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CHALLENGES OF MOBILIZATION ON HIV/AIDS BY THE AMERICAN INDIAN

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clamor communique #30

The epidemic of diabetes, cancers and alcoholism within Native American populace are the symptoms of our history with the, now, dominate culture. Our very existence and identity as America's original population is defined on how we deal with the symptoms of these diseases that have attacked the life force of our people. As it is said, with out your health, you have nothing. So, it is clear that we must confront these diseases if we are to survive and be healthy.

Along with many other diseases impacting Native communities, HIV/AIDS has a great potential for destruction. The advent of HIV/AIDS to the other adversities faced by Tribal Nations places us in great danger. If allowed to progress, HIV/AIDS will attack and destroy the core component of who we are as Native people. The progression that HIV takes in attacking the human immune system will be duplicated through the social and economic structure of Indian country. Just as HIV/AIDS diminishes human defense systems it can also diminish the defenses that we hold precious in protecting our identity as a unique and valuable culture within the dominate society, America.

The new path set forth by the Bush Administration prefers that homeland funding for HIV/AIDS be directed towards HIV positives and prevention efforts

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homelands. Although Native populations can receive assistance for HIV/AIDS issues in any State funded AIDS Drug Assistance Program, these types of services should also be made available on Tribal lands, especially considering that Indian country has all the co-factors for an all out HIV/AIDS epidemic.

The Bush Administration will continue to manipulate the dollars to meet their agendas at the expense of the mostly low-income and silent Americans. If we are to overcome the common threat of HIV/AIDS, than all Americans must come together in one conscience mind and heart. We must use a common sense approach and direct our leadership on all levels to do what's best for the people. Sadly, the American Indian is a textbook example of the health disparities that arise when the band-aid fix mentality is used to address extreme health problems. Problems that in all probability could have been prevented with funds to educate and intervene. The new federal policies on HIV/AIDS places the American Indian farther behind and also exemplifies that all Americans are fair game to the hidden agendas and political aspirations of the Washington power machine. Only by holding our leaders accountable and coming together not only as fellow Americans but more rightly doing what's best to promote the beauty and well being of the human spirit will we conquer HIV/AIDS. In conclusion, I would encourage all Tribal governments to support by Tribal resolution the re-authorization of the Ryan White Care Act in 2004 and the continued inclusion of Native American populations in the language of that act. I would encourage all Tribal Nations to proactively hold government agencies accountable to consultation policies mandated by law. Learn about HIV/AIDS and pass that accurate knowledge on so that the generations of all Nations can move forward in a positive direction.

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be addressed in an abstinence only format. Noted that the best protection against STD's including HIV is to abstain from sex or remain monogamous with an uninfected partner, it is critical that individuals are still educated to the benefits of condom use and protective behaviors. The use of condoms is looked upon negatively by the Bush Administration although they are a proven method of preventing sexually infectious disease and unintended pregnancy. Science continues to demonstrate that comprehensive HIV prevention can not succeed when limited to an abstinence only format. Abstinence is about as foreign an idea to many in Indian country as the concept of Trust Responsibility is to those in Washington. We are told by the great white father in Washington to practice abstinence while generations of American Indians have teetered with government led genocidal attacks against Tribal populations and this continues in the form of inadequate funding for governmental responsibilities to Indian country. What we are hearing is that if we don't conform to the abstinence only approach, you wont get funded. That again is nothing new to American Indians as we've historically been told to conform or face the wrath of the United States policy. Everyone should be alarmed that President Bush favors political standards over public health information and proven science to address HIV/AIDS in America. It seems that Federal policy on HIV/AIDS enhances politically influential powers that have an on-going agenda of dismantling, discrediting and just plain ignoring those populations and communities that are most at risk for HIV/AIDS. The cumulative effect of the new and improved government policy will be an increase in new HIV cases. The American Indian is not immune and will experience the wrath of this new federal policy just as all other at risk groups.

The American Indian struggles in designing a positive path to address the devastating probability of an AIDS epidemic in our populations. As we become more versed in the policies to be proactive to this health challenge, the rules

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change in mid stream. We are familiar with the standard changing of the rules in the middle of the game. No one in this country is more familiar with United States Federal policy than the American Indian. Some say that this policy has created intergeneration grief for the American Indian. Intergenerational reality is what I write of today.

On a daily basis, American Indians feel the effect of inadequate funding, we feel the invisibility of being an at risk population. We are beginning to see the potential genocidal epidemic of HIV/AIDS starring our way.

One of the defenses that we as Native people hold dear to us and is in peril is our land. Our Native land base, defined by Treaty, Statue, Court decisions and inadequately protected by the United States Constitution, is jeopardized by the onslaught of HIV/AIDS in Indian Country. The structure of traditional Native society is founded in our relationship to the land. Family and kinship are held together based on overwhelming religious and spiritual convictions which are intimately associated with the land and sacred sites within a Tribal area. Contrary to mainstream thought, Native philosophy dictates that man is not superior to the animal world and dictator of the environment but rather we are a component of the natural order of our surroundings. Hence our Native populations view health in a broad and holistic nature. And it is the land which assists in keeping us healthy. The healing practices utilizing the natural elements of our well established homelands were outlawed in the early 1900's and Western medicine was not provided to alleviate the new diseases that came with Euro contact. Not until the passage of the 1978 American Indian Religious Freedom Act were we allowed to legally utilize the traditional medicines and practices that our ancestors had utilized for optimal health.

historical obligation based on treaty, law, and trust responsibility." In 2000 President William Jefferson Clinton reaffirmed by executive order that the American Indian should continue to be looked upon as having unique status as sovereign Nations. With that comes an obligation by the United States government to address Tribal Nations with the same respect given to State Governments and even foreign lands.

Regarding HIV/AIDS, the Health Resources Service Administration (HRSA) directs funding dollars allocated for the Ryan White Care Act. This government agency has been weak and at times non-compliant with the rules set forth to address their interaction with Tribal populations. The Clinton Executive Order, which is still standing, and the 1975 Self Determination and Education Assistance Act dictate that government agencies consult with Tribal Nations with any proposed actions by those agencies that may affect Tribal populations. In the spring of 2003, HRSA exhibited their limitations to meeting these federal mandates by replacing a qualified Native American woman with a non-Native to oversee the Native component within the HRSA HIV/AIDS Bureau. This highlighted the fact that HRSA has no guidelines in place to ensure that in this specific position, newly appointed staff was not adequately trained to the issues of Indian country or cultural competency for our populations. Without this working knowledge it would seem impossible to carry out the requirements needed in performing Tribal consultation or implementing the best possible services as required by law. This type of scenario is by no means limited to HRSA but is common throughout interactions between Federal and State agencies that deal with Indian country. They seem to ignore their own governing laws. For the American Indian, this is an added challenge in addressing our health disparities and in our acceptance by the mainstream as true sovereign Nations.

Foremost in addressing HIV/AIDS within Indian country, Tribal people have an inherent right to quality health care and a right to receive this care on our

of competitive grant distribution undermines self-determination and well-established Tribal sovereignty.

Funding areas of concern include the Center for Disease Control, which of course is mandated to follow in the divine knowledge of the governmental direction. They must do this regardless of the fact that the new policies will shift already inadequate resources away from other effective strategies (specifically health education and risk reduction) which are critical to keeping at risk individuals uninfected. Despite overwhelming scientific data about the effectiveness and necessity of these intervention efforts, there is still an on going trend by influential components who site their own moral standards and political agendas rather than utilizing basic common sense and proven science. The new mandates initiatives fail to support comprehensive prevention strategies for at-risk populations, which of course include the American Indian, women of color, and the poor. These populations comprise a vast majority of new HIV infections in the United States each year and require comprehensive, ongoing prevention interventions that reflect the reality of their lives. The CDC self acclaimed years ago, the fact that hard to reach populations like American Indian communities depend enormously on well funded programs developed and implemented by community based organizations. That's good reasoning but little else without dollars to walk the talk.

For the American Indian the new federal policy on HIV/AIDs highlights our greater challenge. The American Indian has been misrepresented and victimized by the mentality that we are wards of the state. The United States that is. In fact, under the laws of the United States constitution, we are not minorities nor should one consider us "special initiatives". We are sovereign Nations within this great Nation and we have inherent rights to be respected. In the Federal court decision, White VS. Califano, it was summarized that "Health care for Indian people is not a racial issue, nor is it a financial issue; it is a legal and

There is a myth within the mainstream that the Federal government provides funding for 100% of Tribal health needs. This myth promotes immediate misunderstandings and adverse relationships with other Federal, State, and private entities, making it difficult to secure adequate funding, especially in the area of HIV/AIDS. It is a reality that the frailties of our Indian health care system will not support the surge of an HIV/AIDS epidemic. Medical, social and economic costs would exaggerate our Indian Health Service health care system, which has operated at 49% of need since it's inception (50) years ago. Presently the IHS operates at a Priority (1) status to address only life or limb threatening situations.

Although HIV/AIDS is being seen as a chronic disease, since those infected are living very long lives, it is still a very dangerous disease. The danger of this disease was addressed in a 1997 a memorandum from the director of the Indian Health Service to all area and associate directors. The Director stated: *"HIV infection may have a greater impact on American life and ultimately Native-American life than any other communicable disease of this century. The impact that AIDS will eventually have on Native Americans, in terms of physical and emotional suffering and the cost of caring for it's victims, cannot be calculated, however, it must be assumed that this is the time to develop strategies which can lessen the human and financial toll."*

With the economic variables involved in health care, Tribes must always be concerned that the underlying agenda of government policy is to force us into covering our health care costs by selling our lands and natural resources. The Emory University Rollins School of Public Health states "failure to reduce new HIV infections in the United States by 50% in the next two years could cost the Nation more than 18 Billion dollars". Where will this money come from? Many times in our collective history the US government has looked towards the Indian

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country to cut funding, steal natural resources and more recently to tap Tribal casino revenues to the point of extortion. The government would prefer that Tribes access court awarded land settlements that we have historically and unilaterally declined to take on the principle that our Traditional homelands and sacred sites are not for sale. With the land being the foundation of the Native American spirit, we have right to question the Congressional allocation of the bare minimum to meet their legal and moral responsibilities to Indian country in the area of health care. The health of our people is as dependent on our land base as it was for our ancestors.

As HIV/AIDS becomes more visible in Indian country, those who have been diagnosed with the disease have been disposed to seek care outside of our Tribal homelands. This is due both to social stigma, discrimination, financial limitations of our IHS service units, confidentiality issues, and clinical limitations in the area of HIV/AIDS. One primary concern is lack of direct access to Ryan White funding. Although Tribes can apply for certain aspects of Ryan White funds, these resources are channeled through the States and planning councils. Tribal governments for the most part have not been part of the process either through poor communication by the State councils or by apathy by the Tribes. The rationale of State councils has been to historically fund on numbers of HIV clients. This rationale can be a problem because HIV/AIDS is undefined in Indian country, hence, this funding structure is unproductive and helps promote an epidemic. As well, historical interactions between State and Tribal governments have often proved ineffective. States continue to battle Tribal Nations over land, natural resources, and jurisdiction. Indian country has not forgotten the statement by our president, George W. Bush, who openly stated, *"my view is that State law reigns supreme when it comes to Indians, whether it be gambling or any other issue."* Such political rhetoric hinders productive and creative solutions to our collective HIV challenges.

Competitive grants can be applied for by Tribes, urban Indian health centers and AI/AN/PI community based organizations who want to apply but many Natives see this as a conquer and divide strategy frequently used by the Federal government. It is viewed as an elimination strategy. Grants do not have the same benefits as 638 contracts, an example would be the ability to share information with IHS and vise versa, lack of contract support dollars and grant employees are not covered by tort claims, thus Tribes would be forced to purchase insurance coverage, creating more unfounded expenses. The concept