Sexually Transmitted Diseases among Alaska Native and Inuit/ First Nations/Métis in Canada: *Discovering Opportunities for Collaboration*

Anchorage, Alaska
April 16-17, 2008
Meeting Report

Indian Health Service
National STD Program
Division of Epidemiology & Disease Prevention
Albuquerque, New Mexico

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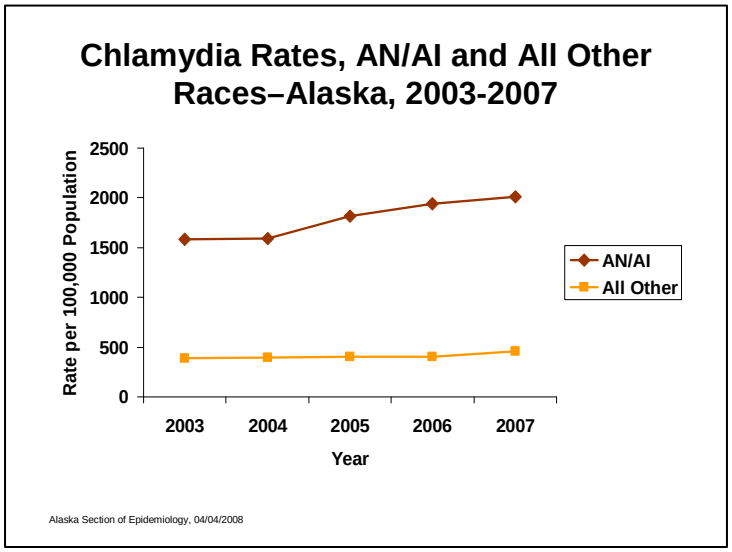
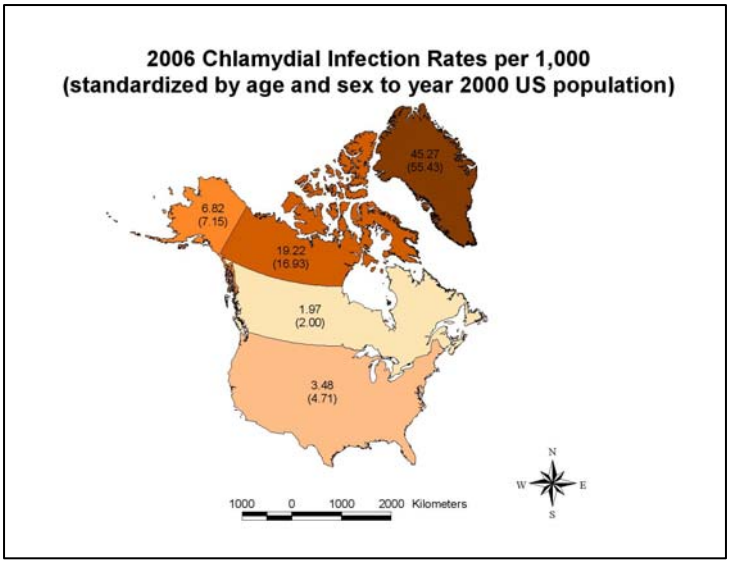
Background and Overview

Arctic regions of North America report sexually transmitted diseases (STDs) rates significantly higher than their southern counterparts [1], suggesting a significant health disparity exists since this region is predominantly inhabited by Alaska Native, First Nation, Inuit, and Métis populations. Chlamydia rates in Alaska were the highest in the United States for 2007 at 733 cases/100,000 population [2], and even higher among Alaska Native men and women (at 980 and 3,070 cases per 100,000 population, respectively) [3]. Canada's northern territories also report the highest chlamydia rates in that country [4]. In 2006, the territory of Nunavut, which is 85% Inuit, reported 3,713 chlamydia cases per 100,000 residents and is predicted to report 3,799 chlamydia cases per 100,000 for 2007. Combined rates of chlamydia and gonorrhea are similarly high for aboriginal populations of the Northwest Territories; (4,920 cases/100,000 population for 2007) [5].



Northern Native populations in the U.S. and Canada share many geographic, historical, cultural, and social similarities. Often, they also share similar social and health factors that may contribute to higher STD rates and have far reaching affects on overall health status including: disproportionately high rates of STDs, adolescent pregnancy, substance abuse, inadequate and limited culturally appropriate health education resulting in minimal knowledge or understanding of sexual risk, and inconsistent use/access to effective



contraception [6]. Additional challenges faced by these communities include small sexual networks, geographic isolation, rapid social change, and competing healthcare priorities. There is limited published data on the contribution of these factors to sexual health and STDs among northern Native populations. Even more limited are culture-based interventions that have proven successful in limiting STD transmission among these groups. The need for culturally appropriate community-based participatory research to develop STD prevention interventions is urgently needed for Native communities in North America.

In April 2008, the Department of Health and Human Services (DHHS), Centers for Disease Control and Prevention (CDC), Indian Health Service (IHS), and Alaska Native Tribal Health Consortium (ANTHC) hosted a joint American-Canadian meeting in Anchorage, Alaska. The summit, entitled "*Sexually Transmitted Diseases among Alaska Native and Inuit/First Nations/Métis in Canada: Discovering Opportunities for Collaboration",* sought to provide a platform for fostering an international partnership to address health disparities and to better define cultural determinants influencing the impact of STDs among Native peoples in the U.S. and Canada. The goals of the conference were to identify existing efforts, gaps in knowledge, and potential opportunities for collaboration in three priority areas: 1) Clinical Care; 2) Prevention Interventions and Research; and 3) STD Education and Messaging as it relates to sexual health and STDs in northern Native populations. Individual workgroups were formed and charged with exploring each of these priority areas. Workgroups identified and prioritized specific action items. The feasibility, impact, and sustainability of identified activities were considered in the prioritization of individual action items.

Several challenges were consistently identified that have direct impact on the development and implementation of appropriate and effective STD interventions among Native populations of the Arctic. These challenges include the lack of culturally appropriate interventions that are consistently implemented and routinely evaluated, the limited prioritization of STDs as urgent health conditions, and the lack of available data on cultural determinants of sexual and healthcare seeking behavior. Available interventions often lack a comprehensive approach to prevention that addresses the underlying social determinants that continue to influence risk-taking behavior. The lack of available surveillance data that effectively describe and define the true burden of disease within Native communities has directly affected the ability of existing public health systems to advocate effectively for the necessary resources and infrastructure required to meet the diverse and competing priorities experienced within this population. Community-level information on cultural aspects of sexuality, sexual networks, health-seeking behaviors, perception of risk, and provision and uptake of testing/screening services were identified as necessary formative components of large scale interventions among these northern Native populations.

Many similarities were highlighted among northern Native populations in the U.S. and Canada. Although each Native community is unique unto itself, the similarities among Arctic Native communities in Canada and the United States are frequently greater than the similarities these same communities may share with the dominant cultures within their home countries. These similarities in turn stimulated ideas regarding potential opportunities for collective work to address health disparities that reach across borders. Opportunities to collaborate exist in the development/refinement of surveillance systems that promote uniform collection of key data elements and enhance communication of STD-related information among partnering agencies. These data can enable programs to more effectively define, prioritize, and direct responsive interventions. The development of a structured network of public health professionals serving northern Native populations could provide a mechanism for promoting collaboration, increasing educational opportunities, sharing of promising practices, and facilitating communication of effective evidence-based prevention interventions that could be widely disseminated, adapted, and expanded to meet the unique cultural and geographic needs of Arctic communities. Participants identified specific collaborative opportunities, including community-level interventions, participatory research on cultural determinants of STDs, culturally appropriate education messaging, and local advocacy and resource allocation for addressing STDs among youth.

In the resource challenged environment of public health, there are opportunities to more effectively utilize developing technologies and new mediums for accessing disenfranchised and underserved hard-to-reach populations. Resource sharing, knowledge transfer, and jointly-supported initiatives may also more strategically position agencies to effectively advocate for STD interventions and clinical services for respective Native populations.

As a result of this unique summit, participants from the United States and Canada collectively identified concrete and actionable opportunities for collaboration to address STD disparities among Arctic populations. These priority areas will serve as the roadmap to guide future collaborative work in the area of STD prevention and provide the necessary framework to ensure a sustained partnership.

Logistics and Representation

Overview
The Indian Health Service National STD Program, with support from the Centers for Disease Control and Prevention, Division of STD Prevention, brought together subject matter experts in the field of STD prevention, research, and clinical care serving northern Native populations from the United States and Canada. The two-day summit provided a forum for sharing collective experiences and challenges, and acknowledging the ongoing needs related to STD education, prevention interventions and clinical services that exist among Native populations. The results of this effort were well-defined next steps for moving forward in partnership to address identified priorities.

In an era of shrinking public health resources, low prioritization of STDs, and rising STD rates among Native populations of Canada and the United States, the two nations met to identify opportunities to collaborate in the areas of STD prevention, education, and clinical care that will serve to benefit northern Native populations in both countries. The conference was a two-day meeting. Day one was devoted to background presentations on current STD surveillance, research and prevention activities in northern Native populations. Day two was devoted to small group discussions and consensus building for future collaborative efforts.

Attendees represented federal/national, tribal, and state agencies, local public health departments, academic institutions, and community-based organizations. Federal agencies represented included: Centers for Disease Control and Prevention (CDC), Indian Health Service (IHS), and Health Canada (HC) including the Public Health Agency of Canada (PHAC) and First Nations Inuit Health (FNIH). Invitees were selected based on their current or recent STD research, prevention, or intervention activities among Native populations or their supervision of staff engaged in these activities. There were 21 meeting attendees from Canada, 31 meeting attendees from Alaska, and 7 attendees from CDC. Attendees' current STD activities included: local and national surveillance, public health research with Native populations, STD clinical services, and community based STD/HIV prevention.

Meeting presenters delivered information on a variety of topics that served as a background for the second day discussion sessions. Presentations on STD surveillance in Alaska and northern Canada demonstrated rising rates of STDs, specifically gonorrhea and chlamydia among northern Native populations. Similar challenges to surveillance and STD clinical services in Canada and Alaska were presented and included transient healthcare staff, specimen transportation and handling challenges, concerns for confidentiality, and minimal logistical support and prioritization of STD services. Presenters from the CDC and PHAC described ongoing collaborations between the two nations and

echoed support for new collaborative efforts related to STD prevention in northern Native populations in the U.S. and Canada.
The importance of community involvement and partnership building in the development and implementation of STD interventions emerged from the presentations and small group discussions as paramount to future collaborative prevention efforts. Historical experiences where outside researchers have conducted non-beneficial research among Native communities continue to influence current research efforts. Attendance by members of aboriginal health research networks at the meeting and the presentation of current efforts provided avenues and support for the development of aboriginal STD prevention research within Canada. Representative speakers from the Alaska Native Tribal Health Consortium (ANTHC) described healthcare and research infrastructure for rural Alaska as well as cultural perspectives on STDs and HIV. These presentations described the opportunities to reframe STD prevention messages into sexual health initiatives that would better fit within a northern Native cultural framework of holistic health.

"It's not about building a research team, but about building a relationship"
--J. Doucet, Pauktuutit Inuit Women of Canada, Ottawa

Formative research involving local community health leaders, tribal leaders, and village elders as well as youth groups were mentioned as critical elements in the development and implementation of STD prevention interventions in northern Native communities. Multiple presentations stressed the need for culturally relevant STD interventions for northern Native populations that are tailored to rural, remote, and isolated communities with limited healthcare infrastructure and knowledge of STDs. Contributing social influences—including substance abuse, changing gender roles, domestic violence, gender empowerment, and stigma—will need to be considered in intervention development.

Several efforts to identify successful interventions and social marketing strategies in STD prevention among northern Native populations are still in the focus group or pilot stages. A pilot social marketing strategy targeting northern Native youth was presented by the Northwest Territories. This strategy promotes youth empowerment, sexual health, and consistent condom use. This region of Canada has also developed a policy statement entitled "*STI: The Naked Truth*", that may be utilized as a model in other regions of Canada and Alaska. ANTHC has conducted focus groups with Native youth to gauge knowledge of STDs and to identify STD educational targets in the development of a social marketing campaign. The National Aboriginal Health Organization has developed guidance on sexual health issues related to natural resource extraction in small northern rural communities and additional guidance on domestic violence among Inuit

women. The Arctic Research Network has developed specific guidance on navigating the research requirements for projects conducted with and among aboriginal communities. The need for additional research and intervention development was demonstrated clearly during the presentations.

Follow-up activities identified at the meeting included: the development of a listserv, participation of attendees in an STD workgroup as part of the International Union for Circumpolar Health (IUCH), and community-level collaborative initiatives. Ideas generated from the small group discussions will be used as starting points for the development of educational initiatives. These collaborative ideas will be further discussed at a future IUCH regional meeting. Identification of resources and other opportunities for collaboration will be prioritized.

The meeting organizers will continue to convene a core group of representative persons to maintain the communication between meeting participants regarding future collaborative activities, research findings, opportunities for information sharing, and resource opportunities. The expansion of the network of persons involved in the development of STD prevention interventions among northern Native populations will be considered an important part of ongoing collaborative efforts.

"Taking a collaborative approach is more effective than working independently"
--L. Albertson, Yukon Kuskokwim Health Corporation, Bethel, AK

Workgroup Overview – Objectives and Process

Overview
The goal for this collective group of diverse, experienced, and committed tribal, local, state, and national public health representatives was to facilitate an open dialog of the issues, challenges, and potential opportunities that exist between U.S. and Canadian partners. The sharing of experiences of program and policy development, strategic planning, community assessment, participatory research, and cultural literacy were core components that provided the structure and substance to workgroup discussions related to three priority areas: Clinical Care Opportunities; STD Prevention Interventions and Research; and Education and Messaging.

The workgroups were asked to identify potential opportunities for collaboration to address gaps in current STD prevention efforts among aboriginal populations. The groups were charged with prioritizing the identified opportunities, taking into account feasibility, resources, and impact. The workgroups gained consensus regarding their top five opportunities, while additional opportunities were also identified.

Workgroup 1: Clinical Care Opportunities

Overview
The members of workgroup 1 sought to describe the current environment in which STD clinical care is being provided in rural Arctic communities. Members shared their understanding and experiences related to available preventative services; defining perceived challenges to providing care in rural communities; and disease management practices. Three main questions framed the groups' discussion: 1) What barriers to care exist in STD clinical practice; 2) How are STD results communicated and partner services delivered; and 3) What STD testing and vaccinations are available? Collectively, the group defined specific challenges to providing comprehensive STD prevention services. These same challenges were the basis for examining what opportunities exist to strengthen public health care systems serving Alaska Native and Inuit, First Nations, and Métis populations.

What barriers exist to care in STD clinical practice?

Barriers to clinical care encompassed multiple overlapping topics. The lack of STD services due to geographic isolation was identified as a topic of considerable concern however, subsequent discussion focused on the barriers to care within current systems where STD services are available.

Confidentiality emerged as a major concern and potential barrier for both Alaskan and Canadian group members. A lack of trust for the system or a perceived concern regarding confidentiality of services, particularly in small, rural settings, by the populations served may prevent individuals' at-risk from seeking STD care even though adequate services may be available.

The lack of prioritization of STDs as a major health issue was mentioned as a reason contributing to the lack of timely STD prevention education, the lack of monetary support to build STD infrastructure (testing, treatment, partner services), and lack of prompt notification to the health department of identified cases. This same lack of prioritization of STD within the provider community was also of concern given their direct access to the populations at risk and ability to promote preventative care.

Provider shortages and rapid provider turnover were identified as logistical barriers to care that frequently depended on local provider recruitment and retention strategies. Insufficient numbers of indigenous/Native health providers may also contribute to diminished STD care seeking behaviors by affected subpopulations that may be hesitant to seek care through a non-Native provider. Many Alaska Native healthcare providers feel uncomfortable returning to their own communities to provide care due to social pressures they encounter. Similar experiences were cited from Canada – Inuit nurses returning to their communities may find it difficult to ask questions related to sexual risk of community members especially among those older than themselves. Some Native healthcare providers may actually be more comfortable delivering STD care outside their home communities.

Provider discomfort with discussion of sexual risk, obtaining clinical specimens (pelvic exam, urethral specimen), and management of partners were highlighted. Limited clinician training in how to take a proper sexual history or how to ask questions that are culturally appropriate was a major concern. Such training is not frequently available in medical schools or as a part of community health aide (CHA) training. In Alaska, CHA's, usually from the same community, deliver care at the village level. This arrangement can result in concerns related to confidentiality by the patient and discomfort in discussing sexual health issues by the health aide.

Categorical funding, limited funding, and missed opportunities to apply for funding make it difficult to expand and improve current services. Opportunities to deliver STD care in urgent care facilities, emergency rooms and other health settings (such as in schools) are often missed.

Cultural bias and the lack of cultural competency are of considerable concern. The overall lack of understanding and/or data on cultural differences and ways to address them effectively in a clinical setting need to be prioritized. The continued

focus on the disease model as opposed to the health model does not fit with Native cultural understandings and teachings of health and wellbeing. A disconnect exists between indigenous and western cultures regarding certain life events. For example, teenage pregnancy, although not encouraged among Alaska Natives and Inuit, has less of a stigma attached as compared to other cultures. The cultural stigma associated with an STD diagnosis is frequently a barrier to seeking STD clinical care and may extend to the community level. A community's perception of STDs may directly affect how STD care and services are or aren't viewed as a priority. Other societal influences, including high rates of alcohol use and substance abuse contribute to risk taking behaviors and ongoing transmission in many communities.

"Social, emotional, cultural, community, and economic factors affect community STI rates"
--J. MacKinnon, Yellowknife Health and Social Services Authority

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A lack of focus and clear definition of desired outcomes related to STD clinical care makes it difficult to prioritize or develop messages that effectively encourage individuals to pursue testing and treatment. In addition, evidence-based information on what clinical practices work to decrease STDs in northern Native populations is scant or non-existent. Providers and populations at-risk may be unsure of what the goals of the services really are. Messages alternate between concepts related to preservation of fertility, remaining symptom-free, halting transmission, and protecting an unborn child, which may make it difficult for target populations to discern what is the intended priority Limited understanding of the consequences of an STD both by the provider and the populations at-risk denotes a gap in knowledge and education at several critical levels. A provider's perception of what an individual may know or an assumption of risk may also lead to a missed opportunity for providing timely and appropriate prevention education.

The lack of involvement of community partners and the target population in the development of prevention interventions may result in limited penetration and/or measurable response. There is disconnect between the "Western" view of clinical care and the community's ability to inform how that care is delivered. In addition, local politics may both hinder and promote clinical STD care depending on the current situation.

How are test results communicated and partner services delivered?

The procedures for reporting test results and managing partner services vary depending upon resources, priorities, skill level, and program capacity. In northern Canada, nurses deliver test results and the quality and extent of partner

management depends greatly upon the skills and comfort-level of staff in providing client-centered comprehensive services that address the specific needs of both index patient and respective partners. In Alaska, a health aide at the community clinic level delivers the results; however, partner services are then delivered by a public health nurse employed by the state or regional corporation. Training in partner management is not available to community health aides.

Frequently, patients experience difficulty recalling specific identifying information for partners, or are unwilling or uncomfortable revealing such information. Current systems that track partner notification activities provide limited information regarding the effectiveness of related activities and do not allow for useful analysis and application at a local-level. Many community members seek STD care outside of their communities, thus challenging effective partner services among these populations may present more of a challenge. A standard model is needed for partner services. Due to the variability of patient and partner management, implementing a standardized approach to providing partner services in high-risk communities may have a positive impact on community-level disease burden and rates of re-infection. There is also a need for expanded use of targeted re-screening among previously diagnosed STD clients

What STD testing and vaccines are available?

The availability and application of STD test technologies and vaccines vary between Alaska and Canada. In northern Canada, not all communities use urine based testing. This is partially due to provider preference, but also related to lab readiness to perform the testing. In Alaska, the Native corporations individually contract for laboratory services with labs that may or may not currently be utilizing urine-based testing. STD screening practices also differ across Canada's northern territories. For example, Nunavut is currently using liquid based cytology for HPV detection while Nova Scotia is using self-collected specimens.

Vaccines are also offered to varying degrees in both the U.S and Canada. The use of Hepatitis B vaccine varies across Canada. In the U.S., it is given at the time of delivery and offered in some STD clinics and to hepatitis C and HIV - infected patients. The HPV vaccine is being given to school-aged children in some provinces. The cost is covered for aboriginal youth in the "per capita" spending that covers First Nations. The HPV vaccine in the U.S. is covered under the Vaccines for Children Program as well as through the Indian Health Services.

Opportunities for Collaboration

> Create a model STD control program in multiple locations and evaluate its impact on STD morbidity trends, treatment. and partner management.
> Aggressively pursue patient treatment and traditional partner services
> Assess the practice and knowledge of medical providers delivering STD care.
> Share information on effective interventions that can be applied or adapted to northern Native populations.
> Assess the delivery and implementation of national screening recommendations such as chlamydia screening guidelines.

Additional Opportunities

> Identify values, qualities and approaches that connect clinical services across cultures.
> Target sexually active young women seeking family planning services as a way of reaching at-risk women with STD prevention services and risk reduction information.
> Increase the availability of self collected specimens in areas where confidentiality and limited healthcare seeking behaviors are evident.
> Consider the use of the Community Readiness Model to assess the community's readiness to accept STD interventions.
> Explore social networking strategies, like those employed by MySpace, FaceBook, and YouTube as an alternative method for reaching at-risk populations.
> Promote universal and comprehensive (holistic) community-based screening. Health fairs would be ideal opportunities for various health issues to be presented in a holistic non-judgmental manner.
> Deliver HPV vaccine to appropriate populations routinely.

Workgroup 2: STD Prevention Interventions and Research

Overview
The members of workgroup 2 discussed the current status of STD prevention interventions and research being conducted among Native populations in the northern Arctic regions of the U.S. and Canada. The specific focus of discussions concentrated on addressing three key questions: 1) How are prevention interventions being promoted and implemented in community settings; 2) How are communities involved in the development and implementation of interventions; and 3) How is the impact of prevention interventions evaluated? Members sought to provide relevant information on current prevention activities occurring in their respective communities while identifying specific challenges and potential opportunities that exist.

How are prevention interventions being promoted and implemented in community settings?

STD prevention interventions are promoted and implemented in numerous ways in both Alaska and Canada. Although a variety of interventions have been initiated, several recurring challenges were identified that affect the feasibility and sustainability of efforts across borders. The lack of resources, including funding and staff, were consistently cited as barriers to the implementation process. Another barrier cited was the categorical funding of prevention programs, and the impact it has on efforts to provide holistic and comprehensive services to at-risk communities.

Prevention interventions that have been implemented are often reactionary and short-term. Interventions targeting Native communities have lacked consistency and coordination, and when combined with limited resources and inadequate infrastructure, efforts often have minimal reach and fail to generate a sustained community investment, which ultimately results in limited impact.

There is limited data on social determinates and underlying risk taking behaviors influencing high rates of STDs among Native populations. The absence of representative data limits the ability of interventions to be responsive to the diverse and changing needs among priority populations, including the needs of other less visible subpopulations that may go unrecognized.

The success of health promotion and implementation efforts within Native communities is directly influenced by several key factors. Participatory community involvement is seen as an essential component of any intervention. The involvement of influential community members and established local resources, including tribal leadership, elders, community health aides (CHA), and Friendship Centers encourages community ownership and fosters collaboration

and support for respective activities from a project's inception. STD prevention interventions in these communities need to be comprehensive to address the broad array of individual and societal needs while attempting to remove the social stigma attached to similar interventions by incorporating them into a comprehensive community-wide healthcare initiative.

"*Building relationships with northern communities is very important in health research – it takes time, but it's worth it*"
--G. Healy, Qaujigiartiit/Arctic Health Research Network, Igaluit

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How are communities involved in the development and implementation of interventions?

Community involvement in the development and implementation of STD interventions is essential and an important first step in any process. Community acceptance and support are often dictated by the level of commitment and overall readiness demonstrated by a community and its membership. It is important for community members to trust those coming into their communities and to feel as though they are a part of the process, throughout the process. Community acceptance can be further promoted by identifying a local champion from within the community itself who can effectively advocate need for the project and has the respect of community members.

Having respect and appreciation for the community process is important. Native communities are unique unto themselves and the processes they undertake to develop and implement an intervention vary. Although the process can often be lengthy and labor intensive, it is crucial to gaining community support.

Expanding the current role community members play in receiving, translating, and disseminating STD prevention information within a community setting is needed. Developing the capacity of the community to actively engage in the process promotes acceptance and sustainability for the intervention from within the community rather than it being perceived as a pressure being applied to the community by unfamiliar outside forces.

Reaching community members at an early age for STD prevention was consistently seen as a priority. More effectively utilizing existing community resources, including schools, story tellers, and Native role models were seen as potential mechanisms for reaching Native youth. Increasing the visibility of STD interventions, while ensuring prevention messaging remains culturally appropriate, will likely increase how specific interventions are perceived and accepted by community members. Developing interventions that are grounded in community roots was seen as a way of connecting intervention strategies with

traditional ceremonies and teachings, and in turn, revitalizing traditional culture among certain subpopulations of northern Native communities.

How is the impact of prevention interventions evaluated?

The importance of evaluation was a shared concern of workgroup members and was discussed in the broader context of its role in assessing the appropriateness, impact, and determination of need for specific interventions among targeted populations. The question of what level of resources should be devoted to evaluation was posed. Conducting extensive evaluation was presented as an impediment to implementing needed programs in a timely manner, especially when resources are limited and the demand for intervention high. Evaluation and understanding the extent to which specific interventions need to be evaluated is viewed as a significant challenge.

The lack of sound baseline data has created challenges to assessing the impact of intervention efforts among target populations. However, to the inexperienced, the requirements of an effective evaluation plan can be intimidating. Some participants spoke of the struggle to assess program impact while not detracting from the effectiveness of the intervention itself.

In communities faced with limited resources, competing priorities, and vast geographic challenges, evaluation often becomes logistically impractical and costly. Limited guidance exists regarding best practices for developing process and outcome measures to assess the effectiveness of STD interventions in Native populations. Additionally, there has historically been a lack of representative numbers for indigenous peoples included in research. This under representation of Native populations limits the power of previous findings to be generalized to a larger Native population.

The ability to develop capacity within organizations and tribes to conduct ongoing evaluation of STD-related activities would facilitate the advancement of sustained community interventions. Community involvement and the support of tribal leadership are critical to the evaluation process. Actively involving communities throughout the process, while utilizing simple and tangible measures, will increase the understanding and engagement of community members.

Opportunities for Collaboration

> Create a formal working group to explore the feasibility and application of enhancing/modifying existing surveillance systems to collect, monitor, and report standardized STD indicators.
> Form a multidisciplinary workgroup to advise, inform, and guide the development of innovative culturally appropriate social marketing campaigns targeting Native populations.

- Create a representative body that can advocate and educate local, national, and international partners regarding the need for resources to support cross-agency collaborative STD initiatives among aboriginal populations of the US and Canada.
- Identify and utilize new and innovative technologies and media to create opportunities of reaching and educating priority populations including youth, homeless, and rural communities.
- Explore ways of more effectively interjecting Native culture and practice as a mechanism for developing culturally appropriate interventions that resonate with, and are more easily identifiable within, the unique heritage of targeted Native communities.

Additional Opportunities

- Encourage collaboration between similar organizations in the U.S. and Canada to share promising practices and work with similar populations.
- Develop specific interventions that target invisible and underserved Native communities, including MSM, homeless, youth, and urban Native populations.
- Develop interventions that target skill building among youth and young adults to make healthy decisions and improve self-esteem.

Workgroup 3: Education and Messaging

Overview
The members of workgroup 3 discussed available resources for education and messaging and how they are currently used to inform the provider community as well as at-risk target populations. The group set out to explore three key questions: 1) What STD-related training is available to providers/clinicians; 2) Which communication strategies are most effective at the local community-level; and 3) How is information about STDs shared currently? Members shared experiences and knowledge related to STD education and prevention messaging, identified gaps in programs and strategized on creative solutions to strengthen systems and mechanisms for information sharing.

What STD-related training is available to providers/clinicians?

There are a wide array of STD education and training opportunities available to clinicians in both the U.S. and Canada. Governments of both countries offer STD training and education for public sector health care providers, either through government-funded training centers or other established networks. Examples in the U.S. include the Centers for Disease Control and Prevention-funded National Network of STD/HIV Prevention Training Centers, the Health Resources Services Administration-funded AIDS Education and Training Centers; in Canada, training is delivered on request by Health Canada and the First Nations and Inuit Health Branch. In Alaska, the Alaska Native corporations have a continuing education system that provides new and ongoing training for the many community health aides located in isolated villages throughout Alaska. In both countries, attendance at professional meetings and conferences is a key strategy for improving STD knowledge. Web-based and distance-based learning modalities are used widely. Lastly, there are many informal opportunities to increase one's understanding of STDs, such as shadowing a more experienced nurse, nurse mentorships, new physician orientations, and reviewing medical journals.

The workgroup identified several gaps in STD training available to providers currently. The barriers were similar in the U.S. and Canada, and included jurisdictional issues, inequitable distribution of training opportunities, a lack of dedicated time for staff to pursue training opportunities, limited agency support, lack of access, staff turnover, and competing priorities.

Several opportunities to improve the availability and delivery of STD education and training were discussed. One idea—from Canada—was to take a regional approach to meet STD training needs, where a point person at the provincial/territorial level would be designated as the STD training lead and would assess, deliver, and coordinate STD training, as needed, throughout that

region. Members felt that STD trainings could be made more sustainable by expanding the cadre of experienced trainers and maximizing teaching opportunities through such activities as increased training of trainers (TOTs), integrating STDs into other existing training for health care providers, cross-training allied professions (such as probation officers and substance abuse counselors), and developing a national level STD training network in Canada, mirroring what currently exists in the U.S. Peer educator guidelines were seen as another strategy to expand STD knowledge at the community-level. Lastly, the group felt that a circumpolar network for sexual health would be a much-needed mechanism to share educational and program materials and to facilitate opportunities to learn from each other as we move forward.

Which communication strategies are most effective at the local community-level?

Workgroup members agreed that in-person delivery of health messages in small group settings is one of the most effective ways to communicate with Native and aboriginal communities in the U.S. and Canada. However, due to the remoteness of many of these Native communities, innovative methods for reaching vulnerable populations must be considered. Harnessing technology as a means of reaching out to youth in these isolated communities, including using YouTube, MySpace, and FaceBook for STD messaging have been used and appear to be effective; community radio was another effective communication modality. Regardless of how the messages are delivered, it's important to build on community traditions, including storytelling, recognizing the role of elders and traditional leaders, and understanding the interplay between community and individual identity. The connection between the educator(s) and the target audience has to be sincere and an emotional connection needs to be made. Establishing a personal connection is an important and could be achieved through the use of a role model from the community or dynamic and positive outreach workers. With the community's support and buy-in, a health educator can ask about existing knowledge of STDs/HIV and can identify and respectfully dispel myths. An invested and supportive community can become a partner in educational efforts. Activities such as youth STD/HIV fairs or STD/HIV poster contests in the schools can assist in convening STD prevention messages to a broader at-risk audience.

One of the gaps the workgroup identified was the lack of an effective mechanism for health educators to share past and current experiences. In other instances, historical local or regional boundary constraints impacted communication and prevented the sharing of information. There have been some very good media and social marketing campaigns, but often they have been carried out in isolation and lessons learned from their successes—and glitches—have not been shared. A related gap is a general lack of evaluation data—or expertise and resources—for these myriad communication efforts. A lack of funds to research, produce,

evaluate, and disseminate communication products has continued to plague prevention programs.

Still, there are many excellent opportunities to expand and improve STD messaging at the community-level. One recommendation was to partner with academic institutions, especially with teacher training programs. Teachers who work with adolescents were viewed as resources for sharing knowledge related to STDs and sexual health. It was felt that much more could be done to build upon social networking technologies already in place to more effectively reach youth through such media as social networking sites, radio, video, and text messaging. Another suggestion was to reach out to the public health divisions of pharmaceutical companies to develop and support communication efforts. The workgroup liked the idea of developing and using a tribal advocacy kit, similar to what has been developed by Project Red Talon of the Northwest Portland Area Indian Health Board. Lastly, the idea for a circumpolar network for sexual health again emerged as an opportunity to expand and improve our communication efforts with the northern arctic populations we serve.

How is information about STDs currently shared?

The workgroup narrowed the scope of this question to focus on how information about STDs is currently shared *in schools*. The members of the workgroup felt that not enough is currently done in schools to prevent STDs and promote sexual health. In Alaska, the boards that govern the public school systems are very conservative and sexuality education and STD screening is very limited, if available. Furthermore, many teachers are reportedly not comfortable teaching about sex, and therefore don't. Canada seems a bit more progressive in its approach to sex education, which is offered in 5th, 6th, 7th, 8th, and 12th grades, but with considerable variation from community to community. Canada has several youth-friendly approaches, including peer teaching, student health councils, and a joint consortium for sexual health.

As already mentioned, one of the gaps identified was the conservative nature of school boards, especially in Alaska. Workgroup members from both the U.S. and Canada felt there was a general lack of services and life skills training for youth. One recommendation to overcome the lack of support by school boards was to engage members of the board in the process, so they are at the table and are made to feel part of the process. Other ideas were to specifically target boarding and residential schools for Native youth and further developing comprehensive school-based interventions—including teaching kids to be their own health care advocates. As previously noted, we felt that the biggest impact on developing teachers' capacity for sexual health education promotion and training would be to start while they are still being trained as teachers.

Opportunities for Collaboration

- Create a circumpolar network for disseminating and sharing information on sexual health (i.e., training, projects, materials, programs).
- Expand current social networking efforts, (e.g. FaceBook, MySpace, YouTube, etc.).
- Identify mechanisms to develop Tribal advocacy for STD and HIV prevention and sexuality education by educating tribal members/leadership to better understand sexual health and related issues.
- Develop and provide sexual health education and training for educators to better prepare them to teach the subject matter effectively to youth early on in their adolescent development. Create an opportunity to bring together educators in a forum to discuss and share experiences such as in hosting a US/Canada School-based Health Symposium for Educators.
- Develop and promote school-based STD interventions in partnership with comprehensive school-based clinics available to a diverse population of youth including GLBTQ.

Additional Opportunities

- Partner with academic institutions.
- Develop prevention messages for a variety of communication media including radio, TV, and print.
- Obtain support and sponsorship from pharmaceutical companies and industry to assist in generating additional resources for prevention programming and messaging.

Summary & Next Steps

Alaska Natives and Inuit, First Nations, and Métis in Canada are disproportionately affected by diabetes, tuberculosis, unintended injury, alcoholism, substance abuse, and STDs. Many of these disparities are long standing and continue to persist. The collective work of summit participants represented an important initial step in beginning to address high rates of STD among Native peoples and to collaboratively work to lessen the impact of related sequelae among vulnerable populations. Increased efforts to evaluate and enhance existing systems and STD management modalities will promote appropriate, responsive, comprehensive, and effective prevention interventions. Creating open channels of communication across programs and agencies will facilitate the sharing of promising practices and an exchange of institutional knowledge. The development of formal representative advisory and working groups charged with assessing, developing, and promoting effective evidence-based interventions for northern Native peoples will encourage collaboration, promote the exploration of innovative and culturally appropriate interventions, and increase the reach and impact of activities among targeted Native populations. Finally, the creation of a broad and diverse network of providers, public health, community, and private industry representatives, with a common goal of expanding and enhancing strategies to effectively message and market affected communities, can create new mechanisms and access points for reaching targeted populations.

Work has already begun on the following items: the development of a listserv, participation of attendees in an STD workgroup as part of the International Union for Circumpolar Health (IUCH), and collaboration on a multilevel village intervention that encompasses community developed educational messages and self-collected STD specimens. Ideas generated from the small group discussions will be used as starting points for the development of educational initiatives. These collaborative ideas will be further discussed at a future IUCH regional meeting. Identification of resources and other opportunities for collaboration will be prioritized.

The meeting organizers will continue to convene a core group of representative persons to maintain the communication between meeting participants regarding future collaborative activities, research findings, opportunities for information sharing, and resource opportunities. The expansion of the network of persons involved in the development of STD prevention interventions among northern Native populations will be considered an important part of ongoing collaborative efforts.

The efforts and related opportunities generated from this two-day meeting will continue to guide the work of partnering agencies. A commitment and dedication

to working together to confront STD disparities among Native populations was demonstrated by all who participated and future efforts will focus on the development of local responses, while also generating a larger discussion and awareness among a broader circumpolar audience.

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