

EDITORIAL:
HIV AND AIDS AMONG AMERICAN INDIANS AND
ALASKA NATIVES

In recent years, increasing emphasis has been placed on race, ethnicity, and culture as they relate to HIV infection, including HIV drug and sex risk behaviors and the development of effective HIV prevention strategies and AIDS care programs. While race, ethnicity, and culture are often used interchangeably, distinction between the terms clearly exist (Stevens, Estrada, Glider, & McGrath, 1998). Race has been defined as a group that is socially defined on the basis of physical criteria (Van den Berghe, 1967), while ethnicity is used to define groups of individuals who share some common culture or are descendants of people from the same involuntary group (Isajiw, 1974). Culture has more often been defined as the totality of society—transmitted behavior patterns, beliefs, institutions, art, and other constructions of various groups. Culture is an evolving, dynamic phenomenon shaped by social, psychological, and historical processes (Szapocznik, 1995).

Consideration of race and ethnicity as they relate to HIV/AIDS typically includes examination of public health data with regard to HIV and AIDS prevalence, specific HIV drug and sex behaviors (i.e., number of times injected drugs, percent of time condoms were used), as well as data on the number and type of services received by AIDS patients. Consideration of culture as it relates to HIV and AIDS more often includes methods and curriculum for HIV prevention programs and approaches to caring for those with AIDS that take into account socially transmitted constructions; thereby resulting in more acceptable, appropriate, and effective service delivery.

AIDS surveillance data by race/ethnicity indicates a disproportionately high percentage of people from minority groups who have AIDS. The estimated population in the United States (U.S.) in 1997 included 28% from minority ethnic groups. For the same year, the percent of AIDS cases attributed to minorities was 67% (Center for Disease Control [CDC], 1998a). Of the 641,086 cases of AIDS reported to the CDC through December, 1997, 1,783 (0.3%) occurred in American Indians and Alaska Natives (AI/ANs) (Center for Disease Control, 1998b). Almost all (98%) were 13 years of age or older. Compared to the total number of persons with reported AIDS cases in the U.S., a higher percentage of AI/ANs with AIDS cases were between 20 and 29 years of age (23% vs. 17%, respectively). Risk characteristics of AI/ANs with AIDS were similar to all persons with AIDS in the U.S. with almost half (49% of AI/ANs and 48% of all AIDS patients) reported exposures being men who have sex with men (MSM). However, a larger percentage of AI/AN AIDS cases were among MSM who were also injection drug users (IDUs) (14% vs. 6%) and a similar percentage of AI/ANs were among those who only injected drugs (20% vs. 25%).

While AIDS prevalence data is useful in looking at historical trends with regard to HIV infection, cases of HIV infection (without AIDS) assists researchers and service providers with understanding more recent trends that may help point to where the epidemic is headed. CDC (1998a) reported that among AI/ANs a higher percentage of HIV cases (compared to AIDS cases) occurred more often in women (33% vs. 21%), in adolescents (5% vs. 1%), and in AI/ANs between the ages of 20 and 29 years of age (40% vs. 21%). Additionally, a higher percent of HIV cases occurred in persons with heterosexual contact as a risk exposure (18% vs. 13%) compared to a lower percentage for MSM (30% HIV cases vs. 41% of AIDS cases).

With regard to geographic distribution, more than half of AIDS cases among AI/ANs resided in five U.S. states at the time of their diagnosis: California (25%), Oklahoma (11%), Washington (7%), Arizona (6%), and Alaska (4%). According to CDC (1998a), AIDS among AI/ANs in the U.S. is clustered in selected areas in the west and in smaller cities in rural areas. However, Rowell (1998) states that it is misleading to portray the AI/AN AIDS epidemic as a predominately western and rural phenomena. When comparing percent of AI/AN AIDS cases through 1997 with percent AI/AN 1995 census data, AIDS cases among AI/ANs are similar to the geographical distribution of AI/ANs. AIDS among AI/ANs is not a predominately rural phenomena as 68% of AI/AN AIDS cases were reported in cities with populations of over 500,000. Moreover, Rowell (1998) cautions readers that the CDC data may not be accurate given past misreporting of race/ethnicity of AI/ANs and gaps in reporting between Indian Health Service to state departments of health.

Given the concerns about the accuracy of data with regard to HIV and AIDS among AI/ANs, and the lack of information about HIV risk behaviors, AIDS care, and culturally appropriate intervention strategies, further research is needed. Data on HIV prevalence among AI/ANs is needed to help illuminate characteristics of those becoming infected so that at-risk groups of AI/ANs can be targeted for prevention efforts. Information about the types of risk that place AI/ANs at risk need to be identified so that appropriate intervention strategies can be developed. Additionally, barriers and facilitators to accessing AIDS care for AI/ANs who are infected with HIV need to be studied so that earlier treatment can be obtained. A better understanding of available AIDS services for AI/ANs, the helpfulness of these services, and how service providers might enhance AIDS care services is needed. Moreover, further research is needed on appropriate and effective HIV prevention strategies that take into consideration the culture of AI/AN people.

The collection of articles included in these special issues (Volume 9, Issue 1 and 2) attempt to fill the gaps in knowledge that exist with regard to AI/ANs who are either at risk for becoming infected with HIV or who are already infected. The first four articles in Volume 9, Issue 1, examine HIV risk behaviors of AI/AN drug users who are at risk for becoming infected

with HIV. Baldwin, Maxwell, Fenaughty, Trotter, and Stevens examined alcohol use among AI/AN drug users noting significant positive associations between injection drug use and alcohol use as well as crack cocaine use and alcohol use. AI/ANs who reported more episodes of alcohol use before or during sex also reported a higher occurrence of unprotected sex promoting the investigators to recommend that HIV prevention efforts focus on how alcohol consumption may increase risk behaviors. Reynolds, Fisher, Estrada, and Trotter looked at the relationship between unemployment, education, drug use, and needle sharing risk behaviors of AI/ANs. Results indicated that those who were unemployed both at baseline and at a 6-month follow-up reported more drug use and higher levels of needle sharing risks. Furthermore, those with a higher level of educational attainment were more likely to transition to employment, underscoring the need for drug treatment as well as enhanced vocational and educational opportunities for AI/ANs. Stevens, Estrada, and Estrada examined differences in HIV drug and sex risk behaviors between American Indians enrolled at two separate HIV prevention sites, and between male and female drug users. Not only were risk behavior differences between individuals enrolled at the two sites noted, but at both sites females reported higher HIV risk behaviors than their male counterparts on several HIV sex related behaviors. These findings prompted the investigators to not only recommend community-specific interventions but gender-specific interventions as well. Concurring with the need for more intensive, gender-specific interventions, Fisher, Fenaughty, Paschane, and Cagle found in their five-year study that Alaska Native women were at high risk for gonorrhea and were at high risk for HIV due to behaviors related to blood-borne disease transmission. These researchers also found that White men who had sex with both White and Alaska Native women were significantly less likely to use condoms with Alaska Native women.

Included in Volume 9, Issue 2 are four articles that address issues of urban American Indians at risk for HIV; the healthcare needs, social service needs, and culturally sensitive case management services for American Indians, Alaska Natives, and Native Hawaiians (AI/AN/NHs); and, an example of a culturally appropriate method for working with AI/AN/NH populations who are either at risk or who are already infected with HIV. Unlike the first four articles in Volume 9, Issue 1, these works focus on both drug using and non-drug using AI/AN/NH people. In the first article, Walters, Simoni, and Harris examine factors that place urban American Indians living in New York City at risk for becoming infected with HIV. Results support the impact that lifetime trauma and drug use have on individuals' HIV sex risk behaviors, leading the authors to support the use of a postcolonial framework in American Indian HIV studies. Following this study, Duran, Bulterys, Iralu, Graham, Edwards, and Harrison investigate the health care and social service needs, barriers to care and satisfaction with services among urban and rural American Indians. Need for services as well as access to services were

reported by both groups. The researchers concluded that limited access to essential services impedes American Indians with HIV/AIDS in being able to maintain effective medical regimens. Also working with a population already infected with HIV/AIDS, Bouey and Duran examine client satisfaction of the *Ahalaya* case management model which was designed to provide culturally sensitive services to HIV infected AI/AN/NHs. Benefits of the program were noted, including positive changes (pre-post enrollment) in self-supported quality of life. While the results are promising the investigators conclude that these types of services need to be expanded. In the final manuscript of this special issue Tafoya articulates how storytelling—a culturally driven approach—can be used as a powerful tool in HIV prevention work with AI/AN/NHs. For deeper understanding of how storytelling can be used, Tafoya forgoes the more academic style of writing and engages the reader in the experience of storytelling. Many of the important issues discussed in the previous contributions are touched upon in Tafoya’s storytelling, challenging the reader to look for culturally propelled strategies to enhance effectiveness of HIV prevention and AIDS care programs serving AI/AN/NH populations.

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