REAGAN IN HIS STATE OF THE UNION MESSAGE SAID, "TONIGHT, THEN, WE ARE STRONG. PROSPEROUS. AT PEACE. AND WE ARE FREE."

REAGAN SHOULD HAVE SAID, "TONIGHT THEN, I HAVE BEEN SHAMEFUL, AN IMMORAL AND UNCHARITABLE PRESIDENT WHO HAS CONFIRMED THAT EVERY AIDS PATIENT IS A LIVING HUMAN BEING WHO IS NOT ENTITLED TO LIFE OR HEALTH, BUT TO QUARANTINE AND DEATH. AND THEN I WILL BE AT PEACE."

HE SAYS HISTORY WILL RECITE A PROUD HISTORY OF HIS ACCOMPLISHMENTS. BUT HISTORY WILL NOT BE ABLE TO ASK THE THOUSANDS AND THOUSANDS WHO WILL HAVE DIED FROM AIDS OR THE THOUSANDS OF NICARAGUAN WOMEN, MEN AND CHILDREN WHO HAVE BEEN KILLED BY BILLIONS OF AMERICAN DOLLARS ABOUT REAGAN'S PROUD ACCOMPLISHMENTS.

TODAY HE WILL CONTINUE HIS LEGACY OF DEATH BY ASKING FOR 50 million MORE IN CONTRA AID. THE 50 MILLION SHOULD GO TO SALARIES FOR MORE HEALTH CARE PROVIDERS FOR PEOPLE WITH AIDS AND ARC.

MANY HEALTH CARE PROVIDERS AND AIDS VOLUNTEERS ARE LESBIANS AND I AM HERE AS A LESBIAN TO BE ARRESTED TO SHOW SUPPORT FOR ALL MY SISTERS AND BROTHERS WHO DAILY FACE THE BRUNT OF AIDS.
WHEN I WAS A GIRL, IN THE SUMMERTIME I USED TO GO CHERRY PICKING WITH MY GRANDMOTHER. SHE ALWAYS WORE AN APRON OVER HER DRESS, A WIDE-BRIMMED STRAW HAT, AND A VERY LIGHT WEAVE MAN'S SHIRT TO COVER HER ARMS FROM THE SUN. WE EACH CARRIED A WHITE TIN PAIL WITH A RED-RINGED BRIM. MY GRANDMOTHER ALWAYS LISTENED TO EVERYTHING I HAD TO SAY ABOUT THE WORLD BEYOND THE RESERVATION WHICH I KNEW EXISTED BECAUSE OF TELEVISION. IT WAS ONE OF MY FAVORITE EXPERIENCES WITH HER, TO WALK DOWN THE HILL, DOWN THE WORN PATH TO THE CHERRY TREES, ALWAYS LISTENING FOR A POSSIBLE STRAY RATTLESNAKE. WE USUALLY PICKED THE HOTTEST PART OF THE DAY TO GO BECAUSE THE RATTLESNAKES WOULD BE SNOOZING IN THE SHADE, SOMETIMES IN THE SHADE OF THE CHERRY TREES. THE CHERRY PICKING HAS PROVIDED VALUABLE INSIGHT FOR ME INTO TODAY'S POLITICAL AND PERSONAL RATTLESNAKES, WHEN THEY SNOOZE AND POSSIBLY WHERE. MY GRANDMOTHER ALWAYS LISTENED TO EVERYTHING I HAD TO SAY, MY IDEAS, NEVER DISAGREEING, ANSWERING WHAT QUESTIONS SHE COULD BUT MOST IMPORTANTLY LETTING ME ENVISION. I TALKED CONSTANTLY ON OUR LITTLE JAUNTS, ALWAYS FULL OF CONFIDENCE AND ABSOLUTE CONVINCION OF THE RIGHTNESS OF MY IDEAS, THAT MY VISIONS WOULD OCCUR. A TRUE BELIEVER EVEN THEN, OR STUBBORN AS MY DEAR ONES DARE TO SAY ABOUT ME NOW. WHO I AM TODAY AT 35 IS DIFFERENT AND YET THE SAME AS THE GIRL WHO WALKED WITH HER GRANDMOTHER. I STILL HAVE CONVINCION AND I STILL DREAM, BUT I ALSO HAVE THE POWER TO ACT.
TWO YEARS AGO I SUGGESTED A CONFERENCE ON RACISM FOR THE LESBIAN COMMUNITY. I WAS CO-CHAIR OF THE LESBIAN AGENDA FOR ACTION, AND WAS THOROUGHLY SHOCKED TO BE THE OBJECT OF OVERT UP-FRONT RACISM, CRESCEENDO RACISM AS LOUD AS THE CHURCH BELLS WHICH RING IN VENICE, ITALY ON SUNDAYS. AND AT OTHER TIMES THERE WAS A GENTLER RACISM, AS FLEETING AS WISPY CLOUDS OVERHEAD. CRESCEENDO OR GENTLE, THE RACISM WAS SEVERE. THE LESBIAN COMMUNITY MAY BE CONSIDERED ECONOMICALLY POOR BUT IT IS AFFLUENT IN RACISM; RACISM IS PART OF LESBIAN WEALTH. RACISM IS SO FUNDAMENTALLY A PART OF OUR SOULS IT IS EVEN DEEPER THAN TRYING TO SHAKE THE CATHOLIC CHURCH. THE SYSTEM OF APARTHEID IN OUR LESBIAN/GAY COMMUNITY MUST BE DISAVOWED, DISMANTLED, DONE AWAY WITH. SUGGESTING SAFE PLACES FOR WHITE PEOPLE AT RACISM CONFERENCES OR ANY CONFERENCES QUITE FRANKLY GIVES ME GOOSE BUMPS, AND MAKES ME THINK OF ROOMS OF WHITE HOODS. THE LESBIAN/GAY COMMUNITY IS ALREADY A SAFE PLACE FOR WHITE LESBIANS AND GAY MEN. THEY DON'T NEED ANY MORE ROOMS OF THEIR OWN.

MY VISION IS THAT, WHEN RACISM ITSELF HAS A TOMB, INSTEAD OF THE TOMBS FOR PEOPLE WHO ARE VICTIMS OF RACISM, ONLY THEN CAN WE BECOME ALLIES, COUSINS.
I want to finish by saying I am glad I pushed for my vision for a conference on racism. However, I may disagree with many things about it. I can respect the hard and painful work producing it. And like my grandmother I hope we can learn to listen as well as she did. I want to end by reading a brief passage from "Water in Not Vanishing," written by my dear friend Chrystos, the Greek Menominee.
Help Us Prevent HIV and AIDS in Native Communities
1993 Needs Assessment Survey

The National Native American AIDS Prevention Center's (NNAAPC) mission is to stop the spread of HIV and other sexually transmitted diseases among American Indians/Alaska Natives/Native Hawaiians by improving their health status through empowerment and self-determination. Our role is to serve as a resource to Native communities and to support community efforts by providing education and information services, thereby enhancing the physical, spiritual, and economic health of Native people.

NNAAPC is conducting this survey among individuals and organizations addressing the AIDS epidemic in Native communities. The results of the survey will help us evaluate our current programs and design programs to better serve the needs of agencies and individuals who are working in HIV prevention among Native communities. This survey is an important part of NNAAPC's future programs.

*It should take no more than 20 minutes to answer all of the questions.*

All you have to do is check the most appropriate answers for most of the questions. In some cases, you will have to check more than one answer for a question. Please return your completed survey in the enclosed addressed, stamped envelope by April 30, 1993. If you have any questions about the survey, please contact Barbara Cameron at 1-510-444-2051.

Thank you for your participation and support.

---

1993 Needs Assessment Survey

Please print your responses. Thank you.

1. **Northwest Portland Area Indian Health Board**
   Name of the organization that you are completing this survey for

2. **Jillene Joseph**
   Name of the person completing this survey

3. **AIDS Prevention Coordinator**
   Your title

4. **520 SW Harrison, Suite 440**
   Mailing address of organization

5. **P.O. Box 97201**
   Town/City, State, Zip code

6. **503-228-4185**
   Business Phone: List area code first

7. **503-228-8182**
   FAX Phone: List area code first
7. Has your organization used the services of NNAAPC?
   [ ] Yes
   [ ] No

8. Which services did your organization use? (Check all that apply.)
   a. [ ] Clearinghouse for Indian-specific HIV information
      [ ] Curricula development
      [ ] Development of HIV/AIDS policies & procedures
      [ ] Media services (public service announcements, articles, press releases, radio programs, etc.)
      [ ] Native Speakers Bureau
      [ ] Technical assistance
      [ ] Toll-free national Indian AIDS LINE
      [ ] Training of HIV educators ("Training of Trainers")
      [ ] Other Training
      [ ] Other services, specify: _________________________________
   b. Does your organization receive NNAAPC's quarterly journal, Seasons?
      [ ] Yes
      [ ] No
   c. Does your organization receive the newsletter, "In the Wind"?
      [ ] Yes
      [ ] No

   ✔ Have you attended a NNAAPC training in the last 5 years? Answer, then if no, skip to question 12.
      [ ] Yes
      [ ] No

   ✔ As a result of a NNAAPC training - Did you, yourself, in the past several years (Check all that apply.)
      [ ] initiate an HIV prevention project or AIDS task force in your community?
      [ ] conduct HIV-related training/presentations in your Native community?
      [ ] serve on any health committee working to improve HIV services in your Native community?
      [ ] speak to key Native leaders in your community about the need for HIV prevention?
      [ ] produce HIV/AIDS educational materials?
      [ ] invite a person with AIDS to speak at a community gathering?
      [ ] join a network of HIV educators or organizations?
      [ ] work with your local IHS or health clinic to improve HIV services to Native people?
      [ ] refer Native people to NNAAPC?
      [ ] develop community organizing strategies for your Native community on HIV prevention?
      [ ] outreach to target populations in the Native community?
      [ ] provide services to Native persons with HIV or AIDS? (✓ referal)
      [ ] other, specify: ________________________________________________
11. √ If you attended a NNAAPC training,
   a. My knowledge of how HIV/AIDS affects the Native community has increased.
      [✓] Yes  [ ] No
   b. I feel better prepared to implement HIV/AIDS prevention strategies in my Native community.
      [✓] Yes  [ ] No
   c. I feel more comfortable providing services to Native clients who are HIV positive or have AIDS.
      [✓] Yes  [ ] No
   d. In general, I find the content of the trainings useful in my HIV prevention work.
      [✓] Yes  [ ] No

12. Are you interested in attending future NNAAPC trainings?
    [✓] Yes  [ ] No

13. Are you willing to attend trainings that are national, regional or in your community? (Check all that apply.)
    [✓] National
    [✓] Regional
    [✓] Local

14. In your opinion, do you believe that NNAAPC serves as an effective information resource on HIV education and prevention for Native communities?
    [✓] Yes but there has been some talk about NNAAPC's trainings, views, etc. came from an urban perspective rather than reservation.
    [ ] No

15. In your opinion, do you believe that NNAAPC has contributed to increasing the awareness of Native health educators about HIV disease?
    [✓] Yes  [ ] No

16. If you received technical assistance from NNAAPC, did the services meet your needs?
    [✓] Yes  [ ] No

17. Does your organization need further technical assistance services to strengthen the HIV prevention efforts in your Native community?
    [✓] Yes  [ ] No
18. If you receive *Seasons*, has it provided information that enabled you to have more knowledge about HIV prevention and the problems of HIV infection in the Native community?
   - [✓] Yes
   - [ ] No

19. If you receive "*In the Wind*", has it provided information that enabled you to have more knowledge about HIV prevention and the problems of HIV infection in the Native community?
   - [✓] Yes
   - [ ] No

20. If you received manuals and other publications from NNAAPC, have those publications been useful in your HIV prevention work in the Native community?
   - [✓] Yes
   - [ ] No

21. Do you believe NNAAPC's core services of training, technical assistance and information services meet the needs of HIV education and prevention in the Native community?
   - [✓] Yes
   - [ ] No

22. What do you believe to be the proper role(s) of a national Native HIV/AIDS organization? Rank all items 1 - 10, with 1 being the most important.

1. Assisting Native communities in developing HIV prevention programs
2. Assisting Native communities in the development of HIV and AIDS service programs
3. Assisting tribal governments to develop HIV and AIDS policies
4. Conducting research on HIV and AIDS in the Native community
5. Developing a national network for Native HIV and AIDS organizations
6. Developing a speakers bureau for Native PWA's including training in public speaking
7. Lobbying for better statistical tracking of HIV/AIDS cases among Native people
8. Lobbying for more HIV funding for Native community projects.
9. Operating a national toll-free HIV and AIDS information line for Native people
10. Providing a centralized location for HIV information and materials relevant to Native people
11. Providing basic HIV/AIDS education training to Native communities
12. Training Native people to conduct HIV and AIDS education

Other, specify: ____________________________________________________________

23. Please specify any changes that you believe should be made to NNAAPC's core services. *(Please print your response.)*

- train the trainers: although I haven't attended a TOT for several years I have heard through the grapevine that the trainings are from an extreme heterosexual and urban focus/perspective with homophobia the underlying agenda.
24. In terms of Training, in which of the following areas do you most need training? (Check all that apply.)

[ ] Basic HIV/AIDS education
[ ] Case management
[ ] Confidential and anonymous HIV antibody testing
[ ] Human sexuality, practices and behavior
[ ] Incorporating HIV/AIDS education into existing programs, e.g., family planning programs
[ ] Native American traditions and values into HIV/AIDS training programs
[ ] Organizing target communities, i.e., women, IDUs, lesbian/gay, youth
[ ] Psycho social issues of HIV and AIDS in Native communities
[ ] Tuberculosis and HIV disease
[ ] Other, specify: ____________________________

25. In general, which of the following learning methods do you prefer? (Check all that apply.)

[ ] Formal, off-site training
[ ] In-house training
[ ] Manuals and other publications
[ ] National conferences
[ ] Working with consultants
[ ] Visits to other organizations
[ ] Other, specify: ____________________________

26. In terms of Technical Assistance, in which of the following areas do you most need technical assistance? (Check all that apply.)

[ ] Advocacy for HIV education and prevention services
[ ] Case management and advocacy for people living with HIV/AIDS
[ ] Creating an effective data base and tracking system
[ ] Development of HIV/AIDS policies and procedures
[ ] Grant writing
[ ] Planning of HIV education and prevention services
[ ] Resource and referral development
[ ] Other, specify: ____________________________

27. In terms of Information Services, which of the following formats do you prefer to receive HIV-related information? (Check all that apply.)

[ ] Brochures
[ ] Handbooks and Manuals
[ ] Monthly newsletter
[ ] Presentations/In-services
[ ] Quarterly journal with in-depth articles on HIV and AIDS
[ ] Reprints of relevant articles
[ ] Videos
[ ] Other, specify: ____________________________
28. Is HIV and AIDS information currently part of any education curriculum offered in your community?
   [ ] Yes
   [ ] No

29. If a comprehensive HIV prevention curriculum were available, in your opinion, would the curriculum be used by your organization?
   [ ] Yes
   [ ] No

30. Which of the following materials are not available to you? (Check all that apply.)
   [ ] Printed material on basic information on HIV and AIDS
   [ ] Printed material on general guidelines for HIV education
   [ ] Printed material on Native traditions, culture, healing techniques and HIV
   [ ] Printed material on organizing communities within the Native community
   [ ] Videos that focus on HIV disease and the Native community
   [ ] Other, specify: ____________________________________________________________

31. What formats do you believe are best for delivery of information of comprehensive HIV prevention curricula? (Check all that apply.)
   [ ] Audio cassette tapes
   [ ] Educational computer software
   [ ] Live presentations
   [ ] Printed materials
   [ ] Videos
   [ ] Other, specify: ____________________________________________________________

32. In terms of computer and communication technologies, does your organization use computers?
   [ ] Yes
   [ ] No

33. If yes, what computer does your organization use? (Check all that apply.)
   [ ] Apple II series
   [ ] IBM or IBM clone
   [ ] Macintosh

34. If computers were available to you with methods to reach other organizations, and a national computer bulletin board was developed to provide HIV-related information to Native communities, would you use the service?
   [ ] Yes
   [ ] No
35. In your opinion, if available, do you believe that Native adults in your community would use educational computer programs to learn about HIV-related information?
   [ ] Yes
   [X] No

36. In your opinion, if available, do you believe that Native youth in your community would use educational computer programs to learn about HIV-related information?
   [ ] Yes
   [ ] No

37. Which of the following topics do you think Native speakers need to address most? (Check all that apply.)
   [X] Barriers within the Native community in providing HIV services, i.e. politics
   [ ] Community and family responses to members who are HIV positive or have AIDS
   [ ] Cultural approaches in counseling
   [X] Cultural traditions and HIV education and services
   [X] Homophobia/Demystifying homosexuality/Traditional roles of Native lesbians and gay men (Two spirited)
   [X] Human sexuality
   [X] Living with HIV disease
   [X] Substance abuse, recovery and HIV
   [ ] Working with Native lesbians and gay men (Two Spirited people)
   [ ] Working with at-risk Native women (reproductive issues, long-term care for children, etc.)
   [X] Working with children and youth
   [ ] Other, specify: ________________________________________________

38. Which of these services are of highest priority to you? Number your responses 1 - 10, With 1 being your highest priority area.
   1. Case management and advocacy skills for people living with HIV/AIDS
   2. Centralized location for printed material and information on HIV/AIDS
   3. Computer services (educational software, computer bulletin board)
   4. Curricula development
   5. Development of HIV/AIDS policies and procedures
   6. Grant writing
   7. Media services (press releases, articles, radio programs, etc.)
   8. Native Speakers Bureau
   9. Toll-free national Indian AIDSLINE
   10. Training of HIV educators
   11. Training on how to organize target communities and coalition building
   [X] Other, specify: ________________________________________________

39. In your opinion, would it be useful to your organization to know how Native people receive information (what newspapers and magazines they read, television programs they watch, radio stations, programs they listen to)?
   [X] Yes
   [ ] No
ABOUT YOU AND YOUR ORGANIZATION  This information is for demographic purposes only.

40. Are you male or female?
   [ ] Female
   [ ] Male

41. Do you identify as American Indian/Alaska Native/Native Hawaiian?
   [ ] Yes
   [ ] No
   Please print name of your tribe: Gros Ventre (Arapaho)

42. How long have you worked with your organization?
   [ ] Less than one year
   [ ] 1 - 2 years
   [ ] 3 - 5 years
   [ ] Other, specify: ________

43. Which of the following would best describe your organization? (Check all that apply.)
   [ ] Native American agency
   [ ] Non-Native agency
   [ ] HIV/AIDS specific
   [ ] Indian Health service
   [ ] Tribal government
   [ ] Social services agency
   [ ] Other, specify: Health Board representing 40 additional tribes, advisory board to CHS

44. How many years has your organization been in operation? (Check only one.)
   [ ] One year or less
   [ ] 1 - 3 years
   [ ] 4 - 6 years
   [ ] Other, specify: 20 + yrs.

45. Does your organization provide HIV-related services?
   [ ] Yes
   [ ] No

If yes, which of the following services does your organization provide? (Check all that apply.)
   [ ] Case management and advocacy
   [ ] Education and prevention
   [ ] Outreach
   [ ] Practical support services
   [ ] Substance abuse counseling
   [ ] TB information
   [ ] Other, specify: materials, TOT, TRA, referral
46. How large is the community in which your organization is located?
   [ ] Metropolitan area (250,000 or more)
   [ ] Mid-size city (100,000 - 249,000)
   [ ] Smaller town or city (less than 100,000)
   [ ] Rural area

47. Is your organization located on a reservation?
   [ ] Yes
   [ ] No

48. Is your organization near a reservation (within two hours drive)?
   [ ] Yes
   [ ] No

49. Please use the space below to print your general comments or share any lessons you have learned working in the field of HIV prevention in the Native community. Please share anything that you feel would be useful for NNAAPC to know.

   "We really need to focus on substance abuse + AIDs issues. Our people need to heal their hurt before they can take HIV seriously. The hard to reach population is the substance abusing population. How can you practice safer sex while drunk/high? We also need to educate people coming in for STD check-ups. Many of those clients don’t come back for follow-up or complete their medications. Reservation life is full of despair. There are some real sick things happening out there - it is hard for our workers to keep motivated when all they see is bad."

Thank you for taking time to fill out this survey.

Please return the completed survey in the enclosed addressed, stamped envelope by April 30, 1993.
It is important for us to remember that in 1987 and 1988, in all of Indian Country, there were only 10 to 12 individuals who were working in HIV prevention and there were even fewer Indian HIV programs in 1987 and 1988. There were virtually no educational materials on HIV and AIDS directed to Native people. There was no technical assistance available to those wanting to do HIV prevention in Indian Country, and there was no culturally-specific training in this area. There had been no real effort to address issues of sexuality and health within a cultural context. Most Native communities were isolated from the major sources of HIV-related information that was being generated in urban areas. And perhaps most important was a lack of awareness in general of the threat of HIV to Native communities and the relationship of other major health problems to the spread of HIV. And in 1988 there was very little data to indicate the magnitude of the problem for Native people other than reported AIDS diagnosed AIDS cases and the results from the military sero-prevalence study. But today, we have almost 500 persons who are working in HIV prevention and care in our Native Communities. And many areas of Indian country now have either an HIV prevention program and/or direct services programs to Native people who are HIV positive. HIV disease in the United States is in its second decade. HIV disease in Native Communities is in its second decade. Other minority and ethnic groups and white organizations have been organizing and organized to deal with HIV disease almost since the beginning of the disease. They have at least 10 to 12
years of experience, medically, socially and politically dealing with HIV and AIDS. But at best we have 5 or 6 years of experience of HIV prevention and care for our people. What we do have more than any other ethnic or minority group in this country is hundreds of years of surviving epidemic after epidemic. We also have many years of dealing with bureaucracy, with bureaucracies that sometimes get in the way of needed services or needed funds. I think as Native people we have able to incorporate into our genetic makeup, the survivor gene that enables us to go on day after day. And now we have yet another epidemic that we must respond to, to ensure once again the survival of our people. Other groups are ahead of us in the sophistication of their programs, in their extensive networks, in their lobbying organizations but we have made an impressive effort in both prevention and care to catch up as it were. We are trying in our community prevention efforts and strategies throughout Indian country to compress a decade of HIV disease prevention into 5 or 6 years. The area that we as a people do not want to catch up on is the rate of HIV infection.

Finally, we conducted a needs assessment survey of the members of the Native AIDS Network.
This past spring we conducted a needs assessment survey of the members of the Native AIDS Network to determine training needs and priority issues and concerns of Native people who are working in HIV and AIDS. The survey revealed that Indian HIV prevention programs face common obstacles and challenges regardless of whether those programs are located in villages in Alaska, small towns on reservations or in large urban communities. The majority of HIV prevention programs in Indian country are funded through the Indian Health Service, and of course all of the programs strongly indicated that funding dollars often did not match the need for services. There are several education and prevention programs spread throughout the United States that have been able to secure funding through Ryan White Care funds, through state and local health departments and from Centers for Disease Control. It's crucial for Native programs to access funds that are outside of traditional funding sources for Indian programs. Often those funding sources erroneously assume that all health care needs for Native people are handled by the Indian Health Service. This means that we need to educate those people to have a more accurate picture of health care services for Indian people. There are some Indian prevention groups that operate on a volunteer basis. In Northern California, for example, Native people formed the Klamath Trinity AIDS Task Force and they have been providing HIV education without any source of government or foundation funding.
They have been working for several years as a volunteer group and have been able to receive support from the two Native AIDS organizations in San Francisco and Oakland and also from the Indian Health Service, mostly in the form of speakers and educational materials. Most Indian people in Northern California who are involved in public health and HIV are familiar with the Klamath Prinny AIDS Task Force and try to be as supportive as possible.

The Fort Berthold HIV/AIDS Task Force, Wellness Team in New Town, North Dakota, began with a grant award from the Bush Northwest Foundation and in affiliation with the Department of Family Medicine at the University of North Dakota. They began with providing AIDS 101 presentations and have developed an educational video that they wrote the script for and now use it as an educational tool. The Milwaukee Indian Health Board in Wisconsin was awarded a $129,000 grant from the US Conference of Mayors to conduct the first HIV Prevention Needs Assessment for the Milwaukee community. They are using the funds to assess the needs of gay and bisexual men, women at risk, the substance abusing populations and adolescents. They were one of 10 organizations throughout the state to be funded. The Penobscot reservation in Maine, along with technical assistance from NNAAPC, has been successful in overcoming Church resistance to HIV education on their reservation, enabling church, educational, health and tribal employees to work together to insure ongoing HIV prevention education for youth.
These organizations are examples of how Indian groups are being successful in their efforts to address HIV education and prevention in their communities. Unfortunately, there are still areas of Indian country that do not have any level of HIV services, whether it is prevention or care programs. There are some areas in Indian country where some of our Indian people have not received basic HIV and AIDS information. The state of Texas is one of the top 15 states with a large Indian population but there isn't an education and prevention program targeted to Native people. But also in Texas, one of their county health departments refused funding for AIDS programs because they didn't feel it was necessary to do HIV prevention. That money could have gone to the Klamath Trinity AIDS Task Force but obviously that county health department in Texas needs some AIDS 101. One of the exciting trends that keeps growing are the requests that come into the NNAAPC office for speakers who are HIV positive. More and more Native groups want to hear Native people who are HIV positive or living with AIDS. Many of these same organizations are also organizing youth conferences and HIV education. Our Indian youth need accurate information about HIV and need to be able to ask frank and direct questions about the disease. As parents we must encourage our and help our youth to get informed. I know from the have learned from...
HIV positive people who have spoken to Indian youth that our youth are hungary for information. In the surveys that were returned to NNAAPC, again and again the frontline HIV workers cited the need for HIV and AIDS prevention to begin at an early age. The workers expressed frustration that as Indian people we are sometimes unwilling to discuss sexuality or to even allow those issues to be discussed in schools.

There were several other issues that were identified as challenges in prevention work. The most prominent issue, whether on the reservation or in cities, was that of denial. The fact that many Indian people still have not accepted that many of our people are at risk. Often substance abuse is closely related to denial. Some of the Indian organizations identified substances by tribal leaders as a significant barrier to prevention work. Also respondents to the survey elaborated on tribal leadership on HIV prevention. Most had the opinion that our tribal leaders need to provide stronger leadership on HIV prevention and needed to be more actively involved. The politics of tribal leaders was also raised as an area of concern. The leadership sometimes changes every several years and that too many programs become politicized depending on who is holding office.
HIV prevention was seen as especially difficult on reservations that were struggling economically because the people are more concerned about feeding their families rather than receiving HIV education. The key for these prevention programs is to convince the people that being informed about HIV is as important as bread and butter.

Organizations also identified adequate staffing of prevention programs as a major problem. Often many organizations have funding for one staff person who serves as the AIDS coordinator, the HIV educator, the case manager and is the dentist too. Another problem for these agencies was personnel turnover which represents a loss in "institutional memory" meaning that training dollars spent on that staff to be HIV educators was lost. The agency would begin again with a new staff person, investing money and resources.

Another personnel problem that was identified was isolation as a significant problem especially if they are the only staff HIV staff person for the reservation. It's important therefore that networks regional networks be formalized for Native HIV workers so that at least by telephone, if not actual meetings, HIV prevention and case management staff can provide peer support to another.
Small tribal health programs identified a need for case management models. Confidentiality was a very important significant problem for reservations and rural areas. It is also a problem in urban environments. Native people absolutely need to have assurance that when they go to their local clinic for testing or other primary care services that their confidentiality will be guaranteed. We know of individuals who are afraid to get services from Indian clinics because the medical staff is either AIDS phobic, homophobic or simply not following protocols for HIV patients. I know of a husband and wife from a reservation in South Dakota who believed that they might be HIV infected but had to leave the state to get tested. Both people tested positive and there was a uncertainty for them as to whether they could live safely on their reservation.

Some prevention programs for Native people have to take a regional approach to their strategies and educational efforts and client services have to accommodate these needs. Native American communities are often spread through several large counties and may rely on one health center or one AIDS service agency. Those if those programs receive funding dollars through their local health department then they are restricted from providing services to clients who do not reside in that county. If reservations are located
a large metropolitan area, often people from the reservation will travel to the city to receive HIV services from urban Indian health clinics. The State of Minnesota is a good example of this where Indian people come from North Dakota, South Dakota, and Minnesota reservations into Minneapolis-St. Paul. I think most of us are aware of the friction that sometimes exists between reservations and urban Indian health programs due to funding issues. But somehow more money needs to be available to meet the additional burdens faced by urban Indian health clinics who provide services to urban Indians and to Indians from the reservations who temporarily move to the cities because they believe it is safer for them to receive HIV services there rather than on their home reservation.

Prevention models needed for Native people have to be designed to meet the community demographics. What works in a city obviously may not work for a reservation. Prevention strategies targeted for adults will be different than for youth, prevention messages for women will differ from those for men. But many of the organizations that responded to our surveys mentioned at length two main components for effective health education and prevention.
One → HIV and AIDS education needs to be incorporated into all aspects of tribal life, into all aspects of Indian community life and activities. Our families, our aunts and uncles, our grandparents need to take some responsibility for allowing our youth, our young people to be able to freely discuss sexuality and sexual behaviours. HIV education needs to be part of our religious and cultural ceremonies, to be incorporated into materials produced by our service organizations, recreational committees or groups whether it's basketball, bowling or rodeos must begin HIV education, tribal governments need to coordinate education efforts with their local health clinics, and in health clinics. HIV education needs to be a regular part of all services and not just in the HIV division.

Second, is healthy communities who are open to change and open to information are the communities where HIV prevention will be more effective. We need to address the basic concept of health which has been happening in many communities. Self-esteem, family violence, sexual abuse, substance abuse are...