Written Testimony

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House Appropriations Committee
American Indian/Native Alaskan Witness Hearings
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Dear Chairman Simpson and esteemed members of the House Subcommittee on Interior, Environment, and Related Agencies:

My name is Selina Moose, I am Inupiat from Alaska and speaking to you today as a member of the Board of Directors of the National Native American AIDS Prevention Center (NNAAPC), and as a concerned Indigenous person. Thank you for allowing me to come to you from Alaska and speak with you today honestly and openly – with what I feel in my heart and what I know in my mind.

I am concerned because I believe that the government has been slowly turning its head away from the scourge of HIV and AIDS, and particularly, not paying attention to its impact on the first peoples of this land. It is this issue I would like to discuss today.

The National Native American AIDS Prevention Center (NNAAPC) is the only national HIV/AIDS-specific Native organization in the United States. Founded in 1987, NNAAPC's mission is to stop the spread of HIV and related health disparities among American Indians, Alaska Natives, and Native Hawaiians. Furthermore, NNAAPC’s aim is to improve the quality of life for members of communities infected and affected by HIV/AIDS. As a result, NNAAPC aggressively addresses HIV stigma, discrimination, homophobia, and complacency in Native communities by providing education, resources, training, and advocacy services. I am proud to say that I have been serving on the NNAAPC Board of Directors since 2004.

We serve a vital role in the field of HIV prevention. We bridge the gap between government decision-makers and the community. We help to translate policy decisions, funding mechanisms, and disseminate information to communities who would otherwise not receive this information. We are the only national organization working within all fifty states with Native peoples on HIV and AIDS. We are the only group led by Native people, employing Native people to help prevent this disease by addressing cultural issues and creating a prevention framework within a Native worldview.

We work closely with other national Native health entities like the National Indian Health Board and the National Council of Urban Indian Health to ensure that HIV is not lost in the wake of other health disparities facing Native peoples. We work everyday with tribal health departments, like a project we have with the Cheyenne River Indian Tribe in

South Dakota to implement and evaluate a multi-session program for Native youth. We work with community coalitions like the group on the Wind River Indian Reservation in Wyoming to put on the first ever local, community-wide HIV conference. We are conducting retreats for Native women in Oklahoma, North Carolina, Minnesota, New Mexico, and Colorado to empower Native women to reclaim their cultural identities as healers and nurturers. We are providing trainings in Alaska to community health workers on how to talk to their community members about HIV, and trainings in Oregon, Hawaii, and Arizona on how to use new technologies to strengthen prevention efforts. This is just examples of the nature of our work. In general, we are creating materials and providing support to the growing prevention and treatment infrastructure in Indian Country.

The need is great and the work is tireless. However, we are finding that as more and more Native communities are responding to our messaging, the federal government is the one pushing us further and further down on the list of priorities.

Federal initiatives continue to de-prioritize prevention efforts with Native peoples. The Centers for Disease Control and Prevention steers this country's HIV prevention efforts and funds the majority of organizations conducting HIV prevention activities. In 2010, the CDC released a total of $215 million over five years in prevention funding directly to grantee organizations. Only one Native organization was funded to conduct prevention activities with Native people. Out of $43 million annually, only a little over $300,000 was granted to a Native organization. The previous funding cycle saw five Native organizations funded to conduct targeted programs for Native Americans.

The Indian Health Service HIV/AIDS Program remains severely underfunded and under-resourced – with only one person currently overseeing all of IHS's HIV testing, prevention, and education programs.

And our organization, the National Native American AIDS Prevention Center, almost closed its doors in 2009. After more than two decades as the only organization providing this level of culturally specific service, our funding disappeared as a reflection of shifting policies and new emerging initiatives. Native Americans were no longer categorized as a racially specific priority population for HIV prevention activities.

With a national focus now on what is being called "High Impact Prevention", federal funders are funneling monies into urban areas and states with high prevalence of AIDS. States like Maryland, Florida, and Texas are receiving more money than ever. However, states with smaller population sizes and consequently fewer people living with AIDS are finding their prevention budgets slashed by up to 50%. Fewer prevention opportunities are available to states like South Dakota, Oklahoma, Wyoming, Idaho, Alaska, Hawaii, and Montana because the money is no longer there to support state prevention initiatives. It is these states, among others, that contain large Native reservations, large Native populations, and where the Native communities are carrying a disproportionate burden of the disease. Furthermore, to compound this issue, Tribal health departments and Native corporations do not have the same opportunities as state health departments to compete for federal HIV prevention and treatment grants to support their own internal prevention programming and grant making capabilities.

“High Impact Prevention” also calls for programs to target specifically African American and Hispanic/Latino communities, further diverting money from Native communities.

I understand that these decisions are based upon the latest HIV and AIDS surveillance, and I do not want to underscore the importance of providing appropriate prevention activities for these communities of color.

Yet, Native Hawaiians and American Indians/Alaska Natives have the third and fourth highest rates of new HIV infections annually, respectively. In fact, between 2007 and 2010, American Indians and Alaska Natives had the highest percentage increase of new HIV diagnoses (8.7%) – higher than any other group. This is astounding when you think about the fact that American Indians and Alaska Natives comprise approximately one percent of the US population. Also, fewer of us survive after having received an AIDS diagnosis. These statistics do not support the deprioritization of our communities – in fact they suggest a serious health disparity. HIV is a serious problem in Native communities, and the federal government continues to overlook this.

I don’t want to just spout out numbers. HIV has a real impact that you cannot read in an epidemiology report. As communities, we face unique HIV prevention and treatment challenges, as direct results of rural geography, historical trauma, cultural distinctiveness, and shifting policies at the federal level.

I first became in involved in this work, and realized the importance of this work when my brother first told me that he had AIDS. I wasn’t ready for the news and didn’t know what to think of it. Other the next few years, I watched how the community treated him as he came home to be with his family. I listened to what people said about him as he tried to live his life with dignity. And then I watched him die. From that day forward, I knew that something had to be done to ensure that no other Native person has to go through what my brother, what I, what my family, and what our community experienced.

I believe that the government has a responsibility to its Native people. The fact that these numbers – and the stories behind them – exist tells me that now is a good time to remind our law makers about their trust responsibility to provide for the healthcare of Native peoples. We need a commitment from the government – a commitment that says that we care and about the health and wellbeing of our Native American people, a commitment that says that the government’s trust relationship to provide for the health of Native people is sacrosanct, and exists not just in writing, but in practice as well. This relationship demands that American Indians and Alaska Native always be placed as a priority population and that we not fall to shifting government whims.

We can always look to the past to learn lessons, and to our ancestors to receive guidance. And this is also how we can begin to sculpt a direction for the future. There are opportunities for the future and I hope that it is of these opportunities that this subcommittee hears me speak.

We are tired of scraping by – tired of making strides and advances only to have funding fail, forcing us to end programs and lay off experienced staff – further stalling progress. In order to beat this disease, we need stability, resources, and support.

With the 2010 release of the President's National HIV/AIDS Strategy, the whole of this country needs to examine how we are meeting the prevention and treatment of needs of people living with and at risk for HIV. This nation cannot afford to continue to allow Indian Country to linger ten years behind the rest of the country in terms of testing resources, access to care, research, and prevention programming. The ambitious goals that President has established will go unmet if we are left behind.

In order to address these health disparities and ensure the health of our Native peoples, I ask you to consider the following, as you move forward with your budget deliberations:

- I ask that Congress increase funding for American Indian and Alaska Native specific HIV programming in the budgets of the Centers for Disease Control and Prevention, Indian Health Service, Office of Minority Health, Office of Women's Health, and the Substance Abuse and Mental Health Services Administration.

- I ask that Congress examine the success of the Special Diabetes Program for Indians that sets aside $150 million annually for local diabetes education and prevention efforts, and model a similar HIV program for Native Americans that would allow for stable funding and local ownership of prevention efforts.

- I ask that Congress designate funds specifically for the creation of a National Native HIV/AIDS Resource Center so that funding can be set aside to create a consistent and persistent presence at the national level to provide support for community efforts, and education and guidance for decision-makers. This center can provide the technical assistance needed to grow infrastructure, strengthen the HIV prevention and treatment workforce, and support the diffusion of federal funds to ensure effective program implementation.

Again, I thank you for the opportunity you have provided me to share some fact and to share my feelings about the state of HIV in American Indian and Alaska Native communities. I hope that you consider our requests in light of what I have shared today. Thank you, and I, of course, would be willing to answer any questions you may have.

Respectfully submitted,

Selina Moose
Board Director
National Native American AIDS Prevention Center