Native Americans and HIV/AIDS

Author

Irene Vernon
6709 Poudre Canyon Road
Bellvue, CO 80512

Native Americans and HIV/AIDS

Overview

This Native Americans and HIV/AIDS monograph has been developed to provide information to law enforcement personnel, caseworkers, counselors, educators, government and tribal health professionals, tribal leaders, and tribal community workers about HIV/AIDS in both urban and reservation Native communities. In addition, it provides supplemental readings, as well as a list of Native American AIDS videos, organizations, and annual conferences.

Native Americans have a long and horrid history of disease which can be seen in the decrease of their population from over 5 million in 1492 to 250,000 in 1900. And as they move into the 21st Century, disease remains a serious threat. Today, there are large scale forces - biological, economic, and social - that place Native peoples at an increased risk for HIV infection and of physical and cultural destruction. Some of the factors which place Native people at high risk for contracting the infection also create barriers to prevention, education, and assistance. Addressing the multiple concerns and issues of HIV/AIDS in Native communities must include community participation, culturally specific programs, and creative funding collaborations.

History of Native Americans and Disease

The story of the introduction of new diseases during first contact with Europeans and their impact upon Native people is well known. The dramatic population drop from approximately five million Native people in 1492 to its low point of 250,000 around 1900 was not due to warfare but to disease.[1] Europeans brought with them many deadly diseases which not only spread among Native people and killed them, but which surfaced again and again. It has been estimated that between the early sixteenth century to the beginning of the twentieth century there have been as many as 93 serious epidemics among Native people, epidemics which have caused significant death and invaded Native people at intervals of approximately every four years.[2] Of the many diseases that Native people encountered, the three greatest early killers were smallpox, typhus, and measles.[3]

Of these three killers smallpox was the leader. In the sixteenth and seventeenth centuries smallpox brought massive destruction, killing whole tribes.[4] By the 1800s, smallpox no longer destroyed entire tribes but it still caused serious damage. For some tribes at that time, mortality rates from smallpox ran between 55% and 90%.[5] Smallpox incited massive demographic disaster among Native people who were highly vulnerable to this new disease. An additional consequence of the many deaths caused by

smallpox was the loss of leaders, knowledge, and an old traditional way of life. Because of similar destruction to lives and societies, many people today refer to AIDS as the “New Smallpox.” If not prevented or aggressively addressed, AIDS could become the next smallpox in Native communities, killing as effectively and dramatically.

In studying Native mortality it is clear that disease alone is not to blame for their many deaths. The diseases themselves, new to Native people, became lethal when combined with grossly inadequate health care and lack of access to medical care. All contributed to the demise in Native health, then, and still today. The initial observation of the poor health conditions of Native people in the late 1800s has remained relatively constant until the publication of the Meriam Report in 1928. The report noted that virtually every activity assumed by the United States government for the promotion of Indian health was below a reasonable standard of efficiency.[6] In response to this report, health conditions improved slightly with increases of nurses, salaries for health service personnel, and hospital facilities. Although there were modest improvements in Indian mortality rates, by the 1930s Native mortality was still 50% higher than that of whites.[7] The number one killer at that time was tuberculosis.

Improvement in Native health was slow for various reasons, many having to do with the economic, social, and political conditions surrounding Native communities and peoples. Slight improvements, however, reappeared in 1955 when the responsibility of Indian health moved from the Bureau of Indian Affairs (with a history of inadequate health care) to the United States Department of Health, Education, and Welfare. With this restructuring came an increase in the accessibility and availability of health services for Native populations, but problems of access to health care continues to plague both urban and reservation communities.

Native Americans and HIV/AIDS

In the United States the cumulative total of AIDS cases, as of December 1997, is 641,086 with an estimated 650,000 to 900,00 Americans living with HIV. It is also estimated that there are 40,000 new infections a year.[8] Since 1992 the increase in the number of people diagnosed with AIDS each year in the United States has been less than 5%, and it is estimated that it will slow down in the upcoming years (in the mid-80s AIDS cases increased by 65-95% each year).[9] The low increase, however, is critically deceiving for specific populations.

Although an increase of AIDS cases overall is less than 5%, there remain significant increases in specific population groups. As indicated in the Centers for Disease Control's (CDC) 1997 publication, *HIV/AIDS Trends*, both men and women of color continue to be the most severely affected by AIDS. While the total number of reported AIDS cases among

whites has decreased from 60% in 1985 to 40% in 1995 this is not true for other races.[10] For Native people their percentage growth for 1995-1996 alone was 18%. Large increases are found all over Indian Country with most cases concentrated in Alaska, Oklahoma, Washington, Arizona, and California.

The overall number of AIDS cases for Native people continues to be less than 1% within the Native population.[11] This percentage, however, is viewed with skepticism by many who work in the health field with Native people. This suspicion derives from the misreporting of race/ethnicity of Native people to the Centers for Disease Control and Prevention (CDC) and poor reporting to states by the Indian Health Services (IHS). Also, it is believed that Native people will not seek diagnosis because of the mistrust Native people have toward the IHS and the federal and state governments. For others, a long history of hopelessness and the intense personal shame attached to the disease prevents many Natives from getting tested. To address the problems of underreporting it is critical to encourage Native peoples to report that they are Native and to also ask service providers to ask before assuming a person's ethnicity.

The cumulative number of reported AIDS cases for Native Americans were 1,783 through December 1997, a substantial increase from two in 1984.[12] Although the cumulative number of Native American AIDS cases is relatively small, one must not wait until it is a full-blown epidemic before the problem is addressed.

Native American HIV/AIDS Risk Factors

The increase of reported AIDS cases among Native people is not surprising given the fact that Native people are considered high risk for contracting the HIV infection. Native people are at danger for acquiring the HIV infection not because of their race but because of behaviors, such as alcohol and substance abuse, in combination with biological, economic, and social co-factors. The presence of co-factors will vary from Native community to Native community and, many, if not all will exist in every area.

A serious biological condition that not only signifies high-risk behavior (i.e., unprotected sexual intercourse) but also can assist in the transmission of HIV is the presence of sexually transmitted diseases (STDs). This is of great concern to many Native communities whose populations have high STD rates. The rates of gonorrhea for Native people, in 1995, were three times that of whites.[13] As for chlamydia, a study in Alaska found that when rates for rural Inupiat women were compared to the local non-Native population the chlamydia rates were ten times higher.[14] In some cases, STDs will allow entry for HIV through open sores or microscopic breaks in affected tissue.[15] Those at greatest risk for contracting the HIV infection are apt to be those who have acquired other STDs. It is suggested that when a

person is infected with a STD “they are two to five times more likely to become infected with HIV.”[16] The IHS, who have some areas with the highest documented rates of chlamydia in the U.S., are actively engaged in controlling STDs because they believe it is one of the most effective means to prevent HIV/AIDS.[17]

STDs consistent with HIV/AIDS, tend to be diseases of poverty because they are intensified by conditions of economic hardship. It is believed that poverty is one of the leading co-factors in the advance of AIDS. In the United States HIV has moved unobstructed through impoverished communities and since many Native communities are impoverished HIV could also run-wild there. Many Native Americans live below the poverty line. As indicated in the 1990 census report, 31.6% of the Native population live below the poverty line compared to 13.1% of all other races in the United States. Economic conditions must be examined in the fight against HIV/AIDS because it can prevent or inhibit Native Americans from obtaining health education, access to good health care, and proper medical treatment - all of which assist in the prevention and treatment of AIDS.

Hand-in-hand with poverty comes a host of other factors, such as poor health, poor diet, and related diseases. Historically, Native peoples have had, and continue to have, higher rates of almost every disease, than the general United States population. Their poor health status makes them more susceptible to the HIV infection. A disease closely related to poor diet and found among many Native peoples is diabetes. Diabetes rates among Native people vary among tribes and communities and it can range from 5% to 50%.[18] A 1998 study shows that “diabetes is a major cause of morbidity and premature mortality” in Native populations.[19] If one is HIV infected, a poor diet weakens the immune system which is important in preventing the progression of HIV to AIDS. The combination of federal government programs that interrupted natural diets of Native peoples, and the introduction of commodity foods, have assisted the rise of poor dietary habits among Native people.

Another disease commonly linked with poverty and people of color is tuberculosis (TB). An airborne disease, TB occurs frequently among people who live close together and with poor ventilation. Many Native people live in crowded conditions and often in substandard housing. Today, TB is 22 times more common among Native Americans than other races in the United States.[20] Having TB places Native people in an alarming situation.

If one is infected by mycobacterium tuberculosis, they usually remain healthy and develop a latent infection, which means that they have the potential to become sick and infectious with active TB. The relationship between TB and HIV is that if infected with HIV the body becomes weakened which will assist in the progression of latent TB infection to active

TB. Those with both HIV and TB have a 100 times risk of developing active TB than people who are infected with TB but not HIV. It is estimated that "roughly fifty percent of persons infected with both HIV and TB are likely to develop active tuberculosis within two years, compared with the lifetime risk of TB of 5-10 percent for persons infected with TB alone."[21] Among the people who are infected with HIV in the U.S., the rate of TB cases is alarmingly 40% higher than the general population.[22] The majority of clients in the National Native American AIDS/HIV Prevention Center Case Management Network have been tested for TB prior to enrolling in case management because they have recognized that "persons infected with HIV are at increased risk for developing TB... to prevent the transmission and avoidance of multiple-drug resistant mycobacterium tuberculosis organisms."[23]

Since economics is closely related to health and disease it may determine time of death. And, most disconcerting are studies that demonstrate that Native women with AIDS have a shorter lifespan. It is important to note however, that AIDS-related deaths, in general, dropped 26 percent between 1995-1996.[24] For Native people, between January 1996 and June 1996, AIDS deaths dropped by 32% when compared to January 1995 and June 1995. The decrease was more substantial among Native people than any other ethnic group and many credit the decline to an increase in access to care and improved treatment options accessed through Native American HIV case management programs which are culturally appropriate. As always however, the death rates were not equal among all Native population groups; women saw an increase over Native men in AIDS-related deaths of 3%.[25]

Economic factors have a powerful influence on the accessibility and quality of health education and care of women, as well as their social behavior. Conditions of poverty contribute to the difficulty or powerlessness to negotiate condom use, particularly if the partner is the one who "brings home the bread." Women whose lives depend on their relationships with men may have a more difficult time demanding that their partners use condoms. Poverty also keeps women at home, and at times, in violent and abusive situations. Studies have shown that women who live under these conditions are scared to demand that their violent partners wear a condom. Women in the United States confront violence regularly with statistics showing that in their lifetime 50% will be battered with one out of three being physically abused repeatedly every year, and most frightening is that every 78 hours a women will be forcibly raped.[26]

Native women are also frequent victims of domestic violence and rape and it is a problem that plagues Native communities. In South Dakota where Native women are a very small portion of the state population they constitute 50% of the domestic violence shelter population.[27] Living with the disease becomes agonizing in a domestic violence situation and because of

denial, shame, fear and economic dependence, women will not seek health care and help. It is clear that class, economics, and gender contribute greatly to the spread of AIDS among Native people.

Combine economic factors with social conditions, such as homophobia, and the chance that Native populations will contract HIV increases. The acceptance, tolerance, and/or discrimination toward gay tribal members will vary from location to location. In many Native societies the treatment of gays reflects the dominant society, discrimination. Native HIV/AIDS clients have complained that some medical staff members are uncomfortable working with them which they feel results in poor quality of health care. When AIDS is associated with homosexuality, in some communities it becomes hidden with devastating results: lack of education, medical treatment, and increased infection rates, hence Native communities must address the degree of homophobia within their respective areas.[28]

It has recently been reported that some of the greatest obstacles facing HIV/AIDS health providers in communities of color stem from internal rather than external sources. Some of these obstacles which not only includes homophobia, but also denial, and mistrust, are present in Indian Country. Denial that HIV/AIDS is a problem in Native communities continues in both urban, rural, and reservation communities. Many still believe that it is a "white man's" disease. But, the knowledge of high STD rates, high substance and alcohol abuse, and conditions of poverty clearly refute the idea that Native people in urban, rural, and reservation communities are not in danger of the HIV infection.

Denial, when combined with mistrust, can lead to devastating results. Several HIV/AIDS infected Natives have noted that some tribal communities have not only denied that HIV/AIDS is a problem but that it has lead to ostracism of those members known to be infected.[29] These types of actions lead many Native people to mistrust and therefore reluctant to access services. The legacy of mistrust that Native people have for the government, public health officials, and the intentions of Western doctors date from their particular histories, some of which include "gifts" of blankets infected with smallpox.[30] Having been deliberately infected with deadly diseases in the past, suspicions that history may be repeating itself are understandable. Another legacy which many Native women carry with them is sterilization abuses. Native American women were at least two times more likely to be surgically sterilized than other women of color and many had been sterilized without informed consent.[31] This history of distrust prohibits many from seeking diagnosis, assistance, and medical attention.

The most critical co-factor, however, is behavioral and includes various forms of substance abuse. For many Native people the main behavioral risk is alcohol abuse and intravenous drug use. Alcohol is not the route of transmission for HIV, but it plays a critical role in the AIDS epidemic in that,

under its influence, protective behaviors are forgotten or ignored.

Although there are many myths about the relationship between Native people and alcohol, such as “Indians cannot hold their liquor,” it is clear that the cumulative effect of alcoholism on Natives is staggering. Alcohol-related accident death rates run approximately three times higher among Natives than the rest of the US population and deaths from alcohol-related diseases run four times the national average. Alcohol’s effect in Indian Country is evidenced by chronic disability, unemployment, family disruption, child abuse, and the destruction of tribal unity.

Alcohol and its relationship to AIDS and Native people cannot be ignored. Alcohol is one of the reasons that Native people are engaging in unprotected sex - it not only decreases inhibitions, but it also alters risk perceptions. Additionally, it places Native people at high risk because of its negative impacts upon the body itself. Alcohol abuse interferes with the body’s use of vitamins and minerals which are critical in maintaining a healthy immune system and it decreases white blood cell counts, inhibiting the body’s ability to fight infection.[32]

Alcohol and drugs have been major agents in the spread of HIV/AIDS among minority people, particularly women, the fastest growing group of people infected. The CDC Prevention reports that the number of women diagnosed with AIDS in the United Stated increased 63% between 1991 and 1995.[33] To stop the spread of HIV, Native people must prevent and treat both alcohol and intravenous drug abuse. A holistic approach to HIV/AIDS education and prevention must include the expansion of alcohol and substance abuse programs to include HIV prevention into their overall treatment plans.

HIV/AIDS Programs

To confront the rise of HIV among Native people programs must be expansive. When addressing women and HIV/AIDS programs need to consider concepts of family, children, sexuality, self-esteem, abuse trauma, and negotiating skills. And, programs which address substance abuse needs to be adapted for women since their exposure to the AIDS virus comes mainly from injecting drugs and from unprotected sex with drug users. We know that many HIV/AIDS prevention interventions have made a difference and that prevention efforts have helped to lower overall rates of HIV/AIDS infection. Hence, Native people need gender and age specific programs to address their unique needs.

Native gay and bisexual men also need programs that take their unique circumstances into consideration. Since they are the largest portion of AIDS cases we must continue to address the rise of HIV/AIDS among them. And, important to prevention and education programs in rural and reservation

areas, discussions of sexual behavior must be addressed openly. This is a difficult but not insurmountable task. Tribal leaders and spiritual leaders must join hands in the effort to break from tribal taboos about discussing sexual behaviors. One must begin these programs by first discussing prevention and educational material with these leaders, then ask them to join in getting the message out into the tribal communities. It is clear that a multilayered campaign must be developed that creates a positive message about inclusivity and tolerance.

Native youth also need specific programs. In the health field it is well known that Naive American youth throughout the United States suffer from poverty, alcohol and substance abuse, emotional and physical abuse, and neglect in numbers greater than the general population. All of these factors place Native youth at danger for acquiring the HIV infection. Addressing the issue of drug abuse is critical for this target group because Native youth show a pattern of earlier initiation to drug use than non-Native youth and because substance abuse by reservation youth is on the rise. Perhaps the smallest, yet tragic incidence of HIV/AIDS infection of Native youth results from child sexual abuse. Alarmingly, child abuse is the number one crime found in Indian Country and it must be addressed in conjunction with HIV/AIDS education.

In addition to addressing gender and age specific issues tribal communities must extend their work to include Native ceremonies and rites. For example, the Native American Women's Center, wisely and insightfully, had extended their AIDS/HIV work to include Sun Dance participants.[34]

The Sun Dance is primarily a ritual of self-sacrifice in that an individual, making a vow to the Great Spirit for their community or family, will pledge to fast, pray, and dance for several days in hopes that his or her prayers will be answered. The Center worked with the spiritual leaders, those who were pierced, and those who made flesh offerings. They educated these ceremonial participants about AIDS, recommended specific Sun Dance precautions, and distributed more than 10,000 scalpels to Sun Dancers and other Sun Dance participants. Each and every Native community must contemplate the rise of AIDS in all aspects of their lives, including spiritual ceremonies.

Case Management Programs are also critical. Case management for HIV/AIDS infected Native Americans, work in collaboration with various local service providers to meet an individual client's needs. Case management services include health maintenance (i.e., support groups, hospitalization, and mental health counseling); practical support services (i.e., home health care, transportation, and day care); in addition, specific Native services (i.e., Native American spirituality, traditional healing, and cultural awareness).

Evidence of good case management is believed to be one of the main

reasons for the drop in the number of Native AIDS deaths. In general, AIDS-related deaths dropped 26 percent between 1995-1996.[35] For Native people, between January 1996 and June 1996, AIDS deaths dropped by 32% when compared to January 1995 and June 1995. The decrease was more substantial among Native people than any other ethnic group. Many believe that the decrease in AIDS-related deaths is credited to an increase in access to medical care and improved treatment options which are accessed through Native American HIV case management programs. As always, however, the death rates were not equal among all Native population groups; women saw an increase in AIDS-related deaths of 3%.[36]

A recent program that many Native communities are participating in and which leads to a strong policy tool is the National Native American HIV/AIDS Client Database.[37] The Database is a repository of data profiling Native American HIV/AIDS clients. Anyone can contribute to the database and the contributing program does not have to be a formal part of their case management network.

The challenge Native people and communities face is disturbing but they persevere in their effort to stop the spread of HIV among Native people by improving their health status, providing educational materials, and providing health assistance. In their drive toward self-empowerment, Native people and communities are developing various forms of community-based care which are culturally sensitive, prevention-oriented, and devoted to the wellness of the community as well as the individual.

Funding

In facing the challenge of providing HIV/AIDS education, prevention and assistance, funding is critical. But, funding for Native health is fraught with a history of problems. Following the history of disease among Native peoples there is a history of insufficient funding for health related issues. Although smallpox decimated whole tribes in the sixteenth century and continued to wreak havoc into the nineteenth century, very little treatment or prevention was undertaken due to a lack of money and interest. It was not until 1832 that Congress allocated funds to arrest the progress of smallpox among tribes. The funds provided, however, were inadequate and frequently health care was tied to United States Indian policy and tribal relationships. Smallpox vaccinations were provided “as long as the Indians remained where the government claimed that they belong - on their reservations.”[38] It was not until the 1860s that vaccinations succeeded in reducing Native American mortality rates from smallpox.[39]

Funding for Indian health care has historically been fraught with disappointment, and in many ways this legacy continues. Today, many organizations and health officials lack the appropriate funding to address the issue of AIDS. A major reason is that AIDS money allocation is formula based; the number of total cases reported is a major factor. Highest priority

is given to programs for populations with the greatest need. As already noted, the total number of Native cases to date is 1,783 less than 1% of the total AIDS cases in the United States. Added to the manner in which money is dispensed is an overall decrease in funding for "Native" programs. In San Francisco, for example, health care reform inspired the renegotiations of new contracts in 1994 that placed previously allotted Native American AIDS program monies in the hands of a National Task Force on AIDS Prevention for People of Color. This action was met with resistance by several Native organizations, believing that Native run programs better address Native needs which must include the cultures and traditions of the various tribes.[40]

Although funding for HIV prevention and programs has not always flowed where it is needed (in this case used preventively before it becomes an epidemic), Native health agencies, organizations, and programs persevere in their efforts to address HIV/AIDS needs and concerns. Native people must be creative in their funding endeavors and collaborative efforts have been shown to be most effective. Native collaboration amongst each other and other health agencies is critical in sharing information and programming. When this collaboration is combined with international connections it will strengthen Native efforts to stop the spread of HIV/AIDS.

Conclusion

With the rise of national articles on the decline of AIDS deaths, the decrease in the number of reported AIDS cases, and the rise of new "cocktail" drugs which assist in AIDS wellness, there is a temptation for people to become too complacent with the AIDS disease. Although recent AIDS news is generally positive, the realities for communities of color remain dismal. Community participation is needed now more than ever. Given the realities of inadequate funding and poverty, coupled with high risk biological, social, and economic factors it clearly benefits each community to educate their members in their own way. Each tribal community will have their own unique needs and conditions and it is up to them to develop education and prevention programs which works best for them.

Definitions

Acquired Immunodeficiency Syndrome (AIDS): An infectious disease characterized by failure of the immune system and believed to be caused by the human immunodeficiency virus (HIV). AIDS is the latest stage of illness resulting from infection with the HIV virus.

Diabetes: A disease caused by an insulin deficiency and characterized by excess sugar in the blood and urine. Diabetes is closely related to poor diet and poor health status and makes them more susceptible to the HIV infection.

Human Immunodeficiency Virus (HIV): One of a large group of

immunodeficiency viruses widely spread among primates and other mammals. HIV is believed to be the causative agent of AIDS in humans.

Intravenous Drug User (IVDU): A person who uses a hypodermic needle to inject drugs into his or her body for a purpose that differs from the drug's intended use. IV drug users frequently share drug paraphernalia (i.e., needles and syringes) providing opportunities to transmit viruses. Viruses are transmitted through blood that remains in the needle or syringe after injection. Intravenous drug users are a crucial link in the spread of HIV.

Sexually Transmitted Disease (STD): A group of diseases that affect men and women and are spread during sexual activity. All STDs are preventable through safe sex. STDs could permit the penetration of HIV through lesions.

Tuberculosis (TB): A bacterial infection caused by Mycobacterium. It is transmitted when a person with active TB coughs or sneezes, releasing microscopic particles in the air. Infection usually occurs only after prolonged exposure to someone with active TB. Once infected by TB, most people remain healthy and develop only latent infection. It is known that HIV-positive people have a higher risk of developing active TB disease. The factors that allow latent TB infection to develop into active disease are unknown.

Supplemental Readings

American Association for World Health. *Be A Force for Change: 1998 World AIDS Day Resource Booklet*. Washington, DC: American Association for World Health, 1998.

Barney, David D. and Betty E.S. Duran. "Case Management: Coordination of Service Delivery for HIV-Infected Individuals." *HIV Mental Health for the 21st Century*. Mark G. Winiarski, ed. New York: New York University Press, 1997.

Benally, Christine and Robert T. Trotter. "Developing Culturally Sensitive HIV-AIDS and Substance Abuse Prevention Curricula for Native American Youth." *Journal of School Health* 9 (1996): 322-328.

Cambridge, Charles. "Anthropologist Warns of AIDS Epidemic Among American Indian People." Ph.D. Diss., University of Colorado, Boulder, 1994.

IHS Primary Care Provider 23 (January 1998).

IHS Primary Care Provider 22 (April 1997).

In the Wind: HIV/AIDS in Native America. The National Native American AIDS Prevention Center.

"HIV/AIDS Among American Indians and Alaskan Native - United States, 1981-1997" *Morbidity and Mortality Weekly Report 47* (March 6, 1998): 154-260

"HIV victim finds new meaning to life: Ministry strengthens goals, spirituality" *Indian Country Today* Nov. 30 - Dec. 7, 1998. A6.

Jennings, Jennifer and Charon Asetoyer. *The Impact of AIDS in the Native American Community.* South Dakota: Native American Women's Health Education Resource Center, revised Summer 1996.

Lieb, Loren E., George A. Conway, Micheal Hedderman, John Yao, and Peter R. Kerndt. "Racial Misclassification of American Indians with AIDS in Los Angeles County" *Journal of Acquired Immune Deficiency Syndromes* 5 (1992): 1137-1141.

Mangum, Anna, Andrea Green Rush and Vince Sanabria. *HIV Prevention with Native American Youth: A Program Planning Manual.* California: National Native American AIDS Prevention Center, 1994.

Metler, Russ, George A. Conway, & Jeanette Stehr-Green. "AIDS Surveillance among American Indians and Alaska Natives"

American Journal of Pubic Health 81 (December 1991): 1469-1471.

National Native American AIDS Prevention Center. "Native American AIDS Statistics - Year Ending December 1996, NNAAPC Fax Back, January 1997.

Rave, Jodi. "Health Care reform Inspires consolidation: Nightmare for Native AIDS" *Indian Country Today* 31 July 1994.

Rowell, Ron. "The Future of Indigenous Health." *Current Issues in Public Health* 2 (1996): 124-129.

_____. *HIV Prevention for Gay/Bisexual/Two-Spirit Native American Men: A Report of the National Leadership Development Workgroup for Gay/Bisexual/Two-Spirit Native American Men*. California: National Native American AIDS Prevention Center, 1996.

_____. "Native Americans, Stereotypes, and HIV/AIDS: Our Continuing Struggle for Survival." *SIECUS Report* (February/March 1990): 9-15.

_____. "Warning Signs: Intravenous Drug Abuse Among American Indians/Alaskan Native." *Drugs and Society* (1990): 21-35.

Rush, Andrea Green. *HIV Prevention in Native American Communities: A Manual for Native American Health and Human Service Providers.* California: National Native American AIDS Prevention Center, 1992.

Seasons. The National Native American AIDS Preventions Center.

Native American AIDS Videos

A Chance for Change. Produced by Gryphon Productions, LTD. Directed by Peter von Puttkamer. 31 min. Nuu-chan-nulth Health Board, Dept. Of National Health and Welfare and Province of British Columbia Ministry of Health. 1990. Videocassette.

A Traditional Kind of Woman: Too Much and Not 'Nuff. Directed by Richard Lance. American Indian Community House. 1998. Videocassette.

AIDS: American Indians Dying Silently. Produced and directed by Conrad & Nichols, LTD. 10 min. New Mexico AIDS Prevention Program, Public Health Division. Videocassette.

AIDS and the Native American Family. Produced by Upstream Productions. Directed by Sandra Osawa. 11 min. Los Angeles County AIDS Program Office. 1990. Videocassette.

American Indians Against HIV/AIDS Leadership Project. Produced by KAT Productions. 17 min. University of North Dakota Department of Family Medicine. 1991. Videocassette.

American Indians Against HIV/AIDS Leadership Project: Presentation by Carole Lafavor. 40 min. University of North Dakota Department of Family Medicine. 1991. Videocassette.

American Indians Against HIV/AIDS Leadership Project: Presentation by John Bird. 2 hrs. University of North Dakota Department of Family Medicine. 1991. Videocassette.

American Indians Against HIV/AIDS Leadership Project: Presentation by

Martin Broken Legs. 2 hrs. 6 min. University of North Dakota Department of Family Medicine. 1991. Videocassette.

An Interruption in the Journey. Produced by Skyman-Smith. Directed by Mona Smith. 20 min. Minnesota AIDS Funding Consortium. 1991. Videocassette.

Circle of Warriors. Produced by Phil Lucas Productions. Directed by Phil Lucas. 27 min. National Native American AIDS Prevention Center. 1989. Videocassette.

Face to Face: Native Americans Living with the AIDS Virus. Produced by Phil Lucas Productions. Directed by Phil Lucas. 45 min. Rural Alaska Community Action Program and Alaska Native Health Board. 1989. Videocassette.

Fighting for Our Lives: Women Confronting AIDS. Produced by Center for Women Policy Studies, Washington DC & Anguiano Productions. Directed by Gail Harris and Kathleen Stol. 29 min. Videocassette.

Her Giveaway: A Spiritual Journey with AIDS. Produced by Skyman-Smith. Directed by Mona Smith. 22 min. Women Make Movies, New York. 1987. Videocassette.

HIV/AIDS: A Threat to Our People, The Three Affiliated Tribes of the Fort Berthold Reservation. Produced by KAT Video Productions. 16 min. University of North Dakota School of Medicine and the Three Affiliated Tribes. Videocassette.

I'm Not Afraid of Me. Produced by Phil Lucas Productions. Directed by Phil Lucas. 29 min. Alaska Native Health Board.1991. Videocassette.

Insights on HIV/AIDS: Native Children to Children. Produced by Rosenda Reins Production. Directed by Beverly Singer. 15 min. 1997. Videocassette.

It Can Happen to Anybody. Produced and directed by Charles Abourezk. 22 min. Native American Women's Health Education Resource Center. 1990. Videocassette.

Living Safe: Knowing About AIDS. Produced by Tri-Video LTD. Directed by Herman Hastings and Clarence Wald. 16 min. Devil's Lake Sioux Tribe. 1989. Videocassette.

Mom & Sons Series. Produced by Circle Eagle Communications. 14:33 min. Native American Women's Health Education Resource Center. 1991. Videocassette.

Plans for Being Two: AIDS Information for Senior High School. Produced by Tri-Video LTD. Directed by Herman Hastings and Clarence Wald. 21 min. Standing Rock Sioux Tribe. 1989. Videocassette.

Vernon, Irene. *Native American AIDS Video Resource Manual.* Colorado: Tri-Ethnic Center for Prevention Resource, 1999.

We Owe It to Ourselves and to Our Children. Produced and Directed Human Health Organization in cooperation with the National Native American AIDS Prevention Center. 8 min. National Native American AIDS Prevention Center. 1989. Videocassette.

Native American AIDS Organizations & Programs ACT NOW - Akwesasne HIV/AIDS Information & Resource Center. Box 747, Hogansburg, NY

13655. Tel: (518) 358-2001.

Ahlaya Project. 1211 N. Shartel, Suite 404, Oklahoma City, OK 73103. Tel: (405) 631-9988.

AIDS Education and Prevention Project. American Indian Health Care Association. 1999 Broadway, #2530, Denver, CO 80202. Tel: (303) 295-3788.

AIDS Education for Maine Off-Reservation Indians. Central Maine Indian Association. 132 N. Main Street, Brewer, ME 04412. Tel: (207) 989-5971.

Alaska Native Health Board HIV/AIDS Project. 4201 Tudor Center, Suite 105, Anchorage, AK, 99508. Tel: (907) 562-6006.

Albuquerque Area Indian Health Board, Inc. - HIV/AIDS Prevention Program. 301 Gold Avenue, SW, #105, Albuquerque, NM 87102. Tel: (505) 764-0036.

AICH Outreach Education Coordinator WISH Program. 306 South Salina Street, Suite, 201, Syracuse, NY 13202. Tel: (315) 478-3767.

American Indian Community House HIV/AIDS Project. 708 Broadway, 8th Floor, New York, NY 10003. Tel: (212) 598-0100.

American Indian Health and AIDS Council. 8205 Wakefield Avenue, Panorama City, CA 91402. Tel: (213) 744-6462.

Borderbelt AIDS Resources Team. PO Box 945, Lumberton, NC 28359. Tel: (910) 739-6167.

Choctaw Health Risk Reduction Education Project. Mississippi Band of Choctaw Health Department. PO Box 6020, Choctaw Branch, Philadelphia, PA 38350. Tel: (601) 656-2211.

Chugachmiut. 4201 Tudor Center Drive, Suite 210, Anchorage, AK 99508. Tel: (907) 562-4155.

Dakota Tribal AIDS Education Prevention Project. Council of Seven Fires. Rte 2, Box 173, Flandreau, SD 57104. Tel: (605) 997-2105.

Fort Defiance Area Native American AIDS Education Project. Navajo Nation Family Planning Corporation. PO Box 1869, Window Rock, AZ 86515. Tel: (602) 871-5092/5093.

Inter-Tribal Council of Arizona – HIV/STD Program. 4205 N. 7th Avenue, Suite 200, Phoenix, AZ 85013. Tel: (602) 248-0071.

Ke Ola Mamo. 1130 N. Nimitz, Suite A-221, Honolulu, HI 96817. Tel (808) 533-0035.

Minneapolis American Indians AIDS Project: Indian Health Board of Minneapolis. 1315 E. 24th Street, Minneapolis, MN 55404. Tel: (612) 721-9879.

Minnesota American Indian AIDS Task Force. 1433 E. Franklin Ave., Suite 19, Minneapolis, MN 55404. Tel: (612) 870-1723.

Montana United Indian Association. PO Box 6043, 515 N. Saunders, Helena, MT 59604. Tel: (406) 443-5350.

National Native American AIDS Prevention Center. 134 Linden Street, Oakland, CA 94607. Tel: (510) 444-2051.

Native American Community Health Centers, Inc.; Native American Pathways. 3008 N. 3rd Street, Phoenix, AZ 85012. Tel: (602) 266-

6363.

Native American HIV/AIDS Prevention Education Program. Northern Arizona Area Health Education Center, Inc. 2501 North 4th Street, Suite 9, Flagstaff, AZ 86004. Tel: (602) 774-6687.

Native American AIDS Project. 1540 Market St., Suite 425, San Francisco, CA 94102. Tel: (415) 5212-2406.

Native American Community Service. 2495 Main Street, Suite 524, Buffalo NY 14214. Tel: (716) 832-2303.

Native American Health/AIDS Coalition. 6025 Prospect, Suite 103, Kansas City, MO 64130. Tel: (816) 333-7500.

Native American Women's Health Education Resource Center. PO Box 572, Lake Andes, South Dakota 57356. Tel: (605) 487-7072.

Navajo AIDS Network. PO Box 1313, Chinle, AZ 86503. Tel: (520) 674-5676.

Northwest Portland Area Indian Health Board: Project Red Talon. 520 SW Harrison St., Suite 335, Portland, OR 97201. Tel: (503) 228-4185.

Papa Ola Lokahi. 222 Merchant St., 2nd Floor, Honolulu, HI 96813. Tel: (808) 536-9453.

Rainbow Community. Milwaukee Indian Health Board. 930 N. 27th Street, Milwaukee, WI 53208. Tel: (414) 937-6600.

San Diego American Indian Health AIDS Program. 3812 Ray Street, San Diego, CA 92104. Tel: (619) 298-9090.

San Diego Health Center. 2561 1st Avenue, San Diego, CA 92103. Tel: (619) 234-2158.

Santa Barbara Indian Health Clinic. 4141 State Street, Santa Barbara, CA 93110. Tel: (805) 681-7356.

Spirit Lake Sioux Tribe. Heath Education Program. Tribal Health Office. 398 Fort Totten, ND 58335. Tel: (701) 766-4235.

Standing Rock Sioux Tribe. Health Education Program. PO Box D, Fort Yates, ND 58538. Tel: (701) 854-7474.

Winnebago Healthy Start. PO Box 3704, Sioux City, IA 51102. Tel: (712) 252-5902.

Yukon Kuskowin Delta Alaska Native AIDS Project. Yukon Kuskokwim Health Corporation. PO Box 528, Bethel, AK 99559. Tel: (907) 543-3321.

Notes

[1] Russell Thornton, *American Indian Holocaust and Survival: A Population History Since 1492* (Norman: University of Oklahoma Press, 1987), 133.
[2] *American Indian Holocaust*, 45.
[3] *American Indian Holocaust*, 43-45.
[4] *American Indian Holocaust*, 62-64.
[5] *American Indian Holocaust*, 64.
[6] Francis P. Prucha, *The Great Father: The United States Government and the American Indians* (Lincoln: University of Nebraska Press, 1984), 293.
[7] *The Great Father*, 330.
[8] American Association for World Health*, Be a Force for Change: 1998 World AIDS Day*

Resource Booklet (Washington, DC: American Association for World Health, 1998), 6.
[9] US Department of Health and Human Services, Center for Disease Control and Prevention, *Progress in Prevention: Research and Support for Community Action: HIV & AIDS Trends*, 1997, 2.
[10] *Progress in Prevention: Research and Support for Community Action: HIV & AIDS Trends*, 8.
[11] *Progress in Prevention: Research and Support for Community Action*, 8.
[12] "HIV/AIDS Among American Indians and Alaskan Native - United States, 1981-1997," *Morbidity and Mortality Weekly Report* 47 (March 6, 1998), 1.
[13] "Controlling Sexually Transmitted Diseases: An IHS Perspective," *The Primary Care Provider* 23 (January 1998), 1.
[14] Ron Rowell and Andrea Green Rush, "HIV and High Risk Behaviors: Sexually Transmitted Disease and HIV," in *HIV Prevention in Native American Communities: A Manual for Native American Health and Human Service Providers* (Oakland, CA: National Native American AIDS Prevention Center, 1992), 29-32.
[15] Jennifer Jennings and Charon Asetoyer*, The Impact of AIDS in the Native American Community* (Lake Andes, SD: Native American Women's Health Education Resource Center, revised, Summer 1996), 7.
[16] American Association for World Health, 31.
[17] "Controlling Sexually Transmitted Disease: An IHS Perspective," 1.
[18] "Diabetes at Highest Levels Ever in the US: Minority Populations Especially Affected," CDC Press Release, 30 October 1997.
[19] "Prevalence of Diagnosed Diabetes Among American Indians/Alaskan Native-United States, 1996," *Morbidity and Mortality Weekly Report* 47 (October 30, 1998), 1.
[20] Paul Farmer, Margaret Connors and Janie Simmons, eds*, Women, Poverty and AIDS: Sex, Drugs and Structural Violence* (Maine: Common Courage Press, 1996), 263-64.
[21] "The Challenge of HIV/AIDS in Communities of Color," National Commission on AIDS, Washington, DC: United States of America, December 1992, 7.
[22] American Association for World Health, 31.
[23] "Update on HIV/AIDS Among American Indians and Alaska Natives*," The IHS Primary Care Provider* 22 (April 1997): 51-52.
[24] "AIDS Study Shows Drop of 26 Percent in Mortality Rate," *Wall Street Journal*, 12 September 1997, B8.
[25] Thomas Edwards, "AIDS Deaths Among Native American Drop by 32%: Cae Management is one of chief causes," NNAPPC Online, www.nnaapc.org/media/itw80la.
[26] Jennifer Peterka, "Sacred Circle responds to abuse: Batterers learn that women are sacred," *Indian Country Today* 14-21, December 1998, B1.
[27] Peterka, B2.
[28] Alexandra Greeley, "Concern About AIDS in Minority Communities," United States Food and Drug Administration, www.fda.gov/fdac/features/0095-aids, printed 08-18-97.
[29] Paul D. Bouey and Betty E.S. Duran, "The Ahalya Case-Management Program for HIV infected American Indians, Alaska Natives, and Native Hawaiians: Quantitative and Qualitative Evaluation of Impacts." Unpublished paper, 1998, National Native American AIDS Prevention Center.
[30] Silija, Talvi, "The Silent Epidemic: The Challenge of HIV Prevention Within Communities of Color," *The Humanist* 57 (Nov/Dec) 1997: 9.
[31] Native American Women's Health Education Resource Center, Report by Jennifer Jennings, and Charon Asetoyer*, The Impact of AIDS in the Native American Community* (revised) Summer 1996 (South Dakota: Native American Women's Health Education Resource Center, 1996), 8.
[32] Ron Rowell, "Alcohol and AIDS," Native American HIV/AIDS Prevention Homepage. www.sfo.com/~denglish/native-aids/seas_2, printed Summer 1997.
[33] "Female AIDS Cases are Rising Swiftly," Washington Post, 17 September 1997, A2.
[34] Personal conversation with Charon Asetoyer, Executive Director of the Native American Women's Health Education and Resource Center, October 1997.
[35] "AIDS Study Shows Drop of 26 Percent in Mortality Rate," *Wall Street Journal*, 12 September 1997, B8.

[36] Thomas Edwards, "AIDS deaths among Native Americans drop by 32%: Case management is one of chief causes," NNAPPC Online, www.nnappc.org/media/itw80la, printed 10-09-97.
[37] Personal conversation with Paul D. Bouey, PhD, MPH, Director of Research and Evaluation, NNAAPC, Summer 1997 and October 1997.
[38] *American Indian Holocaust*, 172, 101.
[39] American Indian Holocaust, 101.
[40] Jodi Rave, "Health Care Reform Inspires Consolidation: Nightmare for Native AIDS," *News from Indian Country*, 21 July 1994.