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THE LINKAGE

NEWSLETTER OF THE BEHAVIORAL AND SOCIAL SCIENCE VOLUNTEER PROGRAM

HIV Prevention Issues Among American Indian and Alaska Native "Two-Spirits"

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Traditionally, "two-spirit" peoples were American Indians or Alaska Natives who occupied a third or fourth gender role in their society and who often were responsible for esteemed cultural, social, and ceremonial roles. Contemporarily, the term "two-spirit" has come to signify the fluidity of gender identity (beyond the dualistic notion of male/female) and of sexuality (beyond the Western notion of nonheterosexual) that characterizes some American Indians and Alaska Natives (hereafter referred to as "Natives"). In urban settings, many gay, lesbian, bisexual, and transgendered (GLBT) Natives identify as "two-spirited."

There is a paucity of research and few culturally relevant services addressing the health concerns and HIV risk and prevention needs of two-spirits. In this article, we overview elements of an indigenist stress-coping model for use in HIV prevention research and practice, CDC surveillance data on Natives, key research findings related to two-spirits and HIV risk, and our current research project on the topic.

According to our indigenist stress-coping model, both environmental and individual factors act as moderators of the relationship between major stressors (i.e., colonization, trauma, and discrimination) and health outcomes (see Walters & Simoni, 2002). Substance use is seen as one maladaptive coping response that contributes to HIV sexual risk behaviors. On the other hand, cultural and spiritual factors are conceptualized as buffering the impact of the traumatic events on substance use, HIV sexual risk behaviors, and mental health outcomes.

Through December 2000, the Centers for Disease Control and Prevention reported 2,337 cases of AIDS among Natives (1897 for males and 439 for females) in the United States. Although this absolute number is relatively small, the AIDS case rate per 100,000 for Natives is 12.7 (17.3 for males and 8.3 for females), which is much higher than for Whites (7.9; 14 for males and 2.2 for females). For men, the major modes of transmission were MSM (57%), IDU (16%), and MSM and IDU (16%). For Natives, this last category is higher than for any other ethnic or racial group.

Discouraging as they are, the AIDS surveillance data are likely huge underestimates for many reasons. First and most importantly, many Natives with AIDS are misclassified as non-Natives (Lieb & Conway, 1992). Second, Natives experience disproportionately high rates of other STDs (Lieb & Conway, 1992). Third, Natives are adversely affected by demographic, economic, and health risk factors associated with increased risk for infection. Fourth, Natives have escalating rates of injection drug use, and are 2 to 3 times more likely than the general populations to engage in excessive drinking (May, 1995)—which often co-occurs with sexually risky behaviors. Finally, preliminary studies suggest that Natives continue to engage in unprotected sexual behavior and inconsistent condom use (Walters & Simoni, 1999; Walters, Simoni, & Harris, 2000) despite high levels of HIV prevention knowledge (Walters & Simoni,

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Robin T. Kelley, PhD, Associate Director

As part of our continuing focus on diverse communities affected by HIV, the Behavioral and Social Science Volunteer (BSSV) Program staff is pleased to present this American Indian/Alaska Native/Native Hawaiian edition of the BSSV Program newsletter. The articles in this edition delve into issues that affect HIV/AIDS prevention efforts in these communities. The authors who contributed to this edition include a staff person from the Native American Capacity Building Assistance Program, scientists from the American Indian community, a community public health worker, a federal project officer, and an epidemiologist. Their work offers insight into a community that is adversely affected by HIV/AIDS, but not frequently highlighted. It is our hope that these articles will provide a better understanding of some of the issues, psychosocial as well as structural, that serve as challenges to HIV-prevention interventions among American Indians/ Alaska Natives/ Native Hawaiians. The BSSV Program staff sincerely thanks these authors for their willingness to share their work and experiences. Through their efforts, they are helping to educate the prevention field on the most efficacious ways to conduct HIV/AIDS prevention among American Indians/ Alaska Natives/Native Hawaiians. We invite you to learn from these authors about HIV prevention among American Indians/Alaska Natives/ Native Hawaiians and benefit from the information presented here.

It is important to note that over the last 2-1/2 years, BSSV Program staff have made a concerted effort to recruit scientists of various cultures, races, and disciplines. Currently our volunteers include 137 Caucasians, 42 African Americans, 31 Latinos/as, 9 Asian/Pacific Islanders, two Middle Easterners, and two American Indians. If you know a behavioral and/or social scientist of color who might be interested in becoming a volunteer, please call the program office (1-800-374-2721, ext. 3993, or the program director at 1-877-754-1404). We in the BSSV Program are pleased to know and support our diverse group of volunteers who offer their time and expertise free of charge to their communities in the fight to prevent HIV/AIDS.▼

The authors who contributed to this edition… scientists from the American Indian community, a community public health worker, a federal project officer, and an epidemiologist. Their work offers insight into a community that is adversely affected by HIV/AIDS, but not frequently highlighted.

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1999). HIV surveillance data may more accurately depict the epidemic among Natives. The Indian Health Service reported that in three western states, HIV rates among third-trimester Native patients were 4 to 8 times higher than rates among childbearing women of all other races.

Specific research on sexuality and sexual orientation among two-spirits is limited to a few recent studies (i.e., Saewyc et al., 1996; 1998). Findings indicate that, compared to non-Natives, Native youth have a higher prevalence of self-reported GLBT identities and a higher prevalence of sexual risk factors (e.g., histories of abuse or running away); earlier onset of heterosexual intercourse; and, among Native lesbian and bisexual girls, more frequent intercourse. Additionally, Native MSM's frequent intercourse, ineffective use of contraception, and exposure to physical abuse were associated with involvement with pregnancy (Saewyc et al., 1998). There are no published studies of adult two-spirits and HIV risk.

To understand two-spirit HIV prevention needs, one must first understand the socio-historical context of this group. Many culturally grounded stories and two-spirit ceremonies and roles may have (either gone underground for protection or have) been destroyed as a result of Christian missionization and the prohibition of American Indian religious practices. As a result, many two-spirits are left with few role models and ways in which to contextualize their gender and sexual identity from an indigenist perspective. Many Native researchers and activists refer to this process of cultural genocide[1] as a form of historical trauma or "soul wound" that can persist for generations (see Stately and Clark article elsewhere in this newsletter). Moreover, the impact of cultural genocide[2] is compounded by everyday microaggressions, from invisibility (as in racial misclassification as non-Native) to outright murder.

Recent anecdotal and empirical evidence suggests that, indeed, two-spirits are at higher risk for trauma than their Native heterosexual and non-Native GLBT counterparts. Two-spirits not only contend with racism and colonization from non-Natives (heterosexual as well as GLBT) but also must deal with pervasive heterosexism or homonegativity in Native communities. Findings from a small study of two-spirit men revealed that traumatic violence exposure was quite high and comparable to or greater than that reported among non-Native GLBT of color: verbal harassment (100% vs. 52-87%); target of objects thrown (36% vs. 25-38%); being chased (77% vs. 13-38%); physical assault (36% vs. 9-24%); assault with a weapon (36% vs. 4-10%); and sexual assault (29% vs. 5-14%; Walters, Simoni, & Horwath, 2001).

Our NIMH-funded HONOR Project is the first study to focus on HIV risk among urban two-spirits. Grounded in the indigenist stress-coping model, it examines the interrelationships among traumatic stress exposures, substance use, mental health, and HIV risk behaviors among 72 two-spirit community leaders and 400 two-spirit individuals across six sites: Los Angeles, San Francisco/Oakland, Seattle/Tacoma, Tulsa, Minneapolis/St. Paul, and New York City. The primary focus of the study is to identify the strengths of two-spirits that lead to adaptive health behaviors despite exposure to traumatic events. Additionally, the project will assist in building the research infrastructure at the local agency level in order to facilitate the design and evaluation of culturally relevant interventions and programs for two-spirits across the country.

For more information about the project, contact Dr. Walters at kw5@u.washington.edu or (206) 543-5647 or the Native Wellness Center HONOR Project staff at (206) 685-0164.

Endnotes

[1] "Cultural genocide" was adopted as a category by the 1994 United Nations Commission on Human Rights, Sub-Commission on the Prevention and Discrimination and Protection of Minorities, during the 46th Session, as stated in the Draft Declaration of the Rights of Indigenous Peoples (E/CN.4/Sub.2/1994/2/Add.1). The Declaration states, "Indigenous peoples have the collective and individual right not to be subjected to ethnocide and cultural genocide, including prevention or and redress for: (a) any action which has the aim or effect of depriving them of their integrity as distinct peoples, or of their cultural values or ethnic identities; (b) any action which has the aim or effect of dispossessing them of their lands, territories, or resources; (c) any form of population transfer which has the aim or effect of violating or undermining any of their rights; (d) any form of assimilation or integration by other cultures or ways of life imposed on them by legislative, administrative or other measures; (e) any form of propaganda directed against them." (E/CN.4/Sub.2/1994/2/Add.1; pg. 4, Article 7). A prime example of cultural genocide is the 1892 Courts of Indian Offenses decree which withheld food rations and imprisoned individuals for practicing cultural and spiritual traditions.Specifically, the decree, in part, states, "Any Indian who shall engage in the practices of so-called medicine men, or who shall resort to any artifice or device to keep the Indians of the reservation from adopting or following civilized habits and pursuits, or shall adopt any means to prevent the attendance of children at school, or shall use any arts of a conjurer to prevent Indians from abandoning their barbarous rites and customs, shall be deemed to be guilty of an offense, and upon conviction thereof, for the first offense shall be imprisoned for not less than ten nor more than thirty days:

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Provided, That for any subsequent conviction for such offense the maximum term or imprisonment shall not exceed six months." (House Executive Document no. 1, 52nd Congress, 2nd Session, Serial 3088, pp. 28-31).

2 Ibid.

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Reconceptualizing Risk: The Role of Historical Trauma in HIV/AIDS Among American Indians and Alaska Natives

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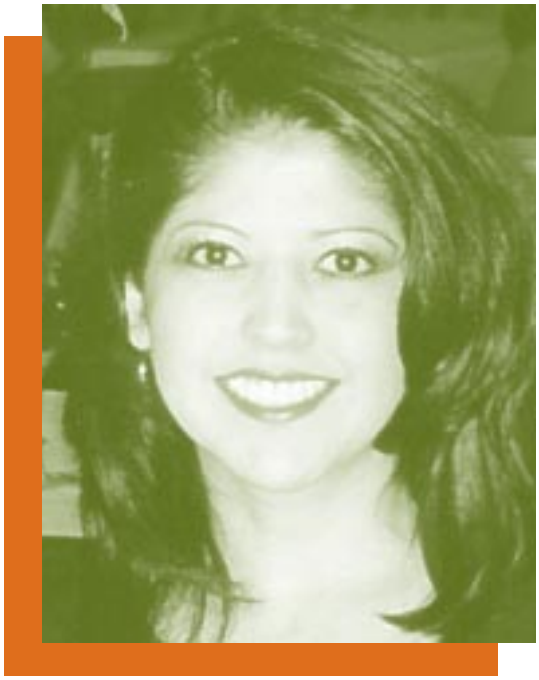

Rose L. Clark, PhD

Historical Background

American Indians/Alaska Natives (AI/ANs) are different than other racial and ethnic groups in the United States because of their social and political history and their government-to-government relationship with the United States. Understanding this sociopolitical history is imperative, as the social and health status of AI/ANs is intricately connected to the influence of European settlers and to the policies of the U.S. government, which focused on physical and cultural genocide,* assimilation, and termination of the tribal sovereignty.

Many federal policies have had a devastating impact on the economic, political, and emotional well-being of Native people because they destroyed tribal and family systems as well as economic and social structures. For example, the removal of AI/AN children through the child welfare system and the federal Indian Boarding School System, which began in 1875, both resulted in forced assimilation and widespread removal of AI/AN children from their homes. The impact of these two policies was devastating on AI/AN communities (Duran & Duran, 1995). Many children died from disease, homesickness, or suicide, and many suffered from physical and sexual abuse (Duran & Duran, 1995). Additionally, many were victims of destructive messages that indoctrinated them with ideas of being culturally and racially inferior.

Multigenerational Historical Trauma

Although rarely studied, the cumulative effects of cultural, spiritual, emotional, and economic losses are believed to substantially contribute to the development of psychiatric disorders among AI/ANs (Manson, 1996; Duran & Duran, 1995). Duran and Duran (1995) describe these losses as a "soul wound," while Yellow Horse Brave Heart and DeBruyn (1998) used the term "historical unresolved

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Capacity Building Assistance Program for HIV Prevention

By Benny Ferro,
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Benny Ferro

Over the past decade, the HIV/AIDS epidemic has reached demographics beyond White men who have sex with men and has disproportionately affected people of color, women, and youth. To combat the epidemic, the Centers for Disease Control and Prevention (CDC) awards prevention dollars to state health departments and health ministries of U.S. territories, city health departments of high-prevalence cities, and community-based organizations to deliver relevant and culturally specific HIV prevention services to their communities. These agencies are funded by the National Minority AIDS Initiative to provide HIV prevention interventions to at-risk populations. Some are funded to provide services to specific populations such as young men of color who have sex with men, while others are funded to offer specific interventions such as HIV counseling and testing in nontraditional venues. Once established, some of these organizations need infrastructure development, some need enhanced resource development, and others need assistance in strengthening their HIV interventions.

In 1988, the CDC funded National and Regional Minority Organizations (NRMO) to strengthen HIV prevention programs through the provision of culturally appropriate technical assistance for community-based organizations serving communities of color. Congress appropriated federal dollars to the Department of Health and Human Services to fight the HIV epidemic. From this appropriation, CDC provided money to directly fund grassroots minority national, regional, and local organizations for technical provision to enhance HIV prevention activities. In addition to developing capacity for the directly funded CBOs, the NRMO program allowed CDC to understand better the needs and concerns of hard-to-reach populations, have greater access to high-risk populations, and provide a mechanism to advocate for enhanced resources and services for these populations. This initiative, now in its third funding cycle, is located in the Capacity Building Branch (CBB) and funds regional and national organizations to provide comprehensive capacity building assistance services with the purpose of increasing core competencies and skills of individuals, organizations, and/or communities. The goal of the HIV prevention capacity building program is to foster self-sufficiency and increase the self-sustaining ability for organizations to improve their own HIV prevention programs, processes, and outcomes.

Until April 1, 2004, there were 31 capacity building assistance (CBA) providers funded by the CDC Division of HIV/AIDS Prevention, CBB. The focus of technical assistance within the CBA program is divided into four priority areas: Priority Area 1: Strengthening organizational infrastructure; Priority Area 2: Enhancing HIV prevention interventions; Priority Area 3: Strengthening community capacity for HIV prevention; and Priority Area 4: Strengthening HIV prevention community planning. The CBB is currently in the process of funding a new 5-year funding cycle. Native organizations will be funded to provide similar focus area activities. Award decisions were still pending at the time of this publication.

Through collaborations, the CBA providers have formed coalitions and networks that address the HIV prevention capacity building needs of American Indians/Alaska Natives/Native Hawaiians, African Americans, Hispanics/Latinos, Asian/Pacific Islanders, men who have sex with men, young men who have sex with men, faith leaders, youth, migrants, and persons living with HIV; otherwise, known as Prevention with Positives. Two of the 31 CBA providers work directly with Native American agencies, tribal health centers, health departments, community planning groups, and CBOs working with Native American communities.

From the inception of the CBA tracking system, there have been more than 70 CBA activities, such as trainings, consultations, presentations, organizational development, curriculum design, etc., specific to Native American agencies. Most of the Native American CBA requests have come from the providers marketing their skills, expertise, and resources rather than a formal request from directly funded Native organizations. Currently, there are only six organizations funded by CDC who target Native Americans in their HIV prevention interventions. Because

only a few organizations are funded to do HIV prevention specifically to the Native American population, it is imperative that the CBA providers market their services.

The two CBA providers funded specifically for providing technical assistance to Native American organizations are the Inter Tribal Council of Arizona (ITCA) and the National Native American AIDS Prevention Center (NNAAPC). What is most unique about ITCA and NNAAPC from the other 29 CBA providers is that they must provide services to a diverse group. Among all of the federally recognized tribes, the state recognized tribes, and those not formally recognized, there are no tribes that have the same needs when it comes to HIV prevention. The Native American CBA providers must address a multitude of issues including cultural differences, language differences, the stigma of the disease, homophobia, differences between traditional and Western philosophies, issues of colonization and abuse, and the unwillingness of the community, elders, and tribal leaders to become involved in HIV prevention. These issues make it difficult to do HIV prevention work as a capacity building assistance provider. However, both ITCA and NNAAPC have successful programs. Here is a brief summary of their programs.

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Inter Tribal Council of Arizona, Inc.

The Inter Tribal Council of Arizona, Inc. (ITCA), provides its member tribes with the means for action on matters that affect them collectively and individually to promote tribal sovereignty and to strengthen tribal governments. ITCA was established in 1952 to provide a united voice for tribal governments located in the state of Arizona to address common issues of concern.

ITCA has provided services to Native populations, specifically American Indians, since 1975. It formed the Regional STD/HIV/AIDS Prevention Project (RSHAPP) in 1991 and targets all identified risk categories. The purpose of RSHAPP is to build and strengthen the capacity of American Indian tribes and to further broaden the development, dialogue, and communication about HIV/AIDS within American Indian communities located in Arizona, Nevada, and Utah. The goal of the RSHAPP is to facilitate the development of capacity building prevention and education programs within tribal communities located in Arizona, Nevada, and Utah. These goals are accomplished through: (a) forming, maintaining, and providing technical assistance to the American Indian HIV/AIDS Prevention Work Groups for Arizona, Nevada, and Utah; (b) developing strategies for involving the tribal communities in capacity building; (c) maintaining the RSHAPP clearinghouse; (d) Circulating the RSHAPP Newsletter, Prevention News; (e) providing the Native American Red Cross Instructor Training (NARCIT) to the tribal communities within Arizona, Nevada, and Utah; and (f) evaluating the program goals and objectives that contribute to providing the tribal communities within Arizona, Nevada, and Utah with the highest level of leadership development, capacity building, and prevention education.

ITCA has been funded by CDC to provide capacity building assistance for more than 10 years. This project provides assistance in CBA Priority Area 3—Community Capacity Building for HIV Prevention. ITCA provides community capacity building assistance to develop community leadership, mobilization strategies, and resources. It also helps to build and maintain networks, partnerships, and coalitions and assists in program policy, as well as technology transfer accompanied by skills building and technical consultation. The sharing of HIV/AIDS information occurs through culturally appropriate dialogue with the American Indian communities and encourages new members from these communities to become actively involved with the American Indian HIV/AIDS Prevention Work Groups. ITCA provides CBA services to Native American populations, community stakeholders, and community planning group members. The target population includes tribal members, tribal health workers, American Indian community-based service providers, community members at large, health promotion/disease prevention service providers, local/state health departments, and the Indian Health Service. ITCA provides services in the western region, specifically, Arizona, Nevada, and Utah. For more information, contact ITCA at: Inter Tribal Council of Arizona, Inc., 2214 North Central Avenue, Suite 100, Phoenix, AZ 85004; Web address: www.itcaonline.com; and telephone: 602-258-4822.

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Building Capacity for HIV/STD Prevention in Native American Communities

(American Indian/Alaska Native/Native Hawaiian)

By Anno Nakai, MA (Saami),
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Anno Nakai, MA

Working With Native American Communities

While Native American communities may share similar risk factors and conditions with other communities of color that are products of a shared experience of marginalization and oppression, it is important to recognize that Native American people (which include American Indians, Alaska Natives, and Native Hawaiians) also have a unique history and experience of sovereignty as the indigenous peoples of their respective lands and nations that is different from other ethnic minority groups. With 554 federally recognized tribes with formal government-to-government relations with the United States and more than 700 distinct villages, nations, and tribal groups with varying degrees of state and federal recognition, it is also important to understand the complex political relationships that affect health conditions, resources, and policies for Native American communities.

As respect for tribal sovereignty is essential to the survival of Native peoples, the first consideration in prevention program development is the building of relationships with tribal leadership. For many Native communities, this includes both the formal leadership structures developed within tribes to relate to external entities and the informal leadership that represents the traditional roles and leadership values of the people. Approaches that support partnership and primary leadership for health development at a community level are more successful in overcoming the challenges of historic mistrust and betrayal.

Empowerment for HIV/STD awareness and prevention is key, as is the need to recognize the cultural strengths of each community as a central resource in the planning process. As Native communities are very diverse, taking the time to assess community assets and the core cultural values of individual communities can provide a solid basis for partnership and greatly enhance the potential for positive health outcomes as a result of planning.

Factors That Influence HIV Risk

Traditional Native Culture and Resilience

- Spirituality
- Child-rearing/Extended Family
- Veneration of Age
- Respect for Nature
- Generosity/Sharing
- Group Harmony/Cooperation
- Autonomy/Respect for Others
- Composure/Patience
- Relativity of Time
- Nonverbal Communication

(Heavy Runner and Morris, 1997)

Figure 1

As current research in the area of HIV/STD risk in Native communities would suggest, a significant factor in risk has been the change and loss of cultural lifeways due to rapid environmental and economic development (see Figure 1). Loss of traditional livelihoods, negative impacts of drugs/alcohol, commercial sex trade, rural to urban migration for employment, and change in extended family relationships have brought a myriad of health risks, including HIV/AIDS. Structural factors that create social risks, such as poverty, racism, religious oppression, and lack of access to medical care and education, also reflect the current fourth world* conditions (Walters and Simoni, 2002) in which many Native people reside.

Not understanding the role of culture in resilience and the suppression of indigenous language, culture, and beliefs have resulted in overwhelming negative outcomes for health. Severing land ties and family bonds through removal and relocation, traditional ways of teaching traditional health, and relationship values were also disrupted in many Native communities. Resiliency factors, such as holistic healing and extended family parenting practices, were also compromised in the process of colonization, leaving community members vulnerable to diseases that involve social and behavioral risk. (Heavy Runner and Morris, 1997).

**Fourth world refers to a situation in which a minority indigenous population exists in a nation wherein a colonizing majority holds institutionalized power and privilege.*

Factors That Influence HIV/STD Risk in Native Communities

- Historical Context Loss/ change of culture due to colonization.
- Environmental Impacts—Current structural and social conditions that reinforce HIV/STD risk (political and economic disparities).
- Biological Risks—The influence of stress, chronic diseases, other STDs.
- Social Factors—Social influences that contribute to risk behavior.
- Individual Acceptance of Risk-The impact of multigenerational trauma.

Figure 2

Native Americans currently have significantly higher rates of poverty, teen pregnancy, STDs, and substance abuse and experience higher rates of violence than the national average. Although Native people are also significantly at risk for HIV/AIDS, many communities have a relatively low perception of risk. Lack of awareness and mobilization to address HIV/AIDS along with cultural barriers in presenting HIV information at tribal/intertribal health forums have resulted in relatively low prioritization in health planning agendas. Given the multiple health issues that Native communities currently face, HIV/AIDS risk is also affected for many individuals by biological factors such as chronic stress, alcohol and other drug use, hepatitis, diabetes, and other STDs (Vernon, 2001).

Confidentiality and stigma around issues related to HIV/STD risk are frequent barriers to testing and referral. With poor case finding and lack of accurate surveillance data, risk behaviors continue in Native communities at an alarming rate. Multigenerational trauma and substance abuse negatively affect self-esteem and cultural identity, contributing to unhealthy acceptance of risk for many individuals. Discomfort around issues related to sexuality and substance abuse also present challenges in prevention, particularly for those at risk due to multiple partners, intravenous drug use, and men who have sex with men.

Capacity Building Strategies

One of the first steps in building capacity for HIV/STD prevention is to engage individual communities in a participatory needs assessment. As the elders are the primary leaders in Native communities, it is important to seek elder approval and support before proceeding with needs assessment and planning activities. Recognizing the expertise that community leaders and stakeholders have in health planning, it is important to identify stakeholders to actively participate in the planning and implementation of the assessment process.

Working with an empowerment perspective, it is important to assess the overall relational and cultural context in which the community understands HIV/STD risk and resilience. The Community Readiness Model is one such assessment process that has been used successfully to guide HIV prevention in Native communities. Based on stages of change and empowerment theory, this model assesses cultural characteristics, general awareness, and the level of community readiness to address issues related to HIV/STD prevention (Jumper-Thurman et al., 2001).

As community ownership in the prevention planning process is key for cultural relevance and sustainability, it is also important to include other resources that may be assets in the implementation of a comprehensive prevention plan. Many Native communities have developed holistic approaches to prevention that include other health disciplines as well as traditional counselors, elders, spiritual advisors, and natural helpers in the community. Capacity building strategies that invest in training for community members also mobilize elders, grandparents, peers and family members to become part of the prevention plan.

Native American Community-Based HIV/STD Prevention Model

Figure 3

Building on the natural strengths and structures within Native communities, strategies for HIV/STD prevention include traditional ways of supporting healthy relationships and promoting sexual health. Extended family parenting, kinship and clan relationships, coming of age ceremonies, traditional storytelling, spiritual practices, and the teaching of lifeway lessons are ways of maintaining the balance of community health and wellness. Working in close partnership with elders and community leaders, HIV/STD prevention can easily be integrated into ongoing wellness activities and cultural events.

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HIV/AIDS Among American Indians and Alaska Natives—United States, 2001

By Laurie Kamimoto, MD, MPH,
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This article was based on HIV and AIDS case information received by the CDC through December 2001 and summarized in the CDC HIV/AIDS Surveillance Report (CDC, 2001). The CDC has received AIDS case reports from all 50 states and the District of Columbia since the early 1980s. As advances in antiretroviral therapy significantly altered the course of HIV infection, prolonging the time between initial HIV diagnosis and development of AIDS, HIV case reporting has become important in understanding HIV transmission. HIV case reporting for this article was limited to 39 areas that conducted confidential, name-based HIV/AIDS reporting initiated before December 2001.[1]

At the end of 2001, an estimated 362,827 persons in the United States were living with AIDS. Of those, 1,304 persons were American Indian/Alaskan Native (AI/AN). Figure 1 (see page 11) includes the number of AI/AN persons (both living and deceased, aged 13 years) diagnosed with AIDS from 1996-2001, by year of diagnosis, compared with other racial groups, and adjusted for reporting delay. A trend of increasing numbers of persons living with AIDS was observed for all racial groups during 1996-2001. The number of AI/AN living with AIDS increased from 812 in 1996 to 1304 in 2001. The increasing number of persons living with AIDS is thought to reflect the use of antiretroviral therapy to prolong life among persons with HIV infection.

Figure 2 (see page 11) reports estimated AIDS incidence (i.e., the number of persons diagnosed with AIDS each year) among AI/AN persons, aged 13 years, compared with other racial groups, and adjusted for reporting delay for 1996-2001. AIDS incidence decreased from 1996 to 2001 for all racial groups. Among AI/AN, the decline in AIDS incidence was modest, from 212 in 1996 to approximately 185 cases in 2000 and 2001. This decline was most likely attributable to the use of antiretroviral therapy, prolonging the time between initial HIV infection and development of AIDS.

A total of 962 AI/AN persons with HIV infection who had not developed AIDS (i.e., HIV without AIDS) was reported to the CDC through December 2001. For this same time period, a total of 2537 AI/AN persons with AIDS was reported (Table).

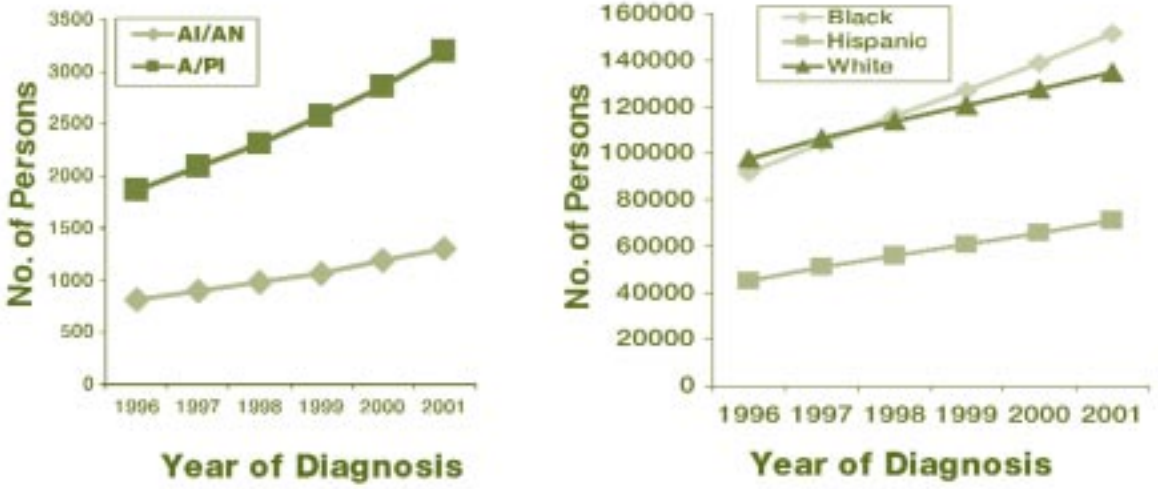
The characteristics of AI/AN persons with AIDS were different than AI/AN persons with HIV without AIDS: Women and heterosexual contacts made up an increased proportion of HIV without AIDS cases compared with AIDS cases, although still constituting an overall minority of HIV (without AIDS) cases. Among AI/AN persons with AIDS, 81% were male; almost three-quarters of AI/AN HIV (without AIDS) cases were male. The AI/AN age group with the greatest proportion (47.7%) of AIDS cases was 30-39 years. Among persons with HIV (without AIDS), AI/AN aged 20-29 years made up the largest proportion of cases (39.2%). AI/AN men who have sex with men constituted the risk category with the highest proportion of AIDS and HIV (without AIDS) cases, 44.2% and 37.7%, respectively. AI/AN persons with a history of injection drug use made up a higher proportion (21.0%) of those with AIDS compared with those with HIV without AIDS (16.9%). Among AI/AN persons with AIDS, heterosexual contact made up a lower proportion of cases than HIV (without AIDS), 9.4% and 14.9%, respectively.

…there is a critical information gap in the ability to track the spread of HIV among AI/AN. There is continued need for case identification through outreach, HIV testing, and early care referral for initiation of effective therapy.

The data reported in this article was subject to at least two limitations. Cases of HIV or AIDS among AI/AN may be underreported because of misclassification to other racial groups (Kelly, Chu, Diaz, Leary, & Buehler, 1996). HIV/AIDS surveillance data through December 2002 captured race and ethnicity together, and, as a result, only those persons identified as non-Hispanic AI/AN were used to characterize AI/AN in this article. Additionally, the majority of the HIV/AIDS cases among AI/AN has been reported from western states where the AI/AN population is concentrated (McNaghten, Neal, & Fleming, 2001). But several states have only recently passed laws requiring HIV case surveillance, or have only begun HIV surveillance in the past few years—e.g., New York, Washington, and California. Because these states with large AI/AN populations are only beginning to report HIV cases, there is a critical information gap in the ability to track the spread of HIV among AI/AN.

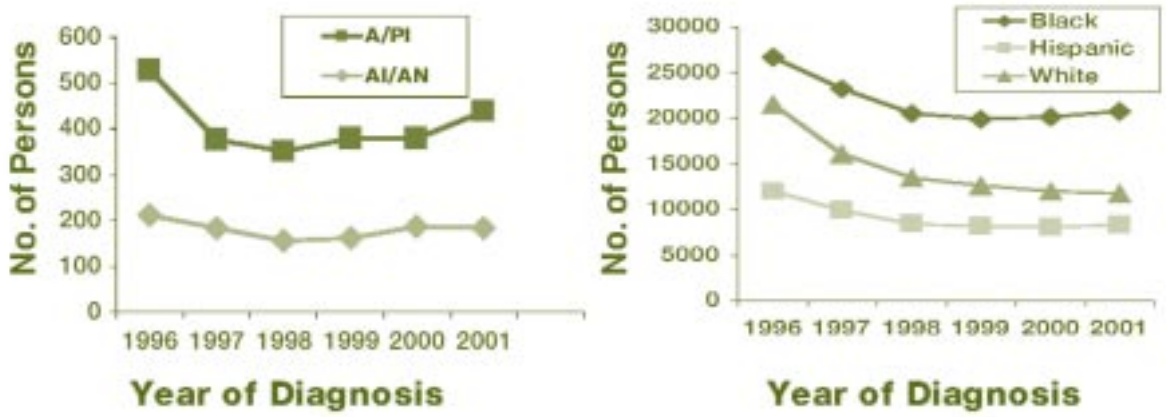
There is continued need for case identification through outreach, HIV testing, and early care referral for initiation

Figure 1. Estimated Number of Persons Living with AIDS, by Race/Ethnicity, 1996-2001*



AI/AN=American Indian/Alaska Native
A/PI=Asian/Pacific Islander
**adjusted for reporting delay*

Figure 2. Estimated AIDS Incidence, by Race/Ethnicity, 1996-2001*



AI/AN=American Indian/Alaska Native
A/PI=Asian/Pacific Islander
**adjusted for reporting delay*

HIV/AIDS,
continued on page 19

Breaking the Silence: A Hero's Story

Michael R. Covone, MPH-MSW,
HIV/AIDS Prevention Program Manager, Alaska Native Health Board

As public health professionals, we are concerned with interventions. We want to do something for a population that will keep that population safe from a condition or disease. Most of us have gone through years of higher education that has taught us that matching an intervention to a person or community is the way we help. In fact, many of us got involved in public health because we want to help.

Conversely, history teaches us that many public health interventions, especially those done with indigenous communities, have not helped and have instead done harm. In most of these cases, the communities involved were not consulted about the problem or the intervention. The resiliencies and strengths a community possesses are often discounted. The traditional ways of doing things and the values they embody are often ignored, even though they are the ways communities have been healing themselves for thousands of years. Given a chance, indigenous communities can heal themselves, using their shared culture as the intervention.

I would like to share a story with you about a community that healed itself. The story starts in late June 2002 when I received a call from a health educator, Selina Moose (see pictured with eagle feather—a gift from Anchorage World AIDS Day, 2002), in Northern Alaska requesting support for an HIV-related situation in her region. She related to me that in a small village (pop. < 500), an Inupiat man was recently diagnosed with late-stage AIDS and was transported to the Alaska Native Medical Center in Anchorage. He had no idea he was HIV positive, and he was concerned that he may have infected other people in his village. He and his family discussed the situation and decided that they must tell the residents of their village about this; anything less would leave "blood on their hands." They thought that telling the truth, although painful, would be honoring their parents' teachings and the values of their Inupiat culture. One of the man's sisters volunteered to go back to the village and tell the community about his disease.

Health professionals dealing with the family tried to discourage them from being so open about his disease. It flew in the face of all accepted ways of dealing with illness in small communities. However, the family was undaunted and remained steadfast in their decision. The sister flew back to the village, consulted the Elder leadership, and held a village meeting to divulge her brother's disease.

Michael R. Covone

Fingers were crossed and health professionals in the region held their breath as the villagers met. Many worried that this disclosure would blow-up in faces of everyone involved.

To the surprise of many, the village opened up their arms and embraced the family. Of course, there was a brief time of fear and anger. Some were fearful that they might have contracted the disease through casual contact. Health education staff was on hand to provide education for the villagers and offer HIV testing. About 50 villagers were tested for HIV that day, and many more realized that they were not at risk.

As the fear and anger began to fade, the villagers accepted the news. When the man returned home, his friends and neighbors visited him and brought him the traditional Native foods he loved and the friendship he needed.

"HIV can wipe out a village—we had to tell our people because not telling them may mean extinction. We honored our parents by thinking of our children and the future generations to come."

Where health professionals expected rejection and shame, the village offered love and support. This response was unexpected by those outside of the culture, but made complete sense to the Inupiat. Because the family made the disclosure with humility and honesty, both traditional Inupiat values, the village accepted the news. They told the truth, before anyone found out through the grapevine. This showed that the family really cared about the people of their village.

As word reached the other villages in the region, health facilities became inundated with calls from

Selina Moose pictured with gift of Eagle Feather at 2002 World AIDS Day Commemoration in Anchorage

concerned residents fearful over a perceived "AIDS Epidemic." Rumors spread and fear abounded. My program responded to this by traveling to every village in the region with a local team of people (see picture) including the Borough Mayor and a traditional counselor. We held town meetings in each village to address the fears of the residents, provide education, and help them understand that it was brave of the man with HIV to make this disclosure. We told them that he sacrificed his confidentiality so that they would know the truth and have an opportunity to protect themselves. Our team reached about 500 Alaska Native people in the region. As a result of these meetings and the education that Alaska Native Health Board (ANHB) and others provided, the fear about HIV/AIDS diminished and awareness took its place.

I am reminded that none of this would have taken place if the man with HIV and his family were not as courageous as they are. It was a selfless act in service of their people and something that had never been done before. It represents a new model for HIV education in remote and rural communities. And it's a model that ANHB or any other community-based organization (CBO) cannot offer. Only the person who has HIV and his/her family can offer this intervention, only they can activate the communal healing systems that their culture provides. It's our job to simply get out of the way and learn.

From left to right: Tiny Devlin-ANHB; Cookie Rose-ANHB; Roswell Schaeffer-Mayor, Northwest Artic Borough; Barbara Cole-Maniilaq; Ella Jones-Maniilaq; Michael Covone ANHB.

"HIV can wipe out a village—we had to tell our people because not telling them may mean extinction. We honored our parents by thinking of our children and the future generations to come."

Below the story in role model format

An Alaska Native Hero's Story

It all began when an Inupiat man discovered he had AIDS. Of course he was devastated and fearful, and as he told his family they shared his grief. Together they sought the support of western medicine.

But soon they began feel the presence of their Ancestors urging them to take action. The family realized that their Ancestors wanted them to look beyond their own suffering and take into account the wellness of their people. They had to tell their people of this disease so that they could be aware and protect themselves. But, no one had ever done this before, and the family was fearful. Some even warned them that doing this would only bring shame to the family and to the village. They again turned to their Ancestors for wisdom. The message came back clearly and the family knew what they had to do.

One brave sister was chosen to bring the word to the villagers. She stood before them with complete humility and did what her Ancestors urged her to: she spoke the complete and utter truth of the illness her brother and their family faced. The villagers were shocked at first. They know how to react. But as the news sunk in they understood what the values of their Ancestors demanded of them.

It is the Inupiat way to help people in need, and that's what they did. Bringing food, love, and acceptance, they completed the healing circle that was started by the family. Soon the whole village learned of AIDS and how to protect themselves. This action had effects far beyond their small village. As other villages heard of this story they too became concerned and reached out for information about this new disease. Soon many people were called to travel to all the villages teaching the people about AIDS. The villagers in the region were relieved and their fear began to diminish.

The villagers had learned that listening to the wisdom of their Ancestors made them grow stronger as a people. And now as this strength grows, so does the love for the family who had the courage to act as their Ancestors would.

This family indeed has a hero story to tell.▼

Reconceptualizing,
continued from page 5

grief." According to these authors, historical unresolved grief originates from the loss of lives, land, and vital aspects of Native culture as a direct result of colonization. Similar to the transfer of trauma to descendents from Jewish Holocaust survivors, the effect of physical and cultural genocide directed at AI/ANs is transferred across generations. Present generations of AI/ANs face layers of repetitive and cumulative traumatic losses that are physical, cultural, and spiritual in nature. These layers of repetitive loss, in addition to the major traumas of the past, are often associated with pain, psychological numbing, and destructive coping styles. These negative outcomes can become so pervasive that a chronic stress disorder (CSD) may develop at the community level. Community-level trauma and its deleterious impact on AI/AN people are of particular importance given the extensive nature of their extended and well-integrated family and clan systems.

HIV Risk Behaviors Among AI/ANs

AI/ANs are disproportionately affected by negative social, economic, and health conditions that are often associated with increased HIV risk. For example, 31.6% of AI/ANs live at or below the federal poverty level, compared to 13.1% for all races (CDC, 1998). Diaz and Ayala (2001) found poverty to be a strong predictor of increased HIV risk among a large national sample of Latino men who have sex with men. Additionally, low levels of contraceptive use combined with high levels of sexually transmitted diseases (STDs) place AI/ANs at risk for exposure to HIV infection (Blum, Harmon, Harris et al., 1992). Finally, AI/ANs have escalating rates of injection drug use (Conway, Ambrose, Chase, Hooper, Helgerson, Johannes et al., 1992), and they are 2 to 3 times more likely than the general population to engage in excessive drinking (May & Moran, 1995), which often co-occurs with sexually risky behaviors (Brassard, Smeja, & Valverde, 1996; Walker et al., 1996).

AI/ANs with AIDS tend to be younger than people living with AIDS in other racial and ethnic groups. Approximately, 23% of AI/ANs with AIDS are between the ages of 20 and 29 (CDC, 1998). In a recent study of risk behaviors among AI/AN youth (grades 9-12), 63% reported having sexual intercourse at least once in their lifetime; 25% had four or more sexual partners in their lifetime; 48% did not use condoms during those sexual encounters; and 38% reported alcohol or drug use just prior to engaging in sexual activity (Bureau of Indian Affairs, 1997).

An unpublished study of HIV sexual risk behaviors among 376 sexually active AI/ANs in Canada who lived off the reservation found that 83% of the study participants reported at least one incident of unprotected sex in the previous 12 months (Bullock et al., 1996). Unprotected sex was significantly more likely for AI/AN men (vs. women) and individuals with a steady (vs. a casual) partner. Consistent condom use was more likely among those familiar with AI/AN traditions and among those reporting a history of physical abuse, whereas inconsistent condom use was positively associated with age and a history of sexual abuse.

Relationship of Trauma and HIV/AIDS

Little is known about the relationship between trauma and risk for HIV. However, it is known that experiences of historical and current traumas are associated with poor mental health outcomes such as post-traumatic stress disorder, alienation, depression, anxiety, and alcohol abuse (Duran & Duran, 1995; Grandbois & Schadt, 1994; Johnson, 1994; Walker et al., 1996). It is also known that the daily stressors of racism and social discrimination are associated with withdrawn behavior, anxiety, depression, and physical complaints related to stress among AI/ANs (Whitbeck, 1992). Unfortunately, the psychological toll of trauma and discrimination among AI/ANs is likely to place them at increased risk for HIV. Diaz and Ayala (2001) found that experiences of social discrimination—specifically homophobia, racism, and poverty—were directly related to increased risk among Latino men who have sex with men.

AI/ANs are the victims of violent crimes at a rate more than 2.5 times the national average and have significantly high rates of child physical and sexual abuse (Bureau of Justice Statistics, 1999). Among non-AI samples, exposure to traumatic and abusive childhoods (Bartholow, Doll, Joy, & Douglas, 1994), sexual abuse (Miller & Paone, 1998), lifetime physical or sexual abuse by a partner (Molina & Basinait-Smith, 1998), and rape (Cunningham, Stiffman, Dore, & Earls, 1994) has been associated with sexual risk behaviors. Given the fact that AI/ANs experience a greater number of life events directly related to violence and trauma than other racial and ethnic groups in the United States, and given the fact that trauma is associated with sexual risk behaviors in non-AI samples, it stands to reason that AI/ANs are likely to be particularly at risk for HIV once the virus enters their communities.

Conclusions

According to the evidence presented in this article, AI/ANs may be particularly vulnerable to HIV and AIDS. Successful approaches to preventing HIV/AIDS in AI/AN communities are likely to include a variety of systems to address the multiple traumatic issues facing the community. Programs are most effective when leaders, including tribal council members, elders, and spiritual leaders, are involved and supportive to create community ownership and investment in improving the quality of life in their communities.

The most successful intervention and treatment programs build upon local values, traditions, and resources that are based on a holistic philosophy that combines the biological, psychological, social, and spiritual aspects of a person's life (Office of Criminal Justice Programs, 2000). It is important to strengthen protective factors and build on the community's cultural strengths. It is also important to address the potential role of multigenerational and current traumas in HIV risk behavior among AI/ANs.

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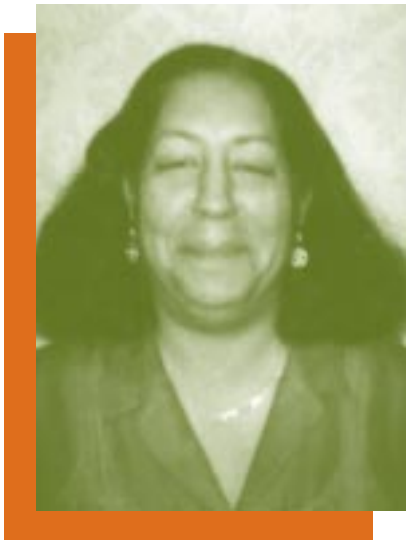
Impressions From the BSSV Basic Training

By Denise Travis, PhD,
Director, Division of Social Work, Indiana University Northwest

In December 2002, I and 31 colleagues in HIV/AIDS research and evaluation met in New Orleans for the BSSV basic training seminar. As I prepared for the trip, my friends shared my excitement of attending this seminar. I expected to meet others that shared my research interests and looked forward to receiving information that would assist me in providing expert evaluation consultation to agencies in my region. What I received was so much more.

There is something very special about this training. Under the direction of the skilled BSSV staff and representatives from the Centers for Disease Control and Prevention (CDC), we were given a wealth of information to enhance our ability to provide technical assistance to community planning groups, community-based organizations, and local health departments. We were able to explore who our customers would be, the anatomy of linkages, communication guidelines, and the cultures of the organizations we will serve. Practice examples were provided through role-play, case studies, and discussion. In addition, it was exciting to learn of the many interventions that have been found reliable in preventing the spread of HIV. Given all of this, one of the most rewarding dynamics of the training was the relationship among the group members. We shared our experiences, talents, outlooks, history, and most important, our laughter. There is something very special about people who come together to share and grow.▼



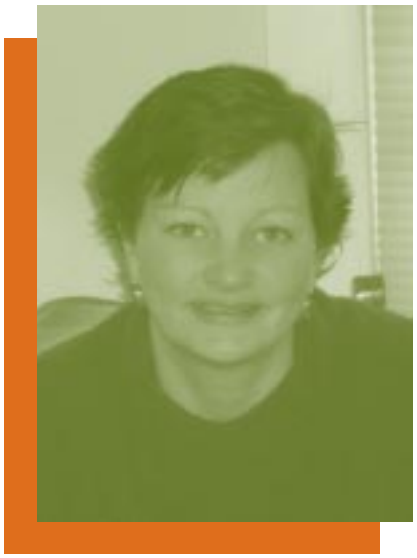
Denise Travis, PhD,

By Alison Paglia, PhD,
University of New Hampshire Assistant, Professor/Senior Faculty Advisor

If I had to summarize the Behavioral and Social Science (BSSV) Program Basic Training that I attended in three words, they would be quality, quality, and quality. Fortunately, I have a couple of paragraphs to summarize.

When I registered for the training, I had already conducted HIV/AIDS research and had provided minor technical assistance to two community agencies. Through these linkages, I had spoken to Duane Wilkerson, Robin Kelley, and to Joseph "Buzz" Prejean, who is currently with the Centers for Disease Control, but who at that time was also serving as a BSSV in my state, New Hampshire. Prior to attending the training, I felt confident in my ability to provide technical assistance and felt familiar with the BSSV Program, so I was unsure what the training would provide. Was the training going to cover what I already knew—survey design and statistical analysis, or just the basics of the BSSV Program?

As I said previously, every aspect of the BSSV Program Basic Training was "quality." On a programmatic level, the facilitators kept on task and on schedule, and we were fed frequently, at a quality level that I was unaccustomed to at previous trainings. As we introduced ourselves, I was astonished at the wealth of knowledge and experience of the attendees—truly a quality group. The information was rich with content ranging from the macro level of HIV/AIDS funding to the micro level of role-playing atypical BSSV linkages. Many activities were structured to challenge the trainees and maximize participant engagement. I left the training feeling excited and empowered. The tremendous knowledge base, extreme competency of all of the training facilitators, newly developed contacts with other volunteers, and the high level of commitment among everyone in attendance made me feel privileged to be a part of the BSSV Program.▼



Alison Paglia, PhD

Capacity Building Assistance
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National Native American AIDS Prevention Center

The National Native American AIDS Prevention Center's (NNAAPC) mission is to stop the spread of HIV/AIDS and related diseases among American Indians, Alaska Natives, and Native Hawaiians. NNAAPC seeks to improve the quality of life for members of these communities infected and affected by HIV/AIDS. NNAAPC was founded in 1987 by a group of concerned AIDS activists, public health workers, physicians, and substance abuse professionals. In 1990, NNAAPC expanded its work to include direct service delivery through the Ryan White Care Act and pioneered a case management model program in Oklahoma. The Health Resources and Services Administration asked NNAAPC to replicate this model, which was later implemented in nine additional states and the Navajo Nation.

Left to right: Juanika Mainor, Gerlinda (GG) Somerville, Benny Ferro, and Brian Kim (Public Health Analysts, Capacity Building Branch, Division of HIV/AIDS Prevention CDC).

NNAAPC has been funded by the CDC since 1988 to provide HIV/AIDS capacity building assistance prevention activities with Native populations. NNAAPC's capacity building and training services are provided to American Indian, Alaska Native, and Native Hawaiian tribes, organizations, tribal agencies; Native American communities; and to those who serve these populations. Capacity building includes both targeted and individualized assistance designed to help Native American communities develop successful HIV prevention programs that work, as well as provide regionally based training that is culturally competent and linguistically appropriate.

NNAAPC provides assistance in CBA Priority Area 2—Intervention Design, Development, and Evaluation. NNAAPC provides assistance in the design, development, and implementation of population-based needs assessments, curricula, culturally competent and linguistically appropriate interventions, and program evaluation. The major goal of this priority area is to improve the capacity of Native American CBOs to design, develop, implement, and evaluate effective HIV prevention interventions for Native American men and women whose behavior places them at risk for acquiring or transmitting HIV and other STDs. For Priority Area 3—Community Capacity Building for HIV Prevention, NNAAPC provides community capacity building assistance in needs assessments, community mobilization, leadership development, and curriculum development. This project is specifically designed to improve the capacity of Native American CBOs serving gay/bisexual/two-spirit men and youth to mobilize their communities to increase their awareness, presence, participation, leadership, and support for HIV prevention. In addition to Priority Areas 2 and 3, NNAAPC also receives funding for Priority Area 4—HIV Prevention Community Planning Effectiveness and Participation. NNAAPC provides technical assistance to incorporate cultural sensitivity (Native parity, inclusion, and representation) into the HIV community planning process and to support a national network of Native American community planning group members. This project enhances the capacity of Native American CBOs and community stakeholders to increase their participation in the HIV prevention community planning process and to improve the responsiveness of the process to the HIV prevention needs of Native Americans at risk.

For more information contact NNAAPC at: National Native American AIDS Prevention Center, 436 14th Street, Suite 1020, Oakland, CA 94612; Web address: www.nnaapc.org; and telephone: 510-444-2051.▼

Building Capacity for HIV/STD,
continued from page 9

Enhancing and Maintaining Capacity

Given the relative lack of health resources in Native communities, capacity for HIV/STD prevention can come and go quickly. Changes in tribal administration and availability of grants reserved for Native populations can have dramatic impacts on the existence of prevention and education programs. Integrating prevention into other health and wellness programs can be a strategy for survival, as is the building of task forces and coalitions for funding development and service delivery. Partnership with local behavioral and/or social scientists through the Behavioral and Social Science Volunteer Program can also be a beneficial means of maintaining the scientific structure of community interventions.

The BSSV Program volunteers in collaboration with Native capacity building assistance (CBA) providers, such as the National Native American AIDS Prevention Center, may prove to be an important link in sustaining the interventions of communities. Since the volunteers have an interest not only in HIV prevention, but in assisting communities to adapt effective interventions, these resources may bolster strategies and recommend techniques not otherwise accessible to tribal health and prevention developers.

Active exchange of information between community members and capacity building assistance providers is important in developing sustainability plans. Often this means investing in leadership training and mentorship for community members so that the ownership for prevention efforts remains comfortably in their hands.

Although program evaluation is a key to enhancing and maintaining program capacity, very few Native HIV/STD prevention programs have been successfully evaluated to date.

To rectify this, we need to encourage partnerships with other groups, such as the BSSVs, to encourage participatory research and evaluation to support Native communities in designing culturally relevant evaluation tools and methods. As with the other aspects of capacity building, engaging community members in planning and interpreting evaluation results has greatly enhanced the usefulness of evaluation information for the overall understanding of health for Native communities.

With a history of negative health outcomes and frequent program failures as a result of government planning and intervention, it is also important to develop sustainable leadership within the community to address the structural barriers that impact program capacity and success. Active exchange of information between community members and capacity building assistance providers is important in developing sustainability plans. Often this means investing in leadership training and mentorship for community members so that the ownership for prevention efforts remains comfortably in their hands.

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HIV/AIDS,
continued from page 11

Table

HIV (without AIDS)* and AIDS cases reported among American Indians and Alaskan Natives, by selected characteristics — through December 2001

Characteristics	HIV without AIDS No.(%)‡	AIDS No.(%)
Sex		
Male	701(73.9)	2057(81.1)
Female	261(27.5)	480(18.9)
Age group (yrs)		
#12	13(1.4)	31(1.2)
13-19	43(4.5)	27(0.3)
20-29	377(39.2)	540(21.3)
30-39	364(37.8)	1209(47.7)
40-49	138(14.3)	546(21.5)
50-59	21(2.2)	140(5.5)
$ 60	6(0.6)	44(1.7)
HIV-exposure category		
Men who have sex with men	363(37.7)	1122(44.2)
Injecting-drug use	163(16.9)	532(21.0)
Men who have sex with men and inject drugs	90(9.4)	351(13.8)
Hemophilia/Coagulation disorder	3(0.3)	35(1.4)
Heterosexual contact	143(14.9)	238(9.4)
Receipt of blood or blood products	3(0.3)	24(0.9)
Mother with/at risk for HIV infection	10(1.0)	29(1.1)
Other/risk not reported or identified	185(19.2)	206(8.1)

* Alabama, Alaska, American Samoa, Arizona, Arkansas, Colorado, Connecticut, Florida, Guam, Idaho, Indiana, Iowa, Kansas, Louisiana, Mariana Islands, Michigan, Minnesota, Mississppi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Virgin Islands, Virginia, West Virginia, Wisconsin, and Wyoming.

‡ Percentages may not add up to 100% because of rounding.

of effective therapy. This article also highlights the need for national HIV reporting in the future to better describe the course of HIV infection and to help equitably allocate resources for care and prevention services. Recent outbreaks of syphilis among men who have sex with men in the United States (CDC, 2002) and the 75% increase in primary and secondary syphilis from 2000 to 2001 among AI/AN (CDC, 2003) are worrisome indicators of a possible future increase in HIV infection among AI/AN.

Endnotes

[1]The 39 areas included: Alabama, Alaska, American Samoa, Arizona, Arkansas, Colorado, Connecticut, Florida, Guam, Idaho, Indiana, Iowa, Kansas, Louisiana, Mariana Islands, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Virgin Islands, Virginia, West Virginia, Wisconsin, and Wyoming. No names or personal identifiers are reported to the CDC.

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Conference Updates

September 10-11, 2004

2004 African American and Hispanic Leadership Conference on HIV/AIDS, "When The Drumbeat Changes, The Dance Changes," Lexington, KY. For more information, contact Ramonda Yocum at 800-420-7431 or visit cdcnpin.org/scripts/display/confDisplay.asp?ConfMor-5098.

October 21-24, 2004

United States Conference on AIDS (USCA), Philadelphia, PA. For more information, visit the National Minority AIDS Council (NMAC) Web site: http://www.nmac.org.

November 6-10, 2004

American Public Health Association, 132nd Annual Meeting and Exposition, Washington, DC. For more information, visit the American Public Health Association (APHA) Web site: http://www.apha.org.

November 11-14, 2004

Fifth Annual National Harm Reduction Conference (HRC), "Working Under Fire: Drug User Health and Justice 2004," New Orleans, LA. Organized by the Harm Reduction Coalition. For more information, visit HRC online at: http://www.lgbtcenters.org/news/news_item.asp?NewsID=601.

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