

**COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
HIV EPIDEMIOLOGY PROGRAM**

**Program Announcement 04017
Final Performance Report**

Report Period: January 1, 2005 – December 31, 2006

**National HIV Behavioral Surveillance Among American Indians and Alaska Natives
“Project Native Voices”**

A. Summary of Project Native Voices

The Los Angeles County (LAC) HIV Epidemiology Program began implementing HIV Behavioral Surveillance among Native Americans living in Los Angeles County in January 2005. Early project activities included outreach to Native American researchers and key stakeholders in Los Angeles County for involvement in a community advisory board (CAB). In addition, the surveillance activity protocol was submitted as a request for exemption from human-subjects research to the Los Angeles County Institutional Review Board (IRB) and the UCLA IRB. Approvals of the exemption requests from both IRBs were granted by August 2005. In September 2005, the Project Epidemiologist, Juli-Ann Carlos, was hired into her position and the bulk of the surveillance activities continued from this point.

As with National HIV Behavioral Surveillance (NHBS), the main objectives of the Native American supplement were to better understand behaviors driving the epidemic in a geographical area, focus on sub-populations at highest risk, and increase knowledge for planning HIV prevention and care. Phase I of this NHBS effort involved formative research to help guide development and implementation of the surveillance activity. Formative research activities included secondary data analysis and the conduct of focus groups with Native women, men who have sex with men (MSM), and male-to-female transgendered persons (TG). In Phase II, the project team worked with the CAB and Native researchers from surrounding states to develop the data collection instrument. In addition to the Core Survey used for the NHBS-IDU phase, the collaborative team of Project Native Voices (PNV) developed a set of local questions to better assess and describe the needs of the Native community and to help shed light on the HIV/AIDS epidemic among Native Americans living in LAC. In Phase III, the project team implemented respondent-driven sampling (RDS) with the intent to enroll a sample of 250 Native women and 250 Native MSM and TGs.

The remainder of this report will describe the findings from the formative research and implementation phases of the study.

B. Surveillance activities

1. Phase I: Formative Research

Phase 1 involved a review and analysis of secondary data available on Native Americans and HIV/AIDS. During this phase, we also collected qualitative data via focus groups to understand and characterize the distribution of HIV within the Native community and to determine the best methods for recruiting the population and collecting NHBS data.

Secondary Data Analysis

Findings from the secondary data analysis suggested that the study would not be concentrated in any one particular area of LAC. Geographically, Native Americans were dispersed broadly throughout the LAC as a result of the Indian Relocation Act (PL959), which took place in the 1950's and 1960's¹. This federal program brought Native men and women living on reservations to urban settings, often depositing these individuals in pairs in a scattered manner through the urban area. Thus, a few small concentrations of Native Americans currently reside in the corridor between downtown LA and Koreatown and in Long Beach but in general the Native population is evenly dispersed throughout the county².

Based on 2000 U.S. Census data, it was clear that this NHBS effort would recruit participants from a large number of tribal affiliations. Of the approximately 139,000 Native persons residing in LAC, there are eleven tribes comprising 1000 members or more and twenty-two tribes with at least 100 members³. We also examined socio-economic characteristics of the Native population using Census data. The median annual income for Native Americans in LAC was \$36,201 and approximately 23% of individuals and 20% of families lived below the poverty line⁴.

Educational attainment was low with 40% of Native Americans over 25 years of age having less than 12 years of education with no diploma⁴. The information about low educational levels was considered during the survey development phase of the project—we worked to ensure that reading levels of the local questions were at the 8th grade level or lower. Secondary data also suggested that substance use and dependency, particularly alcohol and methamphetamine use, may be a significant health challenge for our prospective respondents. Data from publicly funded substance treatment sites indicated that 30 percent of Native American clients identified alcohol and 27% identified methamphetamine as their main issue of concern⁵.

HIV/AIDS data were extremely limited as Native Americans often represent less than 1% of any typical study or survey sample, which leads to unstable or imprecise estimates of study findings. A review of the HIV/AIDS Reporting System (HARS) indicated a total of 91 living AIDS cases among Native Americans in LAC⁶. This number represents less than 1% of all living AIDS cases in LAC; nevertheless, when considering the size of the population, Native Americans had the second highest living AIDS prevalence (3.4/1,000) in the county⁷. Cumulatively, there have been 207 AIDS cases diagnosed in LAC among Native Americans; 63% are attributed to male-to-male transmission (MSM), 14% are among MSM who inject drugs (MSM-IDU), 11% are injection drug users (IDU), and 4% are among heterosexuals⁸.

Although HIV became a reportable disease in California on July 1, 2002, the new surveillance system had not been validated and detailed statistics on reported HIV cases were not available

during the period of secondary data analysis. Thus, we relied on HIV counseling and testing data provided by the Office of AIDS Programs and Policy to better understand more recently diagnosed infections. The overall HIV seroprevalence among Native Americans testing in publicly funded sites in LAC was 1.5%. Thirty-eight percent of the newly diagnosed infections in 2003 were among heterosexual IDU, 13% among MSM, 13% among men who have sex with men and women (MSMW), 13% among women at sexual risk, and 25% of unknown risk⁹.

A review of the research literature identified a number of issues to consider in the development of the project including binge drinking¹⁰, the historical context of diseases¹¹, the cycle of migration^{11,12}, ceremonial cutting^{11,13}, racial misclassification^{11,14}, mental health issues^{15,16}, blood quantum¹⁶, domestic violence¹⁷ and the history of unethical research among Native Americans^{18,19}.

Focus Group Interviews

In addition to the secondary data analysis, Phase 1 included qualitative data-collection methods to better inform the development and implementation phases of the project.

Trained facilitators, who were experienced with and members of the Native community, used standardized, semi-structured interview guides to conduct 5 focus group interviews with 16 total participants. Seven MSM, two transgender and seven adult women were recruited using flyers distributed at community-based organizations throughout LAC. In each focus group, facilitators posed up to 11 open-ended questions with follow-up probes to gather information about the following topics:

- 1) Network characteristics of Native women, MSM and TG
- 2) HIV-related areas of concern, including the publication of findings
- 3) Potential locations for recruitment and interviewing
- 4) Barriers to recruitment

Each focus group included 2 to 5 participants and lasted between 60 to 90 minutes. All five group interview sessions were recorded and audiotapes were transcribed verbatim. Audiotapes and transcripts were reviewed by the Project Epidemiologist to assure accuracy of transcription.

No formal qualitative data analyses were conducted but the Project Epidemiologist (who attended most of the groups) reviewed all the transcripts in order to describe a number of general themes arising during the discussions. Below is a general summary of each of the four above-mentioned themes and the specific findings for each Native sub-group.

General Themes

1) Network Characteristics

While MSM and transgender participants were not as connected to the overall Native community as the female participants, all three groups identified pow wows, Native social services, church and substance use as ways in which Native Americans network in Los Angeles County.

Substance use was common among all three groups of participants noting that divisions within the community lie among those who are sober and those who are not sober.

2) HIV-related Areas of Concern

The main concern for all groups was the lack of discussion about HIV/AIDS in the Native community. MSM expressed a need to educate so the community could come to terms with HIV. TG participants expressed concerns regarding the misinformation in the Native rural and urban communities regarding transmission of HIV, and female participants shared that HIV was a subject not discussed for fear that it might affect their community.

3) Potential Locations for Recruiting and Interviewing

While the answers varied between groups regarding where to recruit participants, all identified United American Indian Involvement (UAI) as a possible location for recruitment of seeds.

4) Barriers to Recruitment

Transportation was considered a major barrier by all groups interviewed. It was suggested that interview locations be central and near public transportation. MSM suggested that a mobile van be used to allow access to other parts of the county. Suggested locations for the van included the Indian Revival Church in Bell Gardens and at the Tongva Community Center. TG requested that the project come to the Hollywood area and suggested Van Ness Prevention as a possible location.

Additional findings for each of the groups are noted below:

MSM

MSM did not identify as being very connected to the overall Native community in LAC and connections with other Native MSM were minimal with the exception of one Native HIV Prevention group (Red Circle Project @ AIDS Project Los Angeles).

MSM participants voiced concerns that the Native community was being ignored by the HIV community and that a need existed for Native-specific HIV groups. With respect to sexual behaviors, participants felt comfortable discussing sex with other gay friends but stated that the Native straight community would not be comfortable. Other risk factors recognized by participants included: alcohol, drugs, self-esteem and self-identity. Participants expressed concern over the release of the results of the study. The concerns were that it might perpetuate stereotypes of Native Americans. It was requested that we highlight the results in a positive manner.

MSM identified numerous agencies to help locate Native MSM including: AIDS Healthcare Foundation, AIDS Project Los Angeles (Red Circle Project), Being Alive, and Minority AIDS Project. The suggestion was to identify gay men first and then we would find the Native MSM. Other suggestions included: health and mental health services, clinics, homeless drop-in centers,

bathhouses, Walmart, colleges and through internet sites such as Craigslist and Myspace. It was also noted that bars were not a good location to recruit Native MSM. Participants did not report meeting other Native MSM in those settings. For the interviews, participants requested locations that were central and near transit lines. AIDS Project Los Angeles was suggested as a possible location as well as The Village (LA Gay and Lesbian Center) and United American Indian Involvement. UCLA was also a suggested site. Participants did not think the project office was appropriate since it was located in a Superior Court building. They reported that Native Americans may be wary of the location. Participants' answers varied when discussing the type of interviewer they would prefer. Of the 7 focus group participants, three preferred a female interviewer, two preferred a gay male, one preferred a heterosexual male and one had no preference. The main concern was that the interviewer was professional, educated and non-judgmental.

One major barrier to recruitment identified by MSM was the lack of Native American specific hangouts, particularly for MSM and TG. They also identified shame of homosexuality, difficulty in disclosing one's identity and shame on one's family as obstacles to the recruitment of Native MSM. Other barriers included work hours and family responsibilities. Some solutions included having weekend hours, and providing van or carpools for participants. It was also suggested that recruitment take place at various pow wows and health fairs where HIV could be included with other health-related information.

Transgenders

TG participants reported seeking some Native specific services but had a limited connection to the overall Native community. It was also reported that many TGs did not tend to venture outside the Hollywood area for services as there were significant safety concerns. Due to the small size of the Native TG population in Los Angeles County, connections existed mainly with other TG, regardless of race/ethnicity.

In the context of HIV, TG participants were most concerned with alcohol use and the connection to high-risk behaviors. The participants felt that their alcohol use had led to their use of injection drugs and decreased condom use. Many of the concerns were TG specific and not necessarily Native specific. For those who participated in sex work, concerns were shared about disclosing one's status and the use of condoms. These activities often meant the loss of a date or income for the individual. The participants also discussed the three condom rule that had been imposed by the local police department. Any person found with more than 3 condoms in their possession was being arrested for the solicitation of sex. TGs were not likely to carry more than three condoms because of the potential for arrest. HIV risk factors discussed included: alcohol, drugs, prostitution and self-esteem. TG participants stated that Native Americans living in LAC would be open to the findings and there would be no concern regarding the presentation of the results.

Participants recommended visiting food lines to recruit Native MSM/TG who were homeless and identified two food lines in Hollywood and one in Santa Monica. Other suggestions included Van Ness Prevention and P.A.T.H. (People Assisting the Homeless) as possible locations to identify other Native MSM or TGs. Participants recommended that a Native gay male or someone of the same gender would be most appropriate for the interviewing staff.

Transgender participants noted that Native TG may not feel comfortable if approached by a non-Native person. It was suggested that recruitment be conducted by a Native person of the same sexual orientation. Participants also reported that the best time to recruit was around the second week of the month when general relief checks had been expended.

Women

Female participants had apparently stronger connections to the overall Native community and female community than two subgroups noted above.

Female participants stressed that HIV and sex were not matters they discussed or heard about in the community. Some discussion of sex might take place through their work but not on a personal level. Other participants noted that they were very uncomfortable discussing sex and thought we needed to guarantee confidentiality and preface our interviews by saying, "This may not be something you're used to hearing..." Potential HIV risk factors included: alcohol, incest, the issue of neglecting one's health, injection drug use, lack of discussion from parents, and a sense that HIV is not important or real. Female participants noted that the Native community may not want to see the results released. They also noted that having the results in black and white might make it more real. It was requested that any release of data be general enough to guarantee confidentiality.

Female participants indicated that passionate Natives needed to stand in front of the cause in order for people to participate. In other words, a Native leader who felt strongly about HIV and its impact on the Native community, would be needed in order for people to feel comfortable participating. Participants recommended we contact schools with Native American associations such as UCLA and USC, as well as attend health fairs, churches and pow wows. Other locations suggested for recruiting female participants included Skid Row (downtown Los Angeles), casinos, Native listserves, Native crafts and businesses, the Whittier Native health clinic, LAC General Hospital, Roybal Clinic, Southern California Indian Center, Torres Martinez Tribal TANF, Tarzana Treatment Center and other treatment centers, as well as the cities of Bell Gardens, Bell and Cudahy. Participants also discussed the importance of contacting elders within the agencies and Native female professionals. The participants expressed concern about being approached by someone from outside the community for participation. Potential interview locations included Skid Row, church, community events, libraries, and any location that was confidential. Participants did not recommend an Indian agency for confidentiality reasons and were particularly concerned about someone identifying them as having participated in the survey. The project office was not recommended as it is located in a Superior Court building and participants were concerned that those who were using drugs may not be likely to enter the building and participate. It was also suggested that we interview participants on the spot as we found them or travel to different areas of LAC to interview people from their geographical areas. Participants recommended a Native woman as the interviewer or to offer study participants with a choice based on their comfort level.

Female participants discussed the basic barrier of recruitment was the hesitation to talk about HIV as well as the possibility that participants would not show up for their appointments. Some

suggestions included providing transportation, childcare, and weekend hours. It was recommended that the American Indian Church and other community events might be other locations for recruitment.

Specific activities associated with Phase 1 are listed below:

- A community advisory board for Project Native Voices was convened which included Native representatives from AIDS Project Los Angeles, United American Indian Involvement, UCLA and the Los Angeles County Department of Mental Health. A total of four meetings were held from November 2005 through May 2006 and focused on formative research activities such as survey development, creation of a study name, logo, and flyer;
- Five focus groups were conducted (2 MSM, 1 TG, and 2 female) with a total of 16 interviews. All group interviews were conducted in English; and
- In December 2005, the Study Epidemiologist presented the findings from the secondary data analysis to the local HIV planning group to inform the community of the activities occurring locally and to solicit assistance in identifying seeds for the project.

2. Phase II: Survey Development

Phase 2 of the NHBS activities was devoted to survey development. In addition to the set of core survey questions used for the IDU cycle of NHBS, we developed local survey questions to gather additional and Native-specific information that might better expand on: 1) the prevalence of sex and drug using behaviors, 2) the prevalence of testing behaviors, 3) the utilization of HIV prevention services, and 4) the HIV needs of the Native American community in Los Angeles County. Through a literature review, input from Native researchers, and discussions with the CAB, 15 topics were identified as being of importance when assessing HIV risk for Native Americans. The topics included marital status, poverty, acculturation, racial misclassification, culture, sexual debut, contraceptive methods, partner characteristics, ceremonial cutting, alcohol use, HIV risk perception, mental health/self-esteem, discrimination/stigma, partner/family violence, and spirituality.

Several existing surveys were used to identify potential questions for the local set of questions:

- Brothers y Hermanos
- HIV Testing Survey for Native Americans
- Honor Project
- NHBS-HET Core questions
- LA Men's Study
- Nuestras Voces (Latino Gay Men's Study)
- YRBS

After significant review and modifications, 79 questions were selected for the local questionnaire. Eleven items were male specific and 3 were female-specific questions. Skip patterns were used to reduce the number of questions for each participant, if applicable.

The Project Epidemiologist programmed the local questions using the Questionnaire Design System (QDS) software and study staff piloted the HAPI data entry program. The approximate completion time for the core, local prevention, and local questions was approximately 45 minutes.

3. Phase III: Implementation

The major objectives of the implementation phase for Project Native Voices are listed below, along with the description of the activities that were completed during Phase III of the active surveillance period. Difficulties experienced in recruiting a sufficient sample size of female and MSM participants are described in detail at the end of the report.

The specific objectives for Phase III were:

Objective A. To estimate the prevalence of sexual and drug-use risk behaviors known to be associated with HIV infection.

Women

Status: Met

Discussion: Sixty-six female interviews were conducted between May 30, 2006 and December 31, 2006. Investigators had a difficult time using the RDS method to recruit female participants and, in consultation with the CDC Project Officer, decided to supplement participant enrollment with a convenience sample. The female study population includes many participants from drug rehabilitation centers, which may have skewed the data, but offers insight into the behaviors of high-risk women within the Native community.

Information regarding the methods used to obtain the sample are detailed below and include an explanation regarding difficulties enrolling MSM, TG and female participants with RDS.

Table 1 provides the results of the descriptive analysis of sexual and drug using behaviors reported by all the NHBS participants including female Native Americans.

Sexual Behaviors

Female participants reported high percentages of unprotected vaginal (89%) and anal (95% of those who reported anal sex) sex in the previous 12 months. In addition, 20% of female participants reported exchanging sex for drugs, money or some other item, and 41% reported having a sexual partner who injected drugs.

Alcohol/Drug Use

When asked about binge drinking, 64% and 35% of women reported binge drinking in the past 12 months and 30 days, respectively. More detailed questions regarding alcohol use were added to the local survey to address the concerns noted in the focus groups. In the previous 12 months, 47% indicated they were unable to stop drinking once they had started, 36% reported being unable to remember, and 45% reported others were concerned about their drinking habits. For non-injection drug use, 56% of women reported some type of usage in the past 12 months with 45% reporting marijuana use and 36% reporting amphetamine

use. When asked if they ever injected drugs, 24% indicated yes, while only 6% injected in the past 12 months. Seventy percent of the sample reported ever being in alcohol or drug treatment and 55% reported being in treatment in the past 12 months.

MSM/TG

Status: Unmet

Discussion: Data collection began May 30, 2006 and continued until December 31, 2006. During this 7-month sampling period, 16 MSM and 3 TG were interviewed. Based on the focus group data and early difficulties in recruiting MSM, it was suspected that RDS may not work for these populations. An explanation of additional methods used to obtain the existing sample size is noted below. Since a sufficient sample size was not collected, we do not have adequate information to achieve the goal of estimating the prevalence of sexual and drug-using behaviors; however, the information collected and reported below provides more information than other local studies have been able to collect to date.

Sexual Behaviors

Of the 19 participants, 84% reported having anal sex in the past 12 months and 69% reported it was unprotected. Additional questions were asked of MSM with 44% reporting *receptive* anal sex and 57 percent reporting it was unprotected. Nearly a third of the subjects indicated they had exchanged sex for drugs, money or other items and nearly half reported having a sex partner who injected drugs in the past 12 months.

Alcohol/Drug Use

Seventy-nine and sixty-three percent of MSM/TG participants reported binge drinking in the past 12 months and 30 days, respectively. When asked the additional alcohol questions, 68% reported being unable to stop drinking once they started, 58% reported they were unable to remember after drinking and 53% indicated someone was concerned about their drinking in the past 12 months. Sixty-eight percent reported some kind of non-injection drug use in the past 12 months with 47% reporting marijuana use and 42% reporting amphetamine use. Crack and cocaine were also high with 37% of respondents reporting usage. When asked about injection drug use, 58% had ever injected drugs and 26% reported injecting in the past 12 months. Eighty-four percent of respondents reported ever being in treatment and 68% reported being in treatment in the past 12 months.

**Table 1. Sexual and Drug-Using Behaviors among Native MSM/TG and Women.
Project Native Voices, 2006.**

	MSM/TG (N=19)	Women (N=66)
	%	%
Sexual Behaviors		
Vaginal sex (past 12 months)	21	100
Unprotected vaginal sex (no condom)	75	89
Anal sex (past 12 months)	84	29
Unprotected anal sex	69	95
Anal receptive sex (MSM only)	44	-
Unprotected anal receptive sex (MSM only)	57	-

Exchange sex for drugs/money/other	32	20
IDU sex partner	47	41
Alcohol w/ sex	79	59
Non-IDU w/ sex	63	48
Alcohol Use		
At least 1 drink (past 12 months)	84	76
At least 1 drink (past 30 days)	74	33
Binge drinking (past 12 months)*	79	64
Binge drinking (past 30 days)*	63	35
Not able to stop drinking (past 12 months)	68	47
Unable to remember after drinking (past 12 months)	58	36
Anyone concerned about your drinking (past 12 months)	53	45
Non Injection Drug Use (past 12 months)	68	56
Amphetamines	42	36
Crack	37	20
Cocaine	37	21
Downers	5	17
Painkillers	5	23
Hallucinogens	5	5
X/Ecstasy	11	9
Special K	0	0
GHB	0	0
Heroin	0	5
Marijuana	47	45
Poppers	11	5
Ever Injected	58	24
Injected in past 12 months	26	6
Ever in Treatment	84	70
Treatment (past 12 months)	68	55

Objective B. *To estimate demographic, social and behavioral correlates of HIV infection.*

Women

Status: Unmet

Discussion: Of the sixty-six female participants interviewed, only one participant reported testing HIV positive. Therefore we are unable to estimate the demographic, social or behavioral correlates of HIV infection for Native American women in Los Angeles County.

* Binge drinking is defined as 4 or more drinks for women and 5 or more drinks for men/transgender.

MSM/TG

Status: Unmet

Discussion: Of the nineteen MSM/TG participants interviewed, seven reported testing HIV positive. Unfortunately, the small sample size does not allow us to estimate the correlates of HIV infection. However, Table 2 presents the distribution of HIV prevalence by demographic, social and behavioral characteristics for the MSM and TG participants.

Demographic characteristics that showed higher levels of HIV prevalence were: age (25 to 29), degrees of Indian ancestry (lesser degrees), location of birth (off the reservation or tribal lands), and education (high school graduates). In addition, 67% of participants who reported extremely low incomes were HIV positive. For behavioral characteristics, 50% of participants reporting amphetamine use and 83% reporting Hepatitis C infection were HIV positive. Social characteristics assessed in the survey included acculturation, identity, spirituality, self-esteem, mental health and past physical or sexual abuse. Among participants reporting the social characteristics with the highest HIV prevalence were those who did not feel a part of the Native American community in Los Angeles, those who were raised off the reservation in a rural setting, those whose practices were non-Indian only, those who did not participate in religious/spiritual rituals and those who reported experiencing anxiety in the past 6 months. HIV prevalence was also high among those who did not report experiencing sadness or depression in the past 6 months.

Although the data suggests that Native Americans who are assimilated into urban settings/culture are at higher risk for HIV, the small sample size does not allow for this conclusion. Additional data are necessary in order to verify these findings.

Table 2. Distribution of HIV Prevalence by Demographic, Social and Behavioral Characteristics among MSM and Transgenders. Project Native Voices, 2006. N=19

Characteristic	HIV Prevalence
	n (%)
Total Population	7 (37)
<i>Demographic Characteristics</i>	
Age	
18-24	-
25-29	2 (67)
30-39	3 (33)
40-49	2 (40)
>50	-
Degree of Indian Ancestry	
Between 1/4 and just under a half	1 (100)
Between 1/2 and just under 3/4	3 (60)
Between 3/4 and just under full blood	-
Full Blood	3 (27)
Born	
Reservation or tribal lands	1 (11)
Off reservation – urban area	3 (60)
Off reservation – suburban area	2 (50)

Off reservation – rural area	1 (100)
Education	
Less than high school degree	-
High school/GED	7 (88)
Some college/technical school	-
College degree or more	-
Annual Income	
\$0 - \$4,999	6 (67)
\$5,000 - \$9,999	-
\$10,000 - \$14,999	1 (33)
Homeless (past 12 months)	3 (30)
Current Health Insurance	4 (57)
Sexual Identity	
Homosexual, Gay or Lesbian	5 (50)
Bisexual	1 (20)
Don't know	1 (33)
Behavioral Characteristics	
Unprotected Anal Sex (past 12 months)	3 (27)
Binge Drinking (past 30 days)*	5 (42)
Binge Drinking (past 12 months)**	6 (40)
Non-injection Drug Use (past 12 months)	5 (39)
Amphetamines	4 (50)
Crack	3 (43)
Cocaine	2 (29)
Ever Injected	5 (46)
Injected (past 12 months)	2 (40)
STD (past 12 months)	1 (33)
Ever diagnosed with Hepatitis C	5 (83)
Social Characteristics	
Acculturation	
Feels part of NA community in LA	
Very Much	-
Somewhat	3 (50)
A little	1 (25)
Not at all	3 (60)
Raised	
Reservation or tribal lands	-
Off reservation – urban area	3 (50)
Off reservation – suburban area	2 (50)
Off reservation – rural area	2 (67)
Indian Identity	
Feel good about Indian identity	
Strongly agree	5 (33)

* Binge Drinking is defined as 5 or more drinks for men/transgender.

Somewhat agree	1 (33)
Neither agree or disagree	-
Somewhat disagree	1 (100)
Strongly disagree	-
Many strengths because I'm Indian	
Strongly agree	2 (25)
Somewhat agree	2 (33)
Neither agree nor disagree	3 (60)
Somewhat disagree	-
Strongly disagree	-
Don't feel welcome in the Indian Community	
Strongly agree	1 (100)
Somewhat agree	4 (44)
Neither agree or disagree	-
Somewhat disagree	-
Strongly disagree	2 (29)
Way you live your life (practices)	
Indian Only	-
Mostly Indian	-
Equally Indian and non-Indian	5 (46)
Mostly non-Indian	-
Non-Indian Only	2 (67)
Spirituality	
Attends religious/spiritual services	
Never	4 (44)
Every day	-
Once/twice a week	1 (25)
Once/twice a month	2 (50)
Once/twice a year	-
Participates in religious/spiritual rituals	
Never	5 (63)
Every day	-
Once/twice a week	1 (33)
Once/twice a month	1 (25)
Once/twice a year	-
Spiritual	
Very spiritual	1 (20)
Moderately spiritual	4 (40)
Slightly spiritual	1 (50)
Not all spiritual	1 (50)
Religious	
Very religious	-
Moderately religious	4 (57)
Slightly religious	1 (20)

Not all religious	2 (33)
Self-esteem	
Like most aspects of your personality	
Definitely yes	6 (43)
Somewhat yes	1 (20)
Somewhat no	-
Definitely no	-
Deserve people's respect	
Definitely yes	5 (39)
Somewhat yes	2 (33)
Somewhat no	-
Definitely no	-
Proud of who you are	
Definitely yes	4 (33)
Somewhat yes	3 (43)
Somewhat no	-
Definitely no	-
Mental Health	
Anxious (past 6 months)	
Never	3 (30)
Sometimes	1 (33)
Most of the time	2 (67)
Always	1 (33)
Depressed (past 6 months)	
Never	2 (67)
Sometimes	5 (39)
Most of the time	-
Always	-
Thought of committing suicide (past 6 months)	
Never	7 (41)
Sometimes	-
Most of the time	-
Always	-
Ever verbally abused	4 (40)
Ever physically abused	4 (40)
Ever forced to have sex	2 (33)

Objective C. *To estimate the prevalence of HIV testing behaviors and utilization of other HIV prevention services.*

Table 3 provides the results of the descriptive (frequency) analysis for HIV testing and prevention service utilization.

Women

Status: Met

Discussion: Of the sixty-six female participants, 91% reported ever testing for HIV and 80% reported testing in the past 2 years with an average number of 1.8 tests for the two-year time frame. Of the 80% who reported testing in the past 2 years, 93% reported receiving *all* their test results. When asked where they received their last HIV test, 27% reported testing in a community or public health clinic followed by an HIV test site (18%) and private doctor's office (15%). The most common reason for testing was being worried about exposure to HIV (42%). When asked about types of tests, 38% reported having an anonymous test and 43% reported having a rapid test. Reported HIV seroprevalence was less than 2% for female participants. The one individual that reported being HIV positive, also confirmed receiving medical care. Sixty-five percent of those who had not tested in the past 12 months indicated they felt they were at low risk.

When asked about other HIV prevention services, 62% of female participants indicated they had received condoms in the past 12 months. Thirty-two percent reported having a one-on-one conversation with an HIV prevention counselor or outreach worker and 36% reported participating in a group HIV session.

It is important to note that the majority of female participants were recruited from United American Indian Involvement and drug rehabilitation sites, which all offered HIV prevention services at the time of recruitment. Our recruitment method, therefore, has likely biased the results to show that Native American women are receiving a higher level of services than is true in the general female Native American population.

Men

Status: Met

Discussion: Of the nineteen participants interviewed, 95% reported ever testing for HIV and 74% reported testing in the past 2 years. Of those who reported testing in the past 2 years, 86% reported receiving *all* test results. Twenty-eight percent reported testing at a community or public health clinic followed by an HIV test site (17%) and an adult HIV specialty clinic (11%). Fifty-percent reported being worried about exposure to HIV as the reason for testing. When asked about the type of test, 39% reported having an anonymous test and 28% indicated they had had a rapid test. Reported HIV seroprevalence was 39% with 86% of positives reporting they had ever been in medical care. Sixty-seven percent of those who did not test in the past 12 months indicated that they thought they were at low risk.

Utilization of HIV prevention services was fairly high. All 19 participants reported receiving condoms during the past 12 months. Seventy-four percent reported receiving a one-on-one conservation with an HIV prevention counselor and 79% reported taking part in an HIV group session.

Table 3. HIV Testing Behaviors and Utilization of other HIV Prevention Services Among Native MSM/TG and Women. Project Native Voices, 2006.

MSM/TG (N=19)	Women (N=66)
---------------	--------------

	%	%
HIV Testing Behaviors		
Ever tested	95	91
Avg. # of times tested (past 2 yrs)	2.0	1.8
Received test results (past 2 yrs)		
Received all results	86	93
Received some results	14	4
Received no results	-	2
Unknown	-	2
Location of recent test		
Outreach/Mobile Unit	6	12
HIV test site	17	18
Needle exchange program	6	-
Adult HIV specialty clinic	11	-
STD clinic	6	2
Community/public health clinic	28	27
Family planning clinic	-	7
Prenatal/ob clinic	-	2
Other outpatient facility	-	5
Hospital (inpatient)	6	5
Drug treatment program	6	5
Private doctors office	6	15
Correctional facility	6	3
Other	6	-
Reason for recent test		
Worried you had been exposed to HIV	50	42
Tested on a regular basis	22	18
Just checking to make sure you were neg	22	28
Required by insurance/military/court	6	-
Other	-	12
Anonymous test	39	38
Rapid test	28	43
Specimen type		
Swab from mouth	28	43
Blood from finger	6	5
Blood from arm	61	50
Unknown	6	2
Recent Result		
Negative	56	97
Positive	39	2
Never obtained results	6	2
Reason did not test (12 mos)		
Afraid of finding out	33	10
Didn't have time to test	-	10
Didn't know where to test	-	5
Think you are at low risk	67	65

Other	-	10
Ever seen provider (pos only)	86	100
Reason for not seeing provider		
Feel good, don't need to go	100	-
Other Prevention Services		
Received condoms	100	62
Received new sterile needles	16	3
Received free kits	11	3
One on one conversation w/ HIV Prevention worker*	74	32
Discussed ways to talk to partner	57	95
Practiced ways to talk to partner	50	57
Discussed ways to effectively use condoms	93	86
Practiced ways to effectively use condoms	57	62
Discussed safe drug injecting practices	36	43
Practiced how to prepare for safe injection	29	24
Organized HIV group session**	79	36
Discussed ways to talk to partner	53	79
Practiced ways to talk to partner	47	63
Discussed ways to effectively use condoms	67	100
Practiced ways to effectively use condoms	53	63
Discussed safe drug injecting practices	40	50
Practiced how to prepare for safe injection	20	4

*Questions below refer to those who participated in a one-on-one conversation with an HIV counselor or outreach worker.

**Questions below refer to those who participated in an organized HIV group session.

Objective D. To characterize prevention service gaps and missed opportunities for prevention.

To evaluate HIV prevention services, two outcome variables were created. Passive prevention was defined as receiving condoms, new sterile needles or kits. Active prevention was defined as receiving HIV testing, one-on-one HIV counseling or a group HIV session.

Women

Status: Met

Discussion: It is important to note that many of the female participants were involved in drug treatment programs at the time of recruitment and therefore may have had increased access to HIV prevention services.

In order to identify gaps in prevention services, female participants that reported unprotected anal sex were compared with female participants that did not report unprotected sex to identify differences in access to prevention services. With passive prevention, very little difference was identified between the two groups. Sixty-one percent of participants who reported unprotected anal sex received some type of passive prevention compared to 65% of

participants that did not report unprotected anal sex. With active prevention, a larger difference was identified although not significant. Eighty-nine percent of female participants that reported unprotected anal sex received some type of active prevention compared to 81% of participants that did not report unprotected anal sex. This suggests that higher risk women are receiving HIV prevention services.

Overall, this group of Native female participants received a very high percentage of active HIV prevention services.

Men

Status: Met

Discussion: Of the nineteen MSM/TG interviewed, all 19 participants had received both passive and active prevention services. As is noted above, the project had a difficult time recruiting MSM and TG into the project. This group of self-selected individuals may be more likely to have participated in HIV prevention services just as they did in the project.

Sampling Difficulties and Approaches Attempted to Improve Recruitment

Early in Phase III, the Project PI and Epidemiologist were concerned by the small network sizes reported by MSM and TG. This information was brought to the attention of Douglas Heckathorn, an author of RDS, by the CDC Project Officer. It was determined that the only way to see whether Respondent Driven Sampling (RDS) would work in this extremely hidden population of Native MSM was to attempt the sampling method.

Unfortunately, the difficulties we experienced with RDS occurred among MSM, TG and women. We had an extremely difficult time identifying productive seeds. When seeds were identified, many were reluctant to participate or often did not show up for appointments. For those seeds who did participate, the chains stopped soon thereafter.

To provide an example of another obstacle we encountered, during the second week of August, a fire occurred in the Superior Court building, which houses the HIV Epidemiology Program. The building remained closed for two weeks and all phone lines were down. The study staff met participants outside the study office but those who called to reschedule were unable to reach the project. All new recruits from new seeds were also unable to make contact with the project. Up to that point, 24 interviews had been completed, including 3 new male seeds and 1 new female seed interview that was completed one week prior to the building closure. During the time that the office was closed various activities took place to further identify new seeds. However, in the weeks that followed, recruitment continued to dwindle. By September 2006, the decision was made to attempt to collect a convenience sample given the unfortunate event that had occurred in August and the success of RDS up to that point. Below is a list of activities to improve study recruitment that took place between August 2006 and December 2006.

August 2006

Made contacts with:

- Cal State University, Long Beach, American Indian Student Services/Alum
- University of California, Los Angeles, American Indian Studies Student Services
- Cal State University, Los Angeles, American Indian Contact
- Rio Hondo College American Indian Group Contact
- JWCH, Institute
- Project Native Voices Community Advisory Board
- United American Indian Involvement, HIV Prevention Board, Member
- United American Indian Involvement, HIV Prevention, Ex-employee
- Native Professional, HIV Prevention Planning Committee, Ex-member
- Native American Family Center

September 2006

Made contacts with:

- Cal State University, Northridge, American Indian Studies, Professor
- Downtown Women's Center
- Casa de las Amigas
- Red Circle Project – AIDS Project Los Angeles
- Changing Spirits
- Associates of UAII HIV Prevention Board Member

Made Presentations to:

- Red Circle Project - AIDS Project Los Angeles
- SPA 4 Meeting

Conducted Outreach to:

- UAII Table - Wednesdays
- Casa de las Amigas
- Downtown Women's Center

Distributed Project Flyers to:

- Local Native listserves
- University American Indian Associations (UCLA, CSULB, Cal Poly)
- Los Angeles Gay and Lesbian Center (The Village, The Spot, Jeffrey Goodman Clinic)
- UAII
- Southern California Indian Center
- Torres Martinez Tribal TANF
- Downtown Women's Center
- Van Ness Recovery House
- Tarzana Treatment Center
- St. Mary's, Long Beach
- AHF Clinics (Downtown, Carl Bean, Hollywood)

- AHF Out of the Closet (Hollywood, N. Hollywood)
- Changing Spirits, Long Beach
- American Indian Counseling Center

October 2006

Made contacts with:

- Southern California Indian Center
- Angel Step II
- Seven Generations

Made Presentations to:

- Cal State University, Northridge, American Indian Studies course

Conducted Outreach to:

- UAII Table – Wednesdays
- Pow Wow – San Dimas
- Angel Step II

Distributed Project Flyers to:

- Southern California Indian Center (included in mailings)

November 2006

Made contacts with:

- American Indian Children's Council
- Seven Generations
- American Indian Counseling Center
- Children's Hospital Los Angeles – Young MSM Project

Made Presentations to:

- Seven Generations Staff Meeting

Conducted Outreach to:

- UAII –Thursdays
- American Indian Children's Council @ American Indian Revival Church
- Pow Wow – Cal State Northridge
- Pow Wow – Cal Poly Pomona

December 2006

Conducted Outreach to:

- UAII – Wednesdays and Thursdays
- UAII – World AIDS Day Event

Geographical Difficulties

Originally, we had hoped to identify seeds from different geographical locations throughout Los Angeles County in the hopes that our final study sample would be representative of the Los Angeles County Native population. This became increasingly difficult as we were unable to identify seeds from a variety of geographical regions. Feedback from our formative research phase (e.g., focus group discussions) promoted the use of a mobile van, conducting interviews in various geographical locations throughout the county, and having interviews in a centralized location. Unfortunately, due to budget limitations, a mobile van was not feasible; however, we did attempt to locate sites such as libraries and community meeting spaces for interviews throughout the county. We had hoped to use Native agencies for meeting space but decided against this plan after female focus group respondents voiced concern about loss of confidentiality in these settings. Some interviews did take place at locations outside of the centralized Metro Service Planning Area (SPA) but many were conducted at the project office and later at United American Indian Involvement. The geographical location, or area code, of the centralized project office may have been a deterrent for those living in Long Beach, Antelope Valley and other areas outside the Metro SPA. We had hoped to identify multiple participants and conduct interviews at confidential locations within other SPAs but this rarely occurred. In addition, the project had a small study staff which made it difficult to cover the entire county. On some occasions when participants were identified outside the Metro SPA, staff would drive out to the location and participants would not show up. In the future, it would be helpful to identify gate keepers in each SPA to assist in identifying seeds in each geographical location and ideally set up interviews within those SPAs.

References

1. National Council on Urban Indian Health website:
[http://www.ncuih.org/Relocation%20\(2\).pdf](http://www.ncuih.org/Relocation%20(2).pdf)
2. The Ralph and Goldy Lewis Center for Regional Policy Studies, UCLA. Socioeconomic Characteristics of American Indians in Los Angeles County, Year 2002, Paper 10.
3. U.S. Census Bureau, Economics and Statistics Administration, U. S. Department of Commerce. The American Indian and Alaska Native Population: 2000, Census 2000 Brief. February 2002.
4. U.S. Census Bureau website: www.census.gov
5. Alcohol and Drug Program Administration, Los Angeles County Department of Health Services. Annual Review of Participants in Alcohol and Drug Programs Contracted by the Alcohol and Drug Program Administration. 2003-04 Fiscal Year.
6. HIV Epidemiology Program, Los Angeles County Department of Health Services. HIV/AIDS Surveillance Summary, July 2005: 1-28.
7. HIV Epidemiology Program, Los Angeles County Department of Health Services. An Epidemiologic Profile of HIV and AIDS in Los Angeles County, 2004: 1-84.
8. HIV Epidemiology Program, Los Angeles County Department of Health Services. HIV/AIDS Surveillance Summary, January 2007: 1-29.
9. Office of AIDS Programs and Policy, Los Angeles County Department of Health Services. HIV Counseling and Testing Data, 2003.
10. Sullivan, C. (1991). Pathways to infection: AIDS vulnerability among the Navajo. AIDS Education and Prevention, Vol. 3, 242-257.
11. Weaver, HN. (1999). Through indigenous eyes: Native Americans and the HIV epidemic. Health & Social Work, Vol. 24, No. 1, 27-34.
12. Brassard, P., Smeja, C. & Valverde, C. (1996). Needs assessment for an urban Native HIV and AIDS prevention program. AIDS Education and Prevention, Vol. 8, 343-351.
13. Claymore, BJ. & Taylor, MA. (1989). AIDS-Tribal nations face the newest communicable disease: An Aberdeen area perspective. American Indian Culture and Research Journal, Vol. 13, No. 3 / 4, 21-31.
14. Lieb, LE., Conway, GA., Hedderman, M., Yao, J. & Kerndt, PR. (1992). Racial misclassification of American Indians with AIDS in Los Angeles County. Journal of Acquired Immune Deficiency Syndrome, Vol. 5, 1137-1141.
15. Robin, RW., Chester, B. & Goldman, D. (1996). Cumulative trauma and PTSD in American Indian communities. In Marsella, AJ., Friedman, MJ., Gerrity, ET., & Scurfield, RM. (Eds.), Ethnocultural aspects of posttraumatic stress disorder (pp 239-254). Washington, DC: American Psychological Association. (Referenced but unable to access)

16. Balsam, K., Huang, B., Fieland, KC., Simoni, JM., & Walters, KL. (2004). Culture, Trauma, and wellness: A comparison of heterosexual and lesbian, gay, bisexual, and two-spirit Native Americans. *Cultural Diversity and Ethnic Minority Psychology*, Vol. 10, No. 3, 287-301.
17. Simoni, JM., Walters, KL., Balsam, KF., & Meyers, SB. (2006). Victimization, substance use and HIV risk behaviors among gay/bisexual/two-spirit and heterosexual American Indian men in New York City. *American Journal of Public Health*, Vol. 96, No. 12, 2240-2245.
18. Duran, B. & Walters, K. (2004). HIV/AIDS prevention in “Indian Country”: Current practice, indigenist etiology models, and postcolonial approaches to change. *AIDS Education and Prevention*, Vol. 16, No. 3, 187-201.
19. Benson, T. (2001). Blinded with science: American Indians, the Office of Indian Affairs, and the federal campaign against Trachoma. In Trafzer, C.E. & Weiner, D. (Eds.), *Medicine ways: Disease, health, survival among Native Americans* (p52-75). Walnut City, CA: Altamira Press.