



A Publication of the National Indian Health Board

A Briefing on HIV/AIDS in Indian Country

FALL 2017

Addressing HIV/AIDS in American Indian and Alaska Native Communities

American Indians and Alaska Natives (AI/AN) face significant health disparities in rates of sexually transmitted infections (STIs) including HIV. From 2005 to 2014, the CDC reported a 63% increase in HIV rates among gay and bisexual AI/AN men alone, while the overall HIV rate for all AI/AN increased by 19% during the same time period¹. In the same report, the CDC also stated that the undiagnosed rate for AI/AN living with HIV hovers around 18%, while the national undiagnosed rate is at 13%. Similar to other demographics, the largest burden of HIV is among AI/AN men who have sex with men, who accounted for 78% of all HIV cases among AI/AN in 2013, as reported by the Indian Health Service². However, AI/AN women show a rate of HIV diagnosis that is three times the rate of White women³.

In addition, data looking at racial and ethnic differences in HIV/AIDS survival between 1998-2005 displayed that AI/AN had the lowest survival rate after an AIDS diagnosis of any race⁴. According to 2013 data from the CDC, roughly 53% of all AI/AN diagnosed with HIV were receiving continuous HIV care compared to 58.2% for Whites, and about 52% of AI/AN were virally suppressed compared to 62% for whites⁵. In addition, survival rates between 2010 and 2014 were lowest among

AI/AN⁶, while in 2014 alone, AI/AN/ Native Hawaiians/ Pacific Islanders were reported to have the highest percentage (25.4%) of Stage 3 (AIDS) at the time of diagnosis⁷ compared with other racial groups.

AI/ANs have the third highest rate of HIV transmission of any race. As Tribes and their advocates look for promising practices to curb these rates, more attention needs to be placed on culturally appropriate frameworks both in gathering data and designing interventions. Although not widely used for HIV prevention and screening in Tribal communities, community-based participatory research (CBPR) practices are well-known as a best practice in AI/AN communities. CBPR is defined as a "...partnership approach to research that equitably involves community members, organization representatives, and researchers in all aspects of the research process."⁸

The primary factor driving CBPR's success in Tribal communities is that it permits Tribal ownership of the research process and promotes Tribal sovereignty. For many communities, this means that programs and interventions resulting from the research will be culturally relevant and thus more effective. Cultural connection is a powerful

protective factor against risky behaviors that can increase the risk of HIV transmission such as drug and alcohol use and unprotected sex, especially among adolescents⁹.

Culturally appropriate interventions show the most promise in preventing HIV transmission rates. Programs such as Project Red Talon and We R Native, both of which are run by the Northwest Portland Area Indian Health Board, showcase how interventions that celebrate cultural traditions and engage youth in holistic wellness are effective methods in reducing HIV rates. Such interventions highlight the social determinants of health that are co-factors in HIV transmission such as poverty and lack of access to health resources, historical and intergenerational trauma, substance and alcohol misuse, and exposure to violence. More importantly, they actively engage community members so that programs are tailored to meet specific community needs.

As Tribes and Tribal organizations consider how to address HIV/AIDS in their communities, the CBPR approach can be a framework worth considering. Ensuring that Tribes have oversight and ownership of interventions further ensures that HIV transmission rates can be reduced. ■

1 Centers for Disease Control and Prevention. Racial and Ethnic Disparities in HIV diagnosis. Retrieved from <https://www.cdc.gov/hiv/pdf/group/raciaethnic/aian/cdc-hiv-natives.pdf>

2 Indian Health Service. AI/AN HIV/AIDS data. Retrieved from <https://www.ihs.gov/hiv/aids/stats/>

3 Centers for Disease Control and Prevention. (2013). National Health Interview Survey Retrieved from

<https://www.cdc.gov/nchs/fastats/american-indian-health.htm>

4 Ibid

5 Centers for Disease Control and Prevention. (2014). HIV Care Outcomes Among Blacks with Diagnosed HIV- United States/ Retrieved from <https://www.cdc.gov/mmwr/volumes/66/wr/mm6604a2.htm>

6 Centers for Disease Control and Prevention. (2015). Diagnoses of HIV Infection in the United States and

Dependent Areas. Retrieved from <https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-2015-vol-27.pdf>

7 Centers for Disease Control and Prevention. (2015). Social Determinants of Health and Selected HIV Care Outcomes among Adults with Diagnosed HIV Infection in 32 States and the District of Columbia. Retrieved from <https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-supplemental-report-vol-21-7.pdf>

8 Burhansstipanov L, Christopher S, Schumacher SA. Lessons learned from community-based participatory research in Indian country. *Cancer Control*. 2005;12:70-76

9 Gone, J. P., & Calf Looking, P. E. (2011). American Indian Culture as Substance Abuse Treatment: Pursuing Evidence for a Local Intervention. *Journal of Psychoactive Drugs*, 43(4), 291-296. doi:10.1080/02791072.2011.628915

U.S. Department of Health and Human Services Secretary's Minority AIDS Initiative Funding

The Secretary's Minority AIDS Initiative Fund (SMAIF) is a crucial component of the overall Minority AIDS Initiative established in 1999 in response to the critical need for targeted HIV prevention and treatment interventions in racial and ethnic minority communities. Administered through the Office of HIV/AIDS and Infectious Disease Policy (OHAIDP), SMAIF funds are then distributed via the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), the Indian Health Service (IHS) and the Substance Abuse and Mental Health Services Administration (SAMHSA).

Current funding under SMAIF is set at \$54 million, and in FY2016 alone, it funded 31 projects across forty states, D.C., and U.S. territories. Specific to Indian Health, the IHS received \$3.6 million in FY2016 to fund HIV work across IHS, Tribal and Urban Indian facilities. SMAIF funds to IHS have been used to meet the goals of the National HIV/AIDS Strategy (NHAS) such as improving HIV testing and care linkage, bolstering comprehensive care, raising viral suppression levels, and expanding access to Pre-Exposure Prophylaxis

(PrEP). More importantly, IHS relies upon SMAIF funds for almost all of its HIV/AIDS program dollars.

Despite its significant contributions towards lowering the burden of HIV in Tribal and other ethnic minority communities, SMAIF funding was cut under the FY2018 President's Budget. As mentioned, a direct consequence of this cut would be elimination of HIV/AIDS funding to the IHS, however, other agencies including the Office of Minority Health, Office on Women's Health, and even www.HIV.gov would lose funds for their HIV prevention, outreach, education and treatment programs.

The National Indian Health Board is closely monitoring this particular stream of funding and would like to hear from any SMAIF awardees who can share information about its role in their communities and in their work.

Should you be interested in sharing information about SMAIF, please contact NIH Deputy Director for Congressional Relations, Michelle Castagne, at mcastagne@nihb.org or at 202-507-4083. ■

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SMAIF IN INDIAN COUNTRY



Transforming Care in Indian Country

Indian Health Service (IHS) projects have **expanded HIV testing and improve prevention, care, and treatment outcomes** among American Indian and Alaska Natives. Approximately 99% of IHS HIV funding comes from SMAIF. As a result of SMAIF funding:

- Prenatal screening increased **67%** (2006-2016)
- HIV screening increased by **63%** for 13-64 year olds (2012-2016)
- HCV screening increased **450%** among baby boomers (2012-2016)

Applying the Harm Reduction Approach to HIV transmission for Injection Drug Users in American Indian and Alaska Native Communities

American Indians and Alaska Natives (AI/AN) rank third in HIV rates based on race. A closer look at modes of HIV transmission reveal some startling disparities that can impact the trajectory of current and future HIV prevention efforts. According to the Centers for Disease Control and Prevention (CDC), the overwhelming majority of HIV transmission among AI/AN women occurs via heterosexual contact (73%), which is consistent with HIV diagnoses among women in the general population. Where HIV transmission for AI/AN women diverge from women overall, however, is with injection drug use. Whereas 13% of HIV transmission among women overall can be attributed to injection drug use, this mode of transmission is responsible for almost a third (27%) of HIV diagnoses among AI/AN women.

Syringe exchange programs have also been shown to increase an individual's requests for and access to substance misuse treatment programs.

Injection drug use (IDU) has long been documented by research to be a high-risk practice for HIV transmission. According to the CDC, people living with HIV can transmit the virus to others by sharing syringes, needles and other equipment used for injecting drugs, such as rinse water, cotton and "cookers" (i.e. the equipment used to cook the drugs in preparation for injection). For individuals who inject drugs with their sexual partners,

IDU has been shown to lower sexual inhibitions and increase sexual risk-taking behaviors such as having sex without a condom. For AI/AN women, this issue is further compounded by high rates of intimate partner violence (55.5%) and sexual assault (56.1%) faced across the lifetime, which can further complicate condom negotiation and other safe and consensual sex practices, and has also been shown to increase other HIV risk behaviors such as sex with multiple partners and substance use.

The concept of harm reduction has been shown to be an extremely effective method of reducing HIV transmission among IDUs. The Harm Reduction Coalition (HRC) defines harm reduction as "...a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use." One of these strategies is expressed by syringe exchange programs. Long seen as a controversial strategy, syringe exchange nevertheless remains an important tool for reducing HIV rates among IDUs. Simply defined, syringe exchange programs permit IDUs to turn in their used needles and other drug injection equipment and access unused injection equipment. By ensuring that every time someone injects drugs they are not sharing the injection equipment and are using new supplies, they are protecting themselves from transmission of HIV and other infections, including Hepatitis C.

Research has clearly demonstrated that syringe exchange programs are not only effective had reducing transmission of diseases such as HIV and Hepatitis C, but also at lowering drug use overall in the long run. For instance, the National Institute for Health (NIH) showcased that HIV transmission rates in communities served by syringe exchange programs (SEPs) were reduced by 30% or more, and that roughly 25 million used syringes were removed from communities

Syringe exchange programs have been linked to reductions both in fatal and non-fatal overdoses

nationwide. SEPs have also been shown to increase an individual's requests for and access to substance misuse treatment programs. For instance, IDUs in Seattle who used SEPs were shown to be five times more likely to enter drug treatment than those who did not use SEPs. The CDC reports that SEPs are also important avenues to link individuals to care, given that the greater majority of programs also include case management services, screening for HIV and other sexually transmitted infections, and clinical and preventative health services.

Even more striking, SEPs have been linked to reductions both in fatal and non-fatal overdoses as they serve as a platform to both access and receive trainings on how to administer overdose-reversing medications such as Naloxone.

Tribal communities across Indian Country have witnessed first-hand the benefits of SEPs through implementation of their own harm reduction programs. With the ban of usage of federal funds for syringe exchange programs lifted back in early 2016, now more than ever Tribes have the opportunity to investigate how SEPs can be beneficial in their communities. More importantly, it permits Tribes to exercise their sovereignty and create interventions that are grounded in compassion, trust, and community building. Only then can the scourge of HIV among IDUs be effectively addressed. ■

Pre-Exposure Prophylaxis and Post-Exposure Prophylaxis – What They Are and What They Can Do to Address HIV in Indian Country

The landscape for HIV prevention and treatment has changed significantly for the better in recent years as advancements in research have led to new medicines flooding the market. People diagnosed with HIV are able to live longer, and have more fulfilling lives. When strictly following their medication regimens, people living with HIV have little to no risk of transmitting the virus, and are even able to have healthy offspring that are not born with HIV. Indeed, the success of HIV medications have led to new movements and social marketing campaigns highlighting how being “undetectable” (i.e. having a viral load so low that it cannot be measured by HIV detection devices) is equal to being “untransmittable.” Two important medical advancements in recent years that markedly improved the lives of those living with HIV and those at risk for HIV are Pre-exposure prophylaxis (or PrEP) and Post-exposure prophylaxis (or PEP).

PrEP – sold under the brand name Truvada – was approved by the Food and Drug Administration (FDA) in 2012. In essence, PrEP is a combination of two highly effective HIV medicines, tenofovir and emtricitabine, consolidated into a pill that should be taken once a day. PrEP is designed specifically for individuals not currently diagnosed with HIV as a form of preventative medicine. Currently, the Centers for Disease Control and Prevention (CDC) does not recommend PrEP for all individuals. It is marketed specifically for populations at high-risk for HIV infection such as those in serodiscordant relationships (i.e., relationships in which one partner is diagnosed with HIV and the other is not), among injection drug users, or among men who have sex with men (MSM)

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who have multiple partners and may or may not consistently use condoms. When taken consistently and in adherence to guidelines from the CDC, PrEP can reduce the risk of HIV infection via sexual contact by up to 92%, and by over 70% among people who inject drugs. However, it is important to note that PrEP is not a silver bullet. Taking PrEP is not a substitute for condom use, safe injection practices, and other preventative HIV measures. However, when PrEP is used in conjunction with other preventative practices, it can be a robust and effective supplement.

PEP is a different form of HIV prevention that is geared specifically for individuals who have been potentially exposed to HIV in order to prevent infection. For many PEP users, HIV exposure may have occurred via numerous pathways including sexual assault, sex without a condom with a person living with HIV who may not be taking their medication, or for people who inject drugs who may have

shared injection equipment with someone diagnosed with HIV. According to the CDC, PEP is only advised for use during emergency situations and must be started within 72 hours after an exposure in order to be effective. When administered within that window, PEP is a very effective tool; however, it does not reduce HIV risk by 100%. For those who are prescribed PEP, they are required to take one to two pills daily for a 28 day period.

Access to PrEP and PEP in American Indian and Alaska Native (AI/AN) communities can be limited; however, options are available. Most insurance providers including Medicaid provide subsidized coverage for PrEP after patients receive pre-authorizations from their providers. AI/ANs interested in PrEP should check with their healthcare providers to learn if PrEP is offered Indian Health Service/Tribal/Urban (I/T/U) facilities. If not, referrals can be provided to other clinics that may administer the medication. However, for individuals without insurance coverage who are not on Medicaid, PrEP can be a highly expensive medication at roughly \$1,300 per month in out-of-pocket expenses. Other avenues include medication assistance programs provided by Gilead, the manufacturer of PrEP, for individuals making less than \$58,000 in annual income. In addition, the Indian Health Service has provided grants to Tribes and Tribal organizations to improve access to comprehensive PrEP services.

As Tribes continue exploring different avenues for addressing the high rates of HIV in AI/AN communities, further education and investigation into PrEP and PEP can be an effective avenue for both providers and consumers. ■

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National Indian Health Outreach and Education (NIHOE) Project is funded by the Secretary's Minority AIDS Initiative Fund.

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