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Violence, HIV/AIDS, and Native American Women in the Twenty-First Century

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> *Kashka instinctively thought back to the night in late November when her husband had gone to his cousin's house and gotten drunk, come home and wanted to have sex. She told him he was too drunk and that she was not interested. In his drunken state, he became angry and left the house. The next morning, on her way to work, she saw her husband coming out of Johnny's house. Everyone in the village knew that Johnny was HIV positive and sexually active. As burdened as she was with her husband's infidelity, she knew that asking him to wear a condom would only make him angry and violent. She also realized that she would have little support from the women in the village if she refused to have sexual relations with her husband.*[1]

As we enter the twenty-first century, Native American women are faced with a variety of health concerns. Two critical and interrelated issues are HIV/AIDS and intimate-partner violence. Both are serious problems by themselves and an even bigger concern where they connect. Kashka's story above demonstrates one way in which domestic violence and HIV/AIDS are related. She felt powerless to say no to sex or to protect herself from a husband she believed might be infected with HIV/AIDS. This relationship has historically been neglected by researchers, but many today are observing and documenting the critical connections between the AIDS pandemic and women's inability to protect themselves due to the impact of violence in their lives.

Many relationships between HIV/AIDS and violence can be found. One is that "women at highest risk for domestic violence are demographically similar to women at risk for HIV infection."[2] In addition, the two health problems intersect when women lack sexual agency, experience abuse and/or rape, and notify their partners of their HIV status.

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My interest in exploring the intersections of HIV/AIDS and domestic violence emanates from my work in the field of AIDS and Native Americans. In the process of research and interviews, it became apparent that violence was a common factor for many who were already infected or at high risk. Therefore, I feel it is critical that we enlarge the conversation about AIDS and domestic violence to include their connections. Prevention of HIV/AIDS may be seriously compromised if domestic violence is not addressed also.

To date there is little literature on these intersections, but more researchers and health officials are beginning to engage in discussions. At the 1997 National Conference of Women and HIV, the connections between domestic violence and AIDS were addressed in a presentation and workshop. The presentation stressed that "women who are more disempowered in relationships may be at increased risk for HIV due to fear of conflict with a partner." The workshop also addressed how subordination of women, in society at large and in interpersonal relationships, serves to deprive women of control over sexual risk. Conversations continued about how child sexual abuse also contributes to risky HIV behavior.[3]

Several books that have examined women and AIDS have noted the lack of research in the area of women, violence, and AIDS and stressed the need for more research. The books have contributed to the debates by at least briefly mentioning that women are placed at risk for HIV due to violence.[4] An extremely insightful and important article by Claudia Garcia-Moreno and Charlotte Watts discussed how women around the world are faced with violence and the implications for HIV/AIDS infection.[5] Since Native women are at high risk of violence, as I will discuss below, this suggests that they are also at high risk for HIV/AIDS.

There is "no reliable data" on the incidence/prevalence of intimate-partner violence and HIV/AIDS among Native populations.[6] Much of the data are held suspect for a variety of reasons but they do, however, provide a place to begin discussions. The purpose of this essay is to highlight a variety of statistics on both HIV/AIDS infection and violence among Natives. This information, provided by the Centers for Disease Control and Department of Justice, should serve as a starting point for engaging in discourses about the intersection of these two important health issues facing tribal communities. It is my hope that others will follow with more studies, data collection, and publications that enlarge the debates and provide helpful information for others.

Of all the reported AIDS cases among women as of June 2001, African Americans represented 58 percent (80,802), Whites 21 percent (29,702), Hispanics 19 percent (27,391), Asian/Pacific Islanders .5 percent (765), and Native Americans .3 percent (460).[7] Although the number of reported AIDS cases among Native women is still low, like other minority women, Native women with HIV/AIDS represent a large percentage of their respective ethnic group. Of those with AIDS, women represent 26 percent of African Americans, 18 percent of Hispanics, 18 percent of Native Americans, 12 percent of Asian/Pacific Islanders, and 8 percent of Whites.[8] It is also important to note that the percentage of Native women with AIDS varies from state to state. In Minnesota Native women represent an alarming 32 percent of the

number of reported AIDS cases among Natives.[9] In addition, recent trends in HIV/AIDS show an increase among women and especially among minority women. Thus, the threat to Native women is more serious than current numbers of infection suggest.

An exploration of domestic violence against Native women also indicates a serious problem. A study of family violence in four Native communities found that the "pressures against recognizing family violence are so great as to cause American Indian tribes and communities to overlook the problem, and thus, to fail to develop intervention to prevent and reduce family violence."[10] This is a dreadful circumstance given the rate of violent crime experienced by Native women. A National Crime Victimization Survey (NCVS) conducted between 1992 and 1996 found that the average annual violent crime rate among Native people was approximately two-and-a-half times the national rate, and the rate for Native women was the highest of all ethnic groups. The survey found that violent crime rate among ethnic females was Native women, 98 per 1,000; Black women, 56 per 1,000; Asian women 21 per 1,000; and White women, 40 per 1,000.[11] It is also important to note that the rate of AIDS among Natives is "11.3 per 100,000 people compared to 9 per 100,000 for whites."[12] It was reported in April 2002 that in the year 2000 Natives continued to "experience the worst rate of violent crime in the Nation."[13]

Women confront violence on a daily basis and it is considered to be one of the most underreported and underestimated crimes in the United States. Fifty percent of women in the United States will be battered in their lifetime, one out of three is physically abused every year, and one woman is forcibly raped every seventy-eight hours.[14] Findings also indicate that violence against women is predominantly intimate-partner violence, particularly for Native women.

Although there is scant literature and research on Native American women and violence, this is changing with the assistance of federal recognition and legislative support. Within the last twenty years the United States has begun to view domestic violence as a crime. Domestic violence has changed from a "technical violation of the law into a bona fide crime with potentially serious consequences."[15] The government has responded by passing supportive legislation such as the Violence Against Women Act of 1994 (VAWA). VAWA was the first piece of legislation aimed at deterring gender-based violence. It asked states to treat domestic violence seriously, create new federal crimes of domestic violence, and encourage collaboration among communities, law enforcement, and health care providers.[16] Although there are problems with the VAWA's full faith and credit component, which is meant to protect Native women who travel, relocate, and/or move across jurisdictions, it has provided much assistance to these women in other areas.[17] Jurisdictional problems are common in Indian Country where tribes have sovereign status and several have their own court systems.

Congress has appropriated $8.2 million for the STOP Violence Against Indian Women Discretionary Grant Program, which is part of the VAWA. The funding is available through 2002 and provides funds for both communities

and tribes.[18] By the end of 1998, two-hundred-and-thirty-eight tribal communities had received funds from the program to combat violence against Native women. The tribes have provided direct services to women, trained tribal law enforcement officers, developed tribal policies and protocols, and helped support specialized units within the tribal justice system. By the end of 1999, one-hundred-sixty different tribes had received funding.[19]

Even with recent governmental assistance and support for antiviolence initiatives and programs, research on domestic violence and minority women is still limited. As late as 1997, researchers still documented the lack of data on domestic violence among ethnically diverse populations, particularly Native American women.[20] This is disheartening given the fact that the Indian Health Service reported in 1991 that "family violence is a serious problem in Indian communities."[21] Recent findings are adding to the literature and increasing concern over the health of Native women. The NCVS study, cited earlier, noted that while Native Americans comprise .6 percent of the US population, 1.4 percent of victims of violence are Natives and the percent of rape/sexual assault against Native people was 5.6 compared to the US average of 4.3 percent.[22] It was also found that Native women had higher rates of intimate-partner violence than other races.[23]

Two states that have large Native populations, New Mexico and South Dakota, have produced a number of reports that examine the condition of women in those states. Their findings about Native women illustrate how serious the situation is and indicate the need for similar studies. New Mexico, a state with a diverse population, has been the focus of several studies on violence. A four-year study that examined the contribution of domestic violence to homicides of women in New Mexico found that Native women "are at particularly high risk of homicide, including domestic violence homicide."[24] The researcher argued that the high rate of domestic violence among Native women is, in part, due to a "relative lack of access to resources." They lacked resources because most of them live in areas isolated from shelters, counseling, and other domestic violence services. These researchers further suggested that socioeconomic factors be examined to gain a deeper understanding of how they impact the violence found among Native people.[25]

A 1996 study of rural New Mexican women found that the types of physical abuse Native American women encountered were kicks and blows, along with verbal abuse. It further determined that Native women sought medical attention more frequently than Anglos and Hispanics and reported domestic violence to law enforcement more frequently. Most telling is that Native American women reported that "physical abuse was the most prevalent form of abuse they and their partners experienced as children."[26] Another study that examined female suicide in New Mexico asserted that intimate-partner violence or interpersonal conflict was associated with "nearly half of suicide deaths in women under the age of 40 years . . . and that a higher number of Native American decedents (52.9%) had alcohol present compared to other ethnic groups, as well as higher blood alcohol levels."[27] It has been argued that "battered women are four to five times more likely to require psychiatric treatment and five times more likely to attempt suicide than women who

report no abuse."[28] As these studies illustrate, Native New Mexican women are in grave danger of violence, and hence HIV/AIDS because they have no personal agency due to the prevalence of violence in their lives.

President Clinton, speaking in New Mexico in October 2000, commented that domestic violence was the number-one health risk for women between ages fifteen and forty-four, and that one-third of all women murdered in the United States were killed by an intimate-partner. The president urged Congress to "reauthorize and strengthen the VAWA" and pointed to its effectiveness among the Pueblos in northern New Mexico.[29] In November 2001 the Department of Justice awarded the Santa Ana and Zuni Pueblos of New Mexico grants to increase support for Native victims of domestic violence and the prosecution of their assailants.[30]

Studies of Native women in South Dakota, like New Mexico, reveal a disturbing situation. In South Dakota Native women are a very small portion of the state population but constitute 50 percent of the domestic violence shelter population.[31] Studies also show that alcohol and drugs are a major factor in violence against women. A 1979 survey conducted on the Pine Ridge Reservation found that "all incidents of abuse studied occurred under the influence of alcohol or drugs," and noted a need for integrating a variety of systems in addressing abuse.[32] Pine Ridge Reservation has gone through a variety of changes in their response to domestic violence. A meeting of elders in 1987 brought about a major change with the adoption of their Spousal Abuse Code. This code is considered to be "one of the strictest in the nation" demanding mandatory arrest with no bond and automatic sentencing for offenders.[33] However, it is still believed that domestic violence on Pine Ridge is currently an "endemic problem."[34]

Domestic violence is also high on the Yankton Reservation of South Dakota. Charon Asetoyer, director of the Native American Women's Health Center, believes that women in abusive relationships are set up "for being extremely vulnerable for coming in contact with HIV."[35] In an effort to address the issues of violence the Women's Center works collaboratively with a neighboring Native domestic violence organization, Cangleska Inc., which assists in training tribal police and conducts youth workshops on domestic violence.[36] In her work with women on the reservation, Asetoyer has also found that many in abusive relationships are powerless and in danger of sexually transmitted diseases because they believe they are in a monogamous relationship when in reality they are not.

Domestic violence is about power and control and it occurs in a variety of forms. Physical abuse is one aspect of domestic violence, which also includes emotional or psychological abuse. Emotional/psychological abuse can manifest itself as social and sexual prejudice, insults, rejection, possessive and punitive behavior, threats to take away children, and financial blackmail. Often a batterer controls the victim's finances and will deny the victim access to money, and hence access to power.[37]

The psychological consequences of domestic violence for women can include depression, suicide, lowered self-esteem, alcohol and other drug abuse, as well as posttraumatic stress disorder—factors which also place

women at risk for HIV/AIDS. When a woman feels powerless, she is unable to make healthy choices and govern sexual risks. She may feel she has no value and that protecting her health is not important. In addition to psychological and physical abuse, poverty is also a cofactor in the spread of HIV/AIDS. For example, poverty contributes to women's dependence and lack of power in the family, particularly if the partner is the one who is the main provider. In the United States the percentage of unemployment for females age sixteen and older is 6.2 percent but for Native women it is 13.4 percent.[38] Unfortunately it has been found that "criminal behavior is associated strongly with income deprivation; thus the geographic concentration of poverty will cause a concentration of criminal violence in poor neighborhoods."[39] Generally, the higher the income a family has, the less likely one is to experience a violent crime. Low income has also been associated with domestic violence and is a cofactor in the spread of HIV/AIDS globally.

In 1999 it was found by the US Department of Justice that persons with a household income of less than $7,500 annually experienced the highest rate of violence of all income categories.[40] While 13.1 percent of all women live below the poverty level, the percentage of Native Americans who live below poverty level is 31.6 percent. Covering basic human needs is extremely difficult when living below the poverty line but when abuse arises it becomes even more difficult to survive because violence can be an additional financial burden. It was found that the costs of being a victim of abuse average $878 for all races in the United States, but Native Americans suffer the highest loss of $936. Of the losses reported by Native people 60.4 percent are for medical expenses.[41] Given the fact that the abused are already at the lower end of the economic scale, an additional $936 places further stress upon the family, particularly the abused woman.

Domestic violence can affect a woman's ability to support herself and her children financially, thus placing her in the "hands" of her provider.[42] A 2000 study suggested that women who reported a history of domestic violence were most likely over twenty-five years old, unemployed, not living with their spouse, and not owning a home or apartment.[43] The American Bar Association found that most domestic violence victims are overrepresented in the welfare population, between 15 and 50 percent report interference from their partner with education, training, or work and that many times their abusers sabotage their work attempts, making it difficult to support themselves.[44] An interesting component of this situation is that "welfare studies show that abused women do seek employment, but are unable to maintain it" and it is believed that "it is possible that domestic violence presents a barrier to sustained labor market participation."[45] The story of a Native woman Rebecca who lived in New Mexico attested to forced control:

> I was very isolated. I never got off the pueblo, maybe once a week. He didn't want me to go back to work, we had no contact with my parents, by then because I had no phone. If we went to get groceries, he was there and he wrote all the checks and drove the car.[46]

The impact of domestic violence upon Rebecca's ability to control her destiny and support herself is clear.

A sense of powerlessness also limits the ability of women to insist on monogamous relationships or condom use, both of great importance in preventing the spread of HIV/AIDS. Condom use is one of the most effective means of preventing HIV/AIDS transmission. Sadly, studies show that fewer than 20 percent of high school and college women who are sexually active use condoms, clearly indicating that new strategies are needed to prevent the spread of HIV.[47] Condom use has been found to be a complex issue in sexual relationships, as it is tied to poverty, self-esteem, preserving good family relations, physical abuse, rejection, and abandonment.[48] It is frequently impossible for women who live in violent and abusive situations to insist on condom use. As indicated in recent studies, this is an important link between women who live in violent situations and HIV risk.[49] Diane Monti-Catania, a health advocate and author, maintains that "a woman who is a victim of violence, whether it was a one-time sexual assault or ongoing forced sex by her partner, rarely has an opportunity to request that a condom be used" and this increases her risk of contracting HIV.[50] Women who live in violent circumstances are too scared to demand that their abusive partners wear a condom, and they also fear being left alone because of their dependency on their abusive partner.[51] For those women who live with violence regularly it has been said that, "living in an environment where you are exposed to violence day after day bleeds all hope out of existence [and] it becomes hard to do things in one's own interest because it feels like, 'what's the point.'"[52] This attitude of helplessness diminishes a woman's ability to be safe from either violence or HIV/AIDS.

Similarly, women who are victims of abuse are also afraid to disclose their HIV status. Reports indicate that violence against women is not just a cause of the AIDS epidemic but also a consequence. For example, some places require partner notification of status and this mandate has placed many women at risk of more violence. A current study noted that 20.5 percent of HIV-infected women reported physical harm since their HIV diagnosis, which was twice as much as that reported by men. Women around the world have been "beaten, thrown out of their house, abandoned by their families, and even murdered, following disclosure of their HIV status to their partner or families."[53] Some men have used a woman's medical condition as an excuse for battering her. Another study found that "HIV-infected women who are abused have more illnesses, including opportunistic infections," which places further burdens and stress upon them.[54] The ultimate pain for some women is learning that "partners deliberately infected them with HIV out of anger or a compulsion to hurt them."[55]

By far the most critical cofactor placing women in danger of HIV infection and domestic violence, however, is their behavior. For adult/adolescent women, the main behavioral risk for AIDS is intravenous drug use, the source of 40 percent of all reported female AIDS cases through June 2001. In the heterosexual exposure category, approximately 38 percent of cases resulted from sex with an intravenous drug user. Tragically, in examining the cumulative

total of reported AIDS cases through June 2001, Native women have a higher percentage of intravenous drug use as a mode of transmission than any other race: American Indian/Alaska Native 45 percent, White (not Hispanic) 42 percent, Black (not Hispanic) 41 percent, Hispanic 39 percent, and Asian/Pacific Islanders 15 percent.[56] Both drug use as well as violence are part of Native women's lives and are frequently linked. In a small study of urban Indian women it was found that 38 percent of them "felt their substance use worsened after their beating began."[57]

Drug use and poverty are also tied to social behaviors that govern sex and money. It is fair to say that many drug users are in deep despair and struggling to survive. In this equation, a woman who is exchanging sex for drugs or money has little power to negotiate condom use, placing herself in severe danger for HIV infection. The drug-use lifestyle also places women at further risk through exposure to assault and rape. Studies indicate that commercial female sex workers are in great danger from sexual violence by their male clients and intimate partners, whether they are drug users or not.[58] Several of the Native women I interviewed for *Killing Us Quietly: Native Americans and HIV/AIDS* told me that they had engaged in intravenous drug use and that prostitution and violence were also active components of their lives. In a 1998 study that had Native Americans as 7 percent of the study group, it was shown that "violence and HIV are emerging as interconnected public health hazards among drug users and their families." Furthermore, it maintained that "rape, assault and the threat of assault are commonplace in the histories of female sex partners of male drug users" and providers of HIV/AIDS education must design prevention/interventions that empower women. The study found that 42 percent of the women reported having been physically assaulted by their partners and 36 percent had been threatened with assault by their partners.[59]

Violence comes in many forms and women and young girls encounter both forced and coerced sexual contact. Sexual coercion is usually perpetrated by male relatives, family friends, or other men in positions of power or influence such as teachers or, at times, boyfriends. Forced sex can be forced prostitution and/or rape. Rape has also led to the transmission of sexual diseases with occurrences ranging from 3.6 to 30 percent. And although the rate is low, transmission of HIV from rape is estimated to be one in five hundred.[60] Of the entire number of violent crimes against women from 1992 to 1996 it was found that "92 percent of rapes of women were committed by known assailants and half of all rapes and sexual assaults against women are committed by friends or acquaintances and 26 percent are by intimate partners."[61] A telephone survey of 8,000 women and 8,000 men found that "1 of 6 U.S. women has experienced an attempted or completed rape as a child and/or adult."[62] Most astounding is that "approximately 4.8 million intimate-partner rapes and physical assaults are perpetrated against U.S. women annually."[63]

The Native woman discussed earlier, Rebecca, attested to the fact that psychological abuse can lead to physical abuse as she reported being raped three times by her husband.[64] In a small study of American Indian women participating in an urban domestic violence program, "38% of the women had experienced marital rape and another 12% reported attempted rape by their

partners."[65] The Bureau of Justice has reported that "urban Indians had a slightly higher rate of victimization (121.3 per 1,000) than their suburban counterparts (103.7) with the rate among rural Natives at 70.8 per 1,000."[66] Also, the Bureau of Justice reported that rape statistics among Native Americans was the highest among all ethnic groups with "Native Americans nearly 13 times more likely to be assaulted or raped than Hispanics, seven times more likely than Whites, five times more likely than African-Americans and 39 times more likely than Asian-Americans."[67] A recent study by the state of Washington found that 23 percent of women in the state had been raped (twice the national average) and that "American Indian women were more likely to have been raped than white women."[68] Teri Henry (Cherokee) has been quoted as saying, "It is commonly known throughout Indian Country that 90 percent of Indian women in chemically dependency treatment are victims of rape and childhood sexual abuse."[69] Since rape is a way for HIV/AIDS to be transmitted it should be addressed in all domestic violence intervention/prevention materials and services.

Many Native people have suggested that the abuse of women is tied to "the issue of their very survival as Indigenous people." And they further argue that each Native woman or child that has been damaged represents an abridgment of a people's future and a step toward genocide.[70] It is also suggested that in an effort to keep tribal people safe and alive one must confront the historical trauma left by the colonizing process. Researchers Bonnie and Eduardo Duran forcefully maintain that the pain and suffering inflicted on tribal people in the past clearly contributes to their suffering today and that this "historical trauma" must be examined more fully to assist in the development of healthy communities.[71] Historical trauma, which is passed through generations, is defined as "unresolved trauma and grief that continues to adversely affect the lives of survivors of such trauma." Many argue that "letting go of the guilt and anxiety that continue to grip Natives in the cycle of violence" can be dealt with only through understanding their individual histories.[72]

The colonization of Native Americans is an integral part of understanding domestic violence. Native health promoters Karen Aritchoker and Charon Aseytoer have addressed how colonization destroyed family structures that protected Native women.[73] Asetoyer has further stated that the disempowerment of Native women has a long history and was supported by early American colonizers and the federal government. She further contends that "domestic violence is not a traditional part of Indian families . . . however, it has become a part of our [Native] community and it is increasing."[74] It is time to examine why and consider what can be done.

When Europeans arrived in North America they brought with them foreign laws and ideas. European laws did not support women's rights. British common law, for example, "condoned wife-beating provided that a husband used a *rod not thicker than his thumb*."[75] Thus physical abuse was not only a socially accepted part of family relations, but also was legally acceptable. This notion influenced American colonial laws. Other European concepts were that women could not own land or participate in government. This was in great contrast to the place of Native women in many tribal societies where

women could own land, divorce their husbands, and participate in government. Native women were also honored, held in great esteem, and lived mainly in egalitarian societies. With the imposition of European laws, values, and ideas, traditional Native ways changed to reflect the dominant society's view of women. Native women soon were viewed as having little value and were considered to be "property and thus the man was to decide what liberties women were to have within the household and within society as a whole."[76] It is living in a society whereby gender relations are unequal that women are unable to protect themselves from sexually transmitted diseases and violence.

It has been maintained by many Native scholars that prior to contact, domestic violence was not found in tribal communities or that it was "both rare and severely reprobated."[77] In examining abuse among the Navajo, for example, it was argued that with the inclusion of certain Euro-American attitudes into Navajo communities, Navajo beliefs of interdependent bonds and equality of sexes changed to patriarchal rule that allowed for intimate-partner violence.[78] According to this perspective, the inclusion of these Euro-American attitudes allowed intimate-partner violence (IPV) not only to surface, but also to survive. And it has been found that "community-based AI/AN intimate-partner violence intervention/prevention programs are based on the philosophy that IPV was not a traditional or common occurrence prior to European contact 500 years ago and subsequent colonization of North and South America." There is also a "growing interest of numerous indigenous groups . . . [in] tradition-based psychoeducational intervention to resolve historical trauma and grief" and promote "cultural recovery."[79]

It is important to understand that Native families were not immune to violence prior to contact, but their worldviews consisting of honoring interdependent relationships dictated that the need for group survival outweighed the hostility of individuals because it disrupts the balance of relationships. In studying the concepts of illness, including victimization, it becomes clear that Natives have their own unique views of illness and wellness. Although there are over five-hundred different tribes with over five-hundred stories about sickness, there are some common features. At the root of this commonality is an understanding about what it means to be healthy. In works focused on Native health it is agreed that "health is often expressed as a balance between a body, mind, and spirit or soul," and "wellness is the possession of moral ways of knowing and enacting this balance."[80] The concept of health and its relationships with "the spirit world, supernatural forces, and religion stands in sharp contrast to the secular emphasis on disturbed physiology and purely physical explanations of Western medicine."[81] For work in the area of HIV/AIDS and violence against women it is important to understand the history of the generational cycles of abusive behavior that places our women in danger. The US government recognized its importance and has sponsored several publications. One of their recent topic-specific monographs that was developed to assist individuals in better understanding issues affecting Native communities (HIV/AIDS, child sexual abuse, violence against women, etc.) addresses the history of victimization in Native communities.[82]

The incorporation of Euro-American ideas has clearly affected the presence of and tribal responses to HIV/AIDS and domestic violence. In examining the problems that Native women encounter in living violence-free it has been found that the destruction of traditional community responses to abuse has allowed violence to exist. Traditional tribal methods of violence interventions that included banishment or ostracism have been "eliminated or limited with the advent of a Western European criminal justice process."[83] The conflict between traditional ways and modern ones are also evident in HIV/AIDS work. For example, the replacement of Native spiritual ways with Christian values has hindered HIV/AIDS prevention and services for gay/bisexual Natives. Gender variances and behaviors, which were accepted as normal aspects of tribal life, became viewed as deviant and immoral.[84] Under these circumstances lesbian women in violent situations are placed in a more precarious position because they are marginalized due to their sexual orientation as well. It is this place of oppression, displacement, alienation, and marginalization that Native women, generally, are born into and must work to change.

It is apparent that Native people are rendered vulnerable to HIV/AIDS through both historical and social processes. Scholar and AIDS activist Paul Farmer argues that people become vulnerable not because it is "nature nor pure individual will that is at fault, but rather [because of] historically given (and often economically driven) processes and forces that conspire to constrain individual agency."[85] Farmer and others are correct in asserting the importance of examining history, plus social and economic factors in the battle against the rise of HIV/AIDS. His suggestion is helpful in understanding the rise of domestic violence in tribal communities. It is also useful to listen to the women themselves and to hear their stories because within them are the keys to understanding their perspectives, power, and resiliency.[86]

To bring back a sense of dignity and honor to Native women, and to keep them safe and healthy, we must understand how the changes in our communities began and why they continue. That understanding is necessary in addressing the challenges Native women face when confronting domestic violence. Not surprising, barriers to effective domestic violence intervention/prevention are similar to those blocking effective HIV/AIDS prevention/intervention. Both areas encounter problems of geographic isolation, denial, mistrust of white agencies and helpers, as well as systems that are not developed to deal with the problems of women at high-risk. The stigmas attached to domestic violence and AIDS will also prevent tribal people from receiving treatment. Stigmas are found to "marginalize, exclude and exercise power over individuals" and, sadly, by blaming certain individuals, society can excuse itself from the responsibility of caring for and looking after them, which can lead to the denial of access to the services and treatments they may need.[87]

Although the problems faced by Native women are vast, they are not insurmountable. Native women and tribal nations have risen to the call and are providing hope. As of 1999 Native women direct most of the Native American domestic violence programs developed under the VAWA.[88] In addi-

tion, numerous grassroots organizations are working on these issues. One of the first Native American grassroots organizations to address domestic violence is the White Buffalo Calf Women's Society. The White Buffalo Calf Women's Society was organized in 1979 by Tillie Black Bear in South Dakota and provided the first domestic shelter for battered women in South Dakota on the Rosebud Sioux Reservation. The shelter today serves "approximately 200 women and 1500 children per year." In 1998 Black Bear was honored for over twenty years of work in counseling victims, conducting workshops for batterers, and working with law enforcement. South Dakota's attorney general described her as "epitomizing the dedication required to help crime victims . . . young and old . . . who live in every corner of the state."[89] This White Buffalo Calf Women's Society continues to provide services for domestic violence, adult sexual assault, survivors of homicide victims, and battery.

Presently, one of the most recognized and "innovative government programs in the country," is Cangleska Inc. Cangleska, which means "medicine wheel" (Lakota), was created in 1987 and is a culturally based social service. The program has a staff of fifteen and has consulted with over five-hundred tribes about combating domestic violence. In 1997 they opened a shelter that has assisted over seven-hundred women and children. Cangleska has proven to be very successful in reducing domestic violence. Much of its success is due to the support and participation of respected tribal men, support of the tribal council and courts, its work with tribal police training, and its well-developed and all-encompassing intervention/prevention programs.[90] In fighting violence, Cecilia Fire Thunder of Cangleska has commented on how critical it is to "break the silence" about domestic violence. Fire Thunder works to educate tribal people not to be silent about domestic violence and she feels that there has been "a small ray of hope" because "each year Native American women are reporting more and more instances."[91] One of the most useful developments of Cangleska is the Sample Tribal Domestic Violence Code. The code is constructed to provide victims of domestic violence with safety and protection; to utilize the criminal justice system in setting standards of behavior within the family that is consistent with traditional Native values; and to prevent future violence through prevention and public education programs. The code is posted on a website (http://www.naicja.org/vawa/sample.htm) as a means of information sharing.

The Navajo have also begun to answer the needs of its women.[92] In 1993 the Navajo enacted the Domestic Abuse Prevention Act which specifies intimate-partner violence as a crime, names the specific protection to be given, and outlines services for victims and penalties for perpetrators.[93] The Navajo Nation has been making strides in dealing with a variety of health issues, in addition to domestic violence, including the incorporation of several HIV/AIDS programs such as the Navajo AIDS Network and Fort Defiance Area Native American AIDS Education Project. Other organizations addressing violence against Native women include Mending the Sacred Hoop STOP Violence Against Indian Women Technical Assistance Project; Sacred Circle; Native American Circle, Ltd.; and the Minnesota Indian Women's Resource Center.[94]

As Native people have become more technically skilled and federal funds have become available, several internet sites dealing with Native women and violence have been created. One of the most useful sites is "Mending the Sacred Hoop," which is a Native American program whose mission is to "assist Native Sovereign Nations to improve their response to Indian women who are victimized by domestic violence and sexual assault and restore safety and integrity to them."[95] The site includes information on their staff, newsletter, and conferences, and details Native women's issues, profiling their activities, backgrounds, philosophical perspectives, and overall directions.

With recent federal funding there has also been a rise in studies on violence and Native women, including the exploration of the impact of law on intervention/prevention programs. For example, a recent study investigated how Native women's safety is affected by responses from the criminal justice system, specifically how "institutional practices carried out by a non-Native criminal justice system enhances or marginalizes attention to the safety needs of Native American women."[96] More funding is still needed, however, to train tribes and organizations on the legal aspects of violence prevention and the development of systems that work more effectively together, particularly since tribes do not have criminal jurisdiction over nontribal members. This is critical in areas such as South Dakota where "as many as 50–60 percent of the relationships on their tribal land alone involve Native women who are in intimate relationships with non-Native men."[97]

Both HIV/AIDS and domestic violence are public health problems that have serious consequences and costs for individuals, families, communities, and tribes; hence we must address both. In an attempt to give direction and recommendations for intervention and prevention, I believe strongly that a holistic and Native approach to HIV/AIDS and violence should take place. In an effort to live AIDS- and violence-free, poverty, gender, substance abuse, and the like must all be examined. Also, effective prevention must consider how these two health problems intersect. A full range of IPV service referrals and appropriate provider training and responsiveness are critical components of effective HIV care programs for women. Another important component of programs is male responsibility. Since the majority of violence committed against women is by men, it is critical that programs address issues of male responsibility, particularly since statistics in some states indicate that a large number of offenders are Native. For instance, in Alaska a ten-year study found that "37 percent of the domestic violence victims and 41 percent of offenders are black or Native, even though the groups together constitutes just 15 percent of Anchorage's population."[98]

I end this exploratory paper with several recommendations. Most importantly, the development of medical self-sufficiency is critical and, in many ways, tied to the sovereign status of tribes. For effective prevention/intervention, tribal people themselves must be the ones to address the problems that plague their communities. One of the most important things I have learned about HIV/AIDS prevention programs is that the ones that work emanate from within the affected communities. I agree with scholars Jeanette Hasssin and Robert S. Young, whose definition of "self-sufficiency" is two-tiered. On

the individual level they find self-sufficiency as "the consequence or action of the empowerment process measured in terms of personal health, attitudes, changes in personal relationships and empowerment of others" and on the communal level, "it can be seen in the development and execution of community-centered programs designed for the health and survival of the community [and] it is evident in their perceived sense of self-efficacy in successfully motivating others to participate in the project and in some situations, obtaining formal tribal support to accomplish their goals."[99] In this instance the goal would be to decrease the transmission of HIV/AIDS and violence against women in their communities.

Another recommendation is the use of community assessments. Since a variety of problems face tribal communities, it is critical that prior to the development of programs/projects the community determine the level of understanding of the problem(s) they face. Colorado State University's Tri-Ethnic Center for Prevention Research has developed a promising intervention model, called the Community Readiness Model, which has been utilized by a number of tribal communities. The Community Readiness Model is an innovative method for assessing the level of readiness of a community to develop and implement prevention programming. Using a series of interactive steps based on expert raters and Delphi method, a nine-stage model of community readiness is determined. The *no awareness* stage suggests that the behavior is normative and accepted; *denial* involves the belief that the problem does not exist or that change is impossible; *vague awareness* involves recognition but no motivation for action; *preplanning* indicates recognition of a problem and agreement that something needs to be done; *preparation* involves active planning; *initiation* involves implementation of a program; *stabilization* indicates that one or two programs are operating and are stable; *confirmation/expansion* involves recognition of limitations and attempts to improve existing programs; and *professionalization* is marked by sophistication, training, and effective evaluation. It is clear to those in the health field that communities must understand the stage they are in prior to making changes within their communities.[100]

I urge the prioritization of these two deadly health problems and recognition of how they intersect. Domestic violence and HIV/AIDS programs/projects and their literature must address the intersection of these health problems and those working in either field must have training on the intersections, as well. Finally, it is important for tribal agencies to draw on the work of other tribes. For example, I suggest that tribal communities share their work with each other, especially their successes. It may be useful to make contact with organizations such as the Native American Women's Health Center on the Yankton Sioux Reservation, White Buffalo Calf Woman Society on the Rosebud Reservation, and Cangleska to discuss the effectiveness and problems they encounter. The work that needs to be done to keep our women safe is daunting but it is attainable. And it is hopeful to know that many individuals, organizations, and tribes are developing positive and helpful programs that show us that with commitment, caring, and collaboration our communities will heal and survive.

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