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PERSPECTIVES

PATHWAYS TO INFECTION: AIDS VULNERABILITY AMONG THE NAVAJO

Carol Sullivan, PhD

Though the development of AIDS cases among Native Americans has paralleled the early stages of the epidemic in the United States, there are socio/cultural distinctions among many U.S. tribes that could lead to transmission differences. Patterns of sexual behavior, IV drug use, suicidality, use of disinhibitors, and the rural-urban migration found among some members of the Navajo Nation are reviewed, along with recommendations for education/prevention program development. The efficacy of anthropological techniques of rapport building and information gathering about sensitive information is also discussed.

The Navajo reservation encompasses about twenty-four thousand square miles of rugged, semi-arid land in the states of Arizona, New Mexico, and Utah. The size of the state of West Virginia, the area is crowded, and several thousand Navajos spill over into adjacent lands, some of which are owned by individuals and some by the Navajo tribe (Locke, 1976, p. 5).

During the late 1980s early 1990s, some of the 146,300 member Navajo Nation lived in rural areas supporting themselves through traditional crafts, sheep ranching, and agriculture. Others worked in tribal affairs, teaching, the health professions, or the tourist trade. Many Navajo have lived away from the reservation at least part of their lives for school or work.

NAVAJO SOCIETY TODAY

Certain aspects of Navajo culture—its language, religion and geographic isolation—insulate it from complete assimilation into mainstream American society. Navajo language, with its unique organization and logic, is still in widespread use. Traditional Navajo diagnosticians and healers, "singers" or "shamans", continue ancient rituals and songs for the ill and distressed. Participation in the old ceremonies gives identity and comfort to tribal members. At the same time, Western health

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care is available. The coexistence of these health care systems is not a problem for the patients, who take from each as they need.

> Not only are the herbs and native medicines administered during many of the ceremonials to the patient beneficial to his physical condition but many white doctors at hospitals and health centers on the reservation have recognized the psychological benefits of the ceremonies in recent years. It is no longer unusual for a Singer to visit a patient in one of the modern hospitals on the reservation either at the invitation of the administrators or with their permission. (Locke, 1976, p. 5)

The degree of acceptance of Navajoan and/or mainstream American health beliefs is related to a) definition of the health problem, and b) access to the resources needed for a cure. By this definition, it is clear that health beliefs are just one aspect of Navajo adaptation to the social and physical environment and can change throughout a lifetime as the environment changes.

IMPORTANCE OF THE NAVAJO PERSPECTIVE

This investigation explored patterns of behavior found among some members of the Navajo Nation that could make them vulnerable to human immunodefiency virus (HIV) infection. It is hoped that these suggestions can assist AIDS preventive planners' discussions of sex, illness, and death for Navajo audiences. For, though the Navajo share some social and economic characteristics with others in America, their thinking and behaving about sexuality and risk taking, within the context of the threat of AIDS, cannot be assumed to be the same. Programs designed for urban prostitutes or IVDUs will have little salience in the rural Navajo reservation.

There are behaviors that create a vulnerability to AIDS infection among some Navajo. This is not to leave the impression that the Navajo are more susceptible to AIDS than other social groups in the United States. But there are patterns of activity among some Navajo that increase their risk of infection by the AIDS virus. These behavioral patterns are reviewed below with suggestions for framing interventions. In conclusion, the necessity for learning Navajo perceptions of the disease through time-tested anthropological research is described.

The following essay discusses patterns of Navajo tribalism, rural-urban migration, binge drinking, and suicidality. Traditional attitudes toward death, gender, and disease processes are also examined. These generalities about Navajo life are only initial suggestions. They are intended to heighten sensitivity and encourage innovative action.

SUPPORTIVE TRIBAL LEADERSHIP ESSENTIAL

Certain characteristics common to tribal societies distinguish them from modern societies and influence tribal disease rate and epidemiology (Polunin, 1977, p. 7). Even though the Navajo are highly acculturated, these features are prevalent and make their vulnerability distinct from those of nontribal peoples in the United States. Among the Navajo, lower overall population density leads to smaller settlements and social groups. Navajo also exhibit greater settlement mobility and isolation, more contact with fewer people, greater resistance to spontaneous changes, and greater vulnerability to external influences (Polunin, 1977, p. 7).

One principal reason tribal organization is salient in mounting prevention is that tribal, political, and religious leaders' support is essential. The single most important aspect of tribalism is, that while it does not impact directly upon transmission patterns, it most emphatically defines implementation. Tribal leaders ultimately decide what resources to allocate to AIDS prevention.

> Before . . . programs can be undertaken . . . the gatekeeping elements of the communities must be educated. Many tribal councils, Indian parents and Indian schools are very conservative about sensitive issues such as alcohol and drugs. Although it is extremely difficult to obtain permission to undertake such programs, it must be pursued. In my experience, the first persons educated should be the tribal, health and educational officials. (May, 1986, p. 192)

Tribes around the globe have usually lived in their country for hundreds of years before the current rulers came. Tribal persons such as the Navajo also often live in impoverished rural villages and rely on seasonal/unskilled work for their livelihood. The Navajo have lacked political power and equitable access to national resources. Many continue to be subsistence farmers with limited work opportunities.

These elements—tribalism, isolation, and poverty—contribute to vulnerability to disease when tribal members travel to urban areas. Traditional norms that, for example, limited sexual activity to prescribed partners or social groups by their very nature limited transmission of infection between persons. But as young Navajo migrated to cities, definitions of permissible sexual behavior changed. Urbanization, and this is true for all groups not just the Navajo, weakens the hold of traditional social norms and lessens the "closedness" of the sexual network. Thus, what was previously a closed, predictable network of sexual partners multiply connected in daily life becomes an open, opportunistic network of known and unknown, Navajo and non-Navajo sexual partners.

AIDS INFECTION RATES

As late as 1987, AIDS transmission patterns among the Navajo were not distinct from the early overall U.S. trend (Helgerson, 1987, p. 1). In June, 1986, 15.7 men per 100,000 were diagnosed with AIDS in the United States (Curran et al., 1988, p. 612). There were 17 documented cases of AIDS and HIV+ among the 146,300 Navajo in 1988 (11.6 per 100,000). Eighty-eight percent (15 of 17) of the cases were males. An official enumeration of the extent of AIDS and HIV-positive infection among the Navajo was not available to the author. This unofficial report of 17 AIDS cases among the Navajo in 1988 should not be accepted as confirmed (personal communication with Leo Morgan, Navajo Nation Health Dept., 1988).

In fact, AIDS cases among all U.S. Native Americans have doubled each year. There were three cases in 1983, 15 in 1985, and 31 by June, 1986 (Johannes, 1987, p. 13). Recent CDC and Indian Health Service (IHS) findings of AIDS rates among all American Indians and Alaskan natives (AI/AN) indicated that the rate may even increase more rapidly in the near future. (Conway, Hooper, Helgerson, Peterson, & Ambrose, 1991, p. 217). It may not continue to parallel the overall U.S. trend.

> Reported cases of American Indian and Alaska Native (AI/AN) with AIDS have a wide geographic distribution and increased markedly during 1989. The distribution of cases by exposure category for AI/AN is (also) distinct from other racial/ethnic groups. (Metler & Stehr-Green, 1990, p. 300)

HIV+ among the Navajo continues to be transmitted primarily by blood transfusion and sexual contact, not needle sharing. IV drug use is in fact infrequent among the Indians.

> Intravenous drug abuse appears not to be very prevalent among Indian people. There are few reports in the literature, and in these, use by Indians is minimal. Review of a national treatment data base reflects only a vary small percentage (less than one percent) of Indian individuals seeking or using available treatment programs off-reservation. (Mail, 1987, p. 9)

In fact there was a reluctance among the Navajo to even pierce the skin (personal communication with Patricia Mail, PHS AIDS Division, 1988).

NAVAJO VULNERABILITY

The following comments are based upon a review of relevant literature as well as interviews with Navajo and non-Navajo, males and females. The fieldwork was conducted in 1987 and 1988.

HIGH RISK SEXUAL BEHAVIORS

The self-described gay Navajo males interviewed agreed that almost all the AIDS cases among the Navajo up to 1988 were among homosexual or bisexual men. This, of course, is similar to the early U.S. trend.

Explicit and well documented information about the magnitude of sexual relations with multiple partners, anal sex, or sex for money or drugs by the Navajo was not available. Therefore, sexually transmitted disease (STD) rates served as an indirect measure of the frequency of high risk sex.

High (greater than the U.S. average) rates of gonorrhea, syphilis, chlamydia, and herpes among the Navajo were documented by area health providers (Attico, 1987, p. 11; Johannes, 1987). These rates were indirect indicators of a significant number of sexual encounters without a condom and between persons, one of whom had an STD.

High levels of STDs in a population imply significant vulnerability to HIV infection (Piot et al., 1988). Several studies of the relationship between HIV transmission and STDs have indicated that, for example, genital ulcers greatly increase the chances of acquiring AIDS (Piot et al., 1988). This is because the genital ulcer was a potential point of entry for the virus into the body. "[T]he damage ulcerative diseases cause to genital skin and mucous membranes may facilitate HIV acquisition or transmission" (Curran et al., 1988, p. 614). HIV could be transmitted by bisexual Navajo males to females, if the females had genital ulcerations. This type of vulnerability exists in the tribe. Twenty-six percent of all pregnant Navajo women seen in the Gallup and Crownpoint prenatal clinics were found to be infected with

chlamydia. ". . . most of these infections were asymptomatic and largely unrecognized by providers" (Toomey & Rafferty, 1987, p. 22).

In brief, some Navajo have potential vulnerabilities to viral transmission because of genital infections. The context within which some of the critical sexual activities are carried out is discussed below. This overview outlines the socio/cultural dynamics of targeted sexual activities occuring among the Navajo.

MALE-WITH-MALE SEX AMONG THE NAVAJO

Homosexual behavior was accepted conduct among many tribes and existed long before the European conquest. The Navajo interviewed in the course of this study made reference to individual Navajo *nadlay* (male wives). They were described as being possessed of special powers and wisdom. The term *nadlay* connotes the sacred more than the sexual. In her historical (mid 1930s) account of the Navajo, Gladys Reichard described a young Navajo man named "Lassos-a-Warrior," a *nadlay.*

> Among the Navajo one variant of homosexual behavior was the *nadlay.* In traditional practice this person was considered, if a medicine man, to be engaging in behaviors which were powerful and mysterious . . . the Navajo called persons of his type *nadlay,* which means "one-who-changes." Individuals who "change" are generally men who prefer women's activities to those of men. Accordingly, they either give up the work men customarily perform, and do women's work or they occupy themselves with women's work while not giving up entirely those things in which men are interested. (Reichard, 1939, p. 11)

The historical precedent for acceptance of institutionalized homosexuality has not necessarily translated into tribal-wide acceptance of Navajo gay life style today. The homosexual males interviewed did not see their activities as the same as those of the *nadlay.* Some did note there were older men, often spiritual specialists, who could be called *nadlay,* but this was distinct from being "gay." Gay men did not admit to any special "powerful or mysterious" status like the *nadlay* possessed.

The numbers of practicing *nadlays* or persons who were involved in a gay lifestyle was impossible to determine. Many interviewees noted the numbers were "high" or "more than you would expect," but these are only assumptions. Navajo gay life style ranged, just as among non-Navajo, from open and public to closeted.

The fact that many gay men kept their sexual preference private indicated that acceptance of Navajo homosexuality was not universal. Negative sentiments toward homosexual behavior by some of the non-gay interviewees was noted. Some interviewees felt homosexuality was an activity of younger boys, "boarding school behavior," to be discarded upon adulthood. Others felt gay male solidarity was a threat to their tribal job security. Some condemned homosexuality as being non-Christian or sinful. In short, the Navajo attitudes toward some sexual activities were similar to those of the larger American society, while they also reflected uniquely Navajo perceptions.

An often discussed feature of Navajo homosexual activity and AIDS prevention was that the Navajo Nation did not officially acknowledge it. Interviewees often observed it would be difficult for the tribe to mount an educational campaign about a behavior it did not recognize.

Anthropologist Walter Williams recently conducted extensive interviews with living *berdaches* (pan-Indian term for a traditional type of Indian homosexual similar to the Navajo *nadlay*) in tribes across the United States (1986). The *berdaches* he interviewed were respected men satisfied with their chosen lifeway. The men Williams interviewed were not part of a politically activist gay community; they appeared to be more isolated, and more religious in attitude.

THE USE OF DISINHIBITORS AND HIGH RISK SEXUAL BEHAVIOR

The chances of engaging in risky sexual behavior such as relations with an unknown partner or unprotected anal intercourse are increased if combined with alcohol consumption. Increasing attention should be devoted to identifying the circumstances under which compliance with safe sex guidelines is suspended. A recent study suggests that the use of drugs and alcohol during sexual activity may be one such circumstance (Stall, McKusik, Wiley, Coates, & Ostrow, 1986, p. 370). Aspects of Navajo drinking patterns have been described by ethnographers. The "where," "how," and "with whom" of Navajo drinking are distinctive. Navajo drinking, particularly in border towns, is public and episodic. This pattern could enhance HIV transmission, because opportunity for sexual activity with a stranger infected with HIV increases if the drinker is in an urban area as opposed to home.

This discussion is not intended to imply that "all" Navajo drink or drink to excess. A survey of Navajos in the early 1970s in four reservation and border town settings indicated that only 30% to 42% of Navajo adults drank, compared with 71% of the U.S. population at that time (Levy & Kunitz, 1974). It is still accurate to say that the alcohol misuse problem is limited only to certain segments of the Navajo population, (May & Smith, 1988).

Disinhibitors such as marijuana and alcohol contribute to the spread of HIV by leading to greater risk taking by users. Alcohol, marijuana, and solvents, the substances most commonly used by Navajos, can lead to sexual acting-out as well as carelessness about personal safety. Stall et al. (1986) have found:

> Men who currently abstained from combining drug and alcohol use with sexual activity were likely to have been at no risk for AIDS . . . during the previous year. . . . The men who currently combined drug use with sex were most likely to have a history of high-risk sexual activity over the previous year. (p. 370)

Reservation drinking customs condone drinking to inebriation, though usually in an episodic "bingeing" fashion (Kuttner & Lorincz, 1967; Hill, 1978). Drinking rapidly in a group situation can rapidly produce high blood alcohol levels and intoxication.

A number of ethnographers have observed and documented Navajo drinking behavior. They have noted the tendency toward heavy consumption in a short time, tolerance of loss of control, and acting out (Levy & Kunitz, 1974). Drunkenness, could, then, be used as an explanation for risky behavior, as an excuse for unprotected sex with an unknown sexual partner.

Ethnographic observations of Navajo drinking patterns during, for example, periodic trips to off-reservation border towns described an exuberant "party time." During this flamboyant excessive drinking a sexual partner was often sought (Hill, 1980, p. 260). The fact that the drinkers usually lived away from town was related to

their drinking style, because they had no homes in which to drink. Talking and partying often took place in well trafficked public places.

Most reservation border towns have a downtown section where this visible and gregarious drinking takes place. It is usually close to a bus terminal, a plasma center, pawn shops, curio shops, and liquor stores that open early in the morning. In this part of town, a person can usually convert a handmade article into ready cash.

Contemporary studies of Navajo drinking customs have not addressed types of associated sexual activities in the detail necessary for a careful evaluation of vulnerability to HIV. The drinking groups observed in the alleys and sidestreets were predominantly male, though sometimes a single woman was with them. The women who could become casual sexual partners were likely to have had other unknown partners. Hill's (1980) description of young Navajo "hell raisers" indicated sexual activity with multiple, possibly unknown, partners.

> Because females are frequently found at scenes of action, hell-raisers use these settings to pursue sexual liaisons. Hell-raisers admire sexual prowess and approve of premarital sexual behavior. The liaisons established may be of a night or weekend's duration or they may develop into longer, more permanent relationships. (p. 260)

This kind of sexual contact could hold a high risk for transmission of HIV. The opportunity to come into contact with a number of previously unknown sexual partners increased in the public drinking settings such as alleys, ditches, and street corners. This "open" sexual network increases the opportunity for sexual contact with someone infected with HIV (Anderson, May, & McLean, 1988). Recent findings indicate a high vulnerability among certain Indian women. "The likelihood of an Indian female whose sexual activities are relatively more "open" being infected with HIV are higher than for Indian males if she is an IVDU" (Metler & Stehr-Green, 1990).

Among homosexuals in the United States, bars have been an important feature of social life. Ample documentation, following from this, can be found for a strong relationship between heavy alcohol use and homosexual socializing (Room, 1985, p. 2). The potentially synergistic interaction between homosexual activity, use of disinhibitors, and a third cofactor, high Navajo suicidality, is examined below.

NAVAJO SUICIDALITY AND VULNERABILITY TO HIV INFECTION

Excessive alcohol consumption, homosexuality, and low self-esteem combine to bring about suicidal ideas or actions. Suicide among Native Americans is particularly high among young men, who also have the most HIV infection. Suicide rates have also been consistently higher among Native Americans than among the general population for many decades. (Sullivan, 1986; Van Winkle & May, 1986). Atkinson et al. (1990) have stated that a psychiatric predisposition to suicide may be a major factor in the relationship between infection and suicidality. This would put an infected or high-risk Navajo at an even greater risk for suicide.

Severe feelings of hopelessness or depression could intensify if a Navajo person's sexual behavior were considered undesirable by contemporary Navajo values. Public awareness of sexually transmitted HIV infection may negatively influence the acceptance of male-with-male or multiple-partner sex. The author has noted that some Navajo expressed negative sentiments about homosexuality. This could readi-

ly impair acceptance of risk reduction behaviors because of the real or perceived lack of social support. A survey of risk reduction behaviors by homosexual men in small cities found that, though factual knowledge about AIDS was high in this sample:

> . . . gay men in small cities encounter fewer social supports for making AIDS precautionary behavior changes, do not benefit from well-organized community with social structures which permit efficient behavior norm redefinition and still perceive AIDS as a distant threat. (Kelly, St. Lawrence, Brasfield, Stevenson, Diaz, & Hauth, 1990, p. 417)

This could lead to withdrawal and depression and further drinking. A depressed person could possibly even seek to become infected in order to passively commit suicide (Papathomopoulos, 1988). Additionally, Navajo suicidality, if exacerbated by alcoholism, makes the Navajo particularly vulnerable to actual suicide if they are infected or at risk of infection.

> There is a higher lifetime prevalence of suicide in people with alcoholism (15%) or depression (15%) than in the general population (1%). This leaves individuals with these conditions especially vulnerable to poor self-care, which may in turn lead to the transmission of AIDS. (Flavin, Franklin, & Frances, 1986, p. 1442)

RURAL-URBAN CIRCULAR MIGRATION AND SEXUAL BEHAVIOR

An important aspect to the relationship of circular migration to HIV transmission is that the Navajo, though a rural population, may be exposed to HIV infection because of their frequent travel to urban areas. The diffusion of HIV could occur initially along networks of sexual interaction between people in urban areas and then to rural partners. For example, persons who have sex with multiple and/or unknown partners in the city, who then return to their rural monogamous partners, could expose them to infection with HIV.

The association of travel, binge drinking, and multiple sexual partners was observed among some Navajo. Though many Navajo lived in urban centers away from the reservation, many relatives remain on the reservation. Being away does not mean that ties are not strong between family members. One of the dynamic links among the Navajo has always been continual visitation (Jessor, Graves, Hanson, & Jessor, 1968; Waddell & Everett, 1980). These visiting patterns, between city and village, could also become pathways by which HIV infection could come to the reservation.

The easy mobility of the Navajo has historical precedent. Prior to the coming of the Spanish colonists to New Mexico, the Navajo were hunters, seed-gatherers, and seasonal farmers. They lived in forked-stick hogans and grew patches of corn, beans, and melons. Their communities were comprised of extended family groups located on high mesas near their fields. They lived a seminomadic life, changing their place of residence as the need for new farming land arose or because of raids from their enemies, the Utes, who lived north of them (Locke, 1976).

Today a Navajo may travel far for college, boarding school, the Armed Services, rodeoing, or the pow-wow circuit. They return home for ceremonies, seasonal activities, and religious functions because, to the Navajo, their real "home" is on the reservation. This makes regular visiting a persistent feature of Navajo life.

An outgrowth of the importance of their reservation home, this author was advised, was that those Navajo diagnosed with AIDS had either made a trip, or are planning a trip, back home to the reservation "before they die." These trips were often to participate in traditional religious curing ceremonies.

The rapidity or strength with which HIV will spread to the reservation cannot be predicted at this time with certainty. There may be as yet unknown factors that will mitigate against Navajo vulnerability. Indeed, some rural African villages have been little impacted by the AIDS virus, while the rates of infection continue to multiply in surrounding border towns.

> The prevalence of HIV-1 in most of rural Africa seems not to have changed significantly. For example, whereas there was a tenfold increase in HIV-1 in urban areas antibody prevalence remained low (0.8%) in one rural area in Zaire between 1976 and 1986. (Piot et al., 1986, p. 574)

This observation suggests that the rate of HIV transmission remained stable in the absence of specific conditions that enhanced its spread. These specific conditions seem to have occurred in some rural parts of Uganda, on the other hand, where the virus has spread rapidly (Piot et al., 1986, p. 574).

LITTLE INTRAVENOUS DRUG USE AMONG THE NAVAJO

> Examination of service data related to drug abuse suggests that there may be much less of a drug problem within Indian communities than for the U.S. population as a whole. (Mail, 1987, p. 7)

It is instructive to compare the travel patterns of IV drug users with those described for the Navajo. The residential permanence of the intravenous drug user contrasts with Navajo mobility. A regular heroin user, for example, does not stray far from home. Daily face-to-face interaction with "the neighborhood" is an essential coping strategy of urban IV drug users.

The potential link between infected IV drug users and the Navajo is likely to be through sex with an infected person, in an exchange of sex for money or drugs during a visit to an urban area. One pathway to infection is then to a migrant Navajo from an infected IV drug user through sexual contact.

SUMMARY OF PATHWAYS TO INFECTION

The first section has outlined behavioral risk factors that could potentially increase vulnerability to HIV infection among Navajos who engaged in them. A model designed to guide AIDS prevention programs points up situations and behaviors that could play a key role in the transmission of HIV among the Navajo. This model can also point out new relationships between cofactors.

AIDS PREVENTION IN THE NAVAJO NATION: LESSONS FROM APPLIED ANTHROPOLOGY

SENSITIVITY

If a team of anthropologists were asked to help mount an AIDS prevention campaign on the reservation, the first step would be to gather data relevant on behaviors and attitudes. This information would be the base for prevention design.

Below are illustrations of the types of data an anthropologist would want to use and examples of how the information could be integrated into AIDS prevention programs for the Navajo tribe. Anthropologists would watch, listen, and ask questions in this case about sexual behavior, migration, disinhibitors, and disease concepts. In the anthropological tradition the researcher is particularly sensitive to the perspectives of different social, religious, and political forces. A detailed discussion of anthropological investigation can be found in two recent excellent publications; see Bernard (1988) and Werner & Schoepfle (1987).

1. Defining AIDS and high-risk behaviors as the Navajo see them.

An assessment of Navajo perceptions of disease causation and prevention has to go beyond mere definitions and descriptions. The investigator cannot choose what aspects of the everyday life of the target group are most germane to AIDS prevention programs. The Navajo are the ones who know the answer to this question, not the researcher. The investigator need not spend a lot of energy looking for differences between the "old" ways and the "new" ways. Rather than focus on what is "traditional" and what is "modern," it is more productive to learn how these concepts translate into behavior.

By way of illustration, there are two disease-related concepts given by Navajo shamans when discussing AIDS. They are described briefly below.

> Ats'iis Ach'aa Naa Baa Dahooz'a" is a literally "Body-a-shield-across-with-it-is-in-danger." "The Body's protective shield (good health) is in danger" is the phrase used by Navajo medicine men to describe AIDS. Navajo medicine men have also noted that AIDS is not a new sickness. It seems to resemble the old "wildcat" sickness they said. (Personal communication with Mark Schoepfle, Program Planner, Navajo Nation, Window Rock, AZ, 1988)

The question then becomes what difference does it make that traditional Navajo shamans have defined AIDS as an "old" disease, "wildcat sickness?" The only way to learn is to ask, listen, and gather data about this definition. It could be that the traditional concepts have little salience, or possibly they are the very core of Navajo understanding of AIDS transmission. Time must be taken to interview different "key" people—native consultants. The interviewer should ask them, in as many different ways as possible, what AIDS is, how it can be treated, and how can it be prevented. Anthropological interviews with "key" people, decision tree modeling, structural and unstructural observations, and a heavy reliance on native (Navajo) consultants can help the researcher, for example, understand what it means when a disease is a "wildcat" sickness or how to repair one's "protective shield."

In the end, the researcher who takes time to listen and document perceptions about disease in general and AIDS in particular will be able to sort out the important from the trivial. He will also have a clearer concept of how to proceed to educate Navajo persons about risk reduction.

2. AIDS prevention may not be appropriate in an STD prevention or alcohol program.

Though it may seem reasonable, and would be cost-saving in the short run, to incorporate AIDS prevention with the established tribal alcohol programs, this may not be effective. These programs often use strong negative pressure to effect

sobriety, but current research on the impact of health threats upon behavior has found that threats do not, by themselves, facilitate behavior change.

Furthermore, the long-term consequences of such distress may be complex. For example, psychological and social distress may ultimately reduce adherence to behavioral risk reduction guidelines or disrupt maintenance of established, positive behaviors (Joseph et al, 1987, p. 247). STD prevention programs stress contamination and disease. The infected person is strongly urged to stop having sexual relations until cured. But condom use and AIDS prevention cannot rely upon fear of infection and enforced abstinence like STD prevention does.

A behavior change message should include concrete strategies for enacting the change and should convey the message that the person "can" in fact change the targeted behavior. Emphasis upon dire outcomes does not convey empowerment, which is closely associated with felt ability to change. Incorporation of AIDS prevention with programs for alcoholics or with STD control programs would imply that the only Navajo who should be concerned about HIV are those already classed as deviant or marginal. And because all sexually active persons, adolescent or adult, need to practice safe sex, it should be in a positive context within all tribal applications.

3. Increasing access to program planning.

Anthropologists have traditionally looked for ways to increase native access to resources while they are conducting their field work. As students of culture and society, they are keenly aware of the effects of feelings of powerlessness or lack of control upon a society. It would be important to give as much control as possible over the AIDS program planning to those persons most likely to be affected by the disease. If the disease is seen as one over which the Navajo have little control, then prevention programs are jeopardized.

The AIDS epidemic could be viewed as a calamity from the outside over which the Navajo have little control. It could be seen as history repeating itself, for the history of Anglo-Indian relationships has been shaped in large part by the devastating effect of European diseases on indigenous peoples. In the 1800s, thousands of American Indians died quickly, and the remainder were frequently too weak to struggle very long.

The Navajo may, at a future time, view the AIDS epidemic as threatening their tribal existence. Fears of impending tribal obliteration could serve to intensify feelings of isolation and helplessness among the Navajo. Nativistic movements or messianic concepts may grow in response. Such phenomenon could stem from a perceived inability to "do" anything about the disease.

By way of illustration, a contemporary ethnographer has described the "terrible apathy" of one Amazonian tribe that recently, soon after exposure to foreign diseases, dwindled from 140 to 65 persons in a few short years.

> . . . they just don't care . . . as a result of the excessive paternalism which the Txukarramae (the more acculturated Indians with whom they were placed) expressed in many ways, a state of growing apathy continued to spread. (Baruzzi, Marcopitoo, Serra, Souza, & Stabile 1977, p. 188)

As the scientific community is seen to be unable to solve the AIDS problem, folk explanations and remedies may grow in importance. Folk theories of the genesis of AIDS frequently express suspicion and mistrust of those in control, those in power.

These theories, omitting grass roots coping strategies, are indicators of lack of control over a situation. If such fears begin to grow at an unusual rate, they would signal the growth of feelings of powerlessness in the face of AIDS.

In sum, prevention messages, it cannot be emphasized too much, must be positive and practical. The clients of the prevention programs must feel they can actually control the spread and effects of the virus. It is accepted that the way to counter perceptions of powerlessness is to put as much control over prevention and program content into the hands of those persons most vulnerable to the infection as is possible. AIDS prevention has to be manageable by, and beneficial to, the targeted people.

Worth (1989, p. 27) has stated the problem clearly.

> By attempting to increase awareness of risk through AIDS education programs targeted to minority communities, we run the risk of creating decision making discord for them. Where awareness of risk runs contrary to traditional values and attitudes, survival strategies, personal goals, or actual behavior the result is often denial of both the behavior and its consequences, to postponement or inaction on decision making to protect oneself. Denial results in an inability to consider or undertake sexual behavior change.

4. Navajo disease management.

> Because all Indians live in a dual world, more effort must be made to integrate the strengths of either or both systems into rehabilitation plans and therapies. . . . virtually all of the Navajo use modern medicine for many medical problems, but these same people also use various types of medicine men and women (e.g., herbalist, changer) for other problems. (May, 1986, p. 192)

AIDS prevention programs should incorporate the "old" ways with the "new" ways just as the Navajo do. Program developers (already knowledgeable about the medical view of AIDS) should seek out and consult with local traditional healers not only for their support but also for their expert advice. This is because indigenous or folk concepts of sickness, among all peoples, influence disease labelling and consequently its management.

It would be a monumental task for any one program person to know how to incorporate the extensive Navajo beliefs about illness in AIDS prevention programs. There are categories of disease, diagnosis, and treatment that are highly complex and difficult to understand. Because AIDS is a grave disease and interventions involve private human activities, it will be essential that the insight of religious practitioners be sought.

Present day Navajo infected with, or at high risk for, AIDS will likely seek out religious traditionalists as well as medical doctors. The former may well have a more concrete or culturally congruent explanation (definition), in fact, for the sickness than the medical doctor.

Reichard's (1974, p. 83) rich historical observations noted the same kind of "shopping" behavior among the Navajo.

> If illness persists, dogma (cause) is not questioned, but rather man must continue to try out different combinations until he includes the proper causes.
>
> Grey Eyes' suggestion of the procedure . . . 'if you try one sing (ceremony) and you don't get well, you have to try another, perhaps many. Sometimes after a man has had many big (elaborate) ceremonies, he does not get better. Then he tries a little (short simple) sing and he gets well. That is because at first they don't know the proper reason for his sickness.'

Anthropological research on how decisions of sickness naming and curing are made has found that what a disease is named defines how the ill person is managed, what treatments are sought, and how familial and tribal resources are expended. This linguistic/cognitive research has contributed to understanding the relationship between culture and illness.

It has been learned, for example, that persons easily define and redefine problems with their health and "shop" around for remedies. This search for therapy stems, for one thing, from the careful balancing by the caretakers (those responsible for naming and managing the illness) of the costs and benefits of available remedies. Janzen (1978) found that shopping for treatment in the African village of Zaire shifted between traditional and contemporary treatments or used them together. The patient and caretakers, it was also found, were as concerned with an explanation (definition) of the malady as with the treatment.

Medical anthologists have frequently observed that, as the illness and the resources of the sick person and the family change, so will the therapies sought. The ill person will often go from one therapy or curer to another as the illness progresses (Young, 1982).

5. Community involvement.

Sy, Richter, and Copello (1989, p. 53) point out in their review of strategies for prevention and control of AIDS that information must be culturally sensitive while also mobilizing community participation. But just how does a program ensure it is culturally sensitive? Pointers are discussed below.

A sensitive researcher who has interviewed key persons and tried to sort out particularly critical elements will begin to be sensitive to some of the deeply felt Navajo values, which are salient to AIDS education. One such critical belief potentially relevant to AIDS education and prevention is the Navajo attitude toward sick and dead persons.

> Contact with the dead (tei'ndi') or anything remotely connected with them is another indefinite reason for disturbance (illness). A house in which a person died may be burned; if not, a hole is torn through the north wall and the roof beams are allowed to fall in, indicating that the place should be avoided. A Navajo would risk freezing rather than seek shelter in such a house or lay a fire with wood from it. (Reichard, 1974, p. 81)

Locke (1976, p. 29) has stated, in confirmation of Reichard's observations about death, "the Navajo find . . . the body and the fact repulsive." Even today there are negative feelings about death among those on the reservation. These feelings include

not wanting to handle a body and having the body taken away as soon as possible (personal communication with Mail, 1988).

If an HIV-infected person is felt to be under a death sentence, familial and social supports for the ill person may be in jeopardy. Illness definition and treatment has to emphasize, just as in prevention, the control the individual has over the infection and its consequences.

A student of Navajo belief systems would caution an AIDS prevention program developer about the potential for strong and conflicted feelings around death and AIDS infected persons by some Navajo clients. The focus of prevention messages should be on living, not on imminent fatal disease. Family members and close friends of persons at high risk for AIDS should be given the opportunity to explore conflicts between deep seated traditional beliefs and medical information. It is possible that negative emotions about the sick and dead would spill over into a denial of feelings for a person who is sick with AIDS-related complex (ARC) or AIDS. This threat to successful management of the infection should also be discussed openly in prevention and treatment programs. It goes without saying that such negative feelings would affect an infected person's capacity to fight the disease.

This suggests that, in order to successfully help the Navajo develop the skills to protect themselves against HIV infection, the entire tribe needs to be sensitized to the impact of feelings about death upon the spread of HIV in the community and the management of infected persons.

6. Outreach education/reaching high risk groups.

AIDS prevention information has to be brought to all Navajo and most particularly to those most vulnerable. These would be young males travelling back and forth from the reservation to the city, those who combine use of disinhibitors with sexual, particularly homosexual, activities, with strangers.

The language and the materials need to be consistent with that found among the urban migrants. They should be congruent with the language and lifeways of young Navajo men.

If, as has been hypothesized in this paper, the most vulnerable persons are those who travel to the city and back to the reservation, then it needs to be decided if the prevention programs need to be located in the cities. Program planners need to decide whether it is better to contact vulnerable persons while they are most likely to be engaging in the high-risk behavior during a visit to town or to bring their educational messages to them through the Chapter meetings and other functions back on the reservation. This issue is complicated by the lack of Navajo Nation jurisdiction outside the reservation. Drinking establishments, where many successful condom distribution programs operate across the United States, are controlled by non-Navajos. These non-Navajos will have to be approached and their support secured for initiation of educational programs.

It is essential that preventive messages travel through the informal networks of the target persons. The educators will need to locate the leaders of these groups and recruit their input in planning and implementation.

This is not as difficult as it sounds. The tribe is small enough so that decision makers and leaders of different groups will be fairly well know across the entire reservation. The program planners just need to plan to spend time learning who these people are and contacting them. They themselves and their assistants need to spend time "in the field" with members of the host community. After all, most ethnographer's time is spent watching and listening.

AIDS intervention and prevention recommendations must be tailored for specific target groups. If, for example, a program targets Navajo men who have sex with men and live on the reservation, then every effort must be made to reach persons in this group. After they are reached the outreach members can enlist them to develop an educational program.

An AIDS educator should not assume that members of the target group hired as outreach educators possess the necessary cultural sensitivity. The director should personally become familiar with the diverse groups in the tribe. Marked differences in education, age, or sex between outreach staff and clients can impede client receptivity and subsequent behavior change and so should be avoided.

Program developers need to spend time with different groups of Navajo in order to understand the new particular points of view and constraints on innovation on the reservation. Ethnographers have developed many techniques for gaining acceptance into a social group that could be taught to others. A project can enlist the support of a person trained in ethnographic techniques to train outreach workers to ask questions that can uncover sensitive private information about fears of infection and sexual activities, for example.

An illustration of the type of issue this kind of informal group could tackle would be how to introduce and facilitate prevention behaviors such as condoms and nonpenetrative sex. These practical hands-on decisions should be made by small groups of the target persons. The Navajo, accustomed to mutuality and communal activities, should be able to work within this setting readily.

CONCLUSION

In conclusion it should be emphasized that as the Navajo Nation prepares to cope with the AIDS epidemic, it is essential tribal leaders take an active part in supporting research and education programs. But even before resources are allocated, Tribal Council members will need to be clear about their positions regarding the sensitive issues associated with AIDS prevention (cf. Beauvais & LeBouef, 1985, p. 165).

> Tribal people have shown the widest variation in their bio-social response to modern life, varying from extinctions and social disappearance to successful adaptations. If we could understand the reason for this, not only would we be able to help tribal people make their adaptations, but the knowledge would be valuable to the whole human species in its response to ever more rapidly changing circumstances. (Polunin, 1977, p. 18)

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