HIV/STD
Prevention Guidelines
for Native American Communities:
American Indians,
Alaska Natives,
& Native Hawaiians

Editors

Anno Nakai
Dennis Manuelito
National Native American
AIDS Prevention Center

Wesley K. Thomas
William L. Yarber
Robin R. Milhausen
Indiana University

James G. Anderson
Purdue University

Irene Vernon
Colorado State University

Sponsored Jointly
by the

Rural Center for
AIDS/STD Prevention
(www.indiana.edu/~aids)
and
National Native American
AIDS Prevention Center
(www.nnaapc.org)

Published 2004

Members of the *Native Communities HIV/STD Prevention Guidelines Task Force*

James G. Anderson
Purdue University
West Lafayette, Indiana

Kurt Begaye
Navajo AIDS Network, Inc.
Chinle, Arizona

Jeanne Bertolli
Centers for Disease Control and Prevention
Atlanta, Georgia

CeCe Big Crow
National Center for American Indian and Alaska Native Health Research
Pine Ridge, South Dakota

Dave Brownell
Centers for Disease Control and Prevention
Atlanta, Georgia

Boyd Andrew Catt-Iron Shell
Rosebud Sioux Tribe
Rosebud, South Dakota

Alex Conchola
National Rural Health Association
Kansas City, Missouri

Anita M. Davis
Confederated Tribes of Warm Springs
Warm Springs, Oregon

Yvonne M. Davis
Albuquerque, New Mexico

Sharon M. Day
Indigenous Peoples Task Force
Minneapolis, Minnesota

Benny Ferro
Centers for Disease Control and Prevention
Atlanta, Georgia

Ashliana Hawelu
Ke Ola Mamo HIV/AIDS Education and Prevention Center
Honolulu, Hawaii

Tim Juliussen
Alaska Native Health Board
Anchorage, Alaska

Juanita Koziol
HRSA, HIV/AIDS Bureau-DTTA
Rockville, Maryland

Robert Livingston
New Mexico Department of Health
Gallup, New Mexico

Anno Nakai
National Native American AIDS Prevention Center
Oakland, California

Monoiki Ah Nee
Life Foundation
Honolulu, Hawaii

Rachel Pacheco
Albuquerque, New Mexico

Susan Pourier
Great Lakes Inter-Tribal Council
Lac Du Flambeau, Wisconsin

Daniel Simpson
Indian Health Service
Rockville, Maryland

Clarence Smelcer
Alaska HIV Prevention
Planning Group
Anchorage, Alaska

Antony Stately
AIDS Project of Los Angeles
Los Angeles, California

Larry Tate
U.S. Conference of Mayors
Washington, D.C.

Wesley K. Thomas
Indiana University
Bloomington, Indiana

Mary Tobacco
Oglala Sioux Tribe Health Education
Pine Ridge, South Dakota

William L. Yarber
Rural Center for AIDS/STD Prevention
Bloomington, Indiana

These guidelines are dedicated to the memory of Alex Conchola, a Guidelines Task Force member who died suddenly on January 16, 2003. Alex was deeply committed to HIV/STD prevention efforts in rural communities. He was a valuable member of the task force and we miss him.

ACKNOWLEDGMENTS

Special thanks to the Native Communities HIV/STD Prevention Guidelines Task Force members who volunteered their time to participate in the task force meeting which provides the foundation for this document. The Guidelines Task Force members also reviewed the text and provided feedback. This document reflects the perspectives of the Guidelines Task Force. The guidelines could not have been prepared without their dedication and commitment.

We are indebted to HIV/STD prevention specialists in Native communities throughout the country who shared information about their model prevention programs. The successful strategies offered by these prevention specialists make an important contribution to these guidelines.

The chapters in the guidelines are the result of the collaborative efforts of the editors. Anno Nakai is the Prevention Programs Manager of the National Native American AIDS Prevention Center (NNAAPC). Dennis Manuelito is the Capacity Building Coordinator for NNAAPC. Wesley K. Thomas is Assistant Professor of Anthropology at Indiana University. William L. Yarber is Senior Director of the Rural Center for AIDS/STD Prevention (RCAP) and Professor of Applied Health Science and of Gender Studies at Indiana University. Robin R. Milhausen is an RCAP research assistant and a doctoral candidate in health behavior at Indiana University. James G. Anderson is an RCAP Co-Director and Professor of Medical Sociology at Purdue University. Irene Vernon is an Associate Professor and the Director of the Center for Applied Studies in American Ethnicity at Colorado State University, Fort Collins. Jeanne Bertolli, Senior Epidemiologist at the Centers for Disease Control and Prevention's (CDC) National Center for HIV, STD, and TB Prevention, contributed the information on the epidemiology of HIV/AIDS in Native communities.

The work of Patrik Kusek and Nikole Sorensen at Wallop Design Group in developing the artwork for this publication is much appreciated. Thanks also to Carrol Stencel at Indiana University Printing Services for her work in developing the final document.

The development of these guidelines was made possible by support from RCAP and NNAAPC, both cooperative agreements funded by the CDC.

Foreword

I am extremely honored to offer some thoughts on the HIV/STD Prevention Guidelines for Native American Communities: American Indians, Alaska Natives, and Native Hawaiians. These Guidelines are an important part of Native American communities' effort to promote, protect, and ensure the future and well-being of their communities. Given the significant nature of health disparities and its adverse impact on Native communities it is essential that Native people assume the leading role in the development of prevention initiatives for and with their communities. This effort moves us in a positive direction, ensuring that knowledge, wisdom and experience of Native people are shared with all who chose to work with us.

These Guidelines offer background and technical information specific to working with Native American communities. One element that will ensure a successful, collaborative effort is the nature of the relationships we develop personally and professionally. In order to ensure our success in this effort I would encourage time and attention to this essential element. The key to this is respect, trust, inclusion and reciprocity – all values that have long been an inherent part of Native communities. We should not forget our indigenous values. These values have served our communities well in the past and do have enduring value.

/Michael E. Bird/

Michael E. Bird
Executive Director
National Native American AIDS Prevention Center

Past President
American Public Health Association

Guidelines Development

These guidelines represent the first national document for HIV/STD prevention among Native American communities. The goal in the development of these guidelines was to reflect the perspectives of a diverse group of HIV/STD prevention specialists in Native communities, which include American Indians, Alaska Natives, and Native Hawaiians.

Leaders in HIV/STD prevention in Native communities were identified and invited to a consultation meeting at Indiana University, Bloomington, in August 2002. This meeting was sponsored by the Rural Center for HIV/STD Prevention, Indiana University, Bloomington, in collaboration with the National Native American AIDS Prevention Center, Oakland, California.

These key leaders comprised the Guidelines Task Force. In response to the increasing threat of HIV/STD among Native communities, the task force members identified essential components of preventive strategies unique to their communities. These valuable contributions are the components of the guidelines.

Following the consultation meeting, the editors developed the text for the guidelines, bringing together the voices of the Guidelines Task Force members. Finally, the material produced by the editors was approved by the Guidelines Task Force members.

These guidelines provide a framework to create HIV/STD prevention programs tailored to Native American persons, reflecting the unique culture of Native communities. The guidelines provide a starting point for program development at the local level.

Suggested Reference:
Native Communities HIV/STD Prevention Guidelines Task Force. *HIV/STD Prevention Guidelines for Native American Communities: American Indians, Alaska Natives, & Native Hawaiians.* Bloomington, IN: Rural Center for HIV/STD Prevention; 2004.

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Native *Cultures*

Introduction

One often overlooked and vital component of effective HIV and other sexually transmitted disease prevention, intervention, and care is the role of culture. Culture can be defined in a number of ways, but generally it is the sum of attitudes, behaviors, customs, and beliefs of a people; and it includes thoughts, styles of communication, ways of interacting, and views of roles and relationships. The need to pay close attention to culture is becoming increasingly important given the cultural diversity that exists in the United States and the continued growth in diversity due to immigration. The ways in which people recognize and respond to this diversity are critical to the development of effective health care and prevention programs.

Culture also informs people about the world around them and how to behave in it. The ways in which people view and interpret health and illness, and seek and deliver care are integrally tied to cultural norms, beliefs, and values, in conjunction with social structures and environmental conditions. Culture can determine how people communicate their symptoms, which ones they report, and to whom. Culture can also affect how people react to medical education and intervention. It is vital, therefore, that health professionals acknowledge and utilize cultural components when addressing health issues and concerns.

Research shows that HIV/STD prevention works best when it promotes change through individual and community empowerment strategies informed by holistic community norms, beliefs, and values. Prevention efforts have failed when they have not been developed for the specific communities and individuals affected, and when the messages are incompatible with basic needs, values, and norms. Cultural differences do not just apply to differences among major groups such as African Americans or Native Americans. Differences must also be recognized within groups, especially among the Native American population that is itself culturally diverse.

Native Cultural Diversity

There are about 560 federally recognized tribes, as well as tribes recognized only at the state level and several others seeking recognition at federal and state level. The United States 2000 Census[1] reported that 2.5 million people classify themselves American Indian/Alaska Native (AI/AN) alone and a total of

4.1 million people classify themselves as AI/AN alone or AI/AN and another race. Within this population is a great diversity of cultures that share a common experience of colonization, a poverty rate twice the national rate, and growing health issues including HIV/STD. Given the overall health status of Native people, urgency for the creation of effective health prevention/intervention and care is apparent. To be effective, Native health programs must address the cultural diversity found among Native peoples and be culturally appropriate. This is especially important for HIV/STD programs that must address sensitive topics such as sexuality.

It is also critical that the cultural differences among American Indians (in the lower 48 states), Alaska Natives, and Native Hawaiians be taken into consideration, particularly regarding the impacts of geography and colonizing histories. The nature of cultural change that has occurred among tribal people is intimately tied to their colonizing histories, experiences with violence, and the result of inter-generational traumas. As well, these Native groups differ in ritual, language, and social structure. Cultural differences are also found between rural and urban tribal members, men and women, and groups such as two-spirits. The rich and complex ways of Native people must be understood to lessen misunderstandings and to provide better health care and prevention services.

Traditionalism

Native people have a long history on their lands. Many Native people say they have been here since time immemorial while others believe that their ancestors migrated here around 30,000 years ago. Whether here from time immemorial or 30,000 years ago, many aspects of Native culture have endured and continue to be passed down from generation to generation. The level of "traditionalism" varies from community to community, and this is an important factor in how prevention efforts should be structured. Although it is not always the case, generally the more isolated the community has been from colonizing forces, the more traditional it has remained. Yet all communities incorporate components from other cultures, particularly from those that are the closest in location or have had the longest association.

The effect of cultural change is apparent, for example, among Natives in the southwestern part of the United States. Because of their colonial experiences with Spain and Mexico, many Hispanic influences have been incorporated in Native architecture, food, spirituality, and attitudes about such things as sexuality and gender variances. In Alaska the story is similar because of the introduction of Russian

Orthodox and other religious traditions. Similarly, Native Hawaiian religious practices changed due to the influence of Protestant missionaries. As a consequence, today spiritual richness and diversity permeates Native communities and affects many aspects of life.

Understanding the nature of Native religious diversity and the values and beliefs held by different communities and individuals is essential in attempting to promote HIV/STD prevention programs that address issues of sexual behavior. After many years, forced and unforced conversion to Christianity has led some Native communities to reject same-sex relationships and variations in gender such as two-spirits; however, many communities have remnants of acceptance and respect for two-spirits. Those working with communities and preparing prevention materials must understand both the traditional beliefs and the nature of the changes that have occurred, which makes HIV/STD work more difficult.

How one speaks about sex and sexuality may also be governed by spiritual traditions. Native communities have enlisted spiritual elders in the fight against the spread of HIV/STD and believe the elder's support is a critical component of prevention and intervention. In other Native communities, Christian Natives and religious organizations have taken an active role in prevention work.

Healing/Healthcare

Prior to colonization, Native people had a wide knowledge of illnesses and remedies—sweat baths, poultices, and mineral wraps—that emanated from their own environments. Within communities there were individuals with knowledge of medicinal plants, sacred healing songs, and the power to heal. Geographic isolation necessitated medical self-sufficiency. Today many rural and urban Native communities continue to use traditional forms of healing and have their own healers and spiritual leaders who have tremendous support. Many Native HIV/AIDS and STD patients have found the combination of traditional and Western medicine an important component of care. While cooperation between traditional and Western healers varies from community to community, professional respect and coordination is growing.

World View

At the core of traditionalism and Native sacredness is a world view of understanding and respect for the circle of life. In this world view people, earth, air, water, and animals are connected and there is acknowledgement of the need of all beings to keep balance in the world. Within the circle of life are respect, obligation, and responsibility. Understanding the world view of tribal people will assist in knowing the importance of each community and all the people in it. This importance can

be found in the respect given to elders because they carry tribal wisdom and are important to cultural perseverance. Elder's support in the fight for HIV/STD prevention is needed. An understanding of Native world views, even in urban areas, is especially important in the development of educational prevention materials. Inclusion of elders and other community members in the preparation phase can produce more acceptable and effective materials.

Social Structure

The social structures found in tribal communities may take several forms including extended families, clans, moieties, bands, and patriarchal or matriarchal structures. Understanding these structures and the social relationships that are part of the structures is important to health for a number of reasons. One of the reasons is that certain responsibilities and obligations may be part of an individual's place within the social structure. For instance, two-spirit men have spoken about the importance of their role as the ones who help take care of children. The social place of Native women and two-spirits in any given community may relate directly to their health care or lack to access of it.

A basic component of the social structure found among most tribal groups is the sense of unity and responsibility for the health of the community. In many tribal communities, strategies for dealing with sickness and wellness are not just an individual concern but a community concern. Because of this social value, it is important to include not just the target population but the entire community in HIV/STD prevention, intervention, and care.

Homelands

Native people are integrally tied to their homelands and understanding these ties is important for understanding the potential pathways for the spread of HIV/STD. Over half of the Native population lives in cities. Many HIV/AIDS infected individuals have moved to urban areas to access better health care and to move away from discrimination. Many, if not most, urban Native people, HIV/AIDS-infected and otherwise, migrate back and forth to rural areas for work, ceremonies, and visits with family and friends. The circular movement of Native HIV-infected people may lead to increasing infections among rural populations. Some Native people perceive this as bringing high-risk behaviors to the reservation by exposing rural partners to the disease. Others worry that Native HIV-infected individuals who do not know their status are unknowingly transmitting HIV.

Language

An aspect of Native cultural survival that speaks to its strength and endurance is the retention of Native

languages. Although thousands of Native languages have been lost due to colonization, many different languages are still spoken. Native languages are still an important cultural component of Native life, with over 281,000 Native speakers in the United States. The importance of language is that it guides the way a community views the world and recognizes its place in it. Embedded in language are generations of wisdom that carry cultural values and help shape a person's self-awareness, identity, and interpersonal relationships. Language strengthens an individual's sense of identity and self-esteem, which are critical aspects for creating a barrier against HIV/STD infection.

Understanding and utilizing traditional tribal languages in prevention and intervention efforts is critical because many communities learn about health and healing through storytelling. Traditional tribal stories and legends grounded in tribal language organize the world and lay out individual and communal responsibilities and obligations. Stories teach individuals how to live in the world, how to behave, how to heal, and how to survive. Native communities that speak their own language have stories and legends that help unify the people. Utilizing this local cultural knowledge is important to communicate effectively with different groups of people.

Each community will also have a form of language that is acceptable, respectful, and appropriate for talking about sex. The language used to discuss sexuality in tribal communities is based on cultural norms that must be learned and incorporated in prevention and intervention materials. Community-based organizations and people within the community have the best capacity to create prevention messages and counseling styles that are most appropriate and effective for their communities. Community participation also ensures accuracy of translation.

Awareness of diversity of language must also take into consideration the language of substance abusers, gang members, women, youth, and elders. Language must be appropriate for age, gender, and behavior (e.g., drug use). Effective HIV/STD messages speak the language of the target-group population as well as the culture in which it is embedded.

Nutrition

Another critically important relationship between culture and HIV is nutrition and diet. While there is no known nutritional means of curing or preventing HIV infection, appropriate nutrition may help to slow the advance of infection. For example, several researchers have found that certain nutrients have a protective effect on the development

of AIDS. Good nutrition for people with AIDS can help minimize loss of body mass and sustain vitamin and mineral levels, which play an important part in maintaining proper function of the immune system.

The diet and nutrition of Native people was dramatically changed with colonization. Food and diet that had developed through years in a given location changed as Native people were dislocated from their traditional lands and/or prohibited from hunting and gathering in their traditional places. Traditional food systems were replaced by the government commodity food program, which gave Native people refined white flour, potatoes, sugar and processed cheeses. They began to depend on high fat, high sugar, and heavily processed foods that contributed to high rates of diabetes, high blood pressure, heart diseases, and obesity among Native people.

As a response to the poor health and diet of many Native people today, communities have been moving back toward traditional Native diets that include low fat, high protein meat, wild fruits and grains, and foods grown using organic gardening methods. Many Natives and health professionals have come to realize that the health of Native people will continue to decline if they do not develop better nutrition, which may slow the progress of HIV to AIDS and allows people with AIDS to maintain a balanced diet for optimal health.

In sum, cultural understanding and cultural competency are critical in providing effective HIV/STD prevention and care in tribal communities. To achieve their goals, academics, researchers, grassroots workers, funding agencies, tribes, states, and the federal government must understand the cultural norms present in the communities where they work. The best way to ensure effective prevention efforts is to have the communities themselves participate in all aspects of HIV/ STD prevention, intervention, care, and assessment. Awareness of and incorporation of cultural aspects should not be limited to the development of HIV/STD prevention, intervention, and care. Cultural aspects must also be used in the assessment of existing programs and services.

Epidemiology *of HIV/AIDS Among Native Communities*

Number of Reported HIV/AIDS Cases

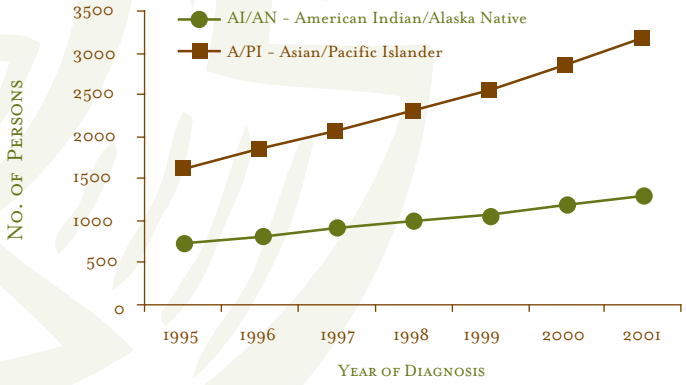
According to data from the National HIV/AIDS Surveillance System[2] through December 2001, a cumulative total of 3,499 HIV/AIDS cases among AI/AN have been reported to the Centers for Disease Control and Prevention (CDC). Of these, 2,537 persons had been reported with AIDS (81% male and 19% female). A total of 962 persons (73% male and 27% female) had been reported with HIV (not AIDS) from the 35 states and 4 territories with confidential HIV reporting as of December 2001.* According to AIDS surveillance information from the state of Hawaii (the only location for which surveillance information is available for Native Hawaiians), 296 AIDS cases among Native Hawaiians (NH) had been reported through December 2002 (88% male, and 12% female).[3] The state of Hawaii began reporting HIV infection in August 2001, and HIV data were not yet available to be released.

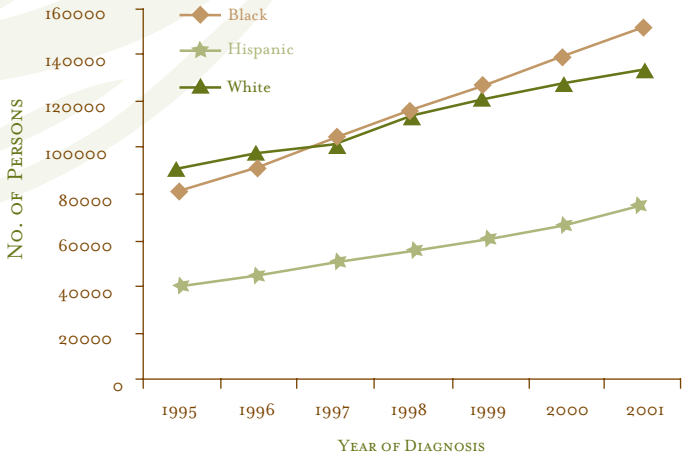
The cumulative total of HIV/AIDS cases among AI/AN includes 31 AIDS cases and 13 HIV cases among AI/AN children less than 13 years old (representing 1.3% of all AI/AN HIV/AIDS cases reported). In comparison, 0.5% of White, 1.9% of Black, 1.7% of Hispanic, and 1.1% of Asian/Pacific Islander (A/PI) persons reported with HIV/AIDS were less than 13 years old.

From 1981 through December 2001, 1,286 deaths have been reported among AI/AN persons with AIDS included in the surveillance system. The estimated number of AI/AN persons living with AIDS in 2001 was 1,304.[2] Figure 1 shows that the numbers of AI/AN people living with AIDS is increasing, as it is for all other racial/ethnic groups. The increase in the number of persons living with AIDS is due to a combination of factors. Although drugs that prolong the time from HIV infection to AIDS are available, persons with HIV are still progressing to AIDS.

* *The following areas have confidential name-based HIV reporting: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Idaho, Indiana, Iowa, Kansas, Louisiana, 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, Virginia, West Virginia, Wisconsin, Wyoming, Guam, American Samoa, Northern Mariana Islands, U.S. Virgin Islands.*

Figure 1. Persons living with AIDS, 1995-2001, by race/ethnicity *





* adjusted for reporting delay

Antiretroviral drugs significantly lengthen the lives of many persons with AIDS, resulting in increased numbers of persons living with AIDS.

AI/AN people represent a small proportion of the total HIV/AIDS cases reported to the HIV/AIDS Surveillance System. Through December 2001, AI/AN represented 0.3% of reported AIDS cases and 0.6% of reported HIV cases, and made up 0.7% of the U.S. population (or 1.5% when both persons who claim AI/AN race alone and in combination with other races are counted).[2,4] Like AI/AN, NH also account for a lower percentage of reported AIDS cases than their proportion of the population. The 296 AIDS cases among NH represent 10.9% of the total number of AIDS cases reported in Hawaii; Native Hawaiians accounted for 12.5% of the state's population in 1990.[3] In Alaska, however, where Alaska Natives account for 17% of the state's population, Native people represent 30% of HIV cases reported from 1996-2000 among males, and 48% of HIV cases reported during the same period among females.[5]

The cumulative total of 3,499 AI/AN persons with HIV/AIDS is less than 1% of the total number of persons with HIV/AIDS among Whites and Blacks (405,530 Whites and 402,161 Blacks reported with AIDS), but must be considered in the context of a much smaller AI/AN total population size, and with the understanding that more than 557 ethnically distinct groups make up the AI/AN population, some with a total of less than 1,000 persons.[6]

AIDS Rates

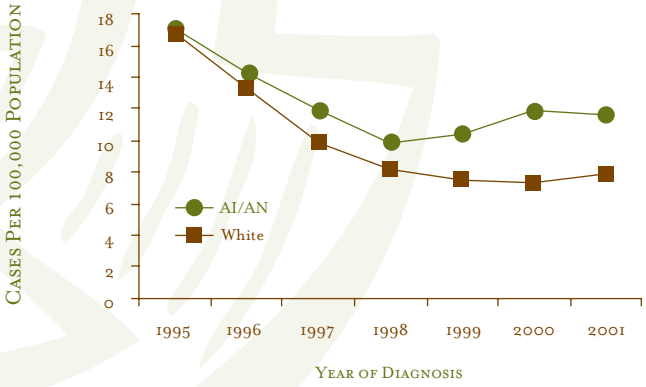
AIDS case rates, unlike the case counts presented previously, take relative population size into account. Figure 2 shows estimated AIDS incidence rates from 1996 through 2001 for AI/AN compared with other racial/ethnic groups. Since 1995, the rate of AIDS among AI/AN has been higher than that for Whites. The AIDS rate in 2001 for AI/AN was 11.7 per 100,000 persons, the third highest rate after Blacks, for whom the rate was 76.3 per 100,000 and Hispanics, for whom the rate was 28 per 100,000. In contrast, the 2001 estimated AIDS incidence rates for Whites and A/PI were 7.9 and 4.8 per 100,000, respectively.

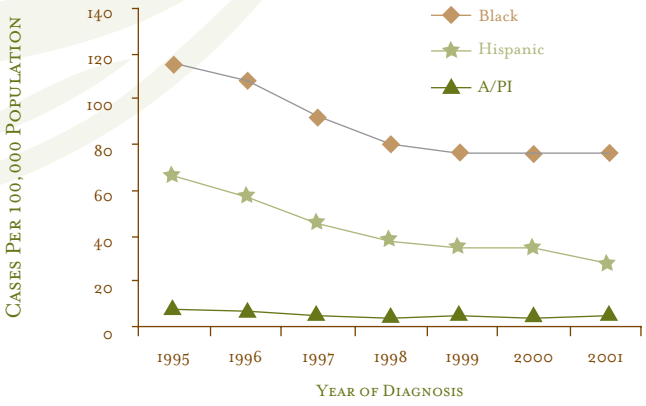
HIV Diagnosis Rates

Using data from the national HIV reporting system, rates of HIV diagnosis were calculated for the 25 states with confidential name-based HIV reporting since 1994.** These data

** *Alabama, Arkansas, Arizona, Colorado, Idaho, Indiana, Louisiana, Michigan, Minnesota, Missouri, Mississippi, North Carolina, North Dakota, New Jersey, Nevada, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Utah, Virginia, Wisconsin, West Virginia, Wyoming.*

Figure 2. Estimated AIDS incidence rates by year of diagnosis and race/ethnicity, 1996 through 2001*





* adjusted for reporting delay

show that the rate of diagnosed HIV infection reported among AI/AN living in these states has averaged 16.4 per 100,000 persons from 1996 - 2000, more than 1.5 times the average rate for Whites (10.0 per 100,000) and nearly 2.5 times the average rate for A/PI (6.6 per 100,000) for the same 5 years, but approximately one-fifth the average rate for Blacks (88.3 per 100,000) and less than one-half the average rate for Hispanics (39.3 per 100,000) for this period. In 2001, 172 AI/AN persons with HIV were reported from 32 states+; of these, 21% were female. In comparison, the percentage of females among non-AI/AN persons with HIV reported from these 25 states varied by race/ethnicity: from 17% among Whites to 38% among Blacks, with Hispanics and A/PI having a female percentage similar to AI/AN (21% and 22%, respectively).

Characteristics of AI/AN Persons Reported with HIV/AIDS Infection

AI/AN and NH with AIDS are likely to be younger than non-AI/AN persons with AIDS. Among AI/AN with AIDS reported through December 2001, 24% were less than 30 years of age, compared with 16% of White, 19% of Black, 20% of Hispanic, and 18% of A/PI persons with AIDS.[2] Among NH reported to the state of Hawaii through December 2000, 20% were less than 30 years of age.[7] In the absence of antiretroviral therapy, progression from HIV infection to AIDS takes an average of 10 years.[8] Many of these young people were likely infected as teenagers.

An analysis of cases reported through December 1997 showed that although 68% of AI/AN persons with AIDS lived in metropolitan areas with populations of more than 500,000 people at the time of diagnosis, AI/AN with AIDS are more likely to be residents of rural areas than non-AI/AN persons with AIDS.[9] This data suggest that HIV/AIDS is both an urban and a rural (reservation) problem.

Modes of Exposure to HIV Among AI/AN Persons Reported With AIDS

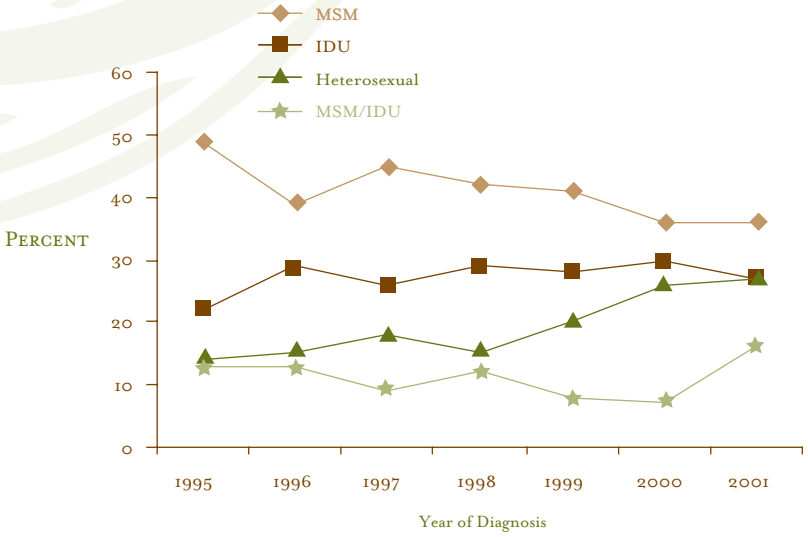
Figure 3 shows that although male-to-male sexual contact and injection drug use (IDU) were the most common ways AI/AN with AIDS had been exposed to HIV, the percentage of AI/AN persons with AIDS whose mode of exposure was through heterosexual contact has increased over time. In 2001, the percentage exposed to HIV through heterosexual contact was equal to the percentage exposed to HIV through injection drug use. The increasing percentage of cases associated with heterosexual contact is in part related to 1) an increasing percentage of AI/AN with AIDS who are female

+ *The 32 states include the 25 listed previously plus Alaska, Nebraska, Florida, New Mexico, Iowa, Texas, and Kansas.*

(16% in 1995 compared with 22% in 2001), and the higher frequency of heterosexual behavior as a mode of exposure among females; and 2) increasing frequency of heterosexual contact as a mode of exposure among males (1% in 1995 versus 6% in 2001).[2]

Male-to-male sexual contact was the mode of exposure for 55% of the cumulative total of male AI/AN with AIDS (72% of those who are exposed through a combination of male-to-male sex and injection drug use are included). By comparison, the percentages of the cumulative totals of male non-AI/AN with AIDS were 55% (for male-to-male sex) and 63% (for male-to-male sex combined with injection drug use). The second most common way male AI/AN AIDS patients were exposed to HIV was through injection drug use (16%, compared with 22% for non-AI/AN). Of male AI/AN AIDS patients, 3%

Figure 3. Estimated percentage of AIDS cases among American Indians and Alaska Natives, by mode of exposure, 1995 through 2001*



* adjusted for reporting delay and unreported risk

were exposed to HIV through heterosexual contact and 2% were exposed through receipt of blood products, compared with 5% and 2% of male non-AI/AN patients, respectively.[2] For the remaining 7% of male AI/AN AIDS patients, no mode of exposure was reported.

In contrast, nearly half (44%) of female AI/AN with AIDS were exposed to HIV through injection drug use, and 37% were exposed through heterosexual contact (compared with 39% and 41% of non-AI/AN with AIDS, respectively). Receipt of HIV-contaminated blood products was the mode of exposure for 3% of female AI/AN with AIDS and 3% of female non-AI/AN with AIDS.[2] For the remaining 15% of female AI/AN AIDS patients, no mode of exposure was reported.

Among NH with AIDS reported in Hawaii, the mode of exposure distri-

Table 1. Top 10 states ranked by number of AIDS cases among AI/AN diagnosed through June 30, 2001

Rank	State	AI/AN AIDS Cases No.	(% of state's total)	Percent of Total US AI/AN AIDS Cases (n=2,733)
1	California	580	(0.5%)	21.2%
2	Oklahoma	289	(6.9%)	10.6%
3	Arizona	271	(3.1%)	9.9%
4	Washington	187	(1.8%)	6.8%
5	New Mexico	110	(4.8%)	4.0%
6	Alaska	107	(20.5%)	3.9%
7	North Carolina	100	(0.8%)	3.7%
8	New York	93	(0.1%)	3.4%
9	Minnesota	91	(2.3%)	3.3%
10	Texas	83	(0.1%)	3.0%
	All Other States	823	(0.2%)	30.1%
	Total	2,733	---	100.0%

bution followed the same pattern described above: of the 296 AIDS cases reported, 73% were exposed through male-to-male sex, with an additional 4% exposed through a combination of male-to-male sex and injection drug use; 8% were exposed through injection drug use, 8% through heterosexual contact, and 7% through other modes of exposure.[3]

Geographic Distribution of Reported HIV/AIDS Cases Among AI/AN

As with the AI/AN population overall, AIDS among AI/AN is unevenly distributed geographically. The top five states according to numbers of reported AIDS cases are California, Oklahoma, Arizona, Washington, and New Mexico. These five states account for more than half (53%) of AI/AN AIDS cases (see Table 1)[10] and correspondingly account for 46% of the AI/AN population.[11]

Co-factors *in the Spread of HIV/STD in Native Communities*

HIV and other STDs present a serious problem in Native communities due to a number of interconnected co-factors which enhance the vulnerability of Native people.[9, 12, 13, 14] The cultural and social climate in which Native people live can contribute to HIV/STD risk behavior.

Cultural and Social Climate

Historical trauma, oppression, prejudice, and racism can have a strong influence on Native life.[14, 15, 16] Colonization of Native Americans has disrupted family structures and traditional ways of being.[16] The forced transition from hunting, gathering, and farming to a cash-based economy has created a climate of poverty that still plagues many Native people. This cultural upheaval, rooted in Westernization and industrialization, has contributed to feelings of internalized shame, depression, and powerlessness.[17] These feelings have led to a mistrust of White helpers and agencies.[16] Many health problems among Native people can be directly attributed to "their colonized status and to associated forms of environmental, institutional, and interpersonal discrimination."[18] Racism makes it difficult for many Native people to access assistance from legal and social service agencies.[19] Research indicates that oppression in conjunction with the chronic stresses linked with discrimination may lead to more physical and mental health problems among minority groups.[18]

Native people are disadvantaged economically. Thirty-two percent of the AI/AN population live below the poverty level, compared to 13% for all other races in the United States. More than one-half of American Indian and Alaska Natives have incomes 200% below the federal poverty level, compared with 25% of Whites.[20] About 40% of housing on reservations is inadequate, and 20% lacks complete plumbing.[15] Native Americans are more than twice as likely to face hunger and food insecurity than other Americans.[15] Further, 16% of AI/AN men and 13% of AI/AN women are unemployed, compared to 6% of men and women in the total U.S. population.[9] Financial barriers to adequate health care and prevention

programming create health disparities between Native people and the larger U.S. population.

AI/AN have less access to education.[15] Native American youth do not have the same educational opportunities as other ethnic groups due to deteriorating school facilities, weak curricula, discriminatory treatment, outdated learning tools, and cultural isolation. This contributes to gaps in achievement with Native American students scoring lower than any other racial or ethnic group in reading, math, and history.[15] Native American students have a corresponding high drop-out rate.

Native men and women are also greatly affected by health disparities and bear a greater burden of health risk factors and chronic disease than other racial or ethnic minority groups.[15, 21, 22] The federal government spends less per person on Native American health care than on any other group it is responsible for, including prisoners, veterans, and military personnel.[15] In a large study of 21 communities in 14 states, including AIs, Blacks, Hispanics, and Asians, AIs were found to have the highest incidence of obesity, current smoking, cardiovascular disease, and diabetes.[22] Approximately 80% of AIs reported one risk factor or chronic condition, and one-third reported three or more.[21] Native women have higher death rates due to diabetes, motor vehicle accidents, chronic liver disease and cirrhosis, alcohol abuse, and suicide compared to other races.[18] AI/AN people have a higher mortality rate than Whites at every stage of the life span.[23] High rates of psychiatric problems and related mental health issues have also been reported in many Native communities. Urban Natives are disproportionately at risk for health-related problems, compared to rural Natives.[18] Unfortunately, Native people are far less likely than Whites to have job-based or other private insurance coverage, and more than one-third are uninsured.[24] Almost one-half of all low income AI/ANs are uninsured.[23]

Geographic isolation characterizes many Native communities. Native Americans living on tribal lands do not have access to services and programs available to other Americans.[15] This may contribute to reduced access to facilities for HIV/STD testing and treatment.[16] Inadequate transportation can also be a limiting factor.[18] Further, medical personnel in these rural areas may have less experience with currently recommended practices for HIV prevention and health care.[9] As well, HIV-related stigma on rural reservations may be an additional barrier to seeking resources.[16]

Traditional Native people may have values and beliefs related to illness and death that are discordant with Western philosophies.[14] For example, Native persons may attribute illnesses, misfor-

tunes, and disabilities to supernatural causes. As well, many AI/AN conceive of death as a continuation of life's journey. Native people strongly believe in the power of the spoken word and may fear discussing sickness and death for fear that they will precipitate self-fulfilling prophecies.[25] Additionally, Native persons may perceive themselves to be at relatively low risk for HIV and other STD, and therefore, prevention may be low on the list of health and economic priorities for tribal leaders. There are also many taboos surrounding the discussion of sex and drug-related behaviors.[26] Finally, key terms used in HIV/STD prevention and health promotion may not have the same meaning for Native people – it is important to consider that English may be a second language for many Native persons.[14] All of these issues pose challenges for traditional intervention strategies.

Behavioral Outcomes

The complex social and cultural climate inhabited by most Native persons can lead to a series of interrelated behaviors which contribute to HIV/STD risk. Native Americans rank at or near the bottom of nearly every social, health, and economic indicator.[15] Poverty and unemployment also contribute to domestic violence, depression, suicide, and lowered self-esteem.[16] Certainly the cycle of poverty, lack of education, and joblessness can play significant roles in substance use, including injection drug use and alcoholism.

As Native culture has assimilated with Western philosophies, some of the traditional beliefs and practices which protected Native people have eroded. For example, previously held attitudes regarding two-spirited people have been replaced by conceptualizations of men who have sex with men (MSM) as "deviant" and "immoral."[25] This has led to closeted sexual behavior; many men desiring sexual contact with men travel off-reservation to urban settings to avoid discrimination, homophobia, or violence, and return to potentially spread infections to males and females. The Western conceptualization of sexual orientation has also placed Native lesbian women at risk for violence.[16] Further, the tribal methods of violence intervention have been eliminated and replaced by a criminal justice system that is not always accessible to Native people[16] even though Native Americans are twice as likely as any other racial or ethnic group to be the victim of a crime.[15]

Native persons, particularly those in sexual minority groups, may misuse substances and alcohol. Alcohol and drug abuse problems in the AI/AN population affect adults and youths, and are associated with increased risk of violence and HIV/STD transmission. In one study, 77% of Native participants reported that they had had a problem with alcohol at some point in their lives,[27] and Native youth

report heavy illicit substance use and binge drinking.[26] AI/AN crack addicts who reported high incidences of alcohol use before or during sex had episodes of blacking out after which they learned that they had had unprotected sex with complete strangers.[28] In addition, there are higher rates of drug use among the AI/AN than non-AI/AN population.[13] Further, Native women have a higher percentage of injection drug use as a mode of HIV transmission than any other race.[16] Women who use drugs often trade sex for money or drugs, placing themselves at increased risk for violence and HIV infection.[15] AI/AN men are twice as likely to be categorized as both MSM and injection drug user as other races[9] – designations associated with increased risk for HIV infection. Individuals using injection drugs are typically not reached though traditional interventions and may be disenfranchised from tribes and communities.

Youth, women, and incarcerated Native people face specific challenges that put them at risk for HIV/STD transmission. Given the fact that 24% of AI/AN AIDS patients are below 30 years old, it appears that most contracted HIV in their youth; thus, AI/AN youth are particularly susceptible to HIV infection. Native youth who currently engage in high rates of sex and drug-related behaviors often drop out of school, are unemployed, and may lack access to comprehensive sexuality education. The abuse and neglect of American Indian and Alaska Native communities is a growing concern. [29, 30, 31] Native women experience high rates of partner violence[16] which renders them powerless to negotiate condom use or sexual exclusivity. Women may not be aware of their partners' nonexclusive sexual behavior with other women or men. Further, women may be more biologically vulnerable to HIV/STD infection.[32] Finally, incarcerated Native persons are at further risk due to the high rates of sex and drug-related behaviors in prison and the lack of culturally relevant prevention programs. This is particularly noteworthy given that an estimated 1 in 25 Native persons are incarcerated (approximately 2.4 times the per capita rate for Whites and 9.3 times the per capita rate for Asians, but about one-half the per capita rate for Blacks).[33]

HIV/AIDS in the Native community is clearly situated within a complex web of historical, social, cultural, economic, and health co-factors. Poverty, unemployment, substance abuse, discrimination, and violence all impact the likelihood of HIV/STD transmission within the Native community. For prevention and treatment programs to be maximally successful, this multifaceted context must be carefully considered.

Components *of a Comprehensive Prevention Program*

One of the primary considerations in building any Native health or prevention program is the need to develop a clear understanding of the core cultural values of the community that the program is designed to serve. Taking the time to plan prevention programs with the full input, knowledge, and involvement of community leaders will enhance the potential for cultural sensitivity and the eventual effectiveness of prevention activities. Because respect for ancestral knowledge, current leadership, and the traditional role of elders in decision-making around community health and education issues are common values in many Native communities, it is important to begin planning for HIV/STD prevention activities by building relationships with members of each individual community.

Prevention programs that are developed with respect for cultural values that support the development of healthy relationships and are planned with the investment and ownership of Native community members have been demonstrated to be more successful and sustainable over time.

Utilizing Community Resources

Successful prevention programs for Native communities often look different from programs developed in non-Native communities. While Native programs may contain similar components like outreach, education, counseling and testing, the way that these services are delivered is often strikingly different. For example, programs such as the Navajo Nation's Grandparent Education Program emphasize the cultural value of youth/elder communication and relationships and are relatively unique to Native communities. Community-building and cultural activities also frequently appear as key activities in Native prevention programs, as the need for empowerment and the building of healthy cultural identity and self-esteem are core components of Native health and prevention concepts.

Mentorship programs that strengthen family and community relationships as a way of teaching essential health information and values rely upon the traditional strengths within Native communities to develop professional health resources. The ability to integrate cultural resources and structures into

the prevention program design and planning is a key component of comprehensive and successful HIV/STD prevention planning.

Prevention programs that are planned by members of the target community easily reflect the values and cultural norms of the individuals that the program is intending to serve. Some of the factors that comprise cultural sensitivity and competency are awareness of language, leadership, beliefs, and traditions. Two other factors that comprise cultural sensitivity and competency are limited knowledge of the unique history of a community with non-Native society, and the current social and health problems that the Native Community experiences as a result of contact with non-Native values and norms. Given the current disparities in health status and relative lack of formal health resources in many Native communities, another key component of successful prevention programming is the investment of training and leadership development within the target community to support HIV/STD prevention efforts.

Resources such as the Native American Red Cross Training,[34] the Circle of Life[35] curriculum for youth in Bureau of Indian Affairs (BIA) schools, and many tribal specific curricula are currently being used to train individuals who are acknowledged as having significant roles, both formal and informal, in Native communities. Elders, traditional counselors, natural helpers, spiritual advisors, youth leaders, and educators are being trained to provide HIV/STD information in their communities in holistic approaches to overall community health and wellness. Prevention programs that acknowledge the natural flow of information and leadership with their community have built allies within these traditional networks to create a strong community base for prevention activities.

Programs with active community education components also help prepare other health professionals such as mental health, domestic violence and substance abuse counselors, health educators, community health representatives (CHRs) and other community health providers to reinforce prevention messages for the whole community. From within these specific populations, programs that target specific segments of the community who are more at risk because of their behavior patterns also recruit and train leadership from within these specific populations to be centrally involved in the prevention and education efforts.

Overcoming Obstacles

Challenges frequently faced by programs in the process of developing culturally-relevant prevention programs include the common lack of Native-specific funds, resources, and materials available for HIV/STD

Prevention Interventions and Strategies

- **Peer education (e.g. MSM, injection drug users, women)**
- **Mentorship**
- **Outreach**
- **Information booths and bulletin boards**
- **Counseling and testing (target frequent gathering places)**
- **Skill-building sessions**
- **Support groups**
- **Prevention case management**
- **Needle exchange**
- **Newsletters, chat-lines**
- **Elder/Grandparent education**
- **Media campaigns, PSAs on television and radio**
- **Theater, video, storytelling**
- **Speakers' bureau (e.g. people living with HIV)**
- **Cultural traditions, tribal stories, and legends**
- **Games and active learning**
- **Internet (e.g. prevention information, chat rooms, listservs)**
- **Young people as leaders**

prevention. Diversity within Native communities can also be a challenge, and a key element of a comprehensive program is the ability to span differences in levels of comfort and awareness around issues related to HIV/STD risk. Not all community members within the same tribal group have had the same exposure to cultural values and resources, and many programs serve intertribal communities that reflect a wide variety of Native languages, beliefs and customs.

Programs that train their outreach and prevention workers to respect and connect with members of the target community "just as they are" can build a unique experience of trust and acceptance for Native people in need of cultural support and connection. The Native American AIDS Project in San Francisco is one such program that provides a vital source of cultural connection for people of many tribes in an urban environment.

Programs that use positive, strength-based approaches that are based on specific cultural values and counseling techniques also tend to be more successful in meeting the needs of high-risk community members. Prevention messages that are positive, accepting, and life affirming can help to build an environment of trust that is essential for program staff to begin to address the difficult issues that contribute to a climate of risk, silence, and fear. Conditions within Native communities that reinforce HIV-stigma, homophobia, sexual violence, gender disparities, and domestic abuse also contribute to HIV/STD risk.

It is important to note that not all approaches will work for all segments of the community. Successful comprehensive prevention programs are sensitive and able to grow progressively with the needs and challenges of the target community.

Given the strong value of family and social connectedness in Native communities, another essential element of a comprehensive prevention program is the integration of family, small group, and community-based social education activities into the range of individual services offered. Risk reduction counseling and skill-building opportunities that are based on social learning provide the opportunity for individual community members to share common challenges while providing peer-to-peer information and support. Programs that build community awareness as a step toward reducing personal risk also recognize the need to change social norms that reinforce risk-taking behaviors in a given community.

As confidentiality is listed as the most common barrier to community members accessing prevention services, the ability to create a safe and respectful environment at both the professional and community level is essential to the success of any prevention program. Part of the work of creating safety to support counseling, testing, and risk reduction services is increasing general community awareness and acceptance for the need for HIV/STD prevention. Grassroots education, social marketing, and media campaigns have been used effectively to reduce the amount of fear, stigma, and social taboos around issues related to HIV risk. "Breaking the Silence: Strengthening the Spirit" is a recent social marketing and video project that addresses HIV/AIDS stigma in Alaska Native communities. (For more information, contact the Alaska Native Health Board at www.anhb.org.)

Prevention messages that are visual, creative, and relevant for the community that they are designed for tend to be more effective in starting conversation and shifting perspectives. In creating community awareness and prevention messages it is important to understand the context for HIV/STD risks by assessing community knowledge, attitudes, beliefs, and behaviors for specific risk groups as well as the general population. Elders, community leaders and Native celebrities who have the trust and respect of their communities make natural spokespersons. Speakers that use traditional storytelling often can effectively touch the heart of a community to inspire positive changes in attitudes and behaviors.

Native people who are HIV positive or who have other STDs and their family members can offer much as public speakers. Programs that foster an

Possible Venues for Strategy Implementation

- > Pow Wows
- > Sweats
- > Dances
- > Casinos
- > Bingo halls
- > WIC offices
- > Family planning centers
- > Cultural retreats
- > Community dinners, house parties, potlucks
- > Drop-in centers
- > Teen centers (e.g. Boys/Girls Clubs, juvenile facilities)
- > Sports programs and clubs
- > Battered women shelters
- > Employment training centers
- > Schools
- > Healthy Start
- > Women's groups
- > Tax centers
- > Public sex environments
- > Prisons
- > Hospitals and treatment centers
- > Homeless shelters
- > Soup kitchens
- > Shooting galleries
- > Sporting events

environment of safety by building public family and community support for HIV positive individuals reinforce the traditional Native values of inclusion, care, and respect that are necessary to mobilize communities to provide better care. Programs that provide integrated prevention services have also learned that providing quality care and social support for HIV positive individuals is an essential part of providing long-term prevention for other members of the community.

Using Theory in Prevention Programming

One of the indicators of success of prevention programs is the strength of the underlying social, behavioral, and cultural theories that those programs are based upon. Many Native programs have developed their own unique models for providing prevention services that are based on the specific cultural needs and considerations of their target community. Whether prevention models are adapted or uniquely developed, it is important to make sure that these models are successfully meeting the prevention needs of the target community. Part of developing a strong theoretical basis for prevention is the need to provide adequate training for both front line staff and administrators to ensure that the program is being applied as intended. Program evaluation information can also be a valuable part of adjusting program

components to continuously improve the success and relevance of the prevention efforts.

Given that very few commonly used and evaluated HIV/STD prevention models and/or behavioral theories have been developed for work in Native communities, there is a need for culturally-based programs to demonstrate success and clearly communicate with funding sources and policy makers the underlying theory that makes their program activities successful. Models based on empowerment theory have been successfully adapted for Native MSM by such groups as the Navajo Nation AIDS Network and Utopia Hawaii. Native programs that have demonstrated their success in changing risk behaviors in their target communities serve as strong models to support the development of culturally relevant prevention programming, such as the Tulsa Area Two-Spirit Society program at the Indian Health Care Resource Center in Tulsa, Oklahoma.

Individual Counseling and Harm Reduction Services

In addition to community-building, awareness, and education services, fundamental to a successful prevention program are individual counseling and harm reduction services. Again, the ability to build trust with the target community is essential for active participation. One consideration is commitment on the part of prevention programs to recruit, train, and hire staff and program volunteers who have the trust and respect of the target community. Often this involves hiring Native program staff who closely reflect the makeup of the target community. Due to issues of confidentiality, some programs have recognized that many members of their target community would prefer to utilize services at non-Native clinics and programs and have built successful referral resources for HIV/STD testing and treatment.[36] Other programs have found that their community members prefer to receive HIV counseling and testing from Native providers. This has challenged programs to build the capacity for culturally-sensitive and confidential testing at local tribal clinics, and to train outreach workers and peer providers to offer counseling and testing services in the field.

Outreach and peer prevention workers often play a pivotal role in Native communities, having the unique ability to build trust and create a bridge for services to individuals who would not otherwise be receiving prevention or care. Again, the need to provide comprehensive training for outreach workers and peer providers is essential to build the level of skill needed for successful risk reduction work.

Prevention Case Management (PCM) is another intervention that has been successfully applied in Native clinics and communities to work with community members who are concerned about their HIV risk and status. PCM, as developed by urban programs like the Native American Pathways Program in Phoenix and the Native American Health Center in San Francisco, is based on intensive social support, risk reduction, partner counseling, and referral services. Rural clinics have utilized CHRs to provide PCM services as a part of the overall system of health care.

Considering the Context for AIDS/STD Prevention

Another key component of a truly comprehensive and effective prevention program is the ability to address social and structural issues that contribute to HIV/STD risk. Factors that frequently contribute to environments of risk in communities of color include institutionalized racism, homophobia, sexual violence, and gender and health disparities. It is important to emphasize that behaviors put people at risk, not sexual orientation, and that HIV/AIDS is more than a "gay man's disease" as commonly perceived.

Factors that uniquely impact Native communities also include lack of recognition and respect for tribal sovereignty and the constant challenge of self-governance within the larger context of federal and state policies. Prevention programs that include a leadership component not only build skills in a community to reduce the health impacts of these societal issues, but also support community members in developing the action and advocacy skills needed to change fundamental policies and institutions that negatively affect Native people's health. Part of this leadership development includes the ability to recognize and resolve conflicts within Native communities that present barriers to cooperation and effective collaboration between community stakeholders, agencies, and programs.

Because many gaps exist in the funding and support available to Native communities for HIV treatment and prevention, programs that focus on positive relationship building between tribes, health departments, and other state resources often benefit in the long run. Often there is also a need to build support for HIV/STD prevention at the tribal and intertribal councils that set health policies and priorities, and urban communities constantly face the challenge of advocating for basic funding and recognition of the need to

provide culturally relevant care for urban Natives. Regional coalition building and the development of Native task force groups to address prevention and care issues have been successful strategies for maximizing HIV/AIDS resources, closing many gaps in services and improving overall access to care for Native community members.

Implementing
A Comprehensive Prevention Program

General Guidelines for Successful Program Implementation

- > Assess needs/assets
- > Develop plan
- > Pilot test
- > Implement plan
- > Evaluate outcomes
- > Revise activities
- > Re-implement

Community Needs Assessment
The first step for successful planning and implementation of a comprehensive prevention program is to engage in a participatory community planning process. This includes starting the planning process by gathering essential information about current community needs, risk behaviors and assets. An initial capacity-building grant can provide the seed money to support prevention planning activities which include gathering background data on general health/prevention issues and preparing for a community-level needs assessment. In addition to assessing risk behaviors and needs, it is also important to assess the general community awareness of HIV and involve the community in planning and implementing assessment activities. Given the geographic mobility of Native communities, migratory populations (e.g. Native people living on rural reservations close to urban centers or border towns) should also be included in community needs assessment. To enhance community participation, it is important to seek out and engage credible and respected members of the focus community who would be good advocates. These individuals can also help to create links for introducing the need and plan the program to community groups and health councils. Respecting tribal sovereignty, programs also need to be aware of protocols and seek formal approval before gathering information of any kind directly from tribal members.

In many states, prevention programs have encountered significant barriers in

obtaining accurate epidemiological data for their community due to the gaps in incidence reporting, lack of testing services, and frequent misclassification of Native peoples. Some strategies for overcoming these barriers include gathering information on health factors and indicators that coincide with HIV and STD risk, including rates of hepatitis, teen pregnancy, domestic violence, substance abuse, incarceration, homelessness, and socio-economic status. In gathering background data, existing resources like population data and disease surveillance information are frequently available at the state and federal level. (For more information, see the Native Grant Support Center at www.nnaapc.org.)

Many public schools, including BIA schools, conduct teen behavioral risk surveys that can be used as credible sources of supplemental information. Tribal clinics can also be a good source for local information that may not be reflected in state and federal records. This information will be helpful in identifying the specific behavioral risks and geographic areas that should be targeted in the planning of a community-level needs assessment. The American Indian Community House in New York is an example of a Native program that conducted a comprehensive community behavioral risk survey to develop effective strategies for prevention planning. (For more information, see the American Indian Community House at www.aich.org.)

Including community members, such as key elders, in the planning and implementation phases of the survey increases the level of trust and participation, as well as the sensitivity of the assessment process to the cultural and demographic needs of the target community. In addition to assessing behavioral risks and needs, many programs have also found it necessary to assess the strengths and assets of the target community to provide the basis

Target Populations

Prevalence data and social circumstances suggest that certain individuals may be at greater risk for HIV/STD infection in many Native communities. Prevention interventions might target those populations.

- **Women**
- **Youth**
- **Men who have sex with men**
- **Transgender individuals**
- **Injection drug users**
- **HIV-positive persons**
- **Sex workers**
- **Incarcerated individuals**
- **Migrant populations**
- **Homeless persons**
- **Urban and rural populations**

for effective program development. Prevention programs that are based on resiliency models often use holistic approaches to assessment, which include information on the traditional resources, knowledge, and structures that could support the implementation of a successful program. Holistic assessments, or assets mapping, also gather information on the context in which the need for prevention services exists, including efforts in the community and the efforts of non-Native programs serving the community. Unique factors that also impact HIV risk in Native communities include rural to urban migration patterns and seasonal events and activities that can influence the level of risk-taking behaviors for community members over time.

Once the general HIV/STD prevention needs of the community have been assessed and priority populations have been identified by specific behavioral risk categories, the next step is to get to know the cultures of these priority populations in greater depth. Some risk populations can be hard to access directly, and it may require targeted ethnographic research to begin to identify social networks, gathering places, and leadership within the specific risk communities. Certain populations, such as injection drug users and non-identified MSM, may not want to be openly identified due to the stigma attached to their risk behaviors. Sensitivity to the need for safety and confidentiality is essential for conducting this level of research. Again, it is important to recruit members of the target community to be part of the planning process. This is likely to increase the successful participation of individuals at high behavioral risk in focus groups, key informant interviews, and supplemental surveys.

The final level of the assessment process is to gather data on prevention efforts that have been designed to meet the needs of these priority populations. The history of programs, both past and present, will provide essential information about lessons learned. In addition to evaluation information from model programs that have demonstrated success in reducing the HIV/STD risk of program participants, programs that have not been so successful can also provide rich information about the specific prevention needs of the target community.

Prevention interventions and program models used by other programs can stimulate ideas for design of a comprehensive program plan (e.g. CDC's *Compendium of HIV Prevention Interventions with Evidence of Effectiveness* at www.cdc.gov/hiv/pubs/hivcompendium/HIVcompendium.htm). Social service and other health-related programs that work with

the priority population may also be key sources of information and potential partners for effective HIV/STD prevention strategies (e.g. foodbanks, shelters, primary care, substance abuse and mental health providers, school programs, businesses frequented by risk community).

Program Design and Implementation

To ensure that the process of program development is driven by the community, an important activity is to develop a community advisory committee or planning task force with diverse members, including tribal leadership, key stakeholders in the community, members of the target community, professional resources, staff of programs with experience in working with target communities, and representitives from potential resources for collaboration. The ideal process would be to gather data from the needs assessment and to review it with a community advisory group prior to setting priorities, identifying funding sources, and developing grant proposals. A clear understanding of the needs of the target community will assist proposal writers in developing realistic prevention goals and strategies, which in turn will enhance the likelihood of successful funding and program implementation.

In addition to meeting with the advisory committee in the development process, it is also helpful to host community dinners and/or town hall meetings to discuss prevention needs with the broader community. Raising general awareness will bring in additional information and build support for the program in the implementation phase. A common barrier for many programs has been the lack of experienced grant proposal writers within Native communities. If the person with grant proposal writing skills is not someone who is knowledgeable about the community, the education process needs to be a two-way exchange of information to avoid designing a program that is not useful for the target community. Working closely with community members, program developers need to understand prevention models that are based on cultural concepts and be able to articulate clearly the viability of these models to potential funding sources. Community-level training is also important for supporting the growth of leadership skills within the target community for active participation in advisory groups and task force meetings.

Communities that invest in capacity-building activities and do extensive background research and planning strengthen their ability to develop competitive proposals. The capacity-building activities in preparation for the program implementation phase can include initial training to build skills at the grassroots level within the commu-

nity. Skill-building opportunities are essential for supporting successful recruitment of potential staff for prevention interventions. Information from the needs assessment will help to match the needs and preferences of the target population with the resources available to the prevention staff within a given community. Sometimes the best prevention interventionists are volunteers, peer prevention workers recruited from the community, or friends and family of people living with HIV/AIDS. Elders, cultural leaders, spiritual advisors, teachers, parents, and youth leaders can all be potential prevention resources. Many programs have developed special training opportunities to enhance the role of community members in prevention, like the Youth and Elder HIV Education Summits held by the Great Lakes Intertribal Council in Wisconsin.

Once sufficient funds have been secured and a plan for recruitment of core staff has been developed, the task of marketing program services to potential participants begins. While building trust with the target community, program staff and volunteers need to be visible, and continue to demonstrate a level of comfort with risk-taking behaviors and environment. The time required to build trust can easily be under-estimated for new services, particularly when working with marginalized segments of the community. Program developers need to build in realistic time and resources for relationship building. Recruitment of the most effective staff members is more likely to ensure the success of the program intervention. Established links to members of the target community are a key consideration for hiring. Program deliverers should be respected in the community and comfortable with their role in discussing HIV/STD risk behaviors. Ongoing training is often needed to support effective prevention skills and will ultimately enable staff members to address sensitive topics with the target population.

Another aspect of relationship building is the need to network with service providers and programs that also work with the target community. Making connections with persons working in other health areas, such as teenage pregnancy, unplanned pregnancy, pregnancy health care, violence prevention, mental health care, drug abuse, and infectious diseases, can enhance program effectiveness and facilitate access to community resources. In order to meet the multiple needs of program participants, prevention workers will need to develop a resource and referral listing.

Developing personal relationships with the staff of key referral sources will enhance the participant linkage to services. Building a network of programs with support services for the target community can also bring

potential partners into collaboration for stronger prevention overall. Developing a list of volunteers and recruiting presenters for a speakers' bureau are additional ways to strengthen resources for successful program implementation. Mentoring HIV positive persons to become active outreach workers, educators, and motivational speakers is another way of supporting prevention activities.

Prevention messages need to be carefully crafted to be relevant for the culture, age, and gender of the target population. Social marketing and media materials can create general awareness and develop the foundation for risk reduction work and HIV/STD testing campaigns. Prevention messages and outreach materials should be developed with active consultation with the target community. Again, focus groups and consumer response to prevention messages and materials are important ways of guiding media and materials development. Tribal language and concepts and use of local variations of the English language can make prevention messages more relevant and meaningful. Providing up-to-date information about risk factors and behaviors and presenting factual data are ways of increasing personal awareness of HIV/STD risk.

In many Native communities, the use of visual materials that reflect specific tribal images is a preferred prevention strategy. Local music, images, and values can increase the community's identification with materials. The use of tribal legends and stories is also a common prevention strategy, as demonstrated by the Warm Springs

Cultural Competence and HIV/AIDS Prevention[37]

- **Partner with local AI/AN people by creating community advisory groups and steering committees**
- **Seek tribal organizational support for all research and program activities**
- **Invite and support the community control of programs in order to improve quality, ensure the longevity and create a sense of ownership**
- **Use formative evaluation including focus groups and ethnographic work**
- **Incorporate traditional values and healing practices in the intervention**
- **Recruit interventionists from the community**
- **Utilize traditional and religious consultants**
- **Use tribal language or localized variations of English**
- **Incorporate traditional, visual and participatory activities into prevention**
- **Develop simple interventions**

Tribal Community Health Education Program. Some programs have used traditional creation stories and teachings to support prevention education, while other programs have developed contemporary stories that reflect cultural values around relationship building, protection, and respect. Use of humor and creative theater productions, such as the Ogitchidag Players of the Indigenous People's Task Force in Minneapolis, can be fun ways of engaging youth in HIV/STD education, as are the use of games and interactive learning opportunities. Peer education and mentorship programs provide another opportunity for social support and learning and empower participants as they strive to reduce personal and peer community HIV/STD risk.

Harm reduction models that accept program participants at their current level of risk behavior are frequently used by prevention workers. Monetary and material incentives have also been useful in engaging hard to reach individuals who may not have at the present time a strong internal motivation for reducing their risk. Hosting community dinners and feeds are good ways of gathering people, as are cultural activities and recreational events enjoyed by members of the target community. Outreach at house parties, pow wows, and forty-nines can be effective ways of reaching members of high-risk populations.

Another effective outreach is visiting bars and businesses frequented by Native people in urban areas and border towns. Getting to know the popular public sex and drug environments can be the key to introducing risk reduction supplies to high-risk individuals. The goal is to build relationships to support harm reduction activities as contact with program participants continues.

Program Evaluation

During the course of program implementation, staff and community members should meet regularly to pilot test, revise, and refine prevention strategies. Program evaluation activities support program improvement over time by recording what does and does not work, and by providing valuable opportunities to share successes of prevention efforts with community members and funding sources. With the lack of Native-specific program models that have been demonstrated as effective in reducing risk behaviors over time, program evaluation has become increasingly important for identifying best practices models to facilitate prevention efforts across the country.

As requirements for securing and maintaining HIV/STD prevention funding have become more competitive for communities of color in recent years, the role of program evaluation has also become more important. A

core component of program implementation and design is the ability to conduct process evaluation to document the way in which a program is implemented, outcome evaluation to measure the success of specific program goals and objectives, and impact evaluation to demonstrate the effect that the program has had on changing risk-taking conditions and behaviors. Data can be collected qualitatively, such as conducting focus groups, community forums, key informant interviews, pilot sessions, observation, and case study information. Program evaluation information is also gathered through quantitative data collection which includes administrative records, community risk assessment and health outcome indicators, and through pre- and post-test surveys. Data from the initial community needs assessment can be compared to later studies, as a way of showing the progress of efforts in a particular community with the final marker of success being a significant reduction of HIV/STD incidence and associated co-factors in risk communities over time.

Like other aspects of program development, the need for cultural understanding and competence is essential for designing effective evaluation activities. As with other forms of research in Native communities, it is important to remember that the community members are truly the experts on their own health conditions and experiences. Program evaluators should be prepared to engage with community advisory members, as well as program staff and administrators, in dynamic and respectful partnerships. The benefits of program evaluation

Recommendations for HIV/AIDS Research in Native Communities[38]

- **Research should come from within the community and have support from community leaders.**
- **Community members should be viewed as the "experts."**
- **Research needs to operate within the cultural framework of the participant's tribe(s) to validate best practices models.**
- **Culturally competent research methods need to be used to develop models that are Native in design, implementation, evaluation and interpretation.**
- **Research partners need to demonstrate commitment to cultural competence in order to establish trust.**
- **Research partners should clearly provide information to the community about the benefits of participating in research.**
- **Native scholars and community members need to be trained in research methods in order to develop effective partnerships.**

also need to be clearly communicated to all those involved, and ways in which program evaluation information can be shared with invested parties should also be clearly established.

To facilitate the greatest health outcomes, the cultural context of the program delivery should be preserved in the evaluation methods as much as possible. Applying established cultural practices to research and evaluation methods includes the effective use of talking circles, storytelling, and the observation of community gatherings for qualitative data collection. The ability of program evaluators to facilitate program participants sharing what they experienced as a result of program participation "in their own words" helps to build an evaluation report that utilizes the power of oral tradition and the telling of community stories to provide guidance for future generations on how health conditions can be successfully met and changed.

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Appendix A
*Directory of Exemplary Prevention Programs**

State: Alaska

Sponsoring Organization:
Alaska Native Health Board

Name of Program:
HIV/AIDS Prevention Program

Description of Program: Engages community members and leaders to determine how they want to deal with HIV/AIDS; promotes statewide media products that are culturally specific yet applicable to others; promotes and develops HIV prevention activities tailored to community needs; provides outreach to Native American women in institutions and to Native American MSMs

Model(s) for Program: Community empowerment and mobilization model used to increase awareness for need to be tested; Partners in Prevention Women's Edition curriculum in substance abuse; Popular Opinion Leader to access Native American MSMs

Target population: Rural residents with a Native American focus; Native American women in institutions; Native American MSMs

Geographical Area(s) Served: Urban and rural areas

Number of Clients: 600 members in the community and women's programs; 50 MSMs

Types of Intervention Provided
Individual Level: Yes
Group Level:
Community Level: Yes
Counseling and Testing:
Outreach, Health Education, etc.: Yes
Case Management and Referrals: Yes

Support Materials: PSA flyers; a training manual; brochure and website under development

Sources of Funding: CDC; state health department

Staff Resources
Full-time:
1 project manager

*** Information current at time of printing.**

1 project coordinator
1 outreach worker
Part-time:
1 outreach worker
Volunteers:

Years in Operation: 35

Program Contact Information:
Michael Covone
Alaska Native Health Board
Anchorage, AK
Phone: 907-743-6108

State: Alaska

Sponsoring Organization:
Alaska Native Tribal Health Consortium

Name of Program:
Ryan White/Title III Early Intervention Services

Description of Program: Specialty clinic and case management; 4 hub sites

Model(s) for Program:

Target Population: High-risk patients and interested community members

Geographical Area(s) Served: Urban and rural areas

Number of Clients: 70

Types of Intervention Provided:
Individual Level:
Group Level:
Community Level: Clinic
Counseling and Testing:
Outreach, Health Education, etc.: Yes
Case Management and Referrals: Yes

Support Materials: Provider brochure; patient brochure; website under development

Sources of Funding: Ryan White Title III Funds

Staff Resources:
Full-time: 1
Part-time: 1
Volunteers:

Years in Operation: less than one year

Program Contact Information:
Terry Bramel
Alaska Native Health Board
Anchorage, AK
Phone: 907-729-2907

State: Arizona

Sponsoring Organization:
Native American Community Health Center, Inc.

Name of Program:
Native American Pathways

Description of Program: Provides healthcare services including medical/family practice, dental/orthodontics clinics, health promotion, disease prevention, senior programs, diabetes, wellness, behavioral health, substance abuse treatment, and HIV care and prevention

Model(s) for Program: Prevention case management; best practices for case management empowerment; trainees empowerment model; harm reduction model; outreach/empowerment model

Target Population:
MSMs; transgendered (TG) individuals

Geographical Area(s) Served:
Primarily urban

Number of Clients:
150 case management;
1000 outreach

Types of Intervention Provided:
Individual Level: Yes
Group Level: Yes
Community Level:
Counseling and Testing: Yes
Outreach, Health Education, etc.: Yes
Case Management and Referrals: Yes

Support Materials: A training manual and promotional materials

Sources of Funding: Indian Health Services Title V AIDS grant; CDC CTR Program; CDC GMOC CBO Program; Substance Abuse Mental Health Services Administration (Substance Abuse) Prevention Case Management and Youth Empowerment

Staff Resources:
Full-time: 8
Part-time: 2
Volunteers: Yes

Years in Operation: 25

Program Contact Information:
Craig Pattee
Native American Community Health Center, Inc.
Phoenix, AZ
Phone: 602-279-5262

State: Arizona

Sponsoring Organization:
Navajo Nation AIDS Network, Inc.

Name of Program:
Navajo AIDS Network, Inc.

Description of Program: Provides culturally appropriate service; outreach in bars and at booths at fairs; floats

in parades; HIV prevention; case management; testing and counseling

Model(s) for Program: Revised version of the Mpowerment model

Target Population: MSMs; high-risk heterosexuals; substance abusers

Geographical Area(s) Served: Primarily urban

Number of Clients: 5000 prevention; 97 case management

Types of Intervention Provided:
Individual Level: Yes
Group Level: Yes
Community Level:
Counseling and Testing: Yes
Outreach, Health Education, etc.: Yes
Case Management and Referrals: Yes

Support Materials: Brochures and outreach training manuals; prevention manual under development

Sources of Funding: Arizona State Health Services (HIV Prevention), Arizona State Health Services (HRSA/Ryan White Care Act Title II; Case Management), Health Resources Services Administration (HRSA); Special Projects of National Significance (SPNS), New Mexico Department of Health; HIV Prevention, New Mexico Department of Health; Ryan White Care Act Title II - Case Management, National Minority AIDS Education Training Center (NMAETC) – Capacity Building Assistance.

Staff Resources:
Full-time: 6
Part-time: 1
Volunteers: 2

Years in Operation: 13

Program Contact Information:
Melvin Harrison
Navajo AIDS Network, Inc.
Chinle, AZ
Phone: 520-674-5676

State: Arizona

Sponsoring Organization:
Phoenix Indian Medical Center

Name of Program:
HIV Center of Excellence

Description of Program: Provides community-based prevention and care through 127-bed medical center with 900 employees

Model(s) for Program:
Health care model

Target Population: All ages of the Navajo population; specific focus on youth and at-risk individuals

Geographical Area(s) Served: Urban and rural

Number of Clients: 110

Types of Intervention Provided:
Individual Level: Yes
Group Level:
Community Level: Yes
Counseling and Testing: Yes
Outreach, Health Education, etc.: Yes
Case Management and Referrals:

Support Materials: A business plan

Sources of Funding: Federal and state grants

Staff Resources:
Full-time:
2 case managers; 1 director
Part-time:
Volunteers:

Years in Operation: 13

Program Contact Information:
Erica Avery
Phoenix Indian Medical Center
Phoenix, AZ
Phone: 602-263-1502, ext. 1541

State: Arizona
Sponsoring Organization:
Tucson Indian Center

Name of Program:
4-in-1 Health Promotion Program

Description of Program: Provides HIV prevention education, prevention case management, and referral services

Model(s) for Program:

Target Population: Youth from age 10; high-risk adults; IDU and substance abuse users

Geographical Area(s) Served:
Primarily urban and some rural areas

Number of Clients: 200 case management; 500 through presentations and health fairs

Types of Intervention Provided:
Individual Level: Yes
Group Level: Yes
Community Level: Yes
Counseling and Testing: Yes
Outreach, Health Education, etc.: Yes
Case Management and Referrals: Yes

Support Materials:
Promotional materials
Sources of Funding:
Indian Health Service Grant; 4-1 Health Promotion Program

Staff Resources:
Full-time: 2 community health administrators; 1 administrator
Part-time:
Volunteers:

Years in Operation: 40

Program Contact Information:
Jocelyn Salt
Tucson Indian Center
Tucson, AZ
Phone: 520-884-7131

State: California

Sponsoring Organization:
American Indian Health Services

Name of Program:
American Indian Health Services

Description of Program: Early referrals for HIV positive persons

Model(s) for Program:

Target Population: All Native Americans

Geographical Area(s) Served: Greater Santa Barbara, California area

Number of Clients: 2000 counseled

Types of Intervention Provided:
Individual Level: Yes
Group Level:
Community Level:
Counseling and Testing: Yes
Outreach, Health Education, etc.:
Case Management and Referrals: Yes

Support Materials:

Sources of Funding: Indian Health Service grant

Staff Resources:
Full-time: 1 coordinator; 2 counselors/social workers HIV certified
Part-time:
Volunteers:

Years in Operation: 4

Program Contact Information:
William Martin
American Indian Health Services
Santa Barbara, CA
Phone: 805-681-7356

State: California

Sponsoring Organization:
Native American AIDS Project

Name of Program:
Native American AIDS Project

Description of Program: Utilizes traditional healers to meet the needs of clients who have been ostracized from communities or families of origin because of substance abuse or sexual orientation; provides prevention case management, individual risk reduction, counseling, talking circles, venue-based street and group outreach, traditional healing, and community events

Model(s) for Program: Behavioral modification; harm reduction model

Target Population: MSMs, TGs, and all at-risk Natives (IDU, substance abusers, young men and women, homeless, marginally housed)

Geographical Area(s) Served:
Primarily urban and a few visits to reservation and rancheria communities

Number of Clients: 80

Prevention Case management clients; 120 individual risk reduction counseling clients; 50 talking circle clients; 85 HIV case managed clients

Types of Intervention Provided:
Individual Level: Yes
Group Level: Yes
Community Level: Yes
Counseling and Testing: Yes
Outreach, Health Education, etc.: Yes
Case Management and Referrals: Yes
Traditional Healing: Yes

Support Materials: Promotional materials; workshop curricula; Native American specific prevention literature

Sources of Funding: CDC; Clean Family Foundation; California Endowment; Care Title 1 Funding; Individual donors

Staff Resources:
Full-time: 7
Part-time: 3
Volunteers: 25

Years in Operation: 9

Program Contact Information:
Joan Benoit
Native American AIDS Project
San Francisco, CA
Phone: 415-777-4290

State: California

Sponsoring Organization:
Native American Health Clinic

Name of Program:
HIV Testing and Counseling Program

Description of Program: Provides prevention case management and prevention for HIV positive persons; offers full range of community

health services

Model(s) for Program: Stages of Change model

Target Population: Any client who has been involved in risky behavior

Geographical Area(s) Served: San Francisco, Oakland and surrounding suburban areas

Number of Clients: 250

Types of Intervention Provided:
Individual Level: Yes
Group Level:
Community Level: Yes
Counseling and Testing: Yes
Outreach, Health Education, etc.: Yes
Case Management and Referrals: Yes

Support Materials: Brochures

Sources of Funding: Indian Health Program via the State of California

Staff Resources:
Full-time: 1 RN; 9 counselors
Part-time:
Volunteers:

Years in Operation: 31

Program Contact Information:
Native American Health Clinic
San Francisco, CA
Phone: 415-621-4371

State: California

Sponsoring Organization:
United American Indian Involvement

Name of Program:
HIV Prevention Program

Description of Program: Provides risk reduction counseling; outreach and encounters; peer health education for youth; group level interventions; and referrals for testing

Model(s) for Program: CDC prevention guidelines; various health education theories

Target Population: All genders and ages over 12; medium to high-risk populations

Geographical Area(s) Served: Service Planning Area 4 of the greater Los Angeles metropolitan area

Number of Clients: 75-100

Types of Intervention Provided:
Individual Level: Yes
Group Level: Yes
Community Level:
Counseling and Testing: Yes
Outreach, Health Education, etc.: Yes
Case Management and Referrals: Yes

Support Materials:

Sources of Funding: Los Angeles County office of AIDS Programs and Policy

Staff Resources:
Full-time: 4
Part-time:
Volunteers:

Years in Operation: 29

Program Contact Information:
Stephanie Sam
United American Indian Involvement
Los Angeles, CA
Phone: 213-202-3970

State: Hawaii

Sponsoring Organization:
Hawaii Island HIV/AIDS Foundation

Name of Program:
Big Island AIDS Project

Description of Program: Provides outreach and individual counseling as well as prevention services through community events

Model(s) for Program:
Harm reduction model

Target Population: HIV+; MSMs; MSMs/IDUs; TGs; high-risk women

Geographical Area(s) Served:
Rural; the entire east side of the Island of Hawaii

Number of Clients: 1,400

Types of Intervention Provided:
Individual Level: Yes
Group Level:
Community Level: Yes
Counseling and Testing: Yes
Outreach, Health Education, etc.: Yes
Case Management and Referrals: Yes
Traditional Healing:

Support Materials: Brochures

Sources of Funding: CDC

Staff Resources:
Full-time: 1
Part-time: 3
Volunteers:

Years in Operation: 12

Program Contact Information:
Lenard Allen
Hawaii Island HIV/AIDS Foundation
Hilo, HI
Phone: 808-981-2428

State: Hawaii

Sponsoring Organization:
Ke Ola Mamo, Honolulu

Name of Program:
Lei Avenue HIV Prevention Program

Description of Program: Safer sex counseling; mentoring program/services for TG youth; basic survival skills, life management skills, name changes; Orasure testing and counseling; outreach; individual and group level intervention

Model(s) for Program: TG youth mentoring project to increase knowledge of HIV and substance abuse prevention (SAP), basic life management skills; cultural classes to decrease HIV/SAP infection and increase employment

Target Population: TG youth ages 14-26; sex workers; substance abusers

Geographical Area(s) Served: Rural
Number of Clients: 40

Types of Intervention Provided:
Individual Level: Yes
Group Level: Yes
Community Level:
Counseling and Testing:
Outreach, Health Education, etc.: Yes
Case Management and Referrals:
Traditional Healing:

Support Materials:
Mentor's Curricula

Sources of Funding: The Substance Abuse and Mental Health Services Association (SAMHSA)

Staff Resources:
Full-time: 4
Part-time:
Volunteers:

Years in Operation: 11

Program Contact Information:
Ke Ola Mamo, Honolulu
Honolulu, HI
Phone: 808-550-0885

State: Hawaii

Sponsoring Organization:
Malama Pono, Kauai

Name of Program:
Malama Pono HIV Prevention Program

Description of Program: Primary prevention for HIV+ persons; harm reduction; individual level interventions; prevention case management; partner counseling and referral services

Model(s) for Program: Harm reduction model; individual level intervention uses the Stages of Change model

Target Population: MSMs; women at risk; TGs at risk

Geographical Area(s) Served: Rural

Number of Clients: 400

Types of Intervention Provided:
Individual Level: Yes
Group Level:
Community Level:
Counseling and Testing: Yes
Outreach, Health Education, etc.: Yes
Case Management and Referrals:
Traditional Healing:

Support Materials:

Sources of Funding: CDC grant via Department of Health

Staff Resources:
Full-time: 2
Part-time: 2
Volunteers: 7

Years in Operation: 8

Program Contact Information:
Jason Yaris
Malama Pono, Kauai
Lihue, HI
Phone: 808-246-9577

State: Hawaii

Sponsoring Organization:
Maui AIDS Foundation

Name of Program:
Maui AIDS Foundation

Description of Program: Provides prevention education; volunteering opportunities; housing assistance; and financial assistance

Model(s) for Program: API support network uses an employment model; Hot Health and Keeping It Up

Target Population: Prevention with Positives; MSMs; IDUs; MSMs/IDUs; women at risk; TGs at risk; youth at risk

Geographical Area(s) Served: Rural

Number of Clients: 8,000-10,000

Types of Intervention Provided:
Individual Level: Yes
Group Level:
Community Level:
Counseling and Testing: Yes
Outreach, Health Education, etc.: Yes
Case Management and Referrals: Yes
Traditional Healing:

Support Materials:
Mentor's Curricula

Sources of Funding: Hawaii State Department of Health (CDC)

Staff Resources:
Full-time: 9
Part-time:
Volunteers:

Years in Operation: 17

Program Contact Information:
Dean Wong
Maui AIDS Foundation
Wailuku, HI
Phone: 808-242-4900, ext. 113

State: Idaho

Sponsoring Organization:
North Idaho AIDS Coalition

Name of Program:
Milestone

Description of Program: Provides HIV prevention for those at risk; prevention case management; and prevention for HIV+ clients

Model(s) for Program: Motivated interviewing and improvising

Target Population: MSMs; IDUs; women at risk

Geographical Area(s) Served: Five northern counties: Bennewah, Bonner, Kootenai, Boundary, and Shoshone

Number of Clients: 12 for PCM

Types of Intervention Provided:
Individual Level: Yes
Group Level:
Community Level:
Counseling and Testing:
Outreach, Health Education, etc.: Yes
Case Management and Referrals: Yes
Traditional Healing:

Support Materials: Mentor's Brochure on Milestones

Sources of Funding: CDC via the Department of Health; United States Public Health Service (USPHS); Health Resources and Services Administration (HRSA)

Staff Resources:
Full-time: 2
Part-time:
Volunteers: 3

Years in Operation: 9

Program Contact Information:
John Carollo
North Idaho AIDS Coalition
Coeur'd Alene, ID
Phone: 208-665-1448

State: Maine

Sponsoring Organization: Wabanaki Mental Health

Name of Program: Wubbubnockeig

Description of Program: Provides counseling and training; community education; and prevention

Model(s) for Program:

Target Population: Native Americans age 13 and over; MSMs; IDUs; heterosexuals HIV+

Geographical Area(s) Served: Rural, urban, reservation

Number of Clients: 12 counseling and training; 200 outreach/education

Types of Intervention Provided:
Individual Level: Yes
Group Level:
Community Level: Yes
Counseling and Testing: Yes
Outreach, Health Education, etc.: Yes
Case Management and Referrals:
Traditional Healing:

Support Materials: Brochure
Sources of Funding: SAMHSA

Staff Resources:
Full-time: 1
Part-time: 1
Volunteers: 1

Years in Operation: 3

Program Contact Information:
Sharon Toma
Wabanaki Mental Health
Bangor, ME
Phone: 207-990-0605

State: Michigan

Sponsoring Organization:
Sault Tribe Health & Human Services Center

Name of Program:
Health Advisory Program

Description of Program: Provides HIV counseling and testing using Orasure; HIV awareness via presentations/education materials including condoms; and case management for HIV+ clients

Model(s) for Program: Peer Opinion Leader model

Target Population: All at-risk populations; MSMs; IDUs; high risk heterosexuals in all racial categories including Native Americans

Geographical Area(s) Served: Reservation and rural communities; some urban

Number of Clients: 12 prevention case management clients, 20,000 through outreach; 250 counseling and testing referrals

Types of Intervention Provided:
Individual Level: Yes
Group Level:
Community Level:
Counseling and Testing: Yes
Outreach, Health Education, etc.: Yes
Case Management and Referrals: Yes
Traditional Healing:

Support Materials: Promotional pamphlets

Sources of Funding: State Department of Community Health; Michigan AIDS funds; Tribal source; Ryan White Care funding

Staff Resources:
Full-time: 1
Part-time: 1
Volunteers:

Years in Operation: 11

Program Contact Information:
Larry Kline
Sault Tribe Health & Human Services Center
Sault Ste. Marie, MI
hone: 906-632-5265

State: Minnesota

Sponsoring Organization:
Indigenous People's Task Force

Name of Program:
Two Spirit Risk Reduction

Description of Program: Provides HIV/STD risk reduction prevention; street outreach; health education; and individual and group intervention

Model(s) for Program: Created own model from existing one modified for cultural appropriateness

Target population: Native MSMs

Geographical Area(s) Served: Primarily (70%) urban Minneapolis and 30% rest of the state

Number of Clients: 500 contacts at bars; 2500 outreach at Pow Wows; 100 through ILIs; 9 via PCM

Types of Intervention Provided:
Individual Level: Yes
Group Level: Yes
Community Level: Yes
Counseling and Testing: Yes

Outreach, Health Education, etc.: Yes
Case Management and Referrals: Yes
Traditional Healing:

Support Materials: Training manual; 5 brochures specific to Native MSMs and 1 for IDUs
Sources of Funding: Minnesota Department of Health and Department of Human Services; CDC

Staff Resources:
Full-time: 2 prevention workers
Part-time:
Volunteers:

Years in Operation: 15

Program Contact Information:
Rhys Fulenwider
Indigenous People's Task Force
Minneapolis, MN
Phone: 612-870-1723

State: Montana

Sponsoring Organization:
Indian Family Health Clinic

Name of Program:
Indian Family Health Clinic HIV Awareness and Prevention Program

Description of Program: Provides testing and pre- and post-test counseling; risk education planning; prevention and awareness information; and street level outreach and intervention

Model(s) for Program:
Harm reduction model

Target Population: Native American men

Geographical Area(s) Served: Rural areas; small towns

Number of Clients: 300

Types of Intervention Provided:
Individual Level: Yes
Group Level: Yes
Community Level: Yes
Counseling and Testing: Yes
Outreach, Health Education, etc.: Yes
Case Management and Referrals: Yes
Traditional Healing:

Support Materials: Training Manual

Sources of Funding: United States Conference of Mayors (USCM)

Staff Resources:
Full-time: 12
Part-time: 6
Volunteers: 2

Years in Operation: 4

Program Contact Information:
Randy Anderson
Indian Family Health Clinic
Great Falls, MT
Phone: 406-268-1510

State: Montana

Sponsoring Organization:
Missoula Indian Center

Name of Program:
Missoula Indian Center

Description of Program: Delivers educational presentations (high schools and some lower grades) and outreach in bars

Model(s) for Program: Use focus groups to improve presentations

Target Population: Native American families and youth; IDU population; Native American men

Geographical Area(s) Served:
Greater Missoula area

Number of Clients: 375-400

Types of Intervention Provided:
Individual Level: Yes
Group Level: Yes
Community Level: Yes
Counseling and Testing:
Outreach, Health Education, etc.: Yes
Case Management:
Referrals: Yes
Traditional Healing:

Support Materials:
Brochure for outreach activities

Sources of Funding: State Health Department; Indian Health Service

Staff Resources:
Full-time: 1
Part-time:
Volunteers: 2

Years in Operation: 22

Program Contact Information:
Kathy Reddies
Missoula Indian Center
Missoula, MT
Phone: 406-829-9515

State: Nevada

Sponsoring Organization:
Walker River Tribal Health Clinic

Name of Program:
Walker River Tribal Health Clinic

Description of Program: Provides HIV prevention through medical services and counseling programs that target gay couples and high-risk teens; offers mental health services, supportive counseling and sponsors two

tribal prevention activities; licensed provider is a tribal member and uses a culturally relevant approach.

Model(s) for Program: Approach is considered supportive counseling

Target population: All ages of tribal population; high-risk teens

Geographical Area(s) Served: Reservation

Number of Clients: 150 mental health; general outreach 550

Types of Intervention Provided:
Individual Level: Yes
Group Level:
Community Level: Yes
Counseling and Testing: Yes
Outreach, Health Education, etc.: Yes
Case Management and Referrals:

Support Materials: Flyers concerning upcoming training sessions

Sources of Funding:
Indian Health Service

Staff Resources:
Full-time: 4
Part-time:
Volunteers:

Years in Operation: 1

Program Contact Information:
Melanie Aragon
Walker River Tribal Health Clinic
Schurz, NV
Phone: 775-773-2005, ext. 2238

State: New Mexico

Sponsoring Organization:
First Nations Community Health Source

Name of Program:
First Nations

Description of Program: Provides services through Native American clinic; offers information and skill-building activities.

Model(s) for Program: Follows guidance by the Community Planning Group (CPG) of New Mexico

Target Population: MSMs; MSMs/IDUs; heterosexuals at risk; IDU African Americans; Native Americans ages 18-30

Geographical Area(s) Served: Mostly urban; some pueblos and reservations

Number of Clients: 1,500

Types of Intervention Provided:
Individual Level: Yes

Group Level:
Community Level: Yes
Counseling and Testing: Yes
Outreach, Health Education, etc.: Yes
Case Management:
Referrals: Yes
Support Materials: HIV 101 manual created by the agency and updated regularly

Sources of Funding:
State health department

Staff Resources:
Full-time: 2
Part-time:
Volunteers:

Years in Operation: 31

Program Contact Information:
Rebecca Rodriquez
First Nations Community
Health Source
Albuquerque, NM
Phone: 505-262-2481

State: New York

Sponsoring Organization:
American Indian Community House

Name of Program:
First Light

Description of Program: Provides community prevention education and information; general and mental health facilities, and targeted outreach to those at risk including IDUs and MSMs; offers referrals to drug and alcohol programs, STD clinics, and test sites

Model(s) for Program: HIV/AIDS and the Medicine Wheel – A Health Journey created by WISH Foundation of upstate New York

Target Population: All ages; emphasis on youth, MSM, and IDU

Geographical Area(s) Served: New York City; Buffalo; Akwasasne Mohawk Reservation; Syracuse; River Head (Long Island)

Number of Clients: 200 NYC area

Types of Intervention Provided:
Individual Level: Yes
Group Level:
Community Level: Yes
Counseling and Testing: Yes
Outreach, Health Education, etc.: Yes
Case Management: Yes
Referrals: Yes

Support Materials:

Sources of Funding: New York State Health Department AIDS Institute

Staff Resources:
Full-time: 1
Part-time:
Volunteers: 10

Years in Operation: 34

Program Contact Information:
Cissy Elm
American Indian Community House
New York, NY
Phone: 212-598-0100

State: Oklahoma

Sponsoring Organization:
Association of American Indian Physicians (AAIP)

Name of Program: HIV/AIDS Core Capacity-Building Program

Description of Program: Provides HIV/AIDS prevention and education program for Native American gay/lesbian/bisexual and transgendered persons; honors traditional healing practices and restores the balance among mind, body and spirit

Model(s) for Program: Health Belief model; Theory of Reasoned Action; Social Cognitive Theory; AIDS Risk Reduction model

Target Population: Gay/lesbian/bisexual and TG two-spirit men and women over 18 years of age; MSM and WSW (women who have sex with women)
Geographical Area(s) Served: Urban
Number of Clients: 12
Types of Intervention Provided:
Individual Level: Yes
Group Level: Yes
Community Level:
Counseling and Testing:
Outreach, Health Education, etc.:

Support Materials: A training manual; promotional materials including ads, flyers, newsletters, facilitation outlines for meetings; group member surveys.

Sources of Funding: US Conference of Mayors; CDC

Staff Resources:
Full-time: 1
Part-time: 1
Volunteers:

Years in Operation: 31

Program Contact Information:
Philip Roulian
Association of American Indian Physicians
Oklahoma City, OK
Phone: 405-946-7072

State: Oklahoma
Sponsoring Organization:
Indian Health Care Resources Center

Name of Program:
The Tulsa Two-Spirit Society

Description of Program: Offers a program curriculum titled "Healing Our Spirit," which teaches clients about the historical role of two-spirit people; organizes bi-weekly meetings and an annual retreat for two-spirits

Model(s) for Program: Jeffrey Kelley prevention model; Healing Our Spirit curriculum

Target Population: Gay/lesbian/bisexual/TG two-spirit Native American men and women from 18 to 70 years old

Geographical Area(s) Served: Urban and rural areas of Oklahoma

Number of Clients: 1230 MSMs and their partners

Types of Intervention Provided:
Individual Level: Yes
Group Level: Yes
Community Level: No
Counseling and Testing: Yes
Outreach, Health Education, etc.: Yes
Referrals: Yes

Support Materials: A training manual and promotional materials

Sources of Funding: Oklahoma State Health Department; United Way T-Cap; some private funds

Staff Resources:
Full-time: 2
Part-time: 2
Volunteers:

Years in Operation: 16

Program Contact Information:
John Cocke
HIV Prevention & Two Spirit Outreach Coordinator
550 S. Peoria Ave.
Tulsa, OK
Phone: 918-588-1900

State: Wisconsin

Sponsoring Organization:
Great Lakes Inter-tribal Council, Inc.

Name of Program:
HIV/AIDS Program

Description of Program: Provides HIV prevention education to eleven federally recognized tribes in the state of Wisconsin

Model(s) for Program: Reducing the Risk and Making Proud Choices

Target Population: All Native American men and women (youth, teens, adults and elders)

Geographical Area(s) Served: State of Wisconsin

Number of Clients: 15,000 via community education venues

Types of Intervention Provided:
Individual Level: Yes
Group Level: Yes
Community Level: Yes
Counseling and Testing:
Outreach, Health Education, etc.: Yes
Referrals: Yes

Support Materials: Promotional brochures

Sources of Funding: State of Wisconsin

Staff Resources:
Full-time: 1
Part-time:
Volunteers:

Years in Operation: 11

Program Contact Information:
Elaine Allen
HIV/AIDS Program Coordinator
PO Box 9
Lac Du Flambeau, WI 54538
Phone: 715-588-3324

State: Wyoming

Sponsoring Organization: Thunderchild Treatment Center

Name of Program:
Thunderchild Treatment Center

Description of Program: Provides harm reduction for high-risk population

Model(s) for Program: For substance abusers the Big Book of Alcoholics Anonymous

Target Population: 75-80% adult men (substance abusers who have been incarcerated multiple times and/or have multiple partners); 20-25% adult women over 18 years of age (IDU, pregnant women)

Geographical Area(s) Served: Northern Plains states: Montana, North Dakota, Wyoming, Nebraska, Eastern Colorado

Number of Clients: 44

Types of Intervention Provided:
Individual Level: Yes
Group Level: Yes
Community Level:
Counseling and Testing:

Outreach, Health Education, etc.: Yes

Support Materials:
A CD-ROM and brochures
Sources of Funding: Center for Substance Abuse Treatment (CSAT)

Staff Resources:
Full-time: 3
Part-time:
Volunteers:

Years in Operation: 32

Program Contact Information:
Kathy Shanor
Thunderchild Treatment Center
Sheridan, WY
Phone: 307-750-2255

Appendix B

*Native Health Agencies Offering HIV/AIDS Programs and Services**

National

National Native American AIDS Prevention Center
Oakland, CA
Phone: 510-444-2051
Website: www.nnaapc.org

Indian Health Service
National HIV/AIDS Program
Rockville, MD
Phone: 301-443-1522
Website: www.ihs.gov

Inter Tribal Council of Arizona, Inc.
Phoenix, AZ
Phone: 602-307-1557
Website: www.itcaonline.com

Tri-Ethnic Center
Colorado State University
Fort Collins, CO
Phone: 907-491-6355
Website: http://triethniccenter.colostate.edu/index.cfm

Regional IHS HIV/AIDS Coordinators

Aberdeen Area
Carol LaFramboise
Phone: 605-226-7456
E-mail: carol.lafromboise@ihsabr.ihs.gov

Alaska Area
John Palmer
Phone: 907-729-3640
E-mail: jpalmer@akanmc.alaska.ihs.gov

Albuquerque Area
Scott Sunde
Phone: 505-248-4040
E-mail: ssunde@abq.ihs.gov

Bemidjii Area
Jenny Jenkins
Phone: 218-444-0488
E-mail: jennifer.jenkins@mail.ihs.gov

Billings Area
Diane Joanette
Phone: 406-247-7125
E-mail: diane.jeanotte@mail.ihs.gov

*** Information current at time of printi**

California Area
Stephen Mader
Phone: 916-930-3927 ext. 308
E-mail: stephen.madder@mail.ihs.gov

Nashville Area
Roy Kennon
Phone: 615-467-1530
E-mail: roy.kennon@mail.ihs.gov

Navajo Area
Jonathan Iralu, MD
Phone: 505-722-1000
E-mail: jiralu@gimc.ihs.gov

Oklahoma Area
Mike Hope
Phone: 405-951-3829
E-mail: mike.hope@mail.ihs.gov

Phoenix Area
Erica Avery
Phone: 602-263-1541
E-mail: erica.avery@mail.ihs.gov

Portland Area
Donnie Lee
Phone: 503-326-2017
E-mail: dlee@pao.portland.his.gov

Tucson Area
Phyllis Spears
Phone: 520-295-2544
E-mail: phyllis.spears@mail.ihis.gov

National Council of Urban Indian Health
Washington, DC
Phone: 202-544-0344
Website: www.ncuih.org

National Indian Health Board
Washington, DC
Phone: 202-742-4262
Website: www.nihb.org

Regional Organizations

East Coast

American Indian Community House
New York, NY
Phone: 212-598-0100
Website: www.aich.org

LifeLines Foundation, Inc. American Indian Program
Baltimore, MD
Phone: 410-837-2258

Wabanaki Mental Health Association, Inc.
Bangor, ME
Phone: 207-990-0605

Midwest

American Indian Health and Family Services of Southeast Michigan
Detroit, MI
Phone: 313-846-3718

American Indian Health Service

of Chicago, Inc.
Chicago, IL
Phone: 773-883-9100

Gerald L. Ignace Indian Health Center, Inc.
Milwaukee, WI
Phone: 414-383-9526

Great Lakes Intertribal Council
Lac Du Flambeau, WI
Phone: 715-588-3324
Website: www.glitc.bfm.org/

Indian Health Board of Minneapolis, Inc.
Minneapolis, MN
Phone: 612-721-9800

Indigenous People's Task Force
Minneapolis, MN
Phone: 612-870-1723
Website: www.indigenouspeoplestf.org/

Inter-Tribal Council of Michigan, Inc.
Sault Ste. Marie, MI
Phone: 906-635-4208
Website: www.itcmi.org

Menominee Tribal Clinic
Keshena, WI
Phone: 715-799-3361
Website: www.menominee.nsn.us/index.htm

Native Family Resource Center
Sioux City, IA
Phone: 712-252-5902

Nebraska Urban Indian Health Coalition
Lincoln, NE
Phone: 402-346-0902
Website: www.nuihc.org

Nebraska Urban Indian Health Coalition
Nebraska Urban Indian Medical Center
Lincoln, NE
Phone: 402-434-7181
Website: www.nuimc.com

Stockbridge Munsee Health and Wellness Center
Bowler, WI
Phone: 715-793-4144
Website: www.mohican.com/HealthCareCenter.htm

United Amerindian Center, Inc.
Green Bay, WI
Phone: 920-436-6630

Plains

Denver Indian Center
Denver, CO
Phone: 303-936-2688
Website: www.denverindiancenter.org

Hunter Health Clinic
Wichita, KS
Phone: 316-262-3611
Website: www.hunterhealthclinic.org

Kanza Clinic
Newkirk, OK
Phone: 580-362-1039

Native American Training Institute
Bismarck, ND
Phone: 701-255-6374
Website: www.Nativeinstitute.org

Oklahoma City Indian Clinic
Oklahoma City, OK
Phone: 405-948-4900

South Dakota Urban Indian Health, Inc.
Pierre, SD
Phone: 605-224-8841

Indian Health Care Resource Center of Tulsa
Tulsa, OK
Phone: 918-588-1900

Intermountain Region

Helena Indian Alliance
Leo Pocha Clinic
Helena, MT
Phone: 406/-449-5796

Indian Family Health Clinic
Great Falls, MT
Phone: 406-268-1510
Website: www.indianfamilyhealth.org/index.htm

Indian Health Board of Billings, Inc.
Billings, MT
Phone: 406-245-7318

Missoula Indian Center
Missoula, MT
Phone: 406-329-3373

North American Indian Alliance
Butte, MT
Phone: 406-782-0461

Thunderchild Treatment Center
Sheridan, WY
Phone: 307-672-3484

Southwest

Albuquerque Area Indian Health Board
HIV Prevention Program
Albuquerque, NM
Phone: 505-764-0036
Website: www.aaihb.org

All Indian Pueblo Council, Inc.
Albuquerque, NM
Phone: 505-884-3820
Website: www.aipcinc.com

Dallas Inter Tribal Center
Dallas, TX
Phone: 214-941-1050

First Nations Community Health Source
Albuquerque, NM
Phone: 505-262-2481

HIV Center for Excellence
Phoenix Indian Medical Center
Phoenix, AZ
Phone: 602-263-1502

Inter Tribal Council of Arizona, Inc.
Phoenix, AZ
Phone: 602-258-4822
Website: www.itcaonline.com

Inter-Tribal Health Care Center
Tucson, AZ
Phone: 928-882-0555

Montrose Counseling Center
American Indian Program
Houston, TX
Phone: 713-529-0037
Website: www.montrosecounseling center.org/

Native Americans for Community Action
Family Health Center
Flagstaff, AZ
Phone: 928-773-1245

Native American Community Health Center
Phoenix, AZ
Phone: 602-266-6363

Native Images
Tucson, AZ
Phone: 928-884-7131

Navajo AIDS Network, Inc.
Chinle, AZ
Phone: 928-674-5676
Website: www.navajoaidsnetwork.org

Tucson Indian Center
Tucson, AZ
Phone: 928-884-7131

Northwest

Alaska Native Health Board
HIV/AIDS Project
Anchorage, AK
Phone: 907-562-6006
Website: www.anhb.org

Alaska Native Tribal Health Consortium
Anchorage, AK
Phone: 907-729-1900
Website: www.anthc.org

Chugachmiut
Anchorage, AK
Phone: 907-562-4155
Website: www.chugachmiut.org

Maniilaq Association
Kotzebue, AK
Phone: 907-442-7243
Website: www.maniilaq.org/home.html

N.A.T.I.V.E Project
Spokane, WA
Phone: 509-325-5502

NARA of the NW
Indian Health Clinic
Portland, OR
Phone: 503-230-9875

Northwest Portland Area Indian Health Board
Portland, OR
Phone: 503-228-4185
Website: www.npaihb.org

Seattle Indian Health Board
Seattle, WA
Phone: 206-324-9360
Website: www.sihb.org

West Coast

American Indian Health & Services
Santa Barbara, CA
Phone: 805-681-7356

American Indian Health Project
Bakersfield, CA
Phone: 661-327-4030

Indian Health Center of Santa Clara Valley, Inc.
San Jose, CA
Phone: 408-445-3415

Native American AIDS Project
San Francisco, CA
Phone: 415-777-4290

Native American Health Center
Oakland, CA
Phone: 510-261-0524
Website: www.nativehealth.org

Native American Health Center
San Francisco, CA
Phone: 415-621-8051
Website: www.nativehealth.org

Nevada Urban Indians, Inc.
Reno, NV
Phone: 775-788-7600

Sacramento Urban Indian Health Project, Inc.
Sacramento, CA
Phone: 916-441-0918

San Diego American Indian Health Center
San Diego, CA
Phone: 619-234-2158
Website: www.sdaihc.com

Three Rivers Indian Lodge
Manteca, CA
Phone: 209-858-2421

United American Indian Involvement, Inc.
Los Angeles, CA
Phone: 213-353-9429

Pacific

Hawaii Island HIV/AIDS Foundation, Island of Hawaii
Hilo, HI
Phone: 808-331-8177

Ke Ola Mamo, Island of Oahu
Honolulu, HI
Phone: 808-550-0885

Life Foundation, Island of Oahu
Honolulu, HI
Phone: 808-521-2437
Website: www.lifefoundation.org

Malama Pono, Island of Kauai
Lihue, HI
Phone: 808-246-9577
Website: www.malama-pono.org

Maui AIDS Foundation, Island of Maui
Wailuku, HI
Phone: 808-242-4900
Website: www.mauiaids.org

Papa Ola Lokahi, Island of Oahu
Honolulu, HI
Phone: 808-597-6550
Website: www.papaolalokahi.org

Canada

Canadian Aboriginal AIDS Network
Ottawa, ON
Phone: 613-567-1817
Website: www.caan.ca

Healing Our Nations
Atlantic First Nations AIDS Task Force
Halifax, NS
Phone: 902-492-4255
Website: www.healingournations.ca

Healing Our Spirit
BC First Nations AIDS Society
North Vancouver, BC
Phone: 604-879-8884
Website: www.healingourspirit.org

Manitoba Aboriginal AIDS Task Force
Winnipeg, MB
Phone: 204-772-6800

National Capacity-Building Assistance Providers

The CDC supports the National Technical Assistance Providers' Network, a group of organizations that provides technical assistance (TA) to community planning groups (CPGs) in a variety of content and issue areas so that such groups can meet the necessary requirements and accomplish the principles of HIV prevention community planning. TA can enable CPGs to achieve their purpose, which is to develop comprehensive HIV prevention plans that best represent the needs of populations at risk for or infected with HIV in their jurisdiction. To request TA, contact your CDC project officer or the Academy for Educational Development. TA Provider Network members can also be contacted directly.

Academy of Educational Development
1825 Connecticut Ave. NW
Washington, DC 20009-1521
Phone: 202-884-8000
Fax: 202-884-8400
Website: www.aed.org
E-mail: fbeadle@aed.org

Advocates for Youth
1025 Vermont Ave. NW
Washington, DC 20005
Phone: 202-347-5700
Fax: 202-347-2263
Website: www.advocatesforyouth.org
E-mail: info@advocatesforyouth.org

Asian and Pacific Islander American Health Forum (APIAHF)
450 Sutter St., Suite 600
San Francisco, CA 94108
Phone: 415-954-9988
Fax: 415-954-9999
Website: www.apiahf.org
E-mail: hforum@apiahf.org

Asian & Pacific Islander Wellness Center
730 Polk Street, 4th floor
San Francisco, CA 94109
Phone: 415-292-3400
Fax: 415-292-3404
TTY: 415-292-3410
Website: http://www.apiwellness.org/
E-mail: info@apiwellness.org

Behavioral and Social Sciences Volunteer Program
American Psychological Association
750 First St. NE
Washington, DC 20002
Phone: 202-336-6050
Fax: 202-336-6198
Website: www.apa.org
E-mail: bssv@apa.org

Inter Tribal Council of Arizona, Inc.
2214 North Central Avenue,
Suite 100
Phoenix, AZ 85004
Phone: 602-258-4822
Fax: 602-258-4825
Website: http://www.itcaonline.com/

National AIDS Education and Services for Minorities (NAESM)
2001 Martin Luther King, Jr. Drive
Suite 602
Atlanta, GA 30310
Phone: 404-753-2900
FAX: 404-752-9610
Website: www.naesmonline.org

National Alliance of State and Territorial AIDS Directors (NASTAD)
444 North Capitol St. NW, Suite 339
Washington, DC 20001
Phone: 202-434-9020
Fax: 202-434-9092
Website: www.nastad.org
E-mail: nastad@nastad.org

National Association for People with AIDS (NAPWA)
1413 K St. NW, 7th Floor
Washington, DC 20005
Phone: 202-898-0414
Fax: 202-898-0435
Website: www.napwa.org
E-mail: bseal@napwa.org

National Minority AIDS Council (NMAC)
1971 13th St. NW
Washington, DC 20009
Phone: 202-483-6622
Fax: 202-483-1135
Website: www.nmac.org
E-mail: info@nmac.org

National Native American AIDS Prevention Center (NNAAPC)
436 14th St., Suite 1020
Oakland, CA 94612
Phone: 510-444-2051
Fax: 510-444-1593
Website: www.nnaapc.org
E-mail: information@nnaapc.org

Tri-Ethnic Center for Prevention Research
Colorado State University
Sage Hall
Fort Collins, CO 80523-1879
Phone: 970-491-3954, 800-835-8091
Fax: 970-491-0527
Website: http://triethniccenter.colostate.edu/index.cfm
E-mail: tecweb@lamar.colostate.edu

United States-Mexico Border Health Association
5400 Suncrest Dr., Suite C-5
El Paso, TX 79912
Phone: 915-833-6450
Fax: 915-833-7840
Website: www.usmbha.org/index.htm

Two-Spirit Groups

Bay Area American Indian Two-Spirits (BAAITS)
1800 Market St., Suite. 411
San Francisco, CA 94102
415-865-5616
Website: http://www.geocities.com/WestHollywood/Castro/8260/
E-mail: bayarea2spirits@hotmail.com

Minnesota Two-Spirits
Indigenous Peoples Task Force
1433 East Franklin Ave., Suite 18A
Minneapolis, MN 55404
612-870-1723, ext. 22
Website: mntwospirits.20m.com
E-mail: rhys@indigneouspeoplestf.org

Montana Two-Spirit Society
PO Box 67
Lame Deer, MT 59043
E-mail: outinmt@aol.com and blayne411@hotmail.com

Northwest Two-Spirit Society
PMB 995
1122 E. Pike St.
Seattle, WA 98122-3934
Website: http://www.nwtwospirit society.org
E-mail: twospiritsociety@yahoo.com

Sacred Circles
PO Box 6353
Corona, CA 92878-6353
310-547-1946
Website: http://www.sacredcircles2000.homestead.com
E-mail: medicinewheel@email.com

Two-Spirit Society of Denver
PO Box 18566
Denver, CO 80213
303-832-4296
Website: http://twospiritdnvr.tripod.com
E-mail: joeynco@hotmail.com or mar_co55@hotmail.com

Two-Spirit Society of North Dakota
E-mail: miguelclair69@hotmail.com

State and National HIV/AIDS Programming and Evaluation Resources

The CDC Divisions of HIV/AIDS Prevention
The HIV mission of CDC is to prevent HIV infection and reduce the incidence of HIV-related illness and death, in collaboration with community, state, national, and international partners. The website includes information on basic science, surveillance, prevention research, vaccine research, prevention tools, treatment, funding, testing, evaluation, software, and training.
website: http://www.cdc.gov/hiv/dhap.htm

also see: CDC Division of Sexually Transmitted Diseases website:
http:www.cdc.gov/nchstp/dstd/dstdp.html

CDC HIV/AIDS Prevention Research Synthesis Project
Compendium of HIV Prevention Interventions with Evidence of Effectiveness. Atlanta, GA: Centers for Disease Control and Prevention; November 1999, Revised.

The Centers for Disease Control and Prevention (CDC) developed the *Compendium of HIV Prevention Interventions with Evidence of Effectiveness* to respond to prevention service providers, planners, and others who request science-based interventions that work to prevent HIV transmission. All interventions selected for this compendium came from behavioral or social science studies that had both intervention and control/comparison groups and positive results for behavioral or health outcomes. The compendium provides state-of-the-science information about interventions with evidence of reducing sex- and/or drug-related risks, and the rate of HIV/STD infections. Printed copies of the compendium may be obtained from the National Prevention Information Network by e-mail (info@cdcnpin.org) or by phone (1-800-458-5231).
Website: http://www.cdc.gov/hiv/pubs/hivcompendium/HIVcompendium.htm

CDC National Prevention Information Network (CDC NPIN)
CDC NPIN offers the nation's largest collection of information and resources on HIV/AIDS, STD and tuberculosis (TB) prevention. The Organization, HIV Prevention

Program Evaluation Materials, and Funding Databases provided by the CDC NPIN offer prevention, intervention, and care program developers support at various stages of the development process.

The Organization Database contains descriptions of over 19,000 national, state and city groups that provide resources and services related to HIV/AIDS, STDs, and TB. The services include case management, counseling and testing, prevention, education and outreach, health care, support services, housing assistance, and legal counseling. The database contains bibliographic descriptions, abstracts, and availability information for more than 16,000 items in over 34 languages and a variety of formats, including brochures/pamphlets, directories, fact sheets, manuals and training guides, monographs, posters, reports, and videotapes.

CDC NPIN also provides an electronic HIV Prevention Program Evaluation Materials Database, which offers information about a number of HIV prevention program evaluation resources. The database lists and summarizes an array of HIV evaluation materials and provides pertinent information about the evaluation process including evaluation subtopics, staff training on evaluation skills, intended audience for evaluations, methods for reporting findings, and strategies for overcoming barriers to evaluation.

CDC NPIN also includes a Funding Database that lists private and government funding opportunities for community-based and HIV/AIDS, STD, and TB service organizations. Included are details about eligibility requirements, application processes, and deadlines. The Funding Database can be used as a starting point for people seeking financial support for HIV/AIDS, STDs, and TB education, prevention, social/support services, and information dissemination.
Website: http://www.cdcnpin.org/scripts/index.asp

Rural Center for AIDS/STD Prevention (RCAP)
RCAP, headquartered at Indiana University, is a joint program of Indiana University, Purdue University, and the University of Colorado-Denver. Primarily focused on promoting prevention of HIV/STD in rural America, the center develops and evaluates educational materials and prevention programs, examines the behavioral and social barriers to HIV/STD prevention which can be applied to prevention programming, and provides prevention resources to professionals and the public.
Website: http://www.indiana.edu/~aids

National Rural Health Association (NRHA)
NRHA is a national membership organization, whose mission is to improve the health and health care of rural Americans and to provide leadership on rural issues through advocacy, communications, education, and research. The NRHA is a non-profit association headquartered in Kansas City, Missouri, with a Government Affairs Office in Alexandria, Virginia. NRHA publishes an HIV/AIDS Rural Resource Directory, a compilation of HIV/AIDS services providing care to rural areas in the United States. Contact information for services in each state is provided. Many of these services make their materials available upon request.
Website: www.nrharural.org/

Wisconsin AIDS/HIV Program
The Wisconsin AIDS/HIV Program assumes public health responsibilities for the following programs and activities: surveillance and epidemiologic investigations; counseling, testing and referral programs; prevention education and risk reduction; life care services; Ryan White Comprehensive AIDS Resource Emergency Act (www.dhfs.state.wi.us/aids-hiv/Resources/Overviews/AIDS_HIV.htm); and the Minority HIV/AIDS Demonstration Project (http.dhfs.state.wi.us/aids-hiv/Resources/Overviews/Minority-Proj.htm). Brochures, posters, consent forms and reports, many available in English and Spanish, can be ordered from the program's website.
Website: http://www.dhfs.state.wi.us/aids-hiv/

Texas Department of Health (TDH) Bureau of HIV and STD Prevention
The TDH Bureau of HIV and STD Prevention provides HIV/STD education and information; collects, interprets, and distributes data relating to HIV and STD; provides guidance to those who oversee, plan for, or provide HIV and STD services, and provides medication and supplies to prevent, manage, and treat communicable diseases.

The TDH Bureau of HIV and STD Prevention has created a warehouse of HIV/STD educational materials available in English and Spanish. An order form is available on the TDH Warehouse website.
Website: http://www.tdh.state.tx.us/hivstd/pie/edmat.htm

Additional Resources:

Anderson, J.G. & Rodriguez, H.R. Social theory in HIV prevention programs: A survey of prevention programs. *The Health Education Monograph* 20, no. 2 (2003): 73-78.

Card, J. J., Benner, T., Shields, J., & Feinstein, N. The HIVAIDS Prevention Program Archive (HAPPA): A collection of promising prevention programs-in-a-box. *AIDS Prevention and Education* 13, no.1 (2001): 1-28.

Card, J. J., Niego, S., Mallari, A. & Farrell, W.S. The Program Archive on Sexuality, Health & Adolescence: A collection of promising prevention programs-in-a-box. *Family Planning Perspectives* 28, no. 3 (1996): 210-220.

Holtgrave, R., Qualls, L, Curren, W., Valiserri, R.O., et al. An overview of the effectiveness and efficiency of HIV prevention programs. *Public Health Reports* 110, no. 2 (1995): 134-167.