

The Changing Face of HIV/AIDS Among Native Populations†

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Abstract—AIDS has steadily increased in recent years, becoming the ninth leading killer of Native people between the ages of 15 and 44. In 2003, the Centers for Disease Control and Prevention (CDC) reported that ethnic minorities account for more than 71% of all reported AIDS cases and that there are still increases in AIDS cases in the American Indian population. Despite the work that has been done related to HIV/AIDS, there remain some major challenges in the prevention of HIV/AIDS in Native communities. Yet, there are changes on the horizon and these changes bring hope to Native communities in the ongoing battle to decrease HIV and AIDS. This article details information about the biological, social, economic and behavioral cofactors related to the rise in HIV/AIDS in Native communities and follows with issues related to special populations and consideration of the unique needs of prevention in these subpopulations. The need for norming of HIV testing is discussed as is the need for Native-specific programs and interventions. Finally, changes in the recognition of the culturally specific needs of Native people are noted and new resources are presented.

Keywords—AIDS/HIV, cofactors, gay men, measurement issues, Native Americans, substance use, surveillance

This article is an effort to provide new information on HIV/AIDS rates among Natives, discuss the responses of the Centers for Disease Control and Prevention (CDC) to the disease, and report on the utilization of the Community Readiness model for prevention and intervention. It is important to note that although vulnerability levels to HIV/AIDS vary from community to community, the biological, social, economic, and behavioral cofactors that continue

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to increase the danger to tribal communities remain constant (Vernon & Jumper-Thurman 2002).

BIOLOGICAL FACTORS AND SEXUALLY TRANSMITTED DISEASES (STDs)

A primary biological factor that places tribal people in a vulnerable position is the continuously high rates of sexually transmitted diseases (STDs) found in these communities. As part of an attempt by the CDC to eliminate syphilis in the United States, they launched a national plan in 1998 to reduce primary and secondary syphilis in adults. A reduction in syphilis among women of reproductive age is generally followed by a decrease in congenital syphilis (CS) rates. In evaluating their goal of reducing CS to less than 40 cases per 100,000 live-born infants, the rates for 2000 was compared to 1997 CS surveillance data. Although CS rates decreased among most people of color, racial/ethnic minorities had the highest rates with 13.2 cases

per 100,000 among Native people compared to 1.5 per 100,000 for Whites. Rates for all ethnic groups showed a decrease except for those of Natives, who had a 20% increase during the examination period, 1997-2000 (CDC 2001).

Gonorrhea is another STD that plagues tribal communities. A study examining gonorrhea rates between 1997 and 1998 found a rate increase of 11.3% among Whites and 17% among Natives (CDC 2000). In a more recent examination of data from the National STD Morbidity Surveillance System, it was found that Natives had the second highest rate of reported gonorrhea, chlamydia and syphilis of all racial/ethnic groups (Bertolli et al. 2004). In a geographical comparison, Alaskan Natives were documented with extremely high gonorrhea rates; in a study of 13 states, in eight states Natives exceeded the rate of 349 per 100,000, which is the U.S. five-year mean, with Alaska reporting 1,470 cases per 100,000. (Toomey, Obershelo & Greenspan 1989). The severity of STDs in tribal communities has prompted the Indian Health Services to address the need for additional training among services providers as well as to acknowledge that "prevention of STDs may be one of the most effective means to prevent HIV/AIDS" (IHS 2003, 1998). It follows that the higher rates of STDs certainly reflect high-risk behaviors for contracting HIV/AIDS (Vernon 2001).

SOCIAL FACTORS

There are a number of social factors that place tribal people at higher risk for HIV/AIDS. First, although the extent of homophobia in tribal communities varies, it does exist across tribal regions. The presence of homophobia in a community can increase both the transmission of HIV/AIDS and later detection of the disease, resulting in higher death rates. It can prevent two-spirit (gay/lesbian/transgender/bisexual) Natives from seeking education and care (Vernon 2001). The discrimination attached to two-spirits who are infected provides an added struggle. Many have spoken about how they have been discriminated against both on and off the reservation. An ACLU AIDS Project Report noted how "discrimination against people living with HIV is still pervasive and affects virtually every aspect of life from employment to housing to access to basic medical care" (Lange 2003). Sadly, the stigma and fear attached to a positive diagnosis keeps people from getting tested, thus perpetuating the transmission of the disease.

Second, the distrust that tribal people have in the health system stems from the legacies of colonization, including the decimation of thousands of tribal people from disease, the subsequent struggle for quality health care services, the breaking of treaty rights, and the diminishing of tribal sovereignty. The lack of funding for Indian health has resulted in a lack of access to quality healthcare and overall health

disparities (Zuckerman et al. 2004; CDC 2003b; Joe 2003). The 2003 U.S. Commission on Civil Rights report detailed the unmet health needs of tribal people and noted that they "lagged 20 to 25 years behind the general population in health status" (U.S. Commission on Civil Rights 2003). Infected (sometimes unknowingly) reservation Natives have moved into urban areas seeking better care, but like many tribal members they return to the reservation for ceremonies, family gatherings, funerals, and marriages. This migratory movement is feared as a possible contribution to the spread of HIV/AIDS. There has been a call to study those who move seeking better or more confidential care because it may provide important information "related to disparities in access to care and unmet need that may be of use to health policy planners and program managers" (London, Wilmoth & Fleishman 2004).

ECONOMIC FACTORS

Another factor that is driving the HIV/AIDS pandemic nationally and globally is poverty. It is well known that HIV/AIDS is moving quickly through third world countries and impoverished communities of color in the United States. Poverty is tied to the transmission of HIV/AIDS in a number of ways. According to the 2000 U.S. census, a three-year average (1998-2000) poverty rate for Native Americans was 25.9%, which is higher than the 9.9% rate for Whites (U.S. Bureau of the Census 2001). Living in poverty can have serious impact upon one's health, for it can prevent obtaining health education, inhibit access to good health care and proper medical treatment, and result in increased health disparities. The impoverished are usually in poor health, have a poor diet, and have other poverty-related diseases, including tuberculosis (TB) and diabetes. For many years TB devastated Native communities, but by the early 1950s the prevalence rate had declined. However, compared to the general U.S. population, TB mortality for Natives remains at a rate five times the national average (Rhoades 2000). The CDC has expressed serious concern about the connection between tuberculosis and HIV because people infected with HIV and living with AIDS are at greater risk of developing multidrug-resistant TB, which is difficult to treat. In addition, if infected with HIV and TB the chances are greater that one will develop AIDS (Vernon 2001). Recently, a newly diagnosed highly resistant strain of rapidly progressive HIV was reported in New York. It appeared to shorten the time necessary for progression of HIV to AIDS; though many details are still lacking, it is of great concern. The 40-year-old man who contracted this strain had never been treated for HIV. He was diagnosed with HIV in December of 2004 and within two to three months experienced the onset of AIDS (New York City Dept. Health 2005). Certainly this is a concern, since New York is one of the ten states with

the largest Native populations (Greabell & Jorstad 2004).

Another disease of poverty that may impact the health of an HIV/AIDS infected individual is diabetes. Tribal people are disproportionately affected by diabetes; incidence of this disease has been increasing for the past sixteen years and at a higher rate compared to other ethnic groups. The CDC (2003a) has stated that "overall, the age specific prevalence of diagnosed diabetes was two to three times higher for AI/AN adults than for U.S. adults" and in 2002, "approximately 30% of Natives less than 55 years of age had diabetes." In some tribal communities, diabetes has grown to epidemic proportions; for example, among the Pimas in Arizona in 1981 approximately 50% of adults age 35 or older had diabetes (Rhoades 2000). In addition to being general indicators of poor health, both TB and diabetes may also make one more susceptible to HIV infection through lowered resistance or immunity. Co-infections are common among tribal people and when combined with HIV/AIDS illness presents a new challenge in treatment and services. It has been found that "the presence of significant psychiatric and substance abuse disorder among people living with HIV produces a new set of problems that may impede treatment progress" and that "unmet needs remain high" for these individuals (Stoff, Mitnick & Kalichman 2004).

SOCIOECONOMIC FACTORS

Violence, particularly when tied to poverty, can also place tribal people at high risk for HIV/AIDS. The connection between HIV/AIDS and violence is a global concern and it has been argued in seminal research that violence is a complex problem that transcends national borders and can increase the transmission of HIV/AIDS, particularly among impoverished communities (Krug et al. 2002). It was also suggested that sexual violence furthers the transmission of HIV/AIDS because the use of force results in cuts and abrasions. Forced sex, especially when the victim is young, may increase the likelihood of unprotected sex and HIV transmission. This type of sexual assault has far-reaching consequences and can also result in HIV-infected victims being forced into sex work and engaging in sexual encounters with multiple partners, as well as placing the victim at higher risk for substance abuse (Krug et al. 2002).

The rates of victimization of tribal people is alarming, and well above those of other racial/ethnic groups in the U.S. For Natives between 25 and 34 years old, the rate of violent crime victimization was more than 2.5 times the rate for others of the same age in the general population. Furthermore, Natives experience a per capita rate of violence twice that of the U.S. population (U.S. Dept. of Justice 2004). Power and gender inequality, poverty, violence, and HIV are linked in a number of studies and result in a

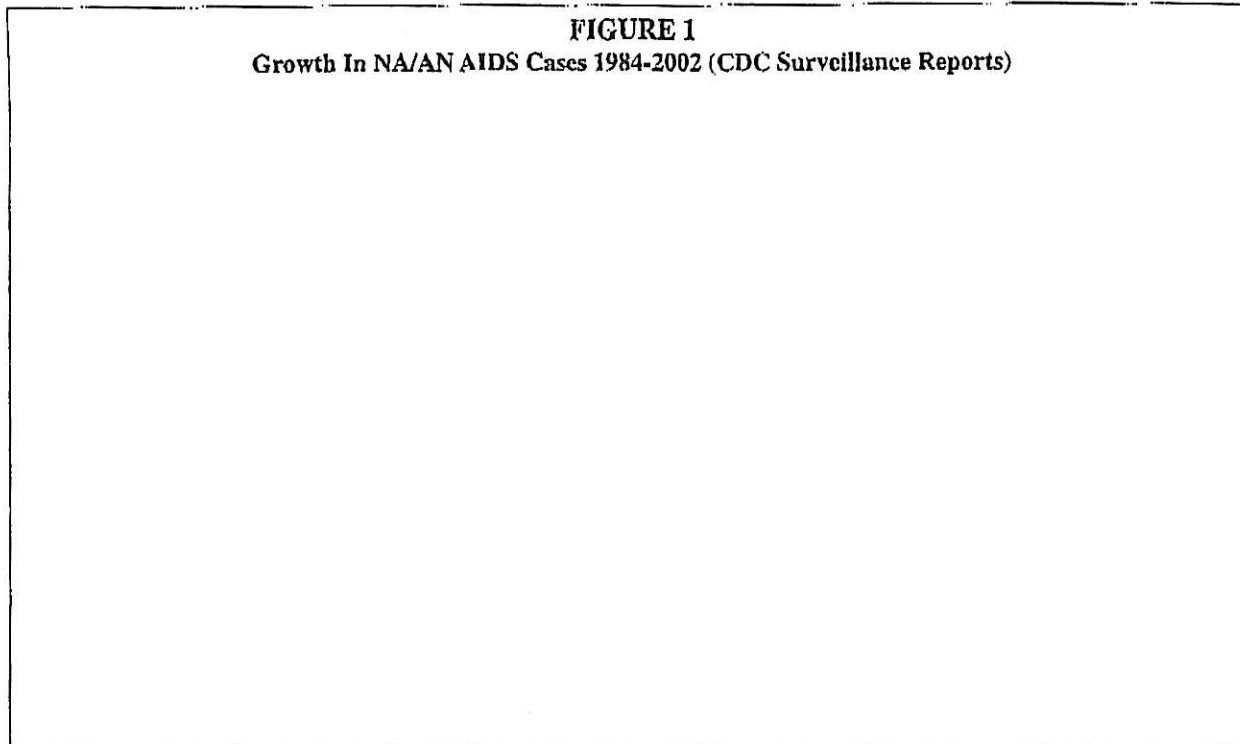
dangerous combination for Native women who face violence regularly. The rate of violent crimes against Native women is 98 per 1,000 females and is the highest among all ethnic categories (U.S. Dept. of Justice 1999). Rates of intimate partner violence against Natives are also higher than for any other race (Tjaden & Thoennes 2000). Disturbingly, between 1992 and 1996 the rate of rape/sexual assault against American Indian women was 5.6% while the U.S. average was 4.3% (U.S. Dept. of Justice 1999). Higher rates of violence against Native women, as a cofactor that places them at risk, continue to be studied and substantiated by researchers (Wahab & Olson 2004). Of greatest concern are Alaskan Native women, who may be 7.6 times more likely than other ethnic groups to be a victim of sexual assault and rape (Rosay 2004). The connection between domestic violence and HIV risk in women can not be overstated, particularly since they are unable to engage in healthy sexual behaviors (such as the use of condoms) when in an abusive relationship. Violence has remained a constant as a cofactor that places Natives at high risk for HIV/AIDS.

SUBSTANCE ABUSE FACTORS

The most critical vulnerability, however, is behavioral. Many tribal communities continue to have substance use and alcohol rates that are beyond the national mean. Although these abuses most often are not actual HIV transmission routes, they do factor in as all precautions are neglected when under the influence. A reexamination of alcohol problems among the Northern Plains and Southwest tribes in 2003 stated that what is known about alcohol use among Natives was often anecdotal, stereotypical and fueled by bias (Spicer et al. 2003). A recent study suggests that "alcohol problems are not nearly as serious as some stereotypes may suggest" (Spicer et al. 2003) and that there are differences among Native communities. Still, substance use remains a very important risk factor for contracting HIV/AIDS (Rolf et al. 2002; Baldwin et al. 2000, 1999, 1996). Professionals working in the area of Native American health and HIV/AIDS commonly state that Native clients believe the use of alcohol was the main factor that placed them at greatest risk for HIV; many stories have been told by those who blacked out while drinking and later learned that they had unprotected sex with strangers or people they normally would not have chosen as a partner.

A recent study of 256 HIV-infected Natives found a higher percentage of tribal people compared to other races who reported intravenous drug use. Particularly alarming was the discovery that 10% of them "began injecting when they were between the ages of nine and 12" (Bertolli et al. 2004). Both substance use and alcohol abuse interfere with the body's absorption of vitamins and minerals and decrease white blood cells, which are important in fighting infection.

FIGURE 1
Growth In NA/AN AIDS Cases 1984-2002 (CDC Surveillance Reports)



CHANGING FACE OF HIV/AIDS

Since the authors' last publication (Vernon & Jumper-Thurman 2002) the cofactors placing Native people at risk for HIV/AIDS remain the same, but the results of surveillance indicate a new turn. Since 1995, the AIDS rates among Natives have been higher than those for Whites (Bertolli et al. 2004). Although AIDS cases have declined for the general U.S. population since the 1990s, this decrease is not evident in communities of color (CDC 2004a). AIDS cases among Native Americans reportedly remain less than 1%, yet a CDC report shows continued increase (CDC 2002; see Figure 1). This dramatic rise should make tribal communities take notice. It's true that the growth varies from community to community but the rising rates remain a concern. The CDC also states that "AIDS cases alone no longer accurately reflect trends in HIV infection" (CDC 2004b). So, it would be wise to pay close attention to HIV infections.

The problems related to accurate surveillance have continued. For example, "the need for statistical information was recognized early by the Indian Health Service and a system of gathering and analyzing this information has been useful not only for assuring high quality of health care but also for appropriate planning of health programs and allocation of resources" (Rhoades 2000). Although fraught with collection problems, the largest being misclassification of ethnicity, the need for accurate data remains. There is a need for data collection that reflects differences among tribes

(Stehr-Green, Bettles & Robertson 2002; Kelly et al 1996; Leiby et al. 1992; Metler, Conway & Stehr-Green 1991).

The HIV/AIDS epidemic itself has changed in several ways: there are more people living with HIV; HIV is moving into rural areas and small cities in the South; new populations are being impacted by HIV (new racial/ethnic groups, women and youth); and tracking HIV has become more complex (CDC 2004b). A recent report that focused on surveillance is very telling and corresponds with CDC surveillance of the disease; it notes that Native youth and women are vulnerable to HIV infection and that "before the widespread use of antiretroviral therapy for HIV, AIDS surveillance data reliably reflected changing patterns of HIV infection and related illnesses in specific populations" (Bertolli et al. 2004). Careful observation of HIV case surveillance is one way to follow the trend and movement of the disease but it does have limitations. Reports from 25 states have shown that the rate of diagnosed HIV infection reported among tribal people living in those states has averaged 16.4 per 100,000 persons, which is approximately 1.5 times the average rate for Whites (Bertolli et al. 2004). HIV case reporting, however, still has some serious challenges. First, one must get tested. HIV case reporting is not comprehensive; name-based HIV reporting occurs in 36 of 50 states and only 25 states have had it in place long enough to provide reliable monitoring of trends over time (Bertolli et al. 2004). It is clear that health professionals and agencies are calling for more HIV testing in an effort to understand the incidence, prevalence,

and characteristics of those who are becoming infected in order to really combat the spread of the disease. A recently published article suggests that routine HIV screening should occur and be expanded upon because it is cost-effective (Sanders et al. 2005). In their publication *HIV Prevention in the Third Decade*, the CDC (2004a) noted that they had recently funded the states of Alabama, Colorado, Michigan, New Jersey and Seattle/King County in Washington to implement what they consider to be the most effective method to analyze new HIV infections—Serologic Testing Algorithm for Recent HIV Seroconversion (STARHS). STARHS analyzes blood samples to determine whether an HIV infection is recent or has been ongoing; it will be utilized in those five states to gather more in-depth HIV information.

The response from tribes to HIV/AIDS prevention in Indian Country has been covered in a recent article by Drs. Duran and Walters (2004) that examines the strengths and weakness of the published literature and argues for the need to apply an “indigenist” etiology paradigm to HIV/AIDS risk and protections. Their article includes a discussion of the numerous postcolonial approaches to HIV/AIDS treatment and prevention; it focuses on the response of the CDC in confronting the rise of HIV infection, including the coordination of agencies and the shift of HIV prevention efforts from at-risk populations to those infected. This includes an effort to decrease the transmission of HIV as well as encourage disclosure of HIV status to sexual partners (Simoni & Pantalone 2004). The CDC is also supportive of the promotion of specific programs/curricula or “diffused effective behavioral interventions” (DEBIs), one of which is focused on case management. The Diffusion of Effective Behavioral Interventions (DEBI) project was designed by the nonprofit Academy for Educational Development in association with the CDC to bring training on science-based, community- and group-level HIV prevention interventions to community-based service providers and state and local health departments. This is meant to enhance their capacity to implement effective interventions at the state and local levels, to reduce the spread of HIV and STDs, and to promote healthy behaviors (for more information go to www.effectiveinterventions.org). A recent article concerned with this effort promoted effective components of case management in Alaskan Native villages and encouraged their application for working with Native Alaskan villages (Barney, Rosenthal & Speier 2004). However, it's important to note that for Native groups, there are challenges associated with the DEBIs. None have been normed on Native groups and none focus on Native groups. One intervention, Community Promise, is being adapted to a Native population, but there remain challenges even with that intervention. It is essential that CDC remain open to allowing Native groups to further explore programs that are culturally based and will have a higher potential for effectiveness with Native groups.

Another interesting study examined health and support service utilization of tribal people who received services in five regional areas through agencies funded by the Ryan White CARE Act. The study indicated that while other racial/ethnic groups comprised 46% of those who received case management services, Natives reflected 55% of the population who received both case management and housing assistance. With the use of case management services the researchers recommended that a “more widespread development of traditional American Indian/Alaska Native case management models” be developed (Ashman, Perez-Jimenez & Marconi 2004).

The importance of helping people get tested and access medical services was confirmed in a study that examined the association between risk behaviors of 244 HIV-positive participants and their HIV medical service utilization (Latkin et al. 2004). It found that risky behaviors were lower among those receiving HIV medical care and that drug users received less care. The study called for interventions that targeted drug users not utilizing medical care, as well as targeting their networks and sex/injection partners. Testing is essential and so is the removal of stigma around testing. Just as one is tested for cholesterol and sugar levels, it should be equally common to be tested for HIV. It is a matter of preservation for the tribes and for their youth: it is important to care about testing for HIV if the rising incidence is to be reduced.

ISSUES RELATED TO PREVENTION AND HIGH-RISK POPULATIONS

Prevention is a key factor in reducing levels of HIV/AIDS in Native communities. In addition to the risk factors detailed above, there are also populations within the Native community that are at high risk. For example, there are many factors unique to gay men and men who have sex with men (MSM) that must be considered when developing effective prevention efforts for Native Americans. Within the Native community, there are gays and lesbians throughout the United States who identify as two-spirit people, as noted above. Although the term two-spirit doesn't refer just to men, MSM are a very high-risk group in the Native community. It is important to note that the term “two-spirit” isn't accepted in all Native communities. Some elders and tribal members find the term offensive and do not consider it traditional, yet the concept and terminology have remained persistent throughout Indian Country. Brotman, Ryan, Jalbert and Rowe (2002) have published a very comprehensive and informative article discussing health care needs and access challenges for two-spirit people. They point out that many prevention specialists, health care policy makers, and providers know very little about two-spirit people related to prevention and health care needs and point out that it is essential that two-spirit people play a major

role in educating professionals and communities if changes are to be made—yet this population isn't always included in essential dialogue.

Though there are numerous publications about MSM, the factors that have been identified in the literature, their importance and impact may vary considerably from ethnic group to ethnic group, urban to rural location, and region to region. In fact, the point has been made that the tribes may react differently to sexual orientation. Some gay men may feel alienated from their tribal culture and others may feel strengthened or supported by their culture. There is the added complexity of racial discrimination as well as discrimination based on sexual orientation. There is an increased chance of frustration among lesbians and gay men who participate in prevention or treatment programs that do not fully reflect an understanding of the needs of two-spirit people and fail to create an open, friendly, culturally sensitive environment in which to discuss issues surrounding sexual orientation. Those involved in prevention efforts should exercise caution not to reinforce internalized homophobia and negative stereotypes of two-spirit people. It is also essential that this group be involved in prevention planning and directing how to increase access to services, and improve quality and responsiveness of service.

Several other identified factors make the problem of HIV/AIDS prevention more complex for two spirit men. Historically, the development of the gay male culture has been social in scope. This is evidenced today by the maintained popularity of gay bars and clubs, which continue to be a focal point of socialization and interaction for gay males of all ages and backgrounds. These locations provide the opportunity for drug use and experimentation, and often provide gay youth with a venue for their first experience with illicit drugs. It is often the case in gay male culture that to remain a socially viable member of the community, one must frequent the bars, thus exposing oneself continuously to drug use and other high-risk behaviors.

Some researchers have reported that adolescent MSM participate in higher rates of unprotected receptive anal sex than older MSM and that sex with older men is highly correlated with exposure to HIV (Morris, Zavisca & Dean 1995). During the 1980s, the median age at HIV infection was older than 30 years. It dropped to 25 years during the period from 1987 to 1991; during that period, one in every four newly infected individuals in the U.S. was age 22 or under (Rosenberg, Biggar & Goedert 1994). Many authors now state that young gay men in their 20s—who were not alive at the onset of the AIDS scare during the late 1970s and early 1980s—are forging a second wave of the AIDS epidemic through unprotected sex, increased drug use, and a misguided faith in emerging HIV/AIDS treatments (HRC 2001; James 2001; Flanders 2000; Schnoebelen 1999). There is reason to believe that these same risk factors hold true for young Native/two-spirit men.

It is clear that there is a great need for and yet a complex challenge involved in development of effective HIV/AIDS prevention efforts due to high levels of cultural and social stress that may increase the potential for drug use and related high-risk behaviors. If prevention efforts are not appropriate to the targeted community and if they do not involve two-spirit people in the development of strategies, the strategies will be less effective and these high risk behaviors will continue to increase.

In the discussion of social factors that may increase HIV infection, it was noted that homophobia must be considered. Homophobia is especially pertinent in the discussion surrounding prevention. The acceptance, tolerance, and/or discrimination toward gay/bisexual tribal members may vary from location to location, but in many Native societies the treatment of gays reflects the attitude of the dominant society—discrimination. When HIV/AIDS is associated with homosexuality it can remain hidden, with devastating results. Those results vary from participating in risky behavior due to the lack of education, failure to seek medical treatment due to risk of discovery, and spreading the disease knowingly or unknowingly, all of which results in increased infection rates. Therefore, Native communities must also address the degree of homophobia and community attitudes about homophobia within their respective areas, which means changing community norms and attitudes.

THE FUTURE

It is promising that the CDC has funded a national initiative to assist American Indian, Alaska Native and Native Hawaiian (AI/AN/NH) communities in the prevention of HIV/AIDS through the provision of Capacity Building Assistance (CBA) for Native organizations, health departments, and organization/tribes serving Native people. Three organizations have been funded through 2009 to provide CBA in four "focus areas." These organizations include the National Native American AIDS Prevention Center (NNAAPC), The Tri Ethnic Center (TEC), and Inter Tribal Council of Arizona (ITCA). All CBA or technical assistance services are for Native-serving community-based organizations, health departments, tribal health organizations, Indian Health Service facilities, and other Native-serving organizations and all services are free and easily accessible through the websites provided below.

NNAAPC (www.nnaapc.org) was founded in 1987 by a group of American Indian and Alaska Native activists, social workers, and public health professionals who advocated for the inclusion of Native communities in HIV prevention efforts. NNAAPC services focus on two areas: organizational development and HIV prevention programming. Organizational development CBA is focused on ensuring that Native-serving organizations have the systems

in place to support an HIV program. Some organizations may receive funding to conduct HIV testing and counseling but not yet have the policies and procedures in place to support such a program, while others may want to start a new HIV program but not have the staff or training capacity to carry out the program; NNAAPC assists with these issues. They also provide strategic planning, human resources and management, board development, grant writing, and fiscal management. Their prevention programming CBA is focused on the integration of Native principles, beliefs, and communication styles into HIV prevention activities. CBA is provided to organizations with varying degrees of exposure to Native communities and with different levels of familiarity with the CDC's evidence-based HIV interventions. NNAAPC's main responsibility is to work with Native-serving organizations to adapt the DEBI HIV interventions for high-risk AI/AN/NH individuals.

The Tri Ethnic Center (www.triethniccenter.colostate.edu/HivAidsPrevention/) has been working in Native communities for over 30 years. It provides CBA to strengthen community access to and utilization of HIV prevention services and to promote HIV testing. TEC uses the highly successful community readiness model (CRM) to improve the capacity of organizations serving Natives in the development of strategies consistent with readiness levels. Strategies consistent with readiness are cost effective and have a much higher potential of success in increasing access to and utilization of HIV prevention and risk reduction and avoidance services.

Many Native communities have already embraced CRM and have applied it successfully to other social concerns. Tribes have utilized the model for prevention of suicide, drug use, partner violence, child abuse and a variety of other concerns. Community readiness is theoretically based and is a respectful, step-by-step, approach to creating positive community change. When applied to prevention of HIV/AIDS, community readiness determines and guides the timing for each step of efforts aimed at changing community norms, behaviors, and attitudes. It utilizes key respondent interviews to determine readiness based on six dimensions: (1) currently existing local programs; (2) knowledge of existing efforts; (3) involvement of leadership; (4) community climate; (5) knowledge of HIV/AIDS, and (6) resources available (Oetting et al. 2001, 1995; Edwards et al. 2000; Jumper-Thurman 2000; Plested et al. 1999, 1998; Donnermeyer et al. 1997).

A CR assessment provides a "community diagnostic" for intervention that sets the foundation for developing strategies to mobilize a community toward HIV/AIDS prevention while gaining the involvement and investment of other organizations, leaders, and community members, thus increasing their capacity to strengthen program efforts and making services more accessible, responsive, and

consumer driven. When services are consumer driven, they have a higher potential for utilization.

Communities who have used the model report that using the CRM: (1) ensures broader involvement of stakeholders; (2) facilitates development of practical strategies for change; (3) integrates the unique culture, values, traditions, history, and beliefs into the strategies; and (4) provides a quantifiable, cost effective evaluative measure of community change.

The Tri Ethnic Center believes that philosopher and author Daniel Quinn (1996) said it best when he suggested that:

If the world is to be saved, it will be saved by people with changed minds, people with a new vision—yet if the time isn't right for a new idea, it will fail. If, however, the time is right, an idea can sweep the world like wildfire. The measures of change are not ease or difficulty, but readiness or unreadiness.

The third CBA provider is the Inter Tribal Council of Arizona (ITCA), formed in 1952 and incorporated as a nonprofit in 1975. ITCA (www.itcaonline.com) provides a united voice to promote American Indian self-reliance through public policy development and independent capacity-building to obtain, analyze, and disseminate information vital to American Indian community self-development. Comprised of 19 Arizona tribal governments, it is involved in the areas of environmental protection/natural resources, health, human services, and infrastructure development as they relate to tribal governments and tribal communities. Their mission is to support leaders of tribal governments in Arizona, with the goal of increasing self-reliance and self-determination.

One branch of ITCA is the National STD/HIV/AIDS Prevention Program (NSHAPP). Established in 1989 to address the increasing disparity of HIV rates among American Indian tribes, it is currently funded by CDC to improve the effectiveness and delivery of HIV prevention services for AI/AN/NH. The NSHAPP is funded through 2009 to strengthen community planning for HIV prevention. It provides CBA to community-based organizations (CBOs), state health departments, local community planning groups (CPGs), tribal health consortia and coalitions, and individual CPG members, to increase parity, inclusion, and representation (PIR) of AI/AN/NHs in community planning. PIR is achieved through coalition development in nine states with most AI/AN/NH populations. Members of new or existing coalitions are engaged in training to increase knowledge of community planning, build leadership, foster consensus of AI/AN/NH issues, and strengthen public speaking skills of members who participate in the community planning process. Technical consultation and training is given to health departments and CPGs on cultural competency and strategies to recruit and retain AI/AN/NH

membership on CPGs. They strive to achieve PIR, ensure cultural competency to recruit and retain AI/AN/NH CPG members, and provide skills building to AI/AN/NH CPG members to encourage active participation that will increase HIV funding opportunities for AI/AN/NH services.

These efforts funded by the CDC certainly have the potential for significant impact toward advancing HIV/AIDS prevention in Native communities. Capacity building is vital to provide effective HIV/AIDS prevention and interventions. The lack of capacity has been noted by several health officials, with particular emphasis on the lack of resources and challenges in management of funds (Grecabell & Jorstad 2004).

Finally, the authors hope that this article has highlighted some of the factors related to reducing HIV/AIDS in the Native community. It is clear that effective prevention requires collaborative efforts from all segments of the community from initial assessment and accurate surveillance to actual program implementation. Likewise, it is important to mention the research community. They, too, must utilize similar collaborative efforts in order to implement effective prevention in Native populations. They must

also successfully link those efforts into a holistic practice/research model that is based on Native concepts.

It is hoped that providers, health workers, researchers, and communities will work together to make a significant impact. Too often, research is viewed in a negative light by Natives. Certainly this is warranted for historical reasons; however, more and more Native researchers are emerging to work with integrity among their own communities. Research sets policy and directs the path that the money travels. We must work together to make certain that research is included within this collaboration. HIV/AIDS prevention efforts must provide a context that will honor and celebrate diversity among people and use as its foundation an empowering paradigm which facilitates collaboration to deal with this very important issue. It is important for the authors, in our multifaceted roles as Native women, scholars, providers, and family members, to work from the strength and resiliency that comes from our traditions, our languages, and the models of health and healing that already exist in tribes. These strengths have carried us through in the past and will do so in the future.

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