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Issues - Groups-Native Americans [Folder 2]

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HIV AMONG NATIVE AMERICANS

ELDERS FROM SEVERAL NATIVE AMERICAN TRIBES HAVE spoken of ancient legends describing a disease that would consume our people, a disease for which there would be no cure," says Betty Duran, a Pojoaque Pueblo Indian. "They believe that disease is AIDS."

Five hundred years ago, there were an estimated five million Native Americans. By the beginning of this century, however, the population had fallen to several thousand, a decimation due, in great part, to diseases brought by Europeans. "We have a history of epidemics nearly wiping out our population," says Ronald Rowell, executive director of the National Native American AIDS Prevention Center. "Smallpox alone killed millions. We're afraid of that demographic collapse happening again with AIDS."

In earlier centuries, it was a lack of immunity that jeopardized so many tribes—and took so many lives. Today, a constellation of factors arising from the historical legacy of oppression is now further weakening Native Americans' immunity against the threat of HIV.

"We're invisible in our own land," says Rowell, who is both Choctaw and Kaskaskia. "People are surprised that AIDS is a problem for Native Americans—or even that we still exist. And when stereotyping interferes with our education, prevention, and surveillance, the results can be tragic."

Fighting Hollywood Stereotypes

Eight years ago, a young Navajo man touched AIDS outreach worker Melvin Harrison on the arm and asked him to step outside into a grocery store parking lot. The man was thin; his hair was falling out. He had AIDS, he said, and needed a hug.

"That's where my real journey started," says Harrison, now executive director of the Navajo Nation AIDS Network. "I cared for this man

HIV in the Far North

When Karen Soto, a Yupik from western Alaska, was diagnosed with HIV several years ago at a public health clinic in New York City, the woman sitting behind the desk neither acknowledged her name nor offered her a chair. She simply said, "You have HIV, and you have less than a year to live."

"I was extremely angry," Soto says. "I thought, You don't even know me, you don't know what I'm capable of." She became an HIV outreach worker at the American Indian Community House in New York. Last year she returned to Bethel, the Alaskan village where her family lives. There she lectures on HIV.

"There are so few Eskimos living with the virus and willing to talk about it," she says. "So if I'm asked by the Tundra Women's Center, by the schools, to speak about HIV, I always say yes."

When she first told her family of her infection, they didn't seem to react. "I began to wonder if they even understood the implications of HIV," she says. "But I've since realized that they know the implications full well; AIDS just doesn't carry a stigma for them. People here aren't afraid to touch each other, to be close. The only people in my community who haven't been accepting have been non-natives.

"Now I call my HIV disease my ugly child," Soto adds. "This child has chosen me. I can't give it away; it will always be with me. Ultimately this child has given me some of the best gifts of my life. I've come to love my ugly child. Just being challenged by HIV, I've done things I never thought I could do."

"We're invisible in our own land. People are surprised that AIDS is a problem for Native Americans—or even that we still exist."

until he died. Now he's always in my dreams, saying, 'Melvin, you gotta keep doing what you're doing, your Navajo people need you.'"

As HIV continues its spread into native communities, the Navajo people—and indeed all Native Americans—are beginning to need caregivers like Harrison more and more. To date, fewer than two thousand AIDS cases have been reported among Native Americans, whose population now numbers more than two million. Yet the HIV infection rate is rising, and many experts believe that the number of AIDS cases among Native Americans is dramatically underreported.

"Hollywood shows glamorized versions of Native Americans, with strong noses and high cheekbones," says Tom Lidot, a board member of Positively Native, a support group for Native Americans with HIV. "So when health agencies report our ethnicity, they may think we look Asian or Latino or white." One Los Angeles study found that nearly 90 percent of Native Americans with AIDS were classified as other races.

Duran points to other reasons for underreporting. "For a lot of Indians," she says, "traditional values mean that anything you do reflects on your community. AIDS is stigmatized, so Indians may claim to be another race, to keep their HIV infection from bringing shame on their community."

She adds that others may not even be tested for fear their confidentiality will not be maintained. "Native communities tend to be close-knit. Many people at risk of HIV infection are not getting tested because friends or relatives work in village or reservation health centers."

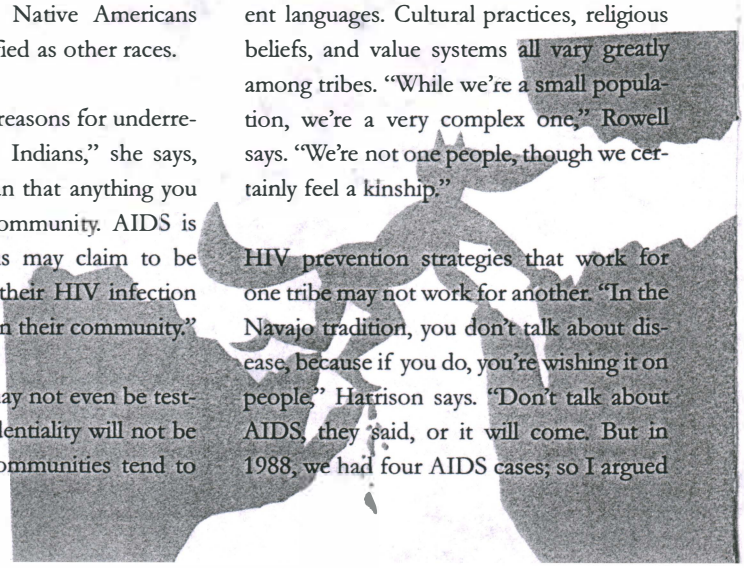
A Crossroads of Vulnerability

Many Native Americans live at the intersection that often places communities of color at risk: low socioeconomic status, high unemployment, and limited access to health care. In some communities, unemployment rates are as high as 50 percent; the average annual income on reservations is less than $5,000. The health status of Native Americans is much poorer than that of the general population: one-third die before the age of forty-five.

In addition, Native American communities often confront factors that can greatly increase vulnerability to HIV infection. For example, rates of sexually transmitted diseases—which can significantly raise the risk of HIV infection—are twice as high for Native Americans than for the population as a whole. Native American communities often must deal with relatively high rates of alcohol use, which can inhibit the practice of safer sex. And injection drug use, once thought to be low among Native Americans, is on the rise.

Several barriers to education reinforce this vulnerability. AIDS outreach workers have been challenged, for example, by the population's tribal and geographic diversity. Native Americans belong to 500 tribes or Alaska Native villages and speak 130 different languages. Cultural practices, religious beliefs, and value systems all vary greatly among tribes. "While we're a small population, we're a very complex one," Rowell says. "We're not one people, though we certainly feel a kinship."

HIV prevention strategies that work for one tribe may not work for another. "In the Navajo tradition, you don't talk about disease, because if you do, you're wishing it on people," Harrison says. "Don't talk about AIDS, they said, or it will come. But in 1988, we had four AIDS cases; so I argued



that it was already here. Now we believe that more than a hundred Navajos have AIDS."

Although geographic isolation has, to date, helped keep HIV infection rates relatively low among Native Americans, more than half of all Native Americans live in cities, where HIV prevalence tends to be higher. The constant movement of people among cities, towns, and reservations is helping the virus reach even the remotest communities.

"People think HIV won't come into their isolated communities, until they realize they know someone with the virus," Duran says. "This denial of AIDS is a big factor in native communities."

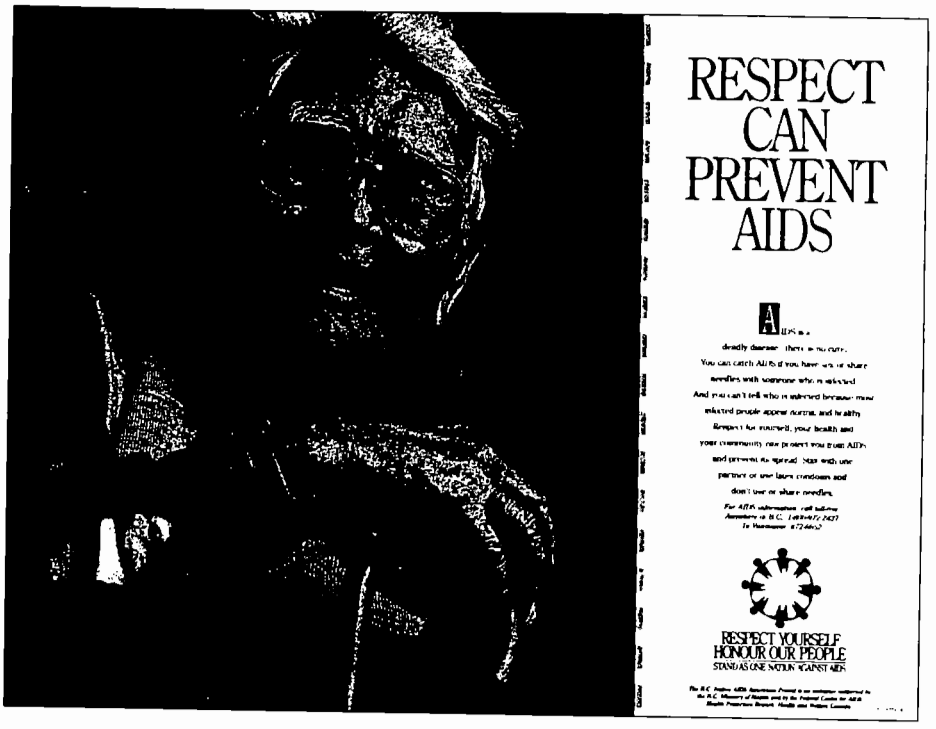
Lidot points to another reason for denial: "Homophobia plays a heavy role in terms of the stigmatization of AIDS," he says. "And yet we've seen community leaders become more understanding when they're reminded that some Native American tribes accepted homosexuality centuries ago."

"We try to educate everyone about the traditional roles gay people played," Rowell says. "In some tribes, for example, gay men became marriage counselors, because they were considered part male, part female. This approach heals wounds between individuals and families, between individuals and tribes. And it raises self-esteem among gay men, which helps them make healthful choices."

The Legacies of History

Native Americans with HIV often encounter numerous barriers to care. Geographic isolation, for example, tends to complicate health care delivery. In Alaska, only 10 percent of the two hundred native villages are accessible by road; people with HIV must spend hundreds of dollars simply to fly into the cities to receive care.

Another major obstacle is a historic distrust of institutions. "For almost half a century, native children were herded up and sent off to boarding schools, where they were prohibited from speaking their own language or practicing their own traditions," Duran says.



"We weren't even classified as American citizens until 1924. As a result, it's time consuming for caregivers to win over clients, to convince them that we're working in their best interests."

Historically complex relationships among federal, state, and tribal governments also have impeded delivery of HIV services. Native Americans with AIDS have been shuffled between agencies or even turned away because there was no clear definition of agency responsibility.

"We fall through the cracks," Rowell says. "Our unique relationship with the federal government has made some state health departments resistant to helping us. And, because most AIDS funding is routed through them, it can be a barrier to getting funds into native communities."

Rowell points to another obstacle: the Indian Health Service (IHS), which provides health care to most Native Americans, is both shrinking and reorganizing. "The IHS is poorly funded and the infrastructure isn't there now," Rowell says. "When you look ahead, it's even more alarming, because it's becoming more fragmented."

Duran agrees: "What's going on with the IHS is scary for Indian people, because they don't know what their future holds in terms of health care."

Elders in Baseball Caps

Designers of Native American AIDS prevention programs have found that messages are most effective when delivered by Native Americans themselves. "Part of the problem in Alaska is that we don't have enough natives talking about AIDS," says Karen Soto, a Yupik with HIV. "In my village, if an Eskimo says AIDS is a problem, then it's true. That's much better than having the message delivered by a white person coming to our snow-bound village wearing high-heeled boots."

Prevention programs that involve people with HIV, elders, and youth are the most effective, according to Lidot, who is HIV director of the San Diego American Indian Health Center. "People don't really understand how AIDS affects them until they meet someone with HIV," he says. "Elders dictate morality standards for the community, and young people set trends for future generations."

Rowell describes the success of skits presented at a community meeting in which elders played adolescents. With baseball caps worn backward, the elders enacted teens discussing AIDS with their parents and grandparents. "Not only did the audience remember the skits well," Rowell says, "but the elders' acting also gave an imprimatur to the message."

Strong respect accorded to elders is just one tradition common to all Native American tribes that has been successfully woven into HIV prevention programs. Other traditions include storytelling, a focus on the extended family, strong spiritual traditions, teaching children survival skills, and humor.

Storytelling in particular helps educators not only to illustrate the issues surrounding AIDS, but also to present difficult material in a nonthreatening way. One HIV prevention kit, for example, includes illustrations of Coyote, the traditional trickster in many native cultures. In the drawings, Coyote dances, scales a precipice, and peers into a pool, where he sees a skull reflected back at him. The storyteller asks the audience to describe Coyote: What does he think of himself? Why does he risk danger? What can his behavior teach Native Americans about protecting themselves against HIV?

Native American care providers have also learned to incorporate traditional methods into the care of people with HIV. For example, the National Native American AIDS Prevention Center has developed the Ahalaya Model, which incorporates traditional healing into HIV case management.

"This model gives clients access to traditional healing and spirituality, which emphasizes their membership within a cultural group, increases their self-esteem, and establishes values that guide behavior and socialization," says Duran, who oversees the project. "These all lead to improved health and a reduction in high-risk behaviors."

This model also provides AIDS education for elders and traditional healers. "We're finding that healers want to include people with HIV in their ceremonies," Duran says. "They're modifying ritual instruments and the ceremonies themselves, so that people with HIV can participate. Some spiritual elders have even taken vision walks in hopes of finding a ceremony, herbal treatment, or song that would be healing for people with HIV."

"Traditional methods of handling disease are old and resonant with Native Americans," Lidot says. "Unfortunately, the medical establishment is taught to invalidate our medicine. When a friend had a medical emergency, doctors told him not to participate in native traditions any more. At one point, when my friend's health began to deteriorate, a physician asked, 'Well, where's your witch doctor shaking his bone now?'"

Harrison is convinced of the power of a holistic approach: "A doctor recently said, 'Melvin, a lot of your clients come here really sick, and I think they'll only live another week or two. But they just keep living on and on.' It's simple: we believe in our ceremonies and herbs, and when our clients believe in them, it helps them gain strength."

Since his own HIV diagnosis in 1987, Lidot, a member of the Tlingit tribe, uses only traditional medicines. He performs morning meditations, gathers cleansing herbs, and participates in week-long healing ceremonies. "It's a major cornerstone of my ability to live," he says. "If I didn't believe in it, I know I wouldn't be alive."

The Alone-and-Afraid Disease

"We've found that when you begin working with clients with HIV, you become their father, mother, grandparent, brother, sister, boss," Harrison says. "You play all those roles, because your clients may not have shared their HIV status with anyone else. But they've had the courage to tell you."

Native American communities have been learning to band together to spread the word about HIV and to care for those infected. Richard La Fortune, who is Yupik, uses storytelling to illustrate this lesson: At the beginning of the story, Raven asks Old Woman Badger why she's been so busy. "My grandson has the Alone-and-Afraid Disease," she answers, stirring her kettle. "I can't talk to anyone about this. The chiefs don't know what it is. I try to make my best medicine, and now I don't have time for anything else."

At the end of the tale, when Raven joins Old Woman Badger in supporting her grandson, she thinks, "I'm beginning to hear a different name for this disease. To be alone and afraid is not good for our people. When we stay together, then we feel our strength." ♥

—Paula Brewer is the editor of the Harvard AIDS Review.

November 19, 1997

Note to Sandy

Through Todd _____

From Matthew

RE: Follow-up Activities to the White House Policy Roundtable on American Indian HIV/AIDS Issues

Background

In February 1996, The Office of National AIDS Policy convened the first White House Policy Roundtable on American Indian HIV/AIDS Issues. During this meeting, the participants developed 11 recommendations (attached) which they believed were necessary to address HIV/AIDS issues in American Indians.

The first recommendation is the convening of an Interagency Working Group on HIV/AIDS in Native Americans. This working group would be used to develop, implement and monitor the other recommendations made during the Roundtable. Please note that it does not appear that any of the recommendations require new legislation in order to be implemented, and most if not all are already being implemented at some level but may not be Indian specific.

Issues

Several inquiries have been made on the status of the recommendations, including inquiries by the co-chair of the Roundtable, as well as the director of policy for the Congress of American Indians. As best as I can tell, none of the other recommendations has been specifically addressed.

ONAP has advised them that it will convene a follow-up meeting in February 1998. (This meeting was originally scheduled for November but was postponed at the request of the Congress of American Indians so that they could focus on their annual conference.)

In order to facilitate action on the part of the Federal agencies, ONAP should engage IHS in discussion aimed at forming an Interagency Working Group. Ideally, the Working Group could have a summary report ready for discussion at the Spring 1998 follow-up meeting.

Discussion

In order to establish the Working Group, (and to be able to report out during the PACHA meeting in December that this will be occurring), it is necessary to clarify the purpose of the Working Group and how it will operate. Attached are my recommendations. Upon your approval, ONAP will begin the process of "buy in" by IHS and other participants. It is hoped that the first meeting of the Working Group would occur prior to the anticipated February 1998 follow-up meeting to the White House Roundtable on American Indian HIV/AIDS Issues

Recommendation

I recommend that you approve the format presented on the attached document and allow ONAP to engage IHS in the development and convening of an Interagency Working Group on HIV/AIDS in Native Americans

Decision

Approve _____ Disapprove _____ Discuss _____ Date _____

Interagency Working Group on HIV/AIDS in Native Americans

(Proposed)

Purpose: To coordinate the Federal response to HIV/AIDS as it relates to both reservation and urban Indian communities.

- -- assess gaps in current efforts related to HIV in Native Americans
- -- develop and implement an "Indian" action plan
- -- monitor Indian-related HIV activities
- -- discussion forum/information sharing

Membership: All major Federal agencies which have programs which impact on AI/AN individuals infected with HIV

- Congressional Native American Affairs Committees/Subcommittee (Senate/House)*
- Department of Health and Human Services
  - -- CDC
  - -- HCFA
  - -- HRSA
  - -- IHS
  - -- SAMHSA
  - -- OHAP/OS/DHHS
  - -- Office of Intergovernmental Affairs/OS
- Department of Housing and Urban Development
- Office of National AIDS Policy, The White House
- Presidential Advisory Council on HIV/AIDS
  Native American Subcommittee*

* There may be a concern that having non-Federal participants may limit discussion of critical management and other in-house issues.

Co-Chairs Indian Health Service
Bureau of Indian Affairs

Structure: Working Group focusing on specific topics/issues. Ad-hoc committees as identified by members. Topical presentation as needed. (A draft agenda is attached)

The first several meeting(s) should focus on the following:

-- obtaining agreement on purpose of working group/expected outcomes
-- outline current activities
-- assess gaps in current activities
-- set action steps/identify specific activities to be implemented
-- identify responsible parties
-- establish due dates for responses/implementation
-- identify funding source

Meetings: Monthly for first three months, then quarterly or as needed based on need.

Staff Support: Provided by IHS.

Travel: None foreseen.

Interagency Working Group on HIV/AIDS in Native Americans

Agenda

(Draft)

Welcome/Introductions

Agency Reports

(Each agency summarizes major activities since the last meeting, upcoming funding/conference/meeting announcements, highlights specific components of their agency.)

Action Item Reports

Discussion of progress in implementing recommendations.

Presentations by responsible parties on activities undertaken/planned to address specific priorities identified by the members of the Working Group. As necessary, presentations by "experts" on issues of concern to Indian communities

New Business

Allow any member the opportunity to present a subject of concern which should be addressed by the working group.

Native American/Alaskan Natives/American Indians HIV/AIDS Policy Roundtable

February 11, 1997

Summary

The White House Office of National AIDS Policy convened an American Indian/Alaskan Natives/Native Hawaiians HIV/AIDS Policy Roundtable on February 11, 1997 that included government agency officials, tribal leaders, and invited guests (attached). The agenda and remarks focused on the trust relationship between the Federal Government and the tribal community to better understand providing health care services for native american communities affected by HIV/AIDS.

Following are a list of recommendations:

- Development of an interagency working group on HIV/AIDS to further develop the recommendations from this policy roundtable;
- Improved data collection through the CDC;
- Recognition and reimbursement for traditional healing utilized among native american communities;
- Assistance with education and awareness at tribal leadership level;
- Technical assistance to native american community council members;
- Inclusion/participation of tribal members on all HIV/AIDS related councils;
- Assistance with improvement among inter-tribal relations and collaboration among tribes;
- Opportunity and incentives to include native americans in AIDS research;
- Improved evaluative measures in defining/measuring outcome;
- Improved provider training/technical assistance for native american populations with HIV; and
- Allocation of monies for testing/counseling among native american communities.

Matthew -
Is this accurate?
- Told

RMartin @ HQE.IHS.GOV
10/21/97 03:03:00 PM

Record Type: Record

To: Daniel C. Montoya

cc:

Subject: Pres. Adv. Council on HIV/AIDS

I have no recommendations on the assessment of the Administrations response to the recommendations by PACHA.

I do have a comment on section II.C.5 concerning prevention and treatment of HIV/AIDS patients in Indian country. The IHS has been directed by the Tribes to distribute the $3.5 million it sets aside for HIV prevention efforts to the local community. They will make the decisions at the local level as to how to spend those funds. Also, they are not required as sovereign nations to report to the IHS what they have done with the funds. They can use them for HIV prevention or if they feel there are higher health care needs in the community, the funds can be used for them.

As for treatment of Indian people infected with HIV or with AIDS, they are treated in IHS and Tribal facilities the same as people with other diseases. In an informal survey I did not identify any location that was not either treating or referring for treatment any Indian patient that had a diagnosis of HIV or AIDS. In fact a month ago there was an article in the Navajo Times on the treatment of Navajo patients at Gallup Indian Medical Center with protease inhibitors and the success they were having. I was also told by Abe Macher that there was good participation by Indian facilities on the recent Treatment Guidelines conference call sponsored by HRSA. To me this is an indication that providers treating Indian people are interested in providing them the best care possible.

Indian people that are having the most problems receiving care for HIVand AIDs are those living in urban locations. Although the IHS provides some resources for their care (about $37million as compared to over $2 billion for reservation based Indian people), it is clear from legislation that Congress and the Administration intends for resources allocated for health care for Indian people to be focused on those living on or near reservations. Therefore, the Urban population, at this time, must return to the reservation to receive the maxinium benefit of health care resources provided to Indian people by the United States Government.

If you want discuss any of this call me at 301-443-1106. Frank Martin, IHS

Yes. It is true. Please note that an Indian person (tribally enrolled) may elect to receive services in ANY urban (non-tribally controlled) clinic if they are indigent. However, they cannot then ask the tribe to cover the cost.

True

Some tribes require their members to recieve care at that tribes clinic - or not expect to be reimbursed for the cost.

source: IHS

Approximately 1% of IHS's budget is for urban Indians, despite the fact they constitute almost ½ of the Indian population.

M

Native American Roundtable Information:

There is a draft of the information regarding the meeting that includes the agenda, speakers, attendees, and subsequent recommendations.

An Interagency Workgroup needs to be established to follow-up on the recommendations.

National Congress on American Indians (NCAI) is requesting SLT's assistance in the "official" establishment of the Interagency Workgroup.

PROJECT: Bob Solis

[redacted]

National Congress of American Indians

2010 Massachusetts Ave., NW
Second Floor
Washington, DC 20036
202.466.7767
202.466.7797 *facsimile*

July 2, 1997

Sandra Thurman, Director
Office of National AIDS Policy
Executive Office of the President
808 17th Street, N.W., 8th Floor
Washington, D.C. 20006

Dear Ms. Thurman:

On behalf of the National Congress of American Indians (NCAI), the oldest, largest and most representative Indian organization in the nation, I am writing to request your assistance in the establishment of an interagency working group on HIV/AIDS to further the recommendations of the American Indians/Alaska Natives/Native Hawaiians HIV/AIDS Policy Roundtable convened by your office on February 11, 1997. As you may know, the formation of an interagency working group was one of many recommendations of tribal leaders, tribal organizations, and others who met with government agency officials to discuss the trust responsibility the federal government has with tribes in providing health care services for Native American communities affected by HIV/AIDS.

NCAI was organized in 1944 in response to termination and assimilation policies promulgated by the federal government which proved to be devastating to Indian Nations and Indian people throughout the country. NCAI remains dedicated to advocating on behalf of the interests of our 230 member tribes on a myriad of issues including the improvement of the quality of life for members of our communities infected and affected by HIV/AIDS. As such, we firmly deem it necessary that the interagency working group be established immediately to begin addressing this critical issue. NCAI is ready to participate in this endeavor and will provide you with any assistance that may be needed.

Your support is greatly appreciated. If you have further questions, please contact me, JoAnn Chase, Executive Director, or Jack C. Jackson, Jr., Director of Government Affairs at (202) 466-7767.

Sincerely,

W. Ron Allen

W. Ron Allen
President

facsimile
TRANSMITTAL

to:	Daniel Montoya - Office of Nat'l AIDS Policy
fax #:	202.632.1096
re:	Letter to Ms. Thurman
date:	July 31, 1997
pages:	2, including this cover sheet.

Attached is a copy of the letter sent to Ms. Thurman on July 2. Look forward to your response.

From the desk of...

Jack C. Jackson, Jr.
Director of Government Affairs
National Congress of American Indians
2010 Massachusetts Ave., N.W. Second Floor
Washington, D.C. 20036

202.466.7767
Fax 202.466.7797

AMERICAN INDIAN/ALASKAN NATIVES/NATIVE HAWAIIANS HIV/AIDS POLICY ROUNDTABLE

Agenda

Tuesday, February 11, 1997

White House Conference Center
Eisenhower Room
726 Jackson Place
10am - 4pm

10:00am	Patricia S. Fleming, Director, Office of National AIDS Policy Charles W. Blackwell, Ambassador, Chickasaw Nation
10:10am	Dr. Phillip Lee, Former Assistant Secretary for Health Department of Health and Human Services
10:30am	Dr. Michael Trujillo, Director Indian Health Service
11:00am	Dr. Joseph O'Neill, Associate Administrator for AIDS, Office of AIDS Research, Health Resources and Services Administration
11:15am	Samuel Taveras, Team Leader Centers for Disease Control and Prevention
11:30am	Adolfo Mata, Acting Associate Administrator for AIDS, Substance Abuse and Mental Health Services Administration
11:45am	Charles W. Blackwell, Ambassador Taunya Banks, Professor of Equality & Jurisprudence, University of Maryland School of Law
12:30pm	Lunch
1:45pm	Discussion
3:00pm	Conclusions/Recommendations
4:00pm	Adjourn

Native American/Alaskan Natives/American Indians HIV/AIDS Policy Roundtable

February 11, 1997

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- Opportunity and incentives to include native americans in AIDS research;
- Improved evaluative measures in defining/measuring outcome;
- Improved provider training/technical assistance for native american populations with HIV; and
- Allocation of monies for testing/counseling among native american communities.

Native American Meeting
February 11, 1997
Participants at White House Round Table

Speakers:

Patricia S. Fleming, Director
Office of National AIDS Policy
808 17th Street, N.W.
8th Floor
Washington, DC 20006
(202) 632-1090

Charles S. Blackwell, Ambassador
Chickasaw Nation
1090 Vermont Avenue, N.W.
Suite 300
Washington, DC 20005
(202) 638-3832

Carole laFavor
Positively Native
3932 Oakland Avenue
Minneapolis, MN 55407
(505) 986-9120

Jeremy Landau
Presidential Advisory Council on HIV/AIDS
119 Del Rio
Sante Fe, NM 87501
(612) 822-3042

Dr. Phillip Lee, Former Assistant Secretary for Health
Department of Health and Human Services
Hubert Humphrey Building, Rm. 716 G
200 Independence Avenue, S.W.
Washington, DC 20201
(202) 690-7694

Dr. Michael H. Trujillo, Director
Indian Health Service
Parklawn Building, Rm. 6-05
5600 Fishers Lane
Rockville, MD 20857
(301) 443-1083

Dr. Joseph F. O'Neill, Associate Administrator for AIDS
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Samuel Taveras, Team Leader
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University of Maryland School of Law
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(410) 706-4045 fax

Federal Participants:

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(202) 690-7694

Ada E. Deer, Assistant Secretary for Indian Affairs
Interior Department
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MS-4140
Washington, DC 20240

Eric Goosby, Director
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Department of Health and Human Services
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Washington, DC 20201

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Katherine Marconi, Director
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Health Resources and Services Administration
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5600 Fishers Lane
Rockville, MD 20857
(301) 443-6560

Frank Martin, Assistant Chief to Dental Services Branch
Indian Health Service
Parklawn Building, Rm. 6A-30
5600 Fishers Lane
Rockville, MD 20857
(301) 443-1106

John Monahan, Director
Office of Intergovernmental Affairs
Advisory Committee Office
Department of Health and Human Services
Hubert Humphrey Building, Rm. 600 E
200 Independence Avenue, S.W.
Washington, DC 20201
ATTN: Jim Mason

Matthew Murguia, Acting Director
Department of Health and Human Services
Division of Policy and Data
Office of Minority Health
Rockwall Building II, Suite 1000
5515 Security Lane
Rockville, MD 20852
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Stephane O'Neill, Acting Director
Center for Substance Abuse Prevention (CSAP)
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Rockwall Building II, 9th Floor
5600 Fishers Lane
Rockville, MD 20857
(301) 443-0365

Additional Participants:

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FACSIMILE COVER SHEET

TO:
Jack C. Jackson, Jr., J.D.

FAX NUMBER:
202-466-7797

FROM: Daniel Montoya

DATE: May 29, 1997

PAGES INCLUDING COVER SHEET: 10

COMMENTS:

This is the material about the Native American/Alaskan Natives/American Indians HIV/AIDS Policy Roundtable you requested.

If there are any questions, please call me at the above number. Thank you.

DRAFT

Interagency Working Group on
Native American/Alaskan Natives/Native Hawaiians HIV/AIDS Policy

Congressional Native American Affairs Committees/Subcommittees (Senate/House)

Department of Health and Human Services -Co-Chair

- Centers for Disease Control and Prevention
- Health Care Finance Administration
- Health Resources and Services Administration
- Indian Health Service – Co-Chair
- Substance Abuse and Mental Health Services Administration
- Bureau of Indian Affairs

Department of Housing and Urban Development

Department of Interior

Office of National AIDS Policy, The White House

Presidential Advisory Council on HIV and AIDS
- Native Americans Subcommittee

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20857

MAR 18 1997

TO: Office of National AIDS Policy

FROM: Director

SUBJECT: Followup to the White House Round Table on American Indian HIV/AIDS Issues

I would like to thank you and the Office of National AIDS Policy for sponsoring the round table meeting on the HIV/AIDS issues of American Indians and Alaska Natives (AI/AN) that was held on February 11 at the White House Conference Center. I believe the meeting was a success; other agencies mentioned that they had learned a lot about the special relationship between the Federal Government and tribal governments and organizations.

I suggest that your office convene a followup meeting of all Executive Branches and agencies that have programs that impact on AI/AN people infected with HIV. This will provide the opportunity to plan for how the Federal Government can best work with tribal organizations and urban Indian programs to establish polices in this area.

I believe the Indian Health Service and the Bureau of Indian Affairs should play a lead role in the proposed meeting, since we have the most experience working with AI/AN tribal governments and organizations.

Please contact R. Frank Martin, D.D.S., Senior Dental Consultant, on (301) 443-1106 to further discuss this matter.

Michael H. Trujillo, M.D., M.P.H.
Assistant Surgeon General