POPULATION FACT SHEET: AUGUST 2010

AMERICAN INDIANS AND ALASKA NATIVES

American Indians and Alaska Natives (AI/ANs) comprise 0.8 percent of the U.S. population and hundreds of diverse tribes and cultures.[1] Approximately 60 percent of the Nation's AI/AN populations live in 11 States; the highest numbers are in California, Oklahoma, and Arizona.[2] Historically, AI/AN populations have suffered high rates of a range of health problems and must contend with multiple barriers to care, including geographic isolation and poverty.[3]

SURVEILLANCE

Among AI/ANs, an estimated 199 new AIDS diagnoses were made in 2008.* A cumulative total of 3,743 AI/ANs have been diagnosed with AIDS by the end of 2008.[4]

Men

- Male-to-male sexual contact was the most common transmission category for AI/AN men diagnosed with AIDS in 2008. Male-to-male sexual contact was lower for AI/AN men (64 percent) than for White men (78 percent) and Asian men (83 percent).[5]

- Injection drug use (IDU) was the transmission category in 14 percent of estimated AIDS diagnoses among AI/AN. Male-to-male sexual contact/IDU also accounted for 14 percent of diagnoses while heterosexual contact was the transmission category in 7 percent of cases.[5]

Women

- IDU was the transmission category for 36 percent of AI/AN women diagnosed with AIDS in 2008—higher than for Asian women (10 percent), Black women (21 percent), Hispanic women (23 percent), and White women (33 percent).[5]

- High-risk heterosexual contact was the transmission category for an estimated 50 percent of AI/AN women diagnosed with AIDS in 2008.[5]

Critical Issues

Although the number of HIV/AIDS cases among AI/ANs is fairly small, several challenges facing this population create significant barriers to HIV care. AI/ANs have high poverty rates and relocate frequently. This population is also at high risk for mental health problems, domestic violence, alcoholism, and substance abuse. In addition, AI/ANs have disproportionately high rates of death from suicide and unintentional accidents.[3]

According to the Bureau of Indian Affairs, more than 70 percent of people working with Native Americans cited methamphetamine as the primary drug problem among this population.[6,7] Methamphetamine has been linked to increased sexual risk-taking behaviors and can act as an immunosuppressant, creating increased risk for HIV infection and transmission.[8,9]

AI/ANs have high rates of various health conditions that may complicate treatment of HIV disease, including hepatitis, tuberculosis, pneumonia, and influenza.[10] Of particular concern are rates of depression, diabetes, and heart disease.[11] AI/ANs are twice as likely as Whites to have diabetes. Moreover, AI/AN adults are 1.2 times as likely as White adults to have heart disease and 60 percent more likely than their White adult counterparts to have a stroke.[3] Research suggests that AI/AN women face alarmingly high rates of health problems, and have higher rates of health care access challenges than women in other racial and ethnic groups.[12]

Approximately one-third of AI/ANs lacked health insurance, a rate comparable to that of Hispanics but much lower than that

* The most recent year for which data are available.

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of non-Hispanic Whites.[13] Approximately 1 in 4 AI/ANs live in poverty.[3] Lack of health insurance, coupled with high levels of poverty, can pose serious barriers to disease prevention and health care services.

Most Indian Health Service (IHS) providers are located near tribal lands in rural areas; yet an estimated 67 percent of AI/ANs live in urban areas. Urban AI/ANs are often poor and uninsured and experience high rates of chronic ailments and poor access to health facilities and providers.[11] Frequent travel to visit family and friends and to participate in religious events can also compromise adherence and access to health care.

THE RESPONSE OF THE HIV/AIDS BUREAU

The HIV/AIDS Bureau (HAB) supports a range of activities to address HIV/AIDS care needs among AI/ANs. Some are funded through the Minority AIDS Initiative. Examples include services to improve access and reduce disparities in health outcomes, and outreach and education services designed to increase minority access to needed HIV/AIDS medications. HAB also funds technical assistance to expand the capacity of agencies to deliver HIV/AIDS care to minorities and training to expand the pool of minority providers in underserved communities. Regional AETCs are offering trainings for AI/AN clinicians and AI/AN-serving clinicians and providers.

HAB has published materials on the cultural, spiritual, and traditional medicine practices of AI/ANs, including *Native American Community Consultation: Access to HIV/AIDS Care Issues*; for further information, see www.careacttarget.org/library/NativeAmericanReport.pdf. HAB has also convened four 1-day meetings with AI/AN representatives. (To learn more, see "consultations" at www.careacttarget.org.)

AI/ANs can receive Ryan White HIV/AIDS Program services even if they are eligible for care from other sources (e.g., through IHS, tribal, or urban Indian health programs and services). Information about IHS facilities' eligibility for Program grants is available at hab.hrsa.gov/law/0701.htm.

Additional population-specific technical assistance can be found at www.careacttarget.org.

NOTES

1 U.S. Census Bureau. *2006–2008 American Community Survey 3-year estimates*. 2008. Available at: http://factfinder.census.gov/servlet/ACSSAFFFacts. Accessed April 13, 2010.

2 U.S. Census Bureau. *American Indians by the numbers*. n.d. Available at: www.infoplease.com/spot/aihmcensus1.html. Accessed April 24, 2010.

3 U.S. Department of Health and Human Services, Office of Minority Health. *American Indian/Alaska Native profile*. n.d. Available at: http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=52. Accessed April 13, 2010.

4 Centers for Disease Control and Prevention (CDC). *HIV Surveillance Report, 2008*. 2010;20. Table 2b.

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6 Health Resources and Services Administration, AIDS Education and Training Center. *Methamphetamine and HIV: What clinicians need to know*. 2007. Available at: www.aidsetc.org/aidsetc?page=cf-meth-te.

7 Carroll R. *Unsafe at any speed: Methamphetamines, sexual risk and HIV*. Conference presentation. U.S. Conference on AIDS; September 19, 2008; Fort Lauderdale, FL.

8 Yeon P, Albrecht H. Crystal methamphetamine and HIV/AIDS. *AIDS Clin Care*. February 2008, 20(2):2-4.

9 Jones V, Donohoe T. *HIV and stimulants: Using national collaboration to develop effective training of trainer (TOT) tools.* Conference presentation. Ryan White All-Grantee Program Meeting. August 27, 2008. Washington, DC.

10 Ashman JJ, Perez-Jimenes D, Marconi K. Health and support service utilization patterns of American Indians and Alaska Natives diagnosed with HIV/AIDS. *AIDS Edu Prev*. 2004;6:238-49.

11 Urban Indian Health Commission. *Invisible tribes: Urban Indians and their health in a changing world: Executive summary*. 2007. Available at: www.kaetc.org/resources/Urban-AIAN-Population-US-Medicine.pdf. Accessed April 25, 2010.

12 Henry J. Kaiser Family Foundation. *Putting women's health care disparities on the map: Examining racial and ethnic disparities at the State level*. 2009. Available at: www.statehealthfacts.org/downloads/womens-health-disparities/Putting%20Womens%20Healthcare%20Disparities%20On%20the%20Map.pdf. Accessed April 26, 2010.

13 U.S. Census Bureau. *Income, poverty, and health insurance in the United States: 2007*. Washington, DC; U.S. Census Bureau;2008:23. Available at: www.census.gov/prod/2008pubs/p60-235.pdf. Accessed April 13, 2010.