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NATIONAL AIDS POLICY COORDINATOR
DEPARTMENT OF HEALTH & HUMAN SERVICES
Room 729H Humphrey Building
200 Independence Ave., S.W.
Washington, D.C. 20201

DAY Tuesday DATE August 3, 1993

TIME 2:00 p.m. LOCATION Rm. 716-G, HHH Bldg.

SUBJECT Meeting with Dr. Lee and Mr. Ron Rowell of the National Native American AIDS Prevention Center

PARTICIPANTS:

Representative from Indian Health Service and Patsy Fleming. The Secretary may drop by. The meeting is scheduled for an hour.

AMERICAN INDIAN/ALASKA NATIVE ACCELERATED PREVENTION CAMPAIGN

Community Description

Oklahoma ranks 18th in geographical area among the states and covers about 70,000 square miles in the geographic center of the United States. The state is divided into 77 counties, with the 1990 estimated census reflecting a population of 3,145,585 million. Oklahoma's rural Indian character is reflected by a population density of 46.1 persons per square mile. As a result of continuing urbanization, of the state's Indian population who now reside in three metropolitan or semi-metropolitan areas are Oklahoma County (24,313), Tulsa County (25,401), and Cherokee County (11,380).

An estimated 252,000 American Indian/Alaska Natives reside in Oklahoma representing 37 tribes, as the largest concentration of Indians in the United States. According to the 1990 U.S. Census, the tribal jurisdiction of Cherokee Nation includes a population of 66,356, the Creek Nation includes a population of 44,964 and Lawton Area Indian population is 13,408 that includes the Kiowa, Apache, Ft. Sill Apache, and Comanche Tribes. Medical and health care service and assistance is provided through 9 service units of the Oklahoma Area Indian Health Service, managing 7 hospitals and 24 health centers. The user population of the Claremore Service Unit is 73,053 and for Tahlequah is 42,720 that total user population exceeds the total user population for the entire Navaho Area. Tribal influence on medical care management is demonstrated by operation of 2 hospitals and 12 health centers by either the Cherokee, Creek, Choctaw or the Chickasaw Tribes.

Poverty and lack of education persist in the Indian communities. The 1980 census showed over 13 percent of the population below the Health and Human Service established poverty level. The 1990 U.S. Census identified American Indian/Alaska Native women with having the highest high school dropout rate in the nation.

The health status of American Indians is lower according to almost every indicator than the United States populations as a whole; life expectancy is 71.1 years as compared with 74.4 for the white population. However, data from 1985 to 1987 showed that 33 percent of all Indians die before the age of 45, compared to 11 percent for the white population in 1986 with the high risk behaviors of substance abuse and alcohol use accounting for the majority of the top ten causes of early death either directly or indirectly.

A study conducted between 1984 and 1988 indicates rates of STDs such as gonorrhea, syphilis, and chlamydia are on average twice as high for American Indian/Alaska Natives as for the United States population as a whole (Toomey, Oberschelp, and Greenspan, 1989). In Oklahoma, American Indian/Alaska Natives are at parity with that statistic. STD rates are higher for American Indians because of high rates of substance abuse and overall poor socioeconomic conditions.

Sexual activity starts early, as evidenced by the teen pregnancy rates; 20 to 25 percent of Indian babies are born to mothers 18 years or younger. Injection drug use may be a more serious problem

than most public health officials realize (Rowell, 1990). Tuberculosis rates are 5 times higher for Indians than for the United States population as a whole. The increase in the number of cases of tuberculosis, especially multidrug resistant TB, is particularly troubling for American Indian/Alaska Natives. TB was a serious infectious disease in Indian population in the first half of this century, and many living today were exposed to TB in their youth, making them particularly vulnerable to the disease. Living conditions in some Indian communities are not much better in 1993 than they were in 1950. According to the 1990 U.S. Census, over half of all American Indians live in standard metropolitan statistical areas. Fewer than one-quarter live on reservation land and the rest live in rural areas.

The Indian Health Service is the provider of last resort for the majority of Indians in Oklahoma (a fact rarely understood by State agencies). State agencies consider their programs as providers of last resort. **The IHS Oklahoma Area receives per capita funding at ~~50~~ 65 percent of the overall IHS funding formula. The 50 percent level is based on the premise that the Oklahoma Indian population can access other state health resources. However, functional access has been very limited or non-existent.** IHS primarily funds clinical services in some urban centers, but the most of intensive services are generally not available for the urban Indian populations.

Epidemiology

Two seroprevalence studies offer evidence of the possible extend of HIV infection among American Indians/Alaskan Natives. The Indian Health Service and CDC have been studying blood samples taken from women attending prenatal clinics and from men and women being evaluated in an IHS-funded STD clinic since 1989. The researchers estimate that, based on their findings, there are approximately 2,730 Indians (range 1,210 to 4,250) who are infected with HIV but are symptomatic. HIV infection in rural areas among Indian women in their third trimester of pregnancy was found at **four to eight times higher** than rates for childbearing women of all races in the same states. This calculation of seropositive Indians may underestimate the true size of the problem because urban areas with high rates of HIV seroprevalence were underrepresented in the study (CDC, 1991).

In 1991, the IHS set up a national drug depot for zidovodine (AZT), aerosolized pentamidine, and other AIDS-related drugs at the Carl Albert Indian Hospital in Ada, Oklahoma, and established a system for making these drugs available for eligible HIV-infected Indians through IHS and IHS-funded providers.

Providing care in a multiplicity of settings that include IHS operated hospitals and clinics, tribally operated hospitals and clinics, and contracted specialized health care services, the cost

of STDs and HIV infection continues to put a severe burden on the already strained IHS budget.

For American Indians living in rural settings, the lack of nearby service is as much a barrier to access as it is for other rural populations. This is especially true of Alaskan native villagers whose only access to care may be the airplane. In the lower 48 states, some Indians with STDs and/or HIV infection drive a reportedly 70 miles in each direction to obtain health care services.

Historical demographers estimate that at the tie of the initial European exploration and settlement of North America, the were 12 to 15 million indigenous "Indian " inhabitants of what is now the contiguous 48 states. By the end of the nineteenth century, the Indian population had been reduced to about 250,000 due largely to epidemics of infectious diseases which raged from the beginning of contact with Europeans. Only in the twentieth century has the Indian population, who had no immunity to "old World" pathogens, have the American Indians began to recover. By the 1990 U.S. Census, 1.87 million people reported themselves as being of American Indian descent.

Oklahoma has the largest non-reservation Indian population. Most Indians living in Oklahoma are descendants of populations that were removed from other parts of the continent to once was known as Indian Territory. Oklahoma Indians were not and are not now one population, but many Tribes, each with their own language, traditions, history, and government-to-government relationship with the United States. Each Tribe determines its own citizenship requirements as a sovereign nation.

The damage to the health and well-being of the American Indian caused by destruction and disruption of traditional economies and cultures owing to disease is still abundantly evident today in Oklahoma. Sexually transmitted diseases (STDs) outnumber all other reported communicable diseases in Oklahoma. In fact, STD reports have consistently exceeded other reported communicable diseases during the past 31 years. The following tables were provided by the State of Oklahoma Department of Health.

STATE OF OKLAHOMA
SEXUALLY TRANSMITTED DISEASE MORBIDITY RATES/AMERICAN INDIANS

STD	1992	RATE PER 100,000
PRIMARY & SECONDARY SYPHILIS	24	9.5
GONORRHEA	217	86.0
CHLAMYDIA	654	259.1

OKLAHOMA AMERICAN INDIAN HIV CASES BY SEX AND AGE

OKLAHOMA AMERICAN INDIAN HIV CASES BY SEX AND AGE AT DIAGNOSIS AS REPORTED IN 1990 - 1992

1990

AGE AT DIAGNOSIS	MALE	FEMALE	TOTAL
Under 5			
5 - 12			
13 - 19			
20 - 29	12		12
30 - 39	7	2	9
40 - 49	3		3
49			
TOTAL	22	2	24

1991

AGE AT DIAGNOSIS	MALE	FEMALE	TOTAL
Under 5			
5 - 12			
13 - 19			
20 - 29	8		8
30 - 39	8		8
40 - 49			
49	1		1
TOTAL	17		17

1992

AGE AT DIAGNOSIS	MALE	FEMALE	TOTAL
Under 5			
5 - 12			
13 - 19	1	1	2
20 - 29	5	4	9
30 - 39	5	2	7
40 - 49	1		1
49	1		1
TOTAL	13	7	20

OKLAHOMA AMERICAN INDIAN AIDS CASES BY SEX AND AGE

OKLAHOMA AMERICAN INDIAN AIDS CASES BY SEX AND AGE AT DIAGNOSIS AS REPORTED IN 1990 - 1992

1990

AGE AT DIAGNOSIS	MALE	FEMALE	TOTAL
Under 5			
5 - 12			
13 - 19			
20 - 29	3		3
30 - 39	10		10
40 - 49	2		2
49	2		2
TOTAL	17		17

1991

AGE AT DIAGNOSIS	MALE	FEMALE	TOTAL
Under 5			
5 - 12			
13 - 19			
20 - 29	5		5
30 - 39	13	1	14
40 - 49	3	1	4
49			
TOTAL	21	2	23

1992

AGE AT DIAGNOSIS	MALE	FEMALE	TOTAL
Under 5			
5 - 12			
13 - 19			
20 - 29	5	1	6
30 - 39	15		15
40 - 49	3		3
49	1		1
TOTAL	24	1	25

1990/91/92 OKLAHOMA AMERICAN INDIAN HIV/AIDS CASES BY SERVICE UNIT

OKLAHOMA AMERICAN INDIAN HIV/AIDS CASES
BY SERVICE UNIT AS REPORTED IN 1990 - 1992

p. 8.0

1990

SERVICE UNIT	AIDS	HIV	TOTAL
1. Clinton			
2. Pawnee		3	3
3. Claremore	8	9	17
4. Shawnee	2	7	9
5. Wewoka			
6. Tahlequah	2		2
7. Lawton	2	2	4
8. Ada		1	1
9. Talihina	3	2	5
TOTAL	17	24	41

1991

SERVICE UNIT	AIDS	HIV	TOTAL
1. Clinton			
2. Pawnee	2	1	3
3. Claremore	12	11	23
4. Shawnee	7	3	10
5. Wewoka			
6. Tahlequah	1		1
7. Lawton		1	1
8. Ada		1	1
9. Talihina	1		1
TOTAL	23	17	40

1992

SERVICE UNIT	AIDS	HIV	TOTAL
1. Clinton			
2. Pawnee		1	1
3. Claremore	13	7	20
4. Shawnee	6	7	13
5. Wewoka	1		1
6. Tahlequah	1	2	3
7. Lawton	2		2
8. Ada	1	1	2
9. Talihina		2	2
TOTAL	24	20	44

1992 AMERICAN INDIAN GONORRHEA MORBIDITY RATE BY COUNTY

COUNTYNAME	Freq	Percent	Cum.
BLAINE	1	0.5%	0.5%
BRYAN	2	0.9%	1.4%
CADDO	12	5.5%	6.9%
CANADIAN	2	0.9%	7.8%
CARTER	2	0.9%	8.8%
CHEROKEE	2	0.9%	9.7%
CHOCTAW	4	1.8%	11.5%
CLEVELAND	4	1.8%	13.4%
COMANCHE	27	12.4%	25.8%
COTTON	1	0.5%	26.3%
CRAIG	4	1.8%	28.1%
CREEK	3	1.4%	29.5%
CUSTER	4	1.8%	31.3%
GARVIN	1	0.5%	31.8%
HUGHES	3	1.4%	33.2%
KAY	5	2.3%	35.5%
LATIMER	1	0.5%	35.9%
LEFLORE	1	0.5%	36.4%
LOVE	1	0.5%	36.9%
MARSHALL	1	0.5%	37.3%
MAYES	5	2.3%	39.6%
MCCLAIN	1	0.5%	40.1%
MCCURTAIN	1	0.5%	40.6%
MCINTOSH	2	0.9%	41.5%
MUSKOGEE	16	7.4%	48.8%
NOBLE	2	0.9%	49.8%
OKFUSKEE	1	0.5%	50.2%
OKLAHOMA	31	14.3%	64.5%
OKMULGEE	3	1.4%	65.9%
OTTAWA	2	0.9%	66.8%
PAYNE	1	0.5%	67.3%
PITTSBURG	1	0.5%	67.7%
PONTOTOC	4	1.8%	69.6%
POTTAWATOMIE	4	1.8%	71.4%
PUSHMATAHA	1	0.5%	71.9%
ROGERS	5	2.3%	74.2%
SEMINOLE	4	1.8%	76.0%
SEQUOYAH	5	2.3%	78.3%
STEPHENS	1	0.5%	78.8%
TULSA	44	20.3%	99.1%
WAGONER	1	0.5%	99.5%
WASHINGTON	1	0.5%	100.0%
Total	217	100.0%	

1992 AMERICAN INDIAN CHLAMYDIA MORBIDITY RATE BY COUNTY

COUNTYNAME	Freq	Percent	Cum.
ADAIR	39	6.0%	6.0%
ATOKA	2	0.3%	6.3%
BECKHAM	1	0.2%	6.4%
BLAINE	6	0.9%	7.3%
BRYAN	5	0.8%	8.1%
CADDO	23	3.5%	11.6%
CANADIAN	14	2.1%	13.8%
CARTER	16	2.4%	16.2%
CHEROKEE	72	11.0%	27.2%
CLEVELAND	8	1.2%	28.4%
COAL	5	0.8%	29.2%
COMANCHE	16	2.4%	31.7%
COTTON	1	0.2%	31.8%
CRAIG	9	1.4%	33.2%
CREEK	5	0.8%	33.9%
CUSTER	19	2.9%	36.9%
DELAWARE	8	1.2%	38.1%
DEWEY	1	0.2%	38.2%
GARFIELD	3	0.5%	38.7%
GARVIN	4	0.6%	39.3%
HASKELL	2	0.3%	39.6%
HUGHES	4	0.6%	40.2%
JACKSON	1	0.2%	40.4%
JOHNSTON	3	0.5%	40.8%
KAY	16	2.4%	43.3%
KINGFISHER	1	0.2%	43.4%
LATIMER	3	0.5%	43.9%
LEFLORE	3	0.5%	44.3%
LINCOLN	1	0.2%	44.5%
LOVE	2	0.3%	44.8%
MARSHALL	2	0.3%	45.1%
MAYES	28	4.3%	49.4%
MCCURTAIN	16	2.4%	51.8%
MCINTOSH	7	1.1%	52.9%
MURRAY	2	0.3%	53.2%
MUSKOGEE	49	7.5%	60.7%
NOWATA	7	1.1%	61.8%
OKFUSKEE	8	1.2%	63.0%
OKLAHOMA	44	6.7%	69.7%
OKMULGEE	7	1.1%	70.8%
OSAGE	4	0.6%	71.4%
OTTAWA	19	2.9%	74.3%
PAWNEE	2	0.3%	74.6%
PAYNE	2	0.3%	74.9%
PITTSBURG	4	0.6%	75.5%
PONTOTOC	18	2.8%	78.3%
POTTAWATOMIE	13	2.0%	80.3%
ROGER MILLS	1	0.2%	80.4%
ROGERS	21	3.2%	83.6%
SEMINOLE	7	1.1%	84.7%
SEQUOYAH	17	2.6%	87.3%
TILLMAN	1	0.2%	87.5%
TULSA	70	10.7%	98.2%
WAGONER	9	1.4%	99.5%
WASHINGTON	2	0.3%	99.8%
WOODWARD	1	0.2%	100.0%
Total	654	100.0%	

1992 AMERICAN INDIAN EARLY SYPHILIS RATE BY COUNTY

COUNTYNAME	Freq	Percent	Cum.
CADDO	1	4.2%	4.2%
CANADIAN	6	25.0%	29.2%
CARTER	1	4.2%	33.3%
MUSKOGEE	1	4.2%	37.5%
OKLAHOMA	6	25.0%	62.5%
PAYNE	2	8.3%	70.8%
PUSHMATAHA	1	4.2%	75.0%
SEMINOLE	1	4.2%	79.2%
TULSA	5	20.8%	100.0%
Total	24	100.0%	

1991/1992 AMERICAN INDIAN STD RATE BY AGE AND SEX

PRIMARY AND SECONDARY SYPHILIS

	Male			Female		
	Indian			Indian		
	Pop	Cases	Rate	Pop	Cases	Rate
0 to 14	40,691	0	0.0	38,540	0	0.0
15 to 19	12,686	1	7.9	11,796	1	8.5
20 to 24	9,401	0	0.0	9,300	0	0.0
25 to 29	9,529	1	10.5	10,094	0	0.0
30 to 34	9,261	0	0.0	9,960	0	0.0
35 to 39	8,103	0	0.0	8,913	0	0.0
40 to 44	7,133	0	0.0	7,858	0	0.0
45 to 49	5,676	0	0.0	6,132	0	0.0
50 to 54	4,695	1	21.3	5,198	0	0.0
55 to 59	3,952	0	0.0	4,657	0	0.0
60 to 64	3,717	0	0.0	4,198	0	0.0
65 to 69	3,256	0	0.0	4,117	0	0.0
70 to 74	2,171	0	0.0	3,121	0	0.0

1992 TOTAL EARLY SYPHILIS TOTALS BY AGE, SEX AND RACE
RATES BY AGE AND RACE

AGE	AM INDIAN			
	M	F	TOT**	RATE*
0-9	0	0	0	0
10-14	0	0	0	0
15-19	0	4	4	16.3
20-24	0	3	3	16.1
25-29	0	3	3	15.3
30-34	3	5	8	41.7
35-39	4	1	5	29.4
40-44	0	0	0	0
45-49	0	1	1	8.5
50-UP	0	0	0	0
UNK	0	0	0	
TOTAL	7	17	24	9.5

Oklahoma 1991
GONORRHEA

Oklahoma State Department of Health

	Male			Female		
	Indian			Indian		
	Pop	Cases	Rate	Pop	Cases	Rate
0 to 4	13,027	0	0.0	12,611	1	8.1
5 to 9	14,069	0	0.0	13,533	0	0.0
10 to 14	13,615	0	0.0	12,576	39	39.5
15 to 19	12,686	20	157.7	11,796	83	703.6
20 to 24	9,401	37	393.6	9,300	67	727.6
25 to 29	9,529	8	84.0	10,094	14	138.7
30 to 34	9,261	11	118.8	9,960	8	80.8
35 to 39	8,103	8	98.7	8,913	5	56.1
40 to 44	7,133	2	28.0	7,858	2	25.5
45 to 49	5,676	1	17.6	6,132	1	16.3
50 to 54	4,695	1	21.3	5,198	0	0.0
55 to 59	3,952	0	0.0	4,657	0	0.0
60 to 64	3,717	0	0.0	4,198	0	0.0
65 to 69	3,256	0	0.0	4,117	0	0.0
70 to 74	2,171	0	0.0	3,121	0	0.0

1992 GONORRHEA TOTALS BY AGE, SEX AND RACE
RATES BY AGE AND RACE

AGE	AM INDIAN			
	M	F	TOT**	RATE*
0-9	0	0	0	0
10-14	0	6	6	22.9
15-19	19	68	88	359.4
20-24	20	35	55	295.6
25-29	12	19	31	158.0
30-34	6	17	23	119.8
35-39	5	2	7	41.1
40-44	1	1	2	13.3
45-49	1	0	1	8.5
50-UP	0	1	1	2.1
UNKNOWN	1	1	2	
TOTAL	65	150	217	96.0

Oklahoma 1991 CHLAMYDIA

	Female			Male		
	Indian			Indian		
	Pop	Cases	Rate	Pop	Cases	Rate
0 to 4	13,611	1	16.1	13,027	1	7.7
5 to 9	13,533	1	7.4	14,069	0	0.0
10 to 14	12,576	14	111.3	13,615	0	0.0
15 to 19	11,796	287	******	12,686	13	102.5
20 to 24	9,300	238	******	9,401	25	265.9
25 to 29	10,094	75	743.0	9,529	10	104.9
30 to 34	9,960	31	311.3	9,261	7	75.6
35 to 39	8,913	11	123.4	8,103	2	24.7
40 to 44	7,858	6	76.4	7,133	1	14.0
45 to 49	6,132	4	65.2	5,676	0	0.0
50 to 54	5,198	1	19.2	4,695	0	0.0
55 to 59	4,657	1	21.5	3,952	1	25.3
60 to 64	4,198	1	23.8	3,717	0	0.0
65 to 69	4,117	0	0.0	3,256	0	0.0
70 to 74	3,121	1	32.0	2,171	0	0.0
75 to 79	2,592	0	0.0			
80 to 84	1,569	0	0.0			
85 to 89	1,287	0	0.0			

1992 CHLAMYDIA TOTALS BY AGE, SEX AND RACE
RATES BY AGE AND RACE

AGE	AM INDIAN			
	M	F	TOT**	RATE*
0-9	0	3	3	5.7
10-14	0	10	10	38.2
15-19	13	275	288	1176.4
20-24	16	200	216	1160.7
25-29	5	67	72	366.9
30-34	2	25	27	140.6
35-39	0	10	11	64.6
40-44	1	4	5	33.4
45-49	0	5	5	42.3
50-UP	0	4	4	8.4
UNKNOWN	1	12	13	
TOTAL	38	615	654	259.1

Although, as of the end of September 1992, American Indian/Alaska Natives accounted for fewer than 1 percent of AIDS cases reported in the U.S., the incidence of AIDS increased faster among Indians than among any other ethnic group from 1889 to 1990 (Mellter, Conway, and Stehr-Green, 1991).

Male-to-male sexual transmission accounted for just over half the reported cases, with injection drug use accounting for approximately twenty-three percent. In 1992, AIDS cases have now been reported in every age group and in every Indian Health Service Area.

STDs/HIV/AIDS among Indian women is overwhelmingly due directly or indirectly to injection drug use; 59 percent of the female/adult/adolescent AIDS cases were exposed through injection drug use (CDC, 1992). All Indian pediatric AIDS cases for which the transmission was reported were due to perinatal transmission from a mother who either used injection drugs or had sex with an injection drug user; none were due to hemophilia-related blood products or to blood transfusions.

PROPOSED PROGRAMS

The Indian Health Service Oklahoma Area Office, Public Health Service, Department of Health and Human Services in coordination and collaboration with the Tulsa Area Chapter of the American Red Cross proposes the following efforts to strengthen the quality and increase the prevention of STDs/HIV/AIDS in the Indian populations of Oklahoma.

Public Health Advisor

The purpose of this position is to serve as liaison and provide on going oversight to identify and resolve major issues regarding STDs with the IHS, State Department of Health, Tribes and Tribal organizations, Oklahoma County and Tulsa County Health Departments, and other IHS health provider. The Public Health Advisor will be assigned to the American Red Cross to enhance that the required consultation, coordination, collaboration, and cooperation.

Blood Borne Pathogens - Preventing Disease Transmission

The purpose of this requirement is to provide STDs/HIV/AIDS Blood Borne Pathogen assessment consultation services for IHS/Tribal Medical staff and other primary care and support providers STDS/HIV/AIDS assessment consultation services will provided through nine (9) one (1) day Program Consultation Clinics. Consultation Clinics will be provided on site at IHS/Tribal Service Unit site in the Pawnee, Claremore, Tahlequah, Shawnee, Wewoka, Lawton, Ada, and Creek Nation Service Units and at the Indian

Health Care Resource Center of Tulsa. Dates for each Program Consultation Clinic will be agreed on with the American Red Cross and the IHS Oklahoma Area AIDS Coordinator and coordinated with Clinical Directors of IHS/Tribal facilities.

The Clinical Case Consultation Clinics will be provided at the average rate of one per month on dates agreed upon by the American Red Cross and the IHS AIDS Coordinator. The American Red Cross will be responsible for working with the Clinical Director and AIDS coordinator at the facility for establishing the time clinic consultation will be held. The contractor will be responsible for publicizing the visit times to the local health departments three (3) weeks prior to the visit. The list of site visits and times will be distributed to each clinical director as to maximize attendance by IHS/Tribal personnel. The IHS Oklahoma Area AIDS Coordinator in coordination with service unit Clinical Director and AIDS coordinator will develop a schedule for IHS/Tribal providers participating in consultations. The American Red Cross will develop and provide textbooks and manuals.

Program consultations clinics will include but not be limited to consultation regarding review of procedural requirements for appropriate assessment of STDs/HIV/AIDS, discrimination of normal and abnormal examinations findings, appropriate levels of assessment, interviewing techniques. identification techniques, case presentation, quality assurance, case reviews and systems analysis. The American Red Cross will prepare a written report at the end of the consultation session and will make a verbal report to the Area Governing Board and to the Area Service Unit Director/Clinical Director Meeting.

Case Management Assessment

The purpose of this requirement is to provide STDs/HIV/AIDS assessment consultation services for IHS/Tribal Medical staff and other primary care and support providers.

STDs/HIV/AIDS assessment consultation clinics will be provided through six (6) one (1) day Consultation Clinics at Oklahoma City Area Indian Health Service Unit sites or at central sites in Oklahoma City, Tulsa or Norman. One (1) day planning session should be held with the Service Unit Aids Coordinator at a central site in Oklahoma City.

Dates for each program consultation clinics will be agreed on by the American Red Cross and the IHS Oklahoma Area AIDS Coordinator and coordinated with the Clinical Directors and Service Unit AIDS Coordinators of the IHS/Tribal facilities. The program consultation clinics will be provided at the average rate of one every other month on dates agreed upon by the American Red Cross and the IHS Oklahoma Area AIDS Coordinator. The American Red Cross will be responsible for publicizing the consultation visits times

to the IHS/Tribal facilities, local health department and State Department of Health AIDS/STD Division at least three (3) weeks prior to the consultation. The list of sites and times will be distributed to each clinical director, Service Unit AIDS coordinator, public Health nurse coordinator and Human Services department, local health department and the State Department of Health AIDS/STD Division.

Program consultation clinics will include but not be limited to consultation regarding: case management services for HIV infected American Indians; methods to access non-IHS services for HIV infected persons; maximization of existing IHS/nonIHS resources; methods to access AIDS-specific drugs and clinical trials; nutrition counseling for HIV infected patients; access of early signs and symptoms of HIV; and long term follow up. A reference guide will be developed and provided to each participant in the consultation clinics.

Ahalaya Project

The National Native American AIDS Prevention Center/Ahalaya Project is the only American Indian center whose sole purpose is to focus on HIV prevention and case management specifically for Native Americans. With the increasing load of both HIV and AIDS patients, the problem of case management is becoming more complicated. The Ahalaya case management project not only continue ongoing services but expand by adding the STD component with an additional Public Health Service Advisor is required to meet the increased case load.

Indian Health Care Resource Center of Tulsa, Inc.

The role of the Tulsa Indian Urban Clinic has greatly expanded. They are currently working with the Cherokee Nation Tribal Health Department, Creek Nation Health Department and the Inter-Tribal Council in North East Oklahoma to provide accurate HIV/AIDS information through inservice training, community forums, health fairs, pow wows, etc. They also work closely with the newly formed AIDS Coalition for Indian Outreach and also assisted with the Alaska Native Youth Leadership Symposium on AIDS. They have established a close relationship with the Tulsa AIDS Coalition, Oklahoma HIV/AIDS Coalition, The National Minority AIDS Council, The National Native American AIDS Prevention Center, the National Association of People with AIDS and Tulsa Chapter of the American Red Cross. The Tulsa Chapter of the American Red Cross in collaboration with the Indian Health Care Resource Center will develop Indian specific STDs/HIV/AIDS educational materials.

Central Oklahoma American Indian Health Council, Inc.

The role of the Oklahoma City Urban Clinic has expanded activities. The Clinic provides information regularly at booth set up at local

pow-wows, community gatherings, and national gatherings such as Red Earth. The clinic also provides a support group weekly to 25 homeless Indians at the Rest Day Shelter. HIV counseling and education is included in all group discussions. There are also three groups who schedule weekly meetings for high risk adolescents concerning STDs/HIV/AIDS.

Service Units

The Oklahoma City Area Indian Health Service (OCA/IHS) has the largest census population and user population of any area of the IHS. The most recent information indicates that the area has a total of 65 AIDS cases and another 100 HIV positive individuals. Both the volume of patients returning home from other state and individuals acquiring the infection within the state appears to be increasing. The Claremore service unit has recently reported two women that have tested positive. They currently have the largest case load with 20 HIV +/AIDS patients being receiving inpatient and outpatient care. An attempt will be made to more closely link the Claremore Service Unit and the Indian Health Care Resource Center of Tulsa, Inc.

The IHS and Tribal AIDS coordinators report a continued denial of the problem in the most traditional communities of the state. The Spring STDs/HIV/AIDS Tulsa Conference for the Albuquerque, Nashville and Oklahoma area for tribal leaders, Indian educators and health care provider did seem to heighten general awareness. The conference was considered to be a major success. The expected attendance of 250 was nearly doubled. An outline of the conference available through either the Oklahoma City Area Office or the Native American Institute on the University of Oklahoma Norman Campus. A knowledge, attitude and behavioral survey was administered to the attendee. It confirmed that even among health care provider that was a significant attitude and behavioral problem relating to high risk sexual behaviors. The entire process of preparing a statement of work, organizing the conference and in fulfilling the terms of the statement of work consumed 50% of the prior fiscal year and approximately a third of the this fiscal year.

Seroprevalence Testing at American Red Cross

The blinded seroprevalence testing for HIV in the Indian population indicates a rate significantly higher than that of the state. The IHS area with the increased rate was also tested for drug usages using the blinded approach through an agreement with the state. Protest counseling continues at about 50 percent of the pretest counseling rate. The American Red Cross would provide alternative sites for STDs/HIV/AIDS testing for pregnant Indian women and high risk adolescents. The American Red Cross will report to the IHS/State Department of Health the results of their testing. The

American Red Cross provides confidentiality in testing at their sites.

Seroprevalence Testing at IHS Facilities

The Ada Service Unit has yet to join in the blinded seroprevalence testing. Ada may be at risk because of the flow of patients from the Dallas-Fort Worth (MSA). The Service Unit is also without an AIDS coordinator or an infection control nurse. The IHS Oklahoma Area AIDS Coordinator in conjunction with the American Red Cross will provide inservice training to tribal and community leaders in STDs/HIV/AIDS.

STDs/HIV/AIDS Education/Certification - American Red Cross

The Lawton Service Unit AIDS coordinator worked with the State of Oklahoma Health Education Department at the Riverside Indian School. Significant information found: pressure to be sexually active (22 percent) and don't know about STDs/HIV/AIDS (41 percent).

The Tulsa Area Chapter of the American Red Cross is located in Tulsa, Oklahoma. According to the 1990 census Northeast Oklahoma has the highest concentration of American Indian/Alaska Natives than anywhere in the United States. Tulsa also has the second largest urban American Indian/Alaska Native population.

In 1991 the American Red Cross, Tulsa Area Chapter collaborated with the Indian Health Care Resource Center and with the input from a statewide Indian Advisory Committee, developed a one year project for a brochure, entitled. "When Raven Mocker Speaks" and a poster entitled, "Look! Listen! Avoid AIDS!" in 1992, the brochure and poster were distributed and follow-up included the pre- and post-testing of students and instructors' evaluations. The final project evaluation concluded that a big gap existed in American Indian/Alaska Natives.

This in turn led to the project, "American Indians Decision to Survive". The goals of the project are to develop an American Indian STDs/HIV/AIDS Instructors Manual and a Guide for training American Indian/Alaskan Native Instructors. A three year grant was award for 1993-1995 by the National Headquarters of the American Red Cross for developing, testing and evaluating a National AIDS Education and Certification Training course for the American Indian/Alaskan Natives. The American Red Cross will develop, test and evaluate a IHS specific Education and Certification Training course for health care professionals and health care providers. In order for the manual to be complete there is a need for additional training materials and supportive literature for both the Education and Certification Training course for American Indian/Alaska Natives and IHS health care professionals and providers.

Therefore, the American Red Cross will develop an appropriate brochure, poster and video with a life expectancy of at least five years or longer, to be used in conjunction with the manuals to make this one of the most unique and valuable resources for STDs/HIV/AIDS training for American Indian/Alaska Natives.

The Red Cross is proposing to use the phrase "Running on Indian Time", which is used and recognized by American Indian/Alaskan Natives, to develop a brochure, poster and video to address all ages with emphasis on grades 6-9. The reading material developed will be designed for the 6th grade reading level. The brochure will emphasize information on STDs/HIV/AIDS prevention by showing that "Running on Indian Time" can be either safe or unsafe. The poster will depict a scene from the video tape. The video will depict realistic situations so that the viewer will understand the implications of STDs/HIV/AIDS by showing the safe and unsafe of "Running on Indian Time".

The project will be based in the Tulsa Area Chapter, Health and Safety Services department with full use of equipment, support personnel and supporting materials that will be utilized for this project.

This project will bring together cultural sensitivity, traditional medicine and holistic approach needed for Indians to survive diseases that at this time knows no barriers on whom it can effect.

The American Red Cross inconjunction with the IHS, the Bureau of Indian Affairs (BIA), the State Department of Education, Tribes, Tribal Organizations, and Community-based Indian organizations will develop a demonstration projection to present and distribute educational material and information on STDs/HIV/AIDS to approximately 33 percent of all Indian youth in the public school system for grades 6-9, BIA funded schools (i.e. Riverside/Sequoyah etc.) and at the Haskell Indian College, Lawrence, Kansas.

The American Red Cross will conduct a series of STDs/HIV/AIDS Training programs by on site sessions at the Service Units with a recognized STDs/HIV/AIDS physician care provider. Consultation Clinics will be conducted on site in the Pawnee, Claremore, Tahlequah, Shawnee, Wewoka, Lawton, Ada, and Creek Nation Service Units.

The American Red Cross will develop culturally appropriate educational campaigns and educational materials that promote STDs/HIV/AIDS Awareness and promotion of the objectives of Healthy People 2000.

STDs/HIV/AIDS Case Management Effectiveness

Conduct a series of Case Management consultation visits at the Service Units by health care providers experience in case management. Topics to be included: case management services for HIV-infected American Indians; how to access non-IHS services which are available for HIV infected persons; making the most of all available services on behalf of patients; early signs & symptoms in HIV positive males and females; lessons learned from long-term survivors of HIV infections; how to access AIDS-specific drugs and Clinical Trials; and nutrition counseling for HIV infected patients.

The American Red Cross serve as an independent collector of medical data to improve quality assurance and to assist the IHS in determining effectiveness of STDs/HIV/AIDS education, outreach, intervention, drug treatment, and other scientific data that is agreed upon with the IHS/American Red Cross. The American Red Cross will serve as a central collection point, provide for the standardization of terminology and data collected, and provide a data base for this information.

Regional Treatment Centers

With the increasing awareness of the link between substance abuse behaviors and sexually transmitted disease, the IHS Regional treatment centers are playing a more important role in STDs/HIV/AIDS prevention efforts. The American Red Cross will conduct outreach presentations to the IHS Regional Treatment Centers that offer STDs/HIV/AIDS prevention information.

Partner Notification

The American Red Cross will develop Partner Notification material for STDs/HIV/AIDs patients that will be distributed to the high risk Indians populations through Tribes, Tribal organizations, and the IHS Community Health Representative Program. The American Red Cross in conjunction with IHS, PHS will provide ongoing intervention activities which include interviewing and partner notification activities for these high risk individuals where the diagnostic stage of these cases indicate the need to identify these cases earlier.

Prisons/Correctional Facilities

Oklahoma has one of the largest number of Indians incarcerated per capita in correctional facilities with the Indian women per capita rate leading the nation.

With the increasing link to high risk sexual behavior in prisons/correctional facilities to sexually transmitted diseases, HIV and AIDS, the American Red Cross will conduct outreach, onsite presentations to the State Correctional facilities American Indian/Alaska Native inmates that offer education, prevention and counseling.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

JUL 30 1993

TO: The Secretary
Through: DS ____
COS____
ES ____

FROM: Assistant Secretary for Health

SUBJECT: Your Drop-By at Ms. Fleming's Meeting with Ron Rowell, Executive Director, National Native American AIDS Prevention Center; August 3 at 2 PM--**BRIEFING**

PARTICIPANTS

Outside the Department

Mr. Ron Rowell, Executive Director
National Native American AIDS Prevention Center (NNAAPC)

HHS Officials

Patsy Fleming, Special Assistant to the Secretary
Philip R. Lee, M.D., Assistant Secretary for Health

BACKGROUND

Mr. Ron Rowell is a citizen of the Choctaw Nation of Oklahoma. He has been the Executive Director of the NNAAPC since 1987 when the organization was founded. At TAB A is a biographical sketch of Mr. Rowell. The NNAAPC was initially funded through monies provided by the Center for Disease Control's HIV/AIDS minority grant program. Supplemental funding for HIV case management services was recently provided by the Health Resources and Services Administration.

ISSUES OF CONCERN

Mr. Rowell is concerned about several issues pertaining to HIV/AIDS in American Indian and Alaska Native (AI/AN) communities. These issues are also highlighted in the National Commission on AIDS report, The Challenge of HIV/AIDS in Communities of Color.

Specifically, Mr. Rowell is concerned about:

- **The limitations of Indian Health Service funding**. He is concerned that when HIV/AIDS was declared a public health priority, funds were taken from the already burdened Indian Health Service (IHS) budget to fund HIV programs. The extra burden of funding HIV programs further limited the IHS ability to provide services for AI/AN populations.

- **Insufficiency of the tribal contract health services budget**. Mr. Rowell is concerned that the tribal budgets for contract health services are extremely limited and that the expensive care of HIV/AIDS patients will rapidly drain those budgets or that the tribes will limit care paid for by contract health services to emergency Priority I situations in order to avoid expensive hospital and tertiary care.

- **IHS leadership failure to prioritize HIV/AIDS**. Mr. Rowell feels there is no public health leadership in IHS capable of prioritizing HIV issues in a manner that will assist the tribal leaders in making informed decisions regarding AIDS and other important health matters.

- **Tuberculosis among HIV infected AI/ANs**. Currently, Mr. Rowell is seeking funding for the NNAAPC to provide tuberculosis (TB) information through their HIV/AIDS prevention activities. Historically, AI/AN populations have experienced a higher rate of TB than all other ethnic groups.

  While increasing rates for TB in the general population are known to be HIV associated, IHS has investigated and determined that this association does not exist among AI/ANs.

Philip R. Lee, M.D.

Attachment:
Tab A - Biographical Sketch of Ron Rowell

BIOGRAPHICAL SKETCH FOR RON ROWELL

Ron Rowell is a citizen of the Choctaw Nation of Oklahoma and is of Choctaw and Kaskaskia Indian descent. He received his Master's of Public Health degree in Community Mental Health with a focus on health planning from the University of California at Berkeley School of Public Health in 1978.

He was hired by the West Bay Health Systems Agency in San Francisco just prior to graduation as a health planner, where he specialized in certificate of need review for renal dialysis facilities, cardiac catheterization laboratories, and skilled nursing facilities. In 1981 he became Director of the San Francisco Refugee Health Agency, a program of the Catholic Social Service (CSS), with responsibility for the Refugee Services Program, which included resettlement, health, and employment.

In 1985 he left the CSS to establish his own consulting business, Achukma, Inc. Between 1985 and 1987, he worked primarily as a market researcher for tribes and Native American corporations. In 1987 he began working with the Indian Health Service (IHS) to train staff on HIV-related issues and came face-to-face with the reality of the threat of HIV to Indian health and survival. Early in 1987 he began to network with a group of concerned Indian health, mental health, and substance abuse professionals around the country to establish a National Native American AIDS Prevention Center (NNAAPC). An unsolicited proposal for the IHS to establish an NNAAPC was submitted to the IHS in July 1987 but was not acted upon by the IHS.

In December of 1987 he took over the position of HIV Antibody Testing Coordinator for the San Francisco Department of Public Health (SFDPH), where he had the support of supervisors in continuing to work on developing NNAAPC. A proposal submitted to the Centers for Disease Control under the National and Regional HIV/AIDS Minority Programs Request For Proposal succeeded and the agency was awarded funding in August. He left the SFDPH to head NNAAPC from September 1988 to the present.

In 1991 Jonathan Mann at Harvard University hired Mr. Rowell as International NGO Liaison for the Eighth International Conference on AIDS in Amsterdam, a consulting position concurrent with his responsibilities at NNAAPC.

Mr. Rowell is active in the American Indian community in San Francisco through his Chairmanship of the Board of Directors of Friendship House Association of American Indians, a 20-bed residential drug and alcohol treatment program. Friendship House was named a national model program by the IHS in 1990. He also serves on the Editorial Advisory Board of AIDS in the World, a

publication of the Francois-Xavier Bagnoud Foundation at Harvard University, et al.

He has published several articles on HIV/AIDS among Native Americans in such journals as Drugs and Society, SIECUS Reports, Winds of Change, AIDS Health Promotion Exchange and others.