



**NATIONAL NATIVE AMERICAN  
AIDS PREVENTION CENTER**

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Dr. Howard Koh  
Assistant Secretary for Health, Office of the Assistant Secretary for Health  
Department of Health and Human Services

Dr. Ron Valdiserri  
Deputy Assistant Secretary for Health Department of HHS, Office of the Assistant  
Secretary for Health  
Department of Health and Human Services  
200 Independence Ave. SW  
Washington, DC 20201

Re: Comment on the *National HIV/AIDS Strategy for the United States and Federal  
Implementation Plan*

Dear Doctors Koh and Valdiserri:

This year witnessed a momentous occasion in HIV prevention and treatment in the United States. In July, 2010, the White House issued the first ever *National HIV/AIDS Strategy for the United States* (NHAS) and introduced a new tactic and policy direction that characterizes the federal government's commitment to ending this epidemic domestically through a concerted and organized effort that encompasses recommended actions to 1.) reducing new HIV infections, 2.) increasing access to care and improving health outcomes for people living with HIV, 3.) reducing HIV-related disparities and health inequities, and 4.) achieving a more coordinated national response to the HIV epidemic. The President, Office of National AIDS Policy, President's Advisory Council on HIV/AIDS, and their affiliates should be commended for prioritizing this important step.

As monumental as this document is, the NHAS still falls significantly short of meeting the needs of all of this country's higher risk populations and communities of color. While no single document can alleviate all of the health disparities in America, and acknowledging that this is the first such attempt in America to coordinate prevention and treatment efforts through such a unified policy effort, the NHAS still fails to acknowledge the impact of HIV and AIDS in American Indian, Alaska Native, Native Hawaiian, Asian American, and Pacific Islander communities, and include them in the recommended courses of action.

This document, and its *Federal Implementation Plan*, is going to serve as the backbone for HIV prevention and treatment efforts in this country. Again, while this concerted effort is encouraging for the future of HIV prevention in America, it is of great concern to Native and Asian communities. Indeed, if America is going to truly address this



**NATIONAL NATIVE AMERICAN  
AIDS PREVENTION CENTER**

epidemic, then it needs to first acknowledge its impact in smaller communities of color, and include them in the plan to eradicate this disease.

It is the hope that this written response to the NHAS will help to provide insight and guidance to the Office of National AIDS Policy as it seeks to put in practice the Strategy and its accompanying *Federal Implementation Plan*.

***Health disparity***

A definition of health disparity appears in the NHAS, as laid out by the *Affordable Care Act*:

“there is a significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates in the population as compared to the health status of the general population.’ In addition, it may be determined, ‘that such term includes populations for which there is a significant disparity in the quality, outcomes, cost, or use of healthcare services or access to or satisfaction with such services as compared to the general population.’”

Native Hawaiians and other Pacific Islanders have the 3rd highest rate of new HIV infections, and American Indians and Alaska Natives have the 4<sup>th</sup> highest rate of new HIV infections. Statistics and epidemiological data released annually by the federal government clearly continually underscore the fact that a health disparity exists within Native, Asian American, and Pacific Islander communities.

Too often, these communities are overlooked by virtue of their relative size. The NHAS states that it did not include statistics on Asian American and Pacific Islander or American Indian/Alaska Native gay or bisexual men “because of small numbers” even though the HIV/AIDS surveillance data for both of these populations is readily available and mirrors the impact the disease has had among gay and bisexual men in other racial/ethnic populations. Men who have sex with men (MSM) -related transmission (inclusive of MSM and MSM/IDU transmission categories) accounts for 88% of current HIV/AIDS cases amongst Native Hawaiian and Pacific Islander men, almost 80% amongst Asian men, and 78% amongst American Indian/Alaska Native men.

While statistics play a role in determining the impact of the disease, it does not take into account the social impact or relative burden of the disease on smaller populations. When an infectious disease is introduced into populations with relatively closed geographic boundaries and histories of serial, inter-population sexual activity, both the social and epidemiological impact can be greater than in those communities that experience greater mobility and choice of sexual partners.



**NATIONAL NATIVE AMERICAN  
AIDS PREVENTION CENTER**

***Poor representation of the needs of Native and Asian communities***

As townhall meetings were being announced and organizations were being solicited to provide specific input into the formulation of the Strategy, enthusiasm and hope for a comprehensive plan soared. Time and resources were spent by a number of engaged tribes, organizations, and community members to attend national and regional town hall meetings conducted by both the Office of National AIDS Policy and those supplemental meetings held by the Office of HIV/AIDS Policy. Efforts were taken to submit organized and collaborative comments both in person and online that reflected the collective concerns of the Native and Asian American communities. This feedback, which was heavily solicited by the government, was apparently not deemed significant, as even the words "American Indian" and "Asian" each only appear three times throughout the body of the entire forty-five page document.

While some of the concerns brought forward during the initial input solicitation, such as holistic health, increased research into community-level interventions, increased cultural competency are mentioned in the Strategy, they are not connected to the needs of the Native or Asian communities.

The strategy acknowledges that it is a challenge to "appropriately respond to HIV in communities that represent a small share of the U.S. population [American Indians, Alaska Natives, Native Hawaiians, Asian Americans, and Pacific Islanders]." This has remained a challenge in federal and state HIV policy and practice since the beginning of the epidemic. It is dismaying that this challenge is continually identified, but no direct action is taken to remedy this problem.

***Focus on gay and bisexual men***

The NHAS rightly speaks extensively about the need to address the disproportionate effect the epidemic is having amongst gay and bisexual men, and as aforementioned, Native and Asian MSM continue to comprise the largest percentage of those living with and newly contracting HIV in those populations. However, the corresponding recommended action simply targets gay/bisexual men and transgender individuals in a vague and general manner.

Many Native communities identify gay, bisexual, transgender and third gender people as two-spirited. Two-spirit identity represents another facet to the LGBT community – one that is not defined by just sexual orientation, but maintains cultural significance as well. Two-spirit men are at greater risk for HIV, and their cultural and social characteristics make them distinctly unique from the general gay, bisexual and transgender community. Efforts targeting these groups more often times than not are designed for members of the dominant society and do not take into account the unique cultural distinctions of gay, bisexual, transgendered and two-spirit Indigenous peoples. Prevention efforts targeting gay, bisexual and transgendered people run the risk of not being culturally appropriate, and ignoring the prevention needs of two-spirit men, as this



**NATIONAL NATIVE AMERICAN  
AIDS PREVENTION CENTER**

population cannot be easily folded in general high risk categories as gay and bisexual men or substance abusers.

***Surveillance activities***

The only recommended action within the strategy that specifically mentions American Indian, Alaska Native, Asian American and Pacific Islander populations is Recommended Action 1.3. This action calls for the need to address HIV prevention in these communities by asking federal and state agencies to support surveillance activities.

Accurate surveillance data and collection systems have long been a point of contention within Native and Asian communities. However, challenges such as varied and confusing reporting mechanisms between jurisdictions (tribal, local, state, funder and federal), the lack of inclusion of states with large Native and Asian populations in CDC reporting, and racial misclassification create epidemiological profiles that are inaccurate and do not portray a truly comprehensive and inclusive picture of the epidemic in America.

As federal, state, and local decisions-makers and private funders utilize government surveillance reports to inform funding and policy decisions, it is of particular concern to Native and Asian communities who then fail to acquire the resources and attention necessary to continue to adequately battle the epidemic in these communities.

So, the Office of National AIDS Policy should be praised for including this important action item into the NHAS. This is a vital step in creating a foundation of solid information that can be used by communities and decision-making bodies to inform future prevention and treatment strategies.

***Recommendations***

While the premises outlined above may have been heard and discussed before by administration officials, they have informed the actions recommended below. These recommendations seek to complement the NHAS and create a solid response to the epidemic in Native communities. While these recommendations are specifically concerning the Native community, it should be said that similar actions steps may be deemed appropriate by the Asian community (in coordination with leaders and organizations from this community), as these two populations share similar characteristics and similar obstacles to HIV prevention.

These recommendations are presented to correspond to the structure and design of the *Federal Implementation Plan*.



**NATIONAL NATIVE AMERICAN  
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**Goal 1, Step 1**

**1.1 Allocate public funding to geographic areas consistent with the epidemic**

Lead Agency/ Other Agencies	Recommended Action
CDC, IHS, CDC OS	The CDC and IHS should coordinate with HHS OS to conduct an official consultation with AI/AN Tribal leaders dedicated to HIV/AIDS to update the community on the state of the epidemic in Indian Country, 2.) discuss the implementation of the <i>National HIV/AIDS Strategy</i> and the <i>Federal Implementation Plan</i> , and 3.) ensure that the unique needs and challenges of Native people are considered when allocating prevention funds

**1.3 Address HIV prevention in Asian American and Pacific Islander (AAPI) and American Indian and Alaska Native (AI/AN) populations**

Lead Agency/ Other Agencies	Recommended Action
CDC, IHS	The CDC and IHS shall jointly convene an external working group comprised of Native community members, epidemiologists, and employees of Native health care entities (including Indian Health Service) to inform strategies to construct a surveillance system that more accurately captures data on Indigenous peoples throughout the United States. In particular, this working group shall focus on methods to 1.) reduce racial misclassification, 2.) accurately collect HIV/AIDS prevention, testing and treatment data, and 3.) further integrate HIV/AIDS prevention, testing and treatment into Native clinics
CDC, IHS, HRSA, SAMHSA, NIH, state and local health jurisdictions	All federal and state agencies should develop single uniform racial and ethnic definitions used to collect and classify data on HIV and AIDS that creates separate and distinct racial/ethnic categories for American Indian, Alaska Natives, Native Hawaiians, Asian Americans, and Pacific Islanders.
HHS OS, IHS	The Office of the HIV/AIDS Prevention & Treatment within the Indian Health Service, as created by the Indian Health Care Improvement Reauthorization and Extension Act, shall work 1.) to provide the Secretary with accurate and current epidemiological data on the state of HIV in AI/AN communities to present to Congress biannually (as laid out in the Act), and 3.) distribute said report freely and widely to Native community stakeholders



**NATIONAL NATIVE AMERICAN  
AIDS PREVENTION CENTER**

**Goal 1, Step 2**

**2.1 Design and evaluate innovative prevention strategies and combination approaches for preventing HIV in high risk communities**

<b>Lead Agency/ Other Agencies</b>	<b>Recommended Action</b>
<b>CDC</b>	The CDC shall require states and local jurisdictions that receive federal HIV prevention funding and have 2% or greater population of American Indians, Alaska Natives, Native Hawaiians, or Pacific Islanders residing within their boundaries to identify specific strategies on how they are going to address the epidemic in and allocate resources to these specific communities within their jurisdictions.
<b>CDC, SAMHSA</b>	CDC and SAMHSA will collaborate with states and localities on pilot initiatives to expand the prevention programming of their local Native communities, villages, and reservations.
<b>NIH, CDC</b>	NIH will work with CDC to develop and implement a plan for promoting the creation and evaluation of homegrown HIV prevention interventions in Native communities

**Goal 2, Step 2**

**2.1 Increase the number of available providers of HIV care**

<b>Lead Agency/ Other Agencies</b>	<b>Recommended Action</b>
<b>IHS</b>	IHS will consider opportunities to foster residency training in HIV management and care at IHS, tribal and urban health care facilities. In particular, attention should be paid to rural regions with large populations of American Indian and Alaska Native people and very limited access to infectious disease care.
<b>HRSA, IHS</b>	HRSA and IHS will develop a joint training platform that will create longer term training and mentoring of current nurses and doctors working within the Service so as to prepare them to perform routine monitoring and care of people living with HIV/AIDS

**2.2 Strengthen the current provider workforce to improve quality of HIV care and health outcomes for people living with HIV**

<b>Lead Agency/ Other Agencies</b>	<b>Recommended Action</b>
<b>HRSA, CDC, IHS, NIH</b>	Federal agencies responsible for providing HIV care to Native people living with HIV/AIDS (whether they be in, on, or off the reservation or their village) shall create a required training platform on Native cultural competency, and effective strategies for engaging Native patients and retaining them in care.



**NATIONAL NATIVE AMERICAN  
AIDS PREVENTION CENTER**

**Goal 3, Step 2**

**2.1 Establish pilot programs that utilize community models**

<b>Lead Agency/ Other Agencies</b>	<b>Recommended Action</b>
<b>HHS OS</b>	HHS OS will collaborate with HHS agencies to engage in demonstration projects to identify and disseminate effective and promising prevention and intervention programming in American Indian, Alaska Native, and Native Hawaiian communities that 1.) are conducted by Native entities, and 2.) incorporate Native approaches to health and wellness.

**2.3 Promote a more holistic approach to health**

<b>Lead Agency/ Other Agencies</b>	<b>Recommended Action</b>
<b>HRSA, CDC, SAMHSA</b>	Funding opportunities should be established that explore the feasibility and effectiveness of integrating traditional Native approaches to healing with medical models and medication regimens to promote positive health outcomes among people living with HIV/AIDS.

Should you have any further questions, or clarification on any of the above premises and recommendations, please do not hesitate to contact Robert Foley [National Native American AIDS Prevention Center, [rfoley@nnaapc.org](mailto:rfoley@nnaapc.org), (720) 382-2244, ext. 303].

Respectfully,

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cc:

Jeffrey Crowley, White House Office of National AIDS Policy

Kim Teehee, White House Senior Policy Advisor for Native American Affairs

Representative Dale Kildee, Vice-Chair of the Congressional Native American Caucus

Representative Thomas Cole, Vice-Chair of the Congressional Native American Caucus

Senator Byron Dorgan, Chairman of the Senate Committee on Indian Affairs