HIV/AIDS among American Indians and Alaska Natives

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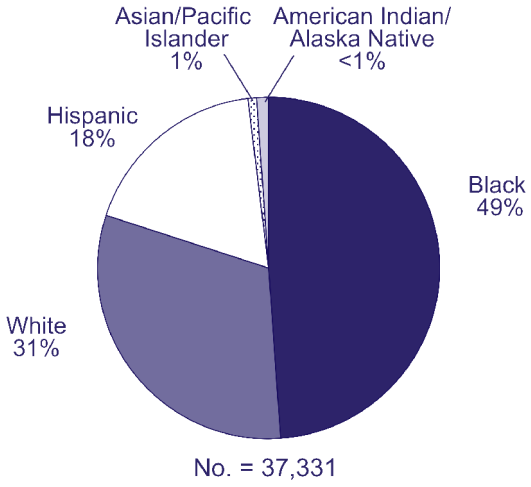
HIV/AIDS is a growing problem among American Indians and Alaska Natives.

Even though the numbers of HIV and AIDS diagnoses for American Indians and Alaska Natives represent less than 1% of the total number of HIV/AIDS cases reported to CDC's HIV/AIDS Reporting System, when population size is taken into account, American Indians and Alaska Natives in 2005 ranked 3rd in rates of HIV/AIDS diagnosis, after blacks (including African Americans) and Hispanics [1]. American Indians and Alaska Natives make up 1.5% (4.1 million people) of the total US population [2]. The rate of AIDS diagnosis for this group has been higher than that for whites since 1995.

Race/ethnicity of persons (including children) with HIV/AIDS diagnosed during 2005



Note. Based on data from 33 states with long-term, confidential name-based HIV reporting.

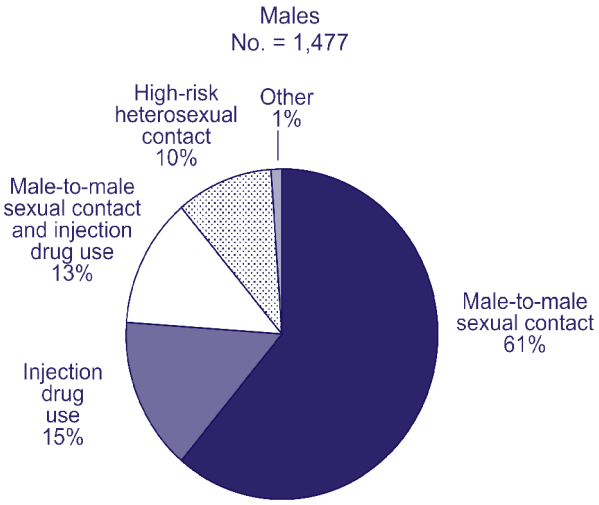
STATISTICS

HIV/AIDS in 2005

(The following bullets refer to the 33 states with long-term, confidential name-based HIV reporting. See the box, before the References section, for a list of the 33 states.)

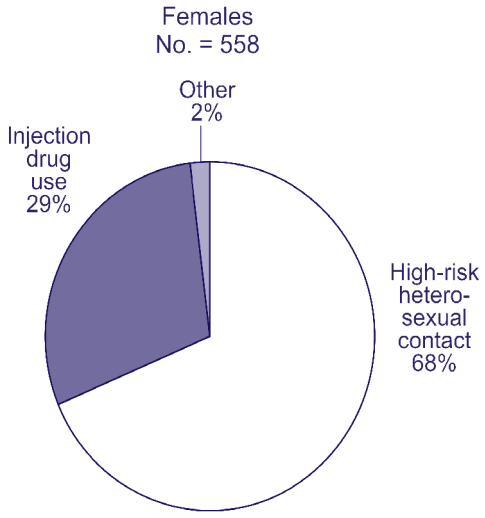
- HIV/AIDS was diagnosed for an estimated 195 American Indians and Alaska Natives (adults, adolescents, and children), representing 0.5% of the total number of HIV/AIDS diagnoses reported for that year [1].
- The rate (per 100,000 persons) of HIV/AIDS diagnosis for American Indians and Alaska Natives was 10.4, compared with 71.3 for blacks, 27.8 for Hispanics, 8.8 for whites, and 7.4 for Asians and Pacific Islanders.
- Women accounted for 29% of the HIV/AIDS diagnoses among American Indians and Alaska Natives [1].

Transmission categories for American Indian and Alaska Native adults and adolescents living with HIV/AIDS at the end of 2005



Note. Based on data from 33 states with long-term, confidential name-based HIV reporting.

Transmission categories for American Indian and Alaska Native adults and adolescents living with HIV/AIDS at the end of 2005 (cont.)



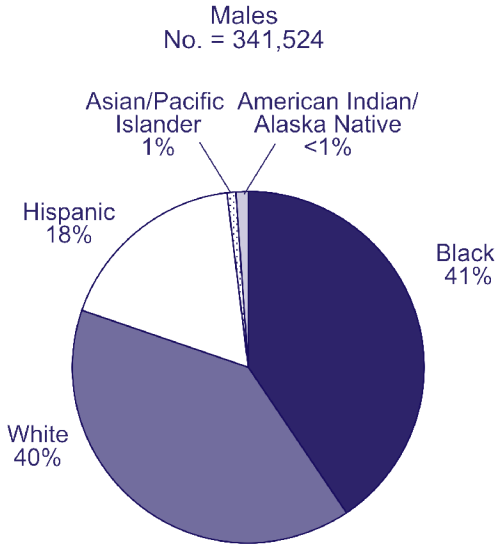
Note. Based on data from 33 states with long-term, confidential name-based HIV reporting.

AIDS in 2005

(See the box, before the References section for explanation of AIDS data.)

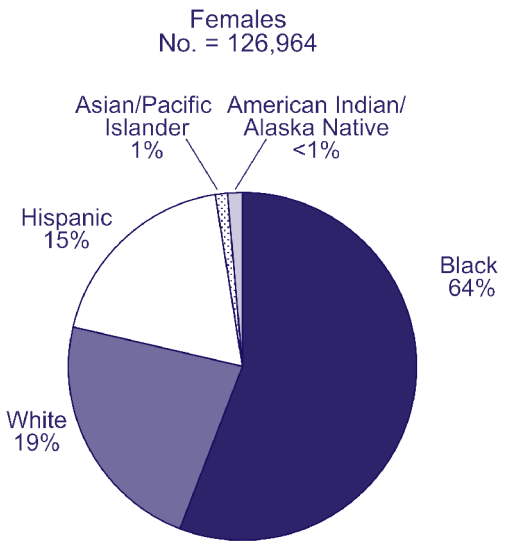
- The estimated rate (per 100,000) of AIDS diagnosis for American Indian and Alaska Native adults and adolescents was 9.3, the 3rd highest after the rates for black adults and adolescents (68.7) and Hispanic adults and adolescents (24.0). The estimated AIDS diagnosis rate was 6.9 for white adults and adolescents and 4.3 for Asian and Pacific Islander adults and adolescents [1].
- AIDS was diagnosed for an estimated 182 American Indians and Alaska Natives, representing approximately 0.4% of all AIDS diagnoses in 2005 [1]. These data include persons whose HIV infection had been diagnosed earlier.
- An estimated 1,581 American Indians and Alaska Natives were living with AIDS [1].
- An estimated 81 American Indians and Alaska Natives with AIDS died in 2005, representing approximately 0.5% of all deaths of persons with AIDS for that year [1].
- From the beginning of the epidemic through 2005, AIDS was diagnosed for an estimated 3,238 American Indians and Alaska Natives [1].
- From the beginning of the epidemic through 2005, an estimated 1,657 American Indians and Alaska Natives with AIDS had died [1]. In comparison, 235,879 whites, 211,559 blacks, 77,125 Hispanics, and 3,383 Asians and Pacific Islanders with AIDS had died.
- Of persons who had received a diagnosis of AIDS during 1997– 2004, American Indians and Alaska Natives had survived for a shorter time than had Asians and Pacific Islanders, whites, or Hispanics. After 9 years, 67% of American Indians and Alaska Natives were alive, compared with 66% of blacks, 74% of Hispanics, 75% of whites, and 81% of Asians and Pacific Islanders [1].
- From the beginning of the epidemic through 2005, AIDS had been diagnosed for an estimated 32 American Indian and Alaska Native children (younger than 13 years) [1].

Race/ethnicity of adults and adolescents living with HIV/AIDS, 2005



Note. Based on data from 33 states with long-term, confidential name-based HIV reporting. Because of rounding, percentages may not add to 100.

Race/ethnicity of adults and adolescents living with HIV/AIDS, 2005 (cont.)



Note. Based on data from 33 states with long-term, confidential name-based HIV reporting. Because of rounding, percentages may not add to 100.

RISK FACTORS AND BARRIERS TO PREVENTION

Race and ethnicity are not, by themselves, risk factors for HIV infection. However, American Indians and Alaska Natives are likely to face challenges associated with risk for HIV infection, including the following.

Sexual Risk Factors

The presence of a sexually transmitted disease can increase the chance of contracting or spreading HIV [3]. High rates of *Chlamydia trachomatis* infection, gonorrhea, and syphilis among American Indians and Alaska Natives suggest that the sexual behaviors that facilitate the spread of HIV are relatively common among American Indians and Alaska Natives. According to 2005 surveillance data by race/ethnicity, the 2nd highest rates of gonorrhea and *Chlamydia trachomatis* infection were those for American Indians and Alaska Natives. The 3rd highest rate of syphilis was that for American Indians and Alaska Natives [4, 5].

Substance Use

Persons who use illicit drugs (casually or habitually) or who abuse alcohol are more likely to engage in risky behaviors, such as unprotected sex, when they are under the influence of drugs or alcohol [6]. Results of the 2005 National Survey on Drug Use and Health indicate that the rate of current illicit drug use was higher among American Indians and Alaska Natives (12.8%) than among persons of other races or ethnicities [7].

Cultural Diversity

To be effective, HIV/AIDS prevention interventions must be tailored to specific audiences. The American Indian and Alaska Native population makes up 562 federally recognized tribes plus at least 50 state-recognized tribes [8]. Because each tribe has its own culture, beliefs, and practices and these tribes may be subdivided into language groups, it can be challenging to create programs for each group. Therefore, prevention programs that can be adapted to individual tribal cultures and beliefs are critically important. Current programs emphasize traditional teachings and the importance of the community.

Socioeconomic Issues

Issues related to poverty (for example, lower levels of education and poorer access to health care) may directly or indirectly increase the risk for HIV infection [9]. Socioeconomic factors, such as poverty, coexist with epidemiologic risk factors for HIV infection in American Indian and Alaska Native communities. During 2002–2004, approximately one quarter (24.3%) of American Indians and Alaska Natives—about twice the national average (12.4%)—were living in poverty [10]. The proportion of the American Indian and Alaska Native population with a high school diploma (66%) in 1990 was less than the national average (75%) [11].

Life expectancy for American Indians and Alaska Natives is shorter than that for persons of other races/ethnicities in the United States; the rates of many diseases, including diabetes, tuberculosis, and alcoholism, are higher; and access to health care is poorer [12, 13].

These indicators demonstrate the vulnerability of American Indians and Alaska Natives to additional health stress, including HIV infection.

HIV Testing Issues

Access to HIV testing and issues concerning confidentiality are important for many American Indians and Alaska Natives. For example, at the time of AIDS diagnosis, more American Indians and Alaska Natives, compared with persons of other races/ethnicities, resided in rural areas [14]. Those who live in rural areas may be less likely to be tested for HIV because of limited access to testing. Also, American Indians and Alaska Natives may be less likely to seek testing because of concerns about confidentiality in close-knit communities, where someone who seeks testing is likely to encounter a friend, a relative, or an acquaintance at the local health care facility.

During 1997–2000, 50.5% of American Indians and Alaska Natives who responded to the Behavioral Risk Factor Surveillance System survey reported that they had never been tested for HIV. This percentage was higher in the southwestern United States, where 58.1% of the American Indians and Alaska Natives reported never having been tested [15].

Data Limitations

Current data regarding HIV infection and AIDS among American Indians and Alaska Natives have limitations.

- **Incomplete surveillance data.** Not all states with large American Indian and Alaska Native populations have been conducting HIV surveillance. For example, California began HIV surveillance only during the past few years and thus is not included in these data.
- **Racial misclassification and underreporting.** Even though the numbers of diagnoses for American Indians and Alaska Natives are relatively low, these numbers may be affected by racial misclassification. Studies in Alaska and Los Angeles have shown that the degree of misclassification differs geographically. In Alaska, 3% of American Indians and Alaska Natives with HIV/AIDS were misclassified as being of another race; in Los Angeles, 56% of American Indians and Alaska Natives with AIDS were racially misclassified [16, 17].

PREVENTION

In the United States, the annual number of new HIV infections has declined from a peak of more than 150,000 during the mid-1980s and has stabilized since the late 1990s at approximately 40,000. Persons of minority races/ethnicities are disproportionately affected by the HIV epidemic. To reduce further the incidence of HIV infection, CDC announced Advancing HIV Prevention (AHP) in 2003 (http://www.cdc.gov/hiv/topics/prev_prog/AHP/AHP-Overview.htm.) This initiative comprises 4 strategies: making HIV testing a routine part of medical care, implementing new models for diagnosing HIV infections outside medical settings, preventing new infections by working with HIV-infected persons and their partners, and further decreasing perinatal HIV transmission.

Through AHP, CDC conducted demonstration projects in American Indian and Alaska Native communities to examine ways to make voluntary HIV testing a routine part of medical care and to implement new models for diagnosing HIV infections outside medical settings. Preliminary data show that through these projects, over 2,000 American Indians and Alaska Natives were tested for HIV. Demonstration projects were conducted at the following sites:

- Salt Lake City, Utah, where a community-based organization (CBO) partnered with the Indian Walk-In Center to offer routine testing—including rapid testing at some sites—to 5 tribal entities and 11 reservations.
- Phoenix, Arizona, where a CBO conducted routine HIV testing in nontraditional settings (e.g., health fairs, powwows) through local outreach.
- Sault Ste. Marie, Michigan, where the Sault Ste. Marie Tribe and the Chippewa Indian Sault Tribe Health Center conducted routine HIV testing for clients aged 17 to 49. Rapid testing was conducted simultaneously at 1 main health center and 4 satellite clinics as well as an urgent care clinic.

CDC, through the Minority AIDS Initiative, supports efforts to reduce the health disparities experienced in communities of persons of minority races/ethnicities who are at high risk for HIV. These funds are used to address high-priority HIV prevention needs in such communities. The following are some CDC-funded prevention programs that state and local health departments and CBOs provide for American Indians and Alaska Natives.

- Helping tribes develop or expand HIV prevention services and improve services for persons infected with, or affected by, HIV/AIDS
- Building and strengthening the capacity of tribal organizations and urban Indian health centers throughout the United States to develop effective HIV prevention through intertribal networking and collaboration
- Providing HIV prevention education in rural Alaska Native communities and implementing an evidence-based intervention, Community PROMISE, in the Yukon-Kuskokwim delta and Maniilaq regions.

Understanding HIV and AIDS Data

AIDS surveillance: Through a uniform system, CDC receives reports of AIDS cases from all US states and territories. Since the beginning of the epidemic, these data have been used to monitor trends because they are representative of all areas. The data are statistically adjusted for reporting delays and for the redistribution of cases initially reported without risk factors. As treatment has become more available, trends in new AIDS diagnoses no longer accurately represent trends in new HIV infections; these data now represent persons who are tested late in the course of HIV infection, who have limited access to care, or in whom treatment has failed.

HIV surveillance: Monitoring trends in the HIV epidemic today requires collecting information on HIV cases that have not progressed to AIDS. Areas with confidential name-based HIV infection reporting requirements use the same uniform system for data collection on HIV cases as for AIDS cases. A total of 33 states (Alabama, Alaska, Arizona, Arkansas, Colorado, Florida, Idaho, Indiana, Iowa, Kansas, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming) have collected these data for at least 5 years, providing sufficient data to monitor HIV trends and to estimate risk behaviors for HIV infection.

***HIV/AIDS*:** This term is used to refer to 3 categories of diagnoses collectively: (1) a diagnosis of HIV infection (not AIDS), (2) a diagnosis of HIV infection and a later diagnosis of AIDS, and (3) concurrent diagnoses of HIV infection and AIDS.

REFERENCES

1. CDC. *HIV/AIDS Surveillance Report, 2005*. Vol. 17. Rev ed. Atlanta: US Department of Health and Human Services, CDC: 2007:1–46. Available at http://www.cdc.gov/hiv/topics/surveillance/resources/reports/. Accessed June 28, 2007.
2. U.S. Census Bureau. The American Indian and Alaska Native population: 2000. Census 2000 Brief. February 2002. Available at http://www.census.gov/prod/2002pubs/c2kbr01-15.pdf. Accessed March 15, 2007.
3. Fleming DT, Wasserheit JN. From epidemiological synergy to public health policy and practice: the contribution of other sexually transmitted diseases to sexual transmission of HIV infection. *Sexually Transmitted Infections* 1999;75:3–17.

4. CDC. *Sexually Transmitted Disease Surveillance, 2005*. Atlanta: US Department of Health and Human Services, CDC; November 2006: Tables 10B, 20B, 32B. Available at http://www.cdc.gov/std/stats/toc2005.htm. Accessed March 15, 2007.
5. McNaghten AD, Neal JJ, Li J, Fleming PL. Epidemiologic profile of HIV and AIDS among American Indians/Alaska Natives in the USA through 2000. *Ethnicity and Health* 2005;10:55–71.
6. Leigh BC, Stall R. Substance use and risky sexual behavior for exposure to HIV: issues in methodology, interpretation, and prevention. *American Psychologist* 1993;48:1035–1045.
7. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. *Results from the 2005 National Survey on Drug Use and Health: National Findings*. Rockville, Md: Substance Abuse and Mental Health Services Administration; 2006. Office of Applied Studies, NSDUH Series H-30, DHHS Publication No. SMA 06-4195. Also available at http://oas.samhsa.gov/NSDUH/2k5NSDUH/2k5results.htm. Accessed March 15, 2007.
8. US Department of the Interior, Bureau of Indian Affairs. Indian entities recognized and eligible to receive services from the United States Bureau of Indian Affairs. *Federal Register* 2003(December 5);68(234):68179–68184.
9. Diaz T, Chu SY, Buehler JW, et al. Socioeconomic differences among people with AIDS: results from a multistate surveillance project. *American Journal of Preventive Medicine* 1994;10:217–222.
10. DeNavas-Walt C, Proctor BD, Lee CH. *Income, Poverty, and Health Insurance Coverage in the United States: 2004*. Washington, DC: US Government Printing Office; August 2005. Current Population Reports P60-229. Available at http://www.census.gov/prod/2005pubs/p60-229.pdf. Accessed March 15, 2007.
11. US Census Bureau. The American Indian, Eskimo, and Aleut population. 2001. Available at http://www.census.gov/population/www/pop-profile/amerind.html. Accessed March 15, 2007.
12. Korenbrot CC, Ehlers S, Crouch JA. Disparities in hospitalizations of rural American Indians. *Medical Care* 2003;41:626–636.
13. Zuckerman S, Haley J, Roubideaux Y, Lillie-Blanton M. Health service access, use, and insurance coverage among American Indians/Alaska Natives and whites: what role does the Indian Health Service play? *American Journal of Public Health* 2004;94:53–59.
14. Bertolli J, McNaghten AD, Campsmith M, et al. Surveillance systems monitoring HIV/AIDS and HIV risk behaviors among American Indians and Alaska Natives. *AIDS Education and Prevention* 2004; 16:218–237.
15. CDC. Surveillance for health behaviors of American Indians and Alaska Natives: findings from the Behavioral Risk Factor Surveillance System 1997–2000. *MMWR* 2003;52(SS-07):1–13.
16. State of Alaska Health and Social Services, Section of Epidemiology. Accuracy of race/ethnicity data for HIV/AIDS cases among Alaska Natives. *State of Alaska Epidemiology Bulletin* 2003;No. 11(May 13). Available at http://www.epi.hss.state.ak.us/bulletins/docs/b2003_11.htm. Accessed March 15, 2007.
17. Hu YW, Yu Harlan M, Frye DM. Racial misclassification among American Indians/Alaska Natives who were reported with AIDS in Los Angeles County, 1981–2002. National HIV Prevention Conference; August 2003; Atlanta. Abstract W0-B0703.

For more information . . .

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Information about personal risk and where to get an HIV test

CDC National HIV Testing Resources
http://www.hivtest.org
Location of HIV testing sites

CDC National Prevention Information Network (NPIN)
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http://www.cdcnpin.org
CDC resources, technical assistance, and publications

AIDSinfo
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