

# what are American Indian/ Alaskan Natives' (AI/AN) HIV prevention needs?

## are AI/AN at risk for HIV?

Yes. American Indians and Alaskan Natives (AI/AN) represent a unique population within the US, not only because of their oppression suffered in the development of this country but also because of their ongoing struggle to gain recognition in the HIV/AIDS epidemic. AI/ANs are not so unique, however, that they are protected from the same behaviors that put all people at risk for HIV infection.

*The long history of oppression of AI/AN in the US has had a devastating effect on the health and well-being of Native Peoples. This history, including colonization, outlawing Native languages and spiritual practices, and centuries of forced relocation, has created justified mistrust of US government programs and health institutions.<sup>1</sup> This legacy continues to shape the experience of AI/AN as they are disproportionately impacted by poverty, ill health, family violence and drug and alcohol abuse. All of these factors are associated with HIV risk.<sup>2</sup>*

Through the end of 2000, AI/ANs comprised 2,337 AIDS cases and 871 HIV cases.<sup>3</sup> AI/AN constitute approximately 1% of the total US population, and just under 1% of reported AIDS and HIV cases.<sup>3</sup> Although these numbers appear small relative to other populations, the impact is considerable. Underreporting and the lack of detailed HIV surveillance of AI/AN may result in significant undercounting of HIV infections.

*Further, AI/AN are often misclassified in terms of race/ethnicity on data collection forms, due to assumptions about names, skin color, residence and even intentionally misleading self reporting.<sup>4</sup> A study of STD data in Oklahoma found that 35% of chlamydia and over 60% of gonorrhea cases among AI/AN had been incorrectly attributed as Hispanic or white.<sup>5</sup>*

## what puts AI/ANs at risk?

HIV research among AI/AN has a short history starting in the early 1990s, with few studies on risk behavior. According to the CDC, for AI/AN men, the leading exposure category for HIV is men who have sex with men (MSM) at 51%, MSM and injection drug use (IDU) 13% and heterosexual IDU 12%. Among women, the primary exposure risk is heterosexual contacts at 41%, followed by IDU at 32%.<sup>3</sup> However, this data does not include data from California, which has the largest Native population of all 50 states.<sup>6</sup>

*AI/AN populations are disproportionately impacted by social, behavioral and economic factors that are associated with HIV risk. AI/AN suffer high rates of poverty and unemployment, with 32% living below poverty level, compared to 13% of the general US population.<sup>7</sup> Native Americans also experience high rates of drug and alcohol use, STDs and violence.<sup>8</sup> Alcohol use in the AI/AN population has resulted in the highest alcohol-related mortality rates for all US populations.<sup>9</sup>*

One study of AN drug users found that alcohol use was the factor that put them at greatest risk for HIV. Many individuals reported blacking out while drinking, and later learned that they had unprotected sex with complete strangers or persons they would not otherwise accept as partners.<sup>10</sup>

*This same study showed that drug using Alaskan Native women are at high risk for gonorrhea infection and HIV infection. AN women were more likely to inject drugs than any other ethnic group among women, and they were more likely to have white male injectors as sex partners. Sex pairs composed of AN women and white men were the least likely of any ethnic pair combinations to use condoms.<sup>11</sup>*

In states with AI/AN populations over 20,000, gonorrhea and syphilis rates are twice as high as among other ethnic groups.<sup>7</sup> Persons with STDs are more likely both to transmit HIV and become infected with HIV if exposed.

*A study of American Indian youth in over 200 reservation-based schools across the US showed that youth engaged in several risk behaviors: the use of alcohol, tobacco and other drugs, risky sexual behavior and suicidal behaviors. Drug use was most commonly associated with other risky behaviors.<sup>12</sup>*

## Says who?

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## what are barriers to prevention?

HIV is often rendered invisible within AI/AN communities that are facing many other severe and more visible health and social problems such as alcoholism, diabetes and unemployment. As a result, there is often great denial about HIV as a problem in AI/AN communities.

*Like in many other tight-knit communities, confidentiality can be difficult to maintain in AI/AN communities, especially in rural areas. This can be a barrier to important prevention activities such as testing for HIV, discussing sexual practices with health care providers, obtaining drug treatment, or buying condoms in local stores.*

Prevention services for AI/AN MSM are severely underfunded, and those that exist may not reach MSM at risk. AI/AN MSM have a wide range of identities, from “gay” to “two-spirit” and may not access services addressed to urban gay men.<sup>13</sup> AI/AN MSM may feel isolated and not seek out needed services because of stigma and denial about homosexuality in some AI/AN communities.

*The AI/AN population is highly diverse, with over 550 federally-recognized tribes. AI/AN consider themselves to belong to Indian nations that are sovereign, with complex relationships between tribal, state and federal governments. Many state and local governments erroneously assume that the IHS is solely responsible for the health-related needs of AI/AN. Less than 1% of IHS budget goes to urban populations, yet more than half of all AI/AN in the US live in urban areas. As a result, AI/AN tribes and organizations are often denied funding opportunities available to other citizens.*

## what's being done?

To address the rising rates of STDs and HIV among adolescents in a rural Arizona Indian tribe, tribal health educators, school officials and public health officials collaborated to establish several programs including school health clinics, Native American HIV+ speakers, peer-produced educational dramas, community educational meetings and radio and newspaper ads. Cases of STDs and HIV peaked in 1990 and slowly declined over the next six years, for a 69% overall reduction in STDs.<sup>14</sup>

*The Indigenous People's Task Force (IPTF) in Minneapolis, MN, promotes health and education for Native persons. Their Ogitchidag Gikinooamaagad (warrior/teachers) peer education/theater program provides youth with a comprehensive HIV/AIDS prevention curriculum, theater instruction and traditional teachings. IPTF's programs have been acknowledged by the US Surgeon General.<sup>15</sup>*

The Indian Health Care Resource Center (IHCRC) of Tulsa, OK provides a biweekly social group for two-spirit Native American men to help build a sense of community, self-esteem and reduce risk behaviors. IHCRC also hosts a relationship skills-building workshop which focuses on helping the participants determine what they want out of relationships, managing triggers to risk behavior and increasing negotiating skills. Each year, IHCRC offers a 4-day retreat with social, cultural and educational activities including traditional meals, a Powwow and stomp dancing.<sup>16</sup>

## what still needs to be done?

AI/AN communities, although diverse in many ways, share a sense of pride, self-determination, spirituality, and resiliency which have helped them fight HIV infection in their communities. These efforts need to be encouraged to ensure sustained HIV prevention. This can only occur with cooperation and collaboration between the many agencies who work with AI/AN, including tribal health care systems, federal, state and local health departments and non-profit agencies. For example, complex funding streams need to be simplified to allow AI/AN communities greater access to prevention resources.

*HIV/AIDS must be made visible in AI/AN communities to prevent the spread of HIV. Visibility can be increased by collecting reliable HIV/AIDS data, including AI/AN in the design and delivery of HIV prevention programs, addressing AI/AN stigma about homosexuality and drug use, and linking to STD, violence, unintended pregnancy, and alcohol and drug abuse prevention programs.*

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15. Indigenous People's Task Force, 1433 East Franklin Ave. Suite 18A, Minneapolis, MN 55404. Contact Sharon Day 612/870-1723. [www.indigenouspeoplestf.org](http://www.indigenouspeoplestf.org)

16. Indian Healthcare Resource Center of Tulsa, 550 South Peoria, Tulsa, OK 74120. Contact Tommy Chesbro 918/382-1275 [www.tulsaindianhealth.com](http://www.tulsaindianhealth.com)