year-old daughter to care for the baby and six siblings. The three youngest had measles, the two-year-old and four-year-old had diarrhea. The baby came down with measles four days later.[1391] The project continued in 1965 with seven public health nurses and three sanitary inspectors.

In 1966 the department received a $233,084 grant from the Office of Economic Opportunity and expanded services to migrant workers to include day-care centers and summer school classes. This was the first statewide program to educate children of migrant families. Under the direction of Judith Bieber, migrant health project coordinator, the department conducted vision, hearing and dental screening at the schools for the children of migrant families. If needed, the department followed up with treatment.[1392]

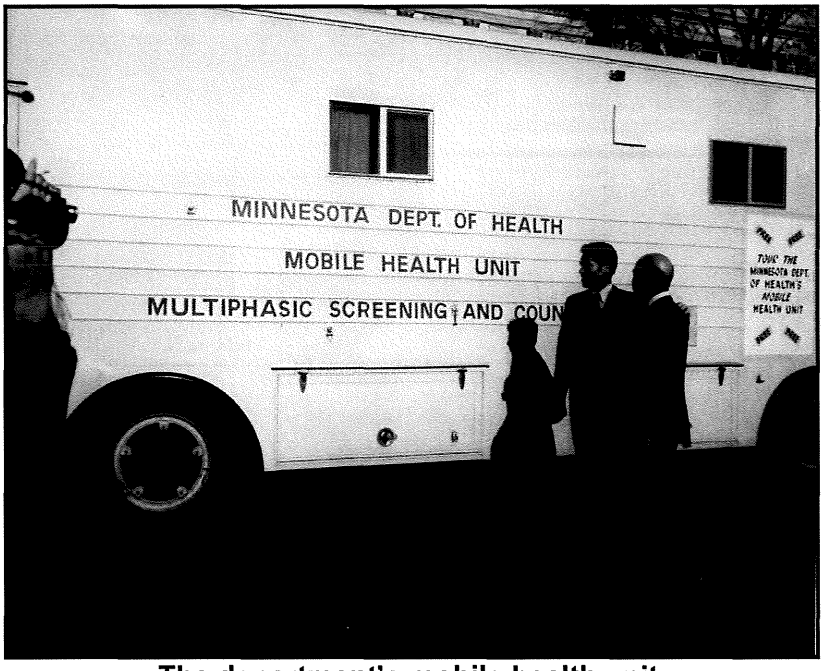
In 1971 a boon to the health of migrant workers and American Indians came with the passage of legislation providing funding for a mobile health clinic. This clinic traveled throughout the state, following the route of migrant workers and providing basic health services. Ernest Kramer, community service development division director, was in charge of the mobile health unit in 1976. It remained in operation in 1999.

[1389] MDH, *Minnesota's Health,* Vol. 15, No. 7, August-September 1961, pp. 4-5.
[1390] MDH, *Minnesota's Health,* Vol. 18, No. 6, June-July 1964, p. 1.
[1391] MDH, *Minnesota's Health,* Vol. 19, No. 4, April 1965, pp. 1-4.
[1392] MDH, *Minnesota's Health,* Vol. 20, No. 6, June-July 1966, p. 3.

144.076 Mobile health clinic.

The state commissioner of health may establish, equip, and staff with the commissioner's own members or volunteers from the healing arts, or may contract with a public or private nonprofit agency or organization to establish, equip, and staff a mobile unit, or units to travel in and around poverty stricken areas and Indian reservations of the state on a prescribed course and schedule for diagnostic and general health counseling, including counseling on and distribution of dietary information, to persons residing in such areas. For this purpose the state commissioner of health may purchase and equip suitable motor vehicles, and furnish a driver and such other personnel as the department deems necessary to effectively carry out the purposes for which these mobile units were established or may contract with a public or private nonprofit agency or organization to provide the service.

HIST: 1971 c 940 s 1; 1975 c 310 s 3; 1977 c 305 s 45; 1986 c 444



The department's mobile health unit.

Maternal and Child Health

Earlier than in most states, the Minnesota Health Department had programs targeted at women and children. Two persons deserve special recognition for the work they did to begin activities in maternal and child health. Dr. William Harrison, working in local health services, and Dr. A. B. Rosenfield, head of maternal and child health, advocated programs for mothers and children during the 1940s and 1950s.

In 1951, the department newsletter proclaimed that 348 mothers and 3,400 infants were alive in Minnesota who would have died if 1915 mortality rates had prevailed in 1950. While the infant mortality rate was dropping, the department was still concerned about the number of deaths.[1393] Infant and maternal mortality was at an all-time low in 1949, but Dr. Rosenfield thought it could be lower. Two studies, one on maternal deaths and the other on infant deaths, were undertaken to try to figure out what could be done. In the meantime, the department advocated for local health programs on a community or county basis to promote better health and lower death rates for infants and mothers.[1394]

A state maternal mortality committee was formed in 1941 to study maternal deaths, but it was discontinued during World War II. Restarted in 1950, the committee was a joint undertaking of the department and the state medical association. Eleven obstetricians and Dr. Rosenfield served on the committee. They made a detailed study of every maternal death that occurred in the state to determine if the death was preventable. Findings were used to develop an educational program to reduce maternal deaths.[1395] The committee established minimum standards for adequate prenatal care. Surveys of physicians indicated they were becoming more careful and conservative in their treatment.[1396]

The focus on maternal and child health continued at the department with the establishment of the maternal and child health division in 1983. To provide input and support for maternal and child health, the Legislature established a maternal and children's health advisory task force in 1982. Meeting regularly with persons outside the department, this task force remained in operation in 1999.

Women's Health

From 1949 to 1999 women's health issues changed considerably in Minnesota. The difference is noted in an excerpt from a speech given by Dr. Walter C. Alvarez of the Mayo Clinic on April 21, 1949, as reported in the Health Department newsletter. He spoke at the Ramsey County Health Day in St. Paul, and his speech, "What Makes Women Nervous," was said to be very popular.

> Women get nervous for many reasons. Some were born with the tendency; some earned it with much hard work; others had it thrust upon them by much sorrow and misfortune. Many women are constantly blowing ten dollars' worth of energy on a ten-cent problem." Dr. Alvarez cautioned women against "trying to make a saintly little Lord Faunteroy out of a normally noisy and active boy" or "trying to make over into a Charles Boyer an ordinary good, kind, but prosaic husband." Many women, he said, are too much concerned about health--their own and their family's--too conscientious about little things, too busy to get enough rest, doing too many things outside the home. Others get too upset about old sorrows or hug their grief too long. [1397]

[1393] MDH, *Minnesota's Health,* Vol. 6, No. 7 & 8, July-August 1951, p. 2.
[1394] MDH, *Minnesota's Health,* Vol. IV, No. 1, January 1950, pp. 1-2.
[1395] MDH, *Minnesota's Health,* Vol. 6, No. 7 & 8, July-August 1951, p. 2.
[1396] MDH, *Minnesota's Health,* Vol. 8, No. 7, July-August 1954, p. 6.
[1397] MDH, *Minnesota's Health,* Vol. III, No. 4, April 1949, p. 3.

Commissioner Marlene Marschall was the first commissioner to strongly emphasize the need to focus on women's health issues. A specific division or unit directed at women has not been created, but women's health has begun receiving greater emphasis.

Elderly

Dr. Walter C. Alvarez spoke about the elderly at Hennepin County's community health day in November 1954. The department's newsletter reported on his speech:

> Too many old people are persecuted and repressed in the name of prolonging their lives. They are subjected to constant nagging by well-meaning relatives who insist on literal observance of doctor's orders. The old person is told he must not smoke, must not eat what he wants, must not exert himself. Hampered and frustrated by endless prohibitions, he is likely to become mentally sluggish and childish and may suffer a complete breakdown. [1398]

In 1953 there were 25 Minnesotans age 100 or older.[1399]

Tuberculosis was more common in the older population. Ninety percent of the tuberculosis deaths in 1958 were in people age 45 and older.[1400]

Disparity in Health Status by Race

Like early tuberculosis and cancer patients, American Indians and other groups, people of color dealt with discrimination. In 1961, the department received objections to the inclusion of "race" on birth certificates. Some people feared the certificate could be used as a basis for discrimination.[1401] In response to these concerns, the board made a decision to eliminate "race" from the birth certificate. The information was transferred to the section for medical and health use only on the bottom of the birth certificate. It became confidential information on a certificate of live birth, as was already the case on the certificate of fetal death. The information would still be available for statistical review, but it would not appear on any copies of the certificate.

In the 1970s, increased attention was directed to the disparities in health status between racial groups in Minnesota. The department compiled a study based on data collected from 1978 and 1982. Findings from this study indicated that the infant mortality rate for people of color, including American Indians, was twice that of the rest of the population, high-risk births (mothers who were under age 17 or over age 39) occurred more frequently in the non-white population, cirrhosis of the liver occurred four times as frequently in American Indian women as in American Indian men, and the overall death rate for the American Indian population between ages 25 and 44 was nearly four times that of the rest of the population.[1402]

[1398] MDH, *Minnesota's Health,* Vol. 8, No. 11, November 1954, p. 4.
[1399] MDH, *Minnesota's Health,* Vol. 9, No. 1, January 1955, p. 1.
[1400] MDH, *Minnesota's Health,* Vol. 14, No. 1, January 1960, p. 3.
[1401] BOH, *Minutes,* January 31, 1961, MHS, p. 22.
[1402] *St. Paul Pioneer Press,* "Minorities Face Poorer Health," December 13, 1986, pp. 1A and 4A.

Based on these and other findings, in 1986 the department produced recommendations for improving the health of minorities. Key to improving health was the reduction of poverty. The study found that 25 percent of Minnesota minorities lived below the poverty line. [1403]

The 1986 report listed 19 recommendations for improving the health of minorities. Among those emphasized were:

- Educational efforts to reduce teen-age pregnancy.
- Prenatal programs for pregnant teenagers.
- Access to preventive care.
- Availability of safe and warm houses.
- Prevention of chemical dependency.
- Health promotion efforts in diet and health screening.
- Access to employment.

Paul Gunderson, Ph.D., director of health statistics, noted the broad approach taken by the report and the involvement needed to improve minority health:

> We were particularly interested in establishing statements that adequately depicted what would have to be done to address the problem in the State. The public sector can't do it all, the private sector can't do it all. I think there's clearly a role for the philanthropic sector, particularly in developing strategies capable of intervening in injury among adolescents, in helping families cope and in working with youth organizations to focus on changing self destructive behavior.[1404]

In 1990 the infant mortality rate for people of color was still disproportionately high. While the state had reached an all-time low of 7.8, the infant mortality rate for people of color was about 2-½ times that of the rest of the population.[1405]

Driven by the need to improve the health status of a targeted population, the department established an office of minority health in 1995. The mission of this unit is:

> ...to assist in improving the health of people of color in Minnesota. Our goal is to reduce the burden of preventive disease and illness by promoting health promotion and disease prevention initiatives; supporting positive health care delivery systems, programs and strategies for people of color; and working to eliminate disparities in the health status of people of color.

[1403] Ibid.
[1404] Ibid.
[1405] *St. Paul Pioneer Press,* "Infant Death Rate Reaches All-Time Low in Minnesota," December 19, 1990, pp.1B, 5B.