

American Indians and Alaska Natives and HIV/AIDS

In 1981, a new infectious disease, AIDS (or acquired immunodeficiency syndrome), was identified in the US. Several years later, the causative agent of AIDS—human immunodeficiency virus (HIV)—was discovered. This discovery coincided with the growing recognition that AIDS in the US was part of a global infectious disease pandemic.

Currently, HIV/AIDS has been reported in virtually every racial and ethnic population, every age group, and every socioeconomic group in every state and most large cities in the US. HIV/AIDS remains a significant cause of illness, disability, and death in the US, despite declines in 1996 and 1997. (US DHHS, 2000). In 2001, an estimated 29,723 AIDS cases were diagnosed among minority racial or ethnic groups, which accounted for more than 70% of all AIDS cases diagnosed that year in the US. (CDC, 2002).

“American Indians and Alaska Natives represent a unique population within the US, not only because of their oppression suffered in the development of this country but also because of their ongoing struggle to gain recognition in the HIV/AIDS epidemic. American Indians and Alaska Natives are not so unique, however, that they are protected from the same behaviors that put all people at risk for HIV infection.” (Rowell and Bouey, 2002).

- **Prevalence and Incidence**
- **Traditional Health Beliefs and Practices**
- **Risk Factors and Challenges**
- **Strengths and Protective Factors**
- **Diet**
- **Adherence Factors**
- **Service Interventions**
- **Complementary and Alternative Medicine (CAM)**
- **References and Resources**

Complementary and Alternative Medicine (CAM)

Definition

The National Center for Complementary and Alternative Medicine (NCCAM) defines CAM as follows:

“CAM covers a broad range of healing philosophies (schools of thought), approaches, and therapies that mainstream Western (conventional) medicine does not commonly use, accept, study, understand, or make available. A few of the many CAM practices include the use of acupuncture, herbs, homeopathy, therapeutic massage, and traditional oriental medicine to promote well-being or treat health conditions.

“People use CAM treatments and therapies in a variety of ways. Therapies may be used alone, as an alternative to conventional therapies, or in addition to conventional, mainstream therapies, in what is referred to as a complementary or an integrative approach.

“Many CAM therapies are called holistic, which generally means they consider the whole person, including physical, mental, emotional, and spiritual aspects.” (HRSA, 2003c).

- **Use of traditional medicine and healers.** Many American Indians continue to practice tribal religions and rely on traditional medicine. One study reported that 70% of Navajos living on the reservation used traditional healers, and another found that approximately 28% of Indians living in Milwaukee and the San Francisco Bay area continued to use traditional practitioners. (Diversity Resources, Inc., 2001).

Suggestion

Respect traditional health practices and values and integrate them with behavioral health and wellness programs.

- **Reticence.** Many Indian people who maintain traditional spiritual and healing practices will not openly discuss these practices because of their private nature, the fear of exploitation and prejudice, and a long history of persecution for their beliefs. (Weaver, 1998).
- **Consulting a traditional healer first.** A patient may consult a traditional healer to diagnose or remove the cause of a disease before consulting a Western physician to cure the symptoms. (Diversity Resources, Inc., 2001).
- **Home treatment.** Economic factors, knowledge about and access to herbs, and distance from biomedical care often influence the decision to seek home treatment. However, over-the-counter remedies are becoming more popular. (Diversity Resources, Inc., 2001).
- **Drum or sweat lodge.** American Indians may work with the drum or sweat lodge in healing. (HRSA, 2003c).

ALIGN: Improving Compliance among Patients Who Use CAM

Ask. It is reasonable to assume that clients may be using one or more CAM products or practices. Research in this area shows that the majority of clients do not mention their use of CAM practices for a variety of reasons. Asking patients about their use of CAM can provide useful information and help build rapport.

Learn. Listen to your patients and learn what you can about their alternative approaches to healing, especially their subjective experiences with perceived efficacy. In addition, there are many books, research journals, web sites, and other resources on this topic.

Integrate. As appropriate, work with patients to integrate their CAM practices into the treatment plan. This can help increase compliance by working with existing beliefs, motivational tendencies, and cultural traditions.

Grow. In many cases, the process of inquiry and integration provides an opportunity for growth for both patients and providers.

Network. As knowledge of CAM increases, it may be useful to network with other interested physicians and CAM providers. Learn about the providers and suppliers of CAM services and products used by your patients. Consider the opportunity for cross-referrals, where appropriate, to trusted healers within the community. (HRSA, 2003c).

Navajo

- The following are possible **causes of disease** according to the traditional Navajo belief system:
 - √ Soul loss.
 - √ Intrusive objects.
 - √ Spirit intrusion or possession.
 - √ Breach of taboo.
 - √ Witchcraft or sorcery. (Diversity Resources, Inc., 2001).
- **Combined use of traditional and modern medicine.** The two approaches to health and illness are viewed as distinct but complementary. It is perfectly acceptable for a person to consult a Navajo diagnostician to identify the cause of a disease and arrange a ceremony to eliminate that cause, as well as to consult a physician to alleviate the symptoms of the disease. (Diversity Resources, Inc., 2001).
- **Navajo language and the classification of illness.** Illnesses are classified by the agents believed to cause them or the ceremonies used to cure them—such as the Wind Way, the Evil Way, the Night Way, the Plume Way, and the Earth and Beauty Way—rather than by the symptoms expressed or the parts of the body affected. The ability to describe the nuances of pain and symptoms in the Navajo language is highly sophisticated, and patients can be good historians of their illnesses if they understand why the physician needs an accurate history. (Diversity Resources, Inc., 2001).

Specific Practices

- American Indian healers may burn herbs to purify people and places in a ritual called **smudging**. Smudging with sage, cedar, and sweet grass is performed to purify places before sacred events or meditation, before beginning an important meeting, or before offering help or healing. It is also used in health centers to keep the space clear and in places where unpleasant events have occurred (e.g., theft, violence). Traditionally, Native Americans would burn smudge in an abalone shell. In the alchemical process of transformation (in this case, purification), the four elements are represented: the shell for water, the match for fire, the herbs and ashes for earth, and the smoke for air. (Rainbow Nations, 2003).

References and Resources

Bouey, P.D., and Duran, B.E.S. (2000). The Ahalyaya case-management program for HIV-infected American Indians, Alaska Natives, and native Hawaiians: Quantitative and qualitative evaluation of impacts. *Journal of the National Center for American Indian and Alaska Native Mental Health Research* 9(2):36–52. [http://www.uchsc.edu/ai/ncaianmhr/journal/9\(2\).pdf](http://www.uchsc.edu/ai/ncaianmhr/journal/9(2).pdf). Cited August 25, 2003.

Brave Heart, M.Y. (2003). The historical trauma response among Natives and its relationship with substance abuse: A Lakota illustration. *Journal of Psychoactive Drugs* 35(1):7–13.

Centers for Disease Control and Prevention (CDC). (2000). American Indians and Alaska Natives and tobacco. <http://www.cdc.gov/tobacco/sgr/sgr1998/sgr-min-fs-nat.htm>. Cited August 12, 2003.

Centers for Disease Control and Prevention (CDC). (2002). Estimated AIDS incidence in racial/ethnic minorities: January 1986–December 2001, United States. <http://www.cdc.gov/hiv/graphics/images/1238/1238.pdf>. Cited August 25, 2003.

Diversity Resources, Inc. (2001). *Culture sensitive health care: American Indian*. Blacksburg, VA: Virginia Tech, Office of Multicultural Affairs, Diversity and Work/Life Resource Center. <http://www.multicultural.vt.edu/divresources/indian.html>. Cited July 8, 2003.

Glanz, K. (2003). *Cancer in women of color monograph*. Bethesda, MD: US Department of Health and Human Services, National Cancer Institute. <http://cancercontrol.cancer.gov/womenofcolor/index.html>. Cited August 27, 2003.

Good Tracks, J. (1973). Native American non-interference. *Social Work* 18(6):30–35.

Gray, N., and Nye, P.S. (2001). American Indian and Alaska Native substance abuse: Comorbidity and cultural issues. *Journal of the National Center for American Indian and Alaska Native Mental Health Research* 10(2):67–84. [http://www.uchsc.edu/ai/ncaianmhr/journal/10\(2\).pdf](http://www.uchsc.edu/ai/ncaianmhr/journal/10(2).pdf). Cited August 22, 2003.

Hendrix, L.R. (2002). *Health and health care of American Indian and Alaska Native elders*. Stanford, CA: Stanford University.

<http://www.stanford.edu/group/ethnoger/americanindian.html>. Cited August 14, 2003.

Human Resource Services Administration (HRSA). (2003a). *Demographics and health disparities*. Module 2, in draft. Washington, DC: Bureau of Primary Health Care, Institute for Healthcare Improvement, Cultural Competence in the Clinical Care Model Project.

Human Resource Services Administration (HRSA). (2003b). *Culture*. Module 3, in draft. Washington, DC: Bureau of Primary Health Care, Institute for Healthcare Improvement, Cultural Competence in the Clinical Care Model Project.

Human Resource Services Administration (HRSA). (2003d). *Pharmacological treatment issues in diverse populations*. Module 6, in draft. Washington, DC: Bureau of Primary Health Care, Institute for Healthcare Improvement, Cultural Competence in the Clinical Care Model Project.

Indian Health Service. (2001a). *Alcoholism and substance abuse*. Rockville, MD: Indian Health Service. <http://info.ihs.gov/Health/Health6.pdf>. Cited August 13, 2003.

Indian Health Service. (2001k). *Indians in urban areas*. Rockville, MD: Indian Health Service. <http://info.ihs.gov/People/People4.pdf>. Cited August 13, 2003.

Indian Health Service. (2002a). *Disparities in health insurance coverage for American Indians and Alaska Natives*. Rockville, MD: Indian Health Service. <http://info.ihs.gov/Resources/Resource5.pdf>. Cited August 13, 2003.

Indian Health Service. (2002b). *Facts on Indian health disparities*. Rockville, MD: Indian Health Service, Office of the Director. <http://info.ihs.gov/Health/Health11.pdf>. Cited August 13, 2003.

Intercultural Cancer Council (ICC). (2001). *American Indians/Alaska Natives & cancer*. <http://iccnetwork.org/cancerfacts/cfs2.htm>. Cited April 24, 2003.

Maldonado, M. (1999). *HIV/AIDS & Native Americans*. Washington, DC: National Minority AIDS Council. <http://nmac.org>. Cited August 25, 2003.

Management Sciences for Health (MSH). (2003a). *The provider's guide to quality & culture*. www.erc.msh.org. Cited July 31, 2003.

Management Sciences for Health (MSH). (2003b). *Reducing health disparities in Asian American and Pacific Islander populations: An interactive virtual seminar for providers*.

May, P.A., and Gossage, J.P. (2001). *New data on the epidemiology of adult drinking and substance use among American Indians for the northern states: Male and female data on prevalence, patterns, and consequences*. *Journal of the National Center for American Indian and Alaska Native Mental Health Research* 10(2):1–26.

[http://www.uchsc.edu/ai/ncaianmhr/journal/10\(2\).pdf](http://www.uchsc.edu/ai/ncaianmhr/journal/10(2).pdf). Cited August 22, 2003.

Minnesota Department of Health. (2001). *Health fact sheet*. November 19.

National Minority AIDS Education and Training Center (NMAETC). (2003). Native American focus. <http://www.nmaetc.org/cultural/NativeAmerican.asp>. Cited August 25, 2003.

Noe, T., Fleming, C., and Manson, S. (2003). Healthy nations: Reducing substance abuse in American Indian and Alaska Native communities. *Journal of Psychoactive Drugs* 35(1):15–25. <http://www.uchsc.edu/ai/hni/>. Cited August 25, 2003.

Office of Minority Health. (2002). National forum on health disparity issues for American Indians and Alaska Natives, September 22–26. http://www.omhrc.gov/omh/tribal%20colleges/2pgtcu/plans_tcu_002.htm. Cited February 13, 2003.

Office of Minority Health and State Center for Health Statistics. (1999). *North Carolina minority health facts: American Indians*.

Office on Women's Health. (2001). *Surgeon general's report on women and smoking: American Indian or Alaska Native women and smoking*. Washington, DC: Office on Women's Health. http://www.4woman.gov/owh/pub/factsheets/smoking_native.htm. Cited August 13, 2003.

Oropeza, L. (2002). *Clinician's guide: Working with Native Americans living with HIV*. Oakland, CA: National Native American AIDS Prevention Center (NNAAPC). <http://ewebs.realtimesites.net/ds-Southwestern/sout-j-1/ImagesCust/970037646-10-01-2002-10-56-57e.pdf>. Cited August 25, 2003.

Prince, R.H. (2000). Transcultural psychiatry: Personal experiences and Canadian perspectives. *Canadian Journal of Psychiatry* 45:431–437. <http://www.cpa-apc.org/Publications/Archives/CJP/2000/June/InReview6.asp>. Cited September 29, 2003.

Rowell, R., and Bouey, P. (2002). *What are American Indian/Alaska Natives' HIV prevention needs?* San Francisco: University of California at San Francisco, Center for AIDS Prevention Studies, AIDS Research Institute. <http://www.caps.ucsf.edu/nativamerican.html>. Cited August 25, 2003.

Smedley, B.D., Stith, A.Y., and Nelson, A.R. (eds.). (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: National Academies Press, Institute of Medicine.

Tafoya, T. (2000). Unmasking Dashkayah: Storytelling and HIV prevention. *Journal of the National Center for American Indian and Alaska Native Mental Health Research* 9(2):53–65. [http://www.uchsc.edu/ai/ncaianmhr/journal/9\(2\).pdf](http://www.uchsc.edu/ai/ncaianmhr/journal/9(2).pdf). Cited August 25, 2003.

US Department of Health and Human Services (US DHHS). (1999). *Regional differences in Indian health 1998–1999*. Washington, DC: US DHHS, Indian Health Service, Office of Public Health, Division of Community and Environmental Health, Program Statistics Team.

US Department of Health and Human Services (US DHHS). (2000). *Healthy people 2010: Understanding and improving health*, 2nd ed. Washington, DC: US Government Printing Office. <http://www.bphc.hrsa.gov/quality/HealthyPeople2010.htm>. Cited August 26, 2003.

Weaver, H.N. (1998). Indigenous people in a multicultural society: Unique issues for human services. *Social Work* 43(3).