

NOT ONE MORE

Fighting AIDS in Communities of Color

Recommendations to Improve HIV/AIDS Services to American Indians, Native Americans, Alaskan Natives and Native Hawaiians



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Printing provided by the
National Minority AIDS Council

Since contact with Europeans, American Indians, Native Americans, Alaska Natives and Native Hawaiians confronted diseases and epidemics which have diminished our numbers and quality of life. More than 25 years into the HIV/AIDS epidemic, HIV infections continue to exact enormous tolls in our communities. Co-factors include substance abuse; lack of and access to comprehensive health care, including HIV/AIDS prevention, treatment and managed care services; and issues of stigma and isolation. The silence surrounding HIV in Native communities can no longer continue. This paper provides recommendations to enhance cultural competency that would result in the slowing of the spread of communicable diseases within Native nations and communities.

According to the 2000 U.S. Census, there are an estimated 4.1 million Native peoples. An estimated 65-68% of Native peoples live in urban settings, not on reservations. Regardless, we often struggle to meet the most basic needs of housing, education and health care. Although these basic human needs are guaranteed in our treaties with the government of the American people, often in exchange for valuable land and resources, historic and contemporary policies developed by the Federal government have never lived up to the promises made. These treaties with Indigenous nations are legally binding under international law reaffirmed as recently as 1990 by a special United Nations study and also preserved as "the supreme law of the land" in the U.S. constitution. It is therefore inconceivable that the American people would want to legally or ethically ignore its obligations to Native nations and peoples.

For Native peoples, the well-being of the community is based on a holistic approach to our people and environment: health, therefore, means more than simply "curing" the individual's illness. It is a way of preserving our community by embracing our own diversity, including those that may be living with physical and mental illness. This is the context in which the United States government and its people must join with Indian communities to wage our fight against HIV and AIDS and healthier Indian communities.

HIV/AIDS

When population size is taken into account, Native Peoples ranked 3rd in the rate of AIDS diagnoses, after African Americans and Hispanics (according to CDC Fact Sheet "HIV/AIDS among AN/Al" (rev 2008)). The rate of AIDS diagnoses for Native people has been higher than that for whites since 1995.

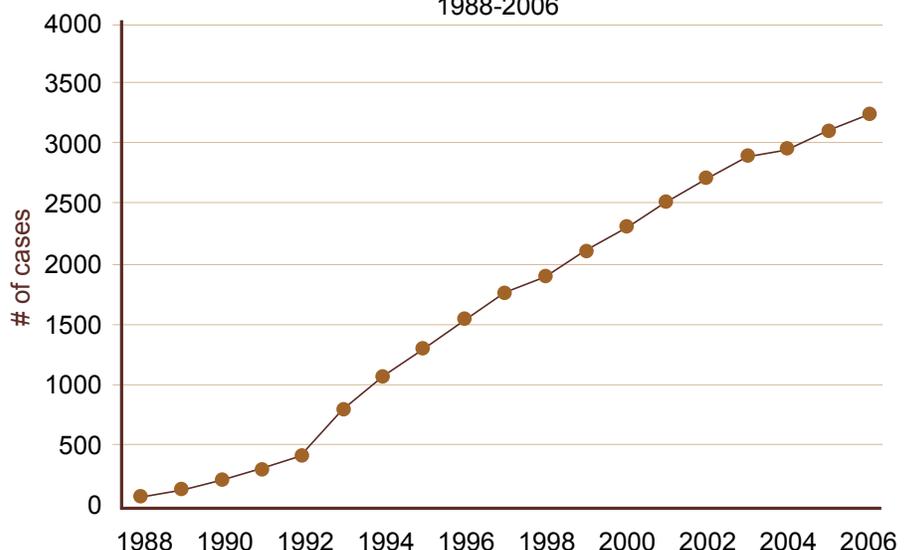
We also face additional challenges: the number of Native Peoples living with HIV/AIDS may actually be much higher as a direct result of racial misclassification; lack of testing opportunities in rural/reservation communities, failure of Native Peoples to access treatment; and the absence of existing prevention and treatment infrastructure for Native people.

Of persons diagnosed with AIDS between 1998 and 2005, Native people had the shortest overall survival rate. Studies show the survival rate of Native people is only 75%, compared to 82% for Blacks, 87% for

Whites, 88% for Hispanics, and 90% for Asian/Pacific Islanders. This is a clear indicator of the unbalanced adversity faced by our communities from this disease.



American Indian & Alaska Native
Reported AIDS Cases
1988-2006



CO-FACTORS

Inability to Access Services

An estimated 65-70% of Native Peoples live in urban settings or off reservation. Indian Health Service ("IHS") contracts with private Indian-controlled nonprofit corporations to run urban Indian health organizations. Today, there are 34 urban Indian health organizations. In fiscal year 2006, Congress spent ONLY 1% of IHS's \$3 billion annual budget on these urban facilities. Additionally, many existing IHS facilities are understaffed, under-funded, and have limited access to treatment advances.

Modes of Exposure

While male-to-male sexual contact and injection drug use (IDU) were the most common ways transmission occurred, the percentage of exposure through heterosexual contact is also increasing. Among Native women living with HIV/AIDS, 66% were infected through heterosexual contact and 32% through IDU.

Sexually Transmitted Diseases

Protocol and tradition, associated with sex and sexuality within Native communities sometimes makes it difficult to discuss and confront STDs. Native Peoples have the 2nd highest rates of gonorrhea, chlamydia, and syphilis infection. For example, in Minnesota it is reported that 90% of American Indian chlamydia and gonorrhea cases have been diagnosed among Native women with only ten percent among Native American men. This demonstrates risky behaviors are occurring. It is known, that infection rates in Native women are growing (16% in 1995 compared with 22% in 2001).

Substance Abuse

Native Peoples have the highest prevalence of substance abuse among all racial and ethnic groups in the US. Alcohol-related deaths in general were 178% higher than the rate for all races combined. Previous data indicates that measurements in states where reservations are located can have rates as high as 438% greater. Rates of illicit drug use are also higher for Native Peoples (12.8%). Methamphetamine use in association with violence is on the rise (CDC, March 2007).

Women

AIDS rate for Native women is four times that of all other races and ethnicities. Women account for roughly 29% of AIDS diagnoses among Native Peoples. One in three Native women are victims of domestic violence. Historic trauma, resulting in alcoholism, drug abuse, mental illness, and violence, are substantial co-factors. Native American and Alaska Native women are more than 2.5 times more likely to be raped or sexually assaulted than other women in the United States in general.

Age

Native Peoples have a young population; thirty-three percent of our peoples are under the age of 18 versus a national average of 26%. This fact alone constitutes a risk factor. Survival rates of many other diseases, including diabetes, tuberculosis, and alcoholism, are also much lower and access to health care is limited.

Socioeconomics/ Education

Almost three times as many Native Peoples live below the poverty line compared to the overall US population (32% v. 13%). Nearly one-third of Native Peoples do not have a high school degree compared to the national average (29% v. 20%). Consequently, fewer Native Peoples graduate from college (11.5% against the national average of 24.4%). Only 88% of homes in Indian Country have a "safe, reliable, in-home, piped water supply and waste water disposal" compared to the national rate of 99%. In Alaska, it's 74%.

Access to Healthcare

Twenty-seven percent of Native Peoples lack health insurance coverage. This rate is significantly higher than that of African Americans (21.6%), Asians and Pacific Islanders (20.9%) and Whites (11.6%).

Racial Misclassification

In one study, the percentage of racially misidentified Native Peoples ranged from 3.7% (in Alaska) to 56% (in California). Because of the general lack of knowledge about Indigenous Americans, we are frequently assumed to be white (70%), Hispanic (16%), black (11%), or Asian/Pacific Islander (2%).



POLICY CONSIDERATIONS

Western Medicine

Survival rates for Native peoples living with HIV/AIDS are lower than any other racial /ethnic group. All Native peoples living with HIV/AIDS suffer from related diseases, diabetes, tuberculosis and Hepatitis. Mental health, alcohol and drug abuse and addiction complicate primary care-seeking behaviors of Native peoples' with HIV. Complex issues related to trust of western medicine providers, stigma related to sexuality, death and generational trauma and depression are huge co-factors and must be addressed.

Medical providers for Native people with HIV must be enabled and empowered to operate at a standard of care for HIV. There is a significant lack of Native medical providers. With 27% of Native Peoples lacking health insurance coverage, it is unacceptable that significant barriers exist within mechanisms of the Ryan White HIV/AIDS Treatment and Modernization Act of 2006 that prevent provision of primary medical care and essential support services to Native people with HIV/AIDS. It is critical that the Act be amended or provisions made to provide a source of payment for HIV specialty and primary health care services for Native peoples with HIV so we can access care. A potential model for study is that adopted by the Alaska Tribal Health System in which a statewide tribal consortia has received Ryan White funding for outpatient clinical care, case management and clinical training.

Traditional Medicine is our Culturally Specific Best Practices

Native Peoples need to have access to traditional medicine practitioners. It is the strength of our traditions and values that are most relevant for the development of cultural practices for prevention. A funding mechanism needs to be created that will allow for treatment by Native traditionalist/medicine practitioners. Native peoples need access to primary prevention, educational health campaigns designed and targeted to Native American communities, primary health care services, transportation, housing and case management services. This goal may be achieved through effective support of best practices models that have been or are being developed. This work is being done from within our communities, regional organizations and Native nations that

appropriately address prevention needs across Native American urban and rural communities.

National Minority AIDS Initiative

It is critical to have federal funds dedicated to Native communities, including tribal clinics, urban clinics, tribal health departments and some urban/non-urban Native organizations. The federal government must help build sustainable capacity in Native communities to address HIV/AIDS as part of the overall health crisis driven by social and structural disparities. The first step would be to increase funding for the Minority AIDS Initiative to \$610 million with a set aside for Natives.

Research & Epidemiological Systems

Collection of reliable data on HIV and AIDS cases in Native communities is one of the biggest bureaucratic barriers to care for Native peoples. Due to problems in racial misclassification as well as simply not being identified in National health studies, Native populations are consistently undercounted or "lost" by being collapsed into an "other" category. The CDC must creatively and collaboratively explore accurate methods and approaches to collecting surveillance, epidemiological, and prevention HIV/AIDS data relative to Native peoples. In turn, the Federal government must provide the necessary support to ensure that such data collection is realistic and possible and that federal HIV/AIDS-related studies adequately include American Indian and Alaska Native populations. This may even mean an oversampling or weighting the data to ensure representation and identification of HIV/AIDS prevention needs for Native Peoples. Accurate and complete information on HIV/AIDS will help public health authorities and their community partners in the fight against HIV/AIDS in Native communities. To that end, we recommend:

1. The appointment of a Data Task Force of Native epidemiologists and researchers to explore potential solutions to this data problem; Develop research calls that explore the social and historical determinants of HIV/AIDS and HCV risk, the identification of culturally-specific factors (e.g., traditional healing) that buffer the impact of trauma and stress on HIV/AIDS risk, as well as the development

of culturally-grounded and culturally-supported HIV/AIDS service and prevention models specific to Native peoples;

2. Exploration of the National Minority Quality Forum which created the "ZIP Code Analysis Project". This project collects data on disease activity among both general and minority populations by zip codes and might be valuable in establishing more accurate data for Indian peoples;

3. Request Indian Health Service aggregate data by the 12 regions in an effort to gain greater accuracy of the areas of highest risk; and,

4. Development of a timeline and budget (with sources) that will clearly establish specific goals in meeting these obligations and requests.

Finally, we have also repeatedly stated, over many decades now in combating this disease, that in working with Native communities, the numbers CANNOT be the only consideration. We have mentioned the legal obligations under our treaties. The moral obligations should also be known to all conscientious Americans. It is therefore critical that in addressing health care in Native America, racial disparity and our historical circumstances cannot be ignored and these issues must be a priority.

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