Evaluating STD Prevention Capacity Within American Indian Tribes: A Comprehensive Assessment Tool

Introduction:

Sexually Transmitted Diseases (STDs) disproportionally impact Native populations and cause significant harm to Tribal communities. In 2004, American Indians were nearly five times more likely than whites to have chlamydia, four times more likely to have gonorrhea, and twice as likely to have syphilis. These infections compromise not only individual well being, but the well being of the community as a whole.

Because of factors such as rural geography, early sexual debut, close-knit sexual networks, and high rates of hepatitis C, substance use, and sexually transmitted diseases, many experts now believe that HIV/AIDS is a "time bomb" that may reach epidemic proportions among Native communities. The number of American Indians and Alaska Natives (AI/AN) diagnosed with AIDS has grown more rapidly than in any other ethnic group, increasing almost 800% from 1990 to 1999. Research shows those infected with STDs are 2 - 5 times more likely to acquire HIV when exposed through sexual contact. Consequently, elevated STD rates among American Indians and Alaska Natives put them at heightened risk for HIV. STD testing, treatment, and prevention programs are an effective tool to help prevent the spread of HIV.

In order to understand the types of STD and HIV prevention services available within local tribal communities, Project Red Talon (PRT) and the Northern Plains Tribal Epidemiology Center (NPTEC) collaborated to develop a comprehensive Tribal STD/HIV Capacity Assessment Survey. The survey was administered to 37 tribes in Idaho, Oregon, Nebraska, North Dakota, South Dakota, and Washington.

Background:

While substantial progress has been made in preventing and treating certain STDs, experts estimate that 19 million new infections occur each year, with almost half of them occurring among young people. In addition to the physical and psychological consequences, these diseases also exact a tremendous toll on the Indian healthcare system. Direct medical costs associated with STDs are nationally estimated to reach $13 billion annually.

Chlamydia: When comparing rates by ethnicity, American Indians have the second highest chlamydia rate in the United States. From 2000-2004, the chlamydia rate among American Indian and Alaska Native women was nearly 5 times higher than the rate reported among white women. Among Native men, the chlamydia rate was 4.75 times higher than the rate reported among white men. **Age Distribution:** Nearly three-quarters of all chlamydia cases occur among 15-24 year olds.

Gonorrhea: In 2004, American Indians and Alaska Natives had the second- highest gonorrhea rate, with 117.7 cases per 100,000, a rate that was 4 times higher than rate reported among whites. From 2000 to 2004, gonorrhea rates increased 19.4% among American Indians and Alaska Natives. **Age Distribution:** In 2004, AI/AN gonorrhea rates were highest among 20-24 year olds.

Syphilis: Between 2003 and 2004, the rates of primary and secondary syphilis increased 14.3% among American Indians and Alaska Natives. During this period, the number of reported syphilis cases decreased among AI/AN men (from 50 to 42), but increased among AI/AN women (from 19 to 35). **Age Distribution:** In 2004, AI/AN syphilis rates were highest among 35-39 year olds.

HIV/AIDS: AIDS has steadily increased in recent years, becoming the ninth leading killer of Native people between the ages of 15 and 44 -- approximately 3,084 AI/ANs have been diagnosed with AIDS since the disease was first encountered in 1980. When compared by ethnicity, AI/AN men and women both had the third highest HIV/AIDS rate in 2004. Among AI/AN males, the HIV/AIDS case rate increased 2.4% from 2001 to 2004, the most significant increase observed among any reported racial or ethnic group. And among females, the rate increased 4.8%, an increase that was second only behind Asian/Pacific Islanders. In 2004, HIV was newly diagnosed for an estimated 206 American Indians and Alaska Natives.

Hepatitis A, B, & C: Historically, hepatitis A rates differed by race, with the highest rates occurring among American Indians and Alaska Natives. AI/AN rates, which were greater than 60 cases per 100,000 prior to 1995, have decreased dramatic ally as a result of widespread vaccination. In the U.S., Hepatitis B is most commonly acquired by adults through sexual transmission. In 2002, the Hepatitis B rate among AI/ANs was second only to non-Hispanic blacks. Hepatitis C virus (HCV) infection is the most common chronic bloodborne infection in the United States; an estimated 2.7 million persons are chronically infected. Data indicates that sexual transmission of HCV accounts for up to 20% of HCV infections. Hepatitis C rates have declined in all racial groups since 1995, but non-Hispanic blacks and AI/ANs continue to have higher incidence rates than other racial or ethnic groups.

Impact: Given the greater proportion of young people in many of our Native communities, high STD rates among AI/AN 15-24 year olds are particularly troubling to those concerned about HIV prevention. Research now shows that those infected with STDs are 2 - 5 times more likely to acquire HIV when exposed through sexual contact. Consequently, elevated STD rates among Native youth and adults put us at heightened risk for the transmission of HIV.

These statistics were obtained from STD Surveillance 2004 [www.cdc.gov/std/stats] and HIV/AIDS Surveillance Report, CDC 2004, Volume 16.

Methods:

Survey Development: Two survey tools were developed to encapsulate a wide range of STD prevention efforts that are available through Tribal Health Departments and tribal/IHS clinics. The "provider" survey targeted STD screening and treatment practices among Indian Health Service (IHS) & tribal clinicians. The "community" survey targeted STD prevention efforts provided by tribal health directors, health program managers, and community health educators. Each survey sought information regarding systems for promoting STD awareness, populations needing services, barriers to access, service utilization, prevention priorities, and training needs.

The Surveys were developed with consideration for the *Community Readiness Model*, which was developed by the Tri-Ethnic Center. The Model identifies six dimensions of readiness that can influence a community's ability to prevent STDs and HIV/AIDS:

1. **Community Efforts:** To what extent are there programs and policies that address STDs/HIV?
2. **Community Knowledge of the Efforts:** To what extent do community members know about local efforts and their effectiveness, and are the efforts accessible to all segments of the community?
3. **Leadership:** To what extent are appointed leaders and influential community members supportive of STD/HIV prevention?
4. **Community Climate:** What is the prevailing attitude of the community toward STDs/HIV and early detection and testing? Is it one of helplessness or one of responsibility and empowerment?
5. **Community Knowledge about the Issue:** To what extent do community members know about or have access to information on STDs/HIV, STD/HIV testing, consequences, and local implications?
6. **Resources Related to the Issue:** To what extent are local resources – people, time, money, space, etc. – available to support efforts?

Region served by the Aberdeen Area Tribal Chairmen's Health Board

By designing questions that addressed all six capacity indicators, the programs were able to assess regional capacity and tailor health promotion strategies to the Tribes' current level of readiness.

Region served by the Northwest Portland Area Indian Health Board

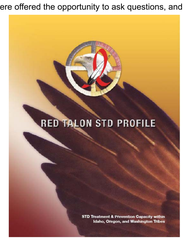
Survey Pre-Testing: After obtaining approval from each Area's IHS IRB (Portland and Aberdeen), the survey tools were pre-tested with key informants to assure comprehension and identify potential problems.

Participation: Following pre-test revisions, both surveys were self-administered by respondents using paper-based and internet format s (via SurveyMonkey.com). Each respondent was sent a packet with a cover letter, a paper copy of the survey form, and a self-addressed stamped envelope. This message was also sent via email with links to the survey imbedded in the message. Clinic staff members responsible for STD treatment and tribal health personnel responsible for STD activities were invited to complete their respective surveys. In most instances, these individuals were Clinicians, Public Health Nurses, Tribal Health Directors, Community Health Representatives, STD and HIV/AIDS Program Coordinators, or Health Educators.

Protection of Privacy and Confidentiality: Each respondent was given a description of the survey's purpose and the estimated time required for completion (20-40 minutes). All participants were given a written assurance of confidentiality. Respondents were offered the opportunity to ask questions, and were free to decline participation and/or refuse to answer questions without penalty.

Analysis: The data collected from Portland Area respondents were compiled and analyzed by an external evaluator, Frank Mondeaux, Ph.D. The data collected from Aberdeen Area respondents were compiled and analyzed by staff from the Northern Plains Tribal Epidemiology Center. Basic descriptive statistics (e.g., frequency distributions, means, etc.) were generated in SPSS to analyze the data. Complete survey results are provided in the Red Talon STD Profile and the Northern Plains Tribal STD and HIV/AIDS Assessment Report.

Regional Variations: Aberdeen Area obtained approval from 10 of the 18 Tribes in their region. The Northwest Portland Area Indian Health Board had 27 of 43 Tribes participate. Because of the approval process required by Aberdeen Area Tribes, and because there are fewer tribes in the Area (18 vs. 43), the sample size from Aberdeen Area was much smaller. In Aberdeen Area, a total of 19 clinicians and 13 community health personnel participated, representing 10 Tribes. In the Northwest Portland Area, a total of 45 clinicians and 45 community health personnel participated, representing 27 Tribes. In Aberdeen Area the clinician sample was made up entirely of clinical providers working within Indian Health Service (IHS) units. In the Northwest, however, respondents represented a variety of Indian health systems, including Tribal health centers (8 of which are tribally-operated and 7 of which are IHS-operated), 22 tribally-operated health stations, 1 IHS-operated health station, and 10 tribally operated prevention programs.

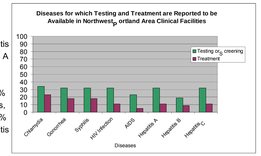


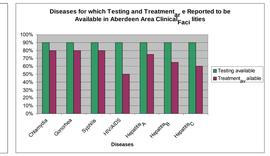
Results: Clinic STD/HIV Efforts

Clinic Staffing: While the majority of clinicians reported having several years of experience working with their local tribe, 90% of Portland Area respondents and 68% of Aberdeen Area respondents indicated that they spent fewer than 10 hours dedicated to STD-related activities per week.

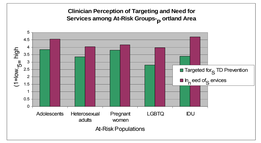
Testing and Treatment: While Northwest Portland Area clinicians reported that, for the most part, tribal health clinics do not consider most STDs to be clinical priorities, Aberdeen Area clinicians indicated that all STDs were a high priority—particularly chlamydia, gonorrhea, and viral hepatitis. Among the highest priority diseases, there were correspondingly high rates of testing and treatment. In all cases, treatment rates lagged behind STD screening and testing rates.

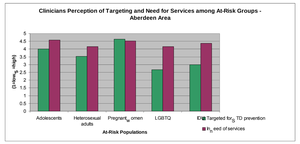
Reporting: Fifty-six percent of respondents in the Portland Area and 58% of respondents in the Aberdeen Area indicated that their clinic had a protocol in place to report STD cases to the local or state STD registry. Reporting rates were higher in the in Aberdeen Area than in the Northwest Portland Area. In the Aberdeen Area, the reporting rates were 85% for gonorrhea, chlamydia, and syphilis, 80% for HIV and hepatitis C, and 75% for hepatitis A and B. In the Portland Area, reporting rates ranged from a high of 70% for gonorrhea and syphilis, to 67% for chlamydia, 64% for AIDS, 50% for Hepatitis C, and 43% for HIV.





Populations Targeted for STD Services: Respondents were asked to rate the extent to which sub-groups were targeted for STD services by the clinic, with answers ranging from "Not Targeted" to "Highly Targeted."





Clinical Training in STDs and HIV: In the Northwest, over 95% of clinicians reported having received training on STD and HIV/AIDS issues, and 90% felt their training was adequate for their needs. In the Aberdeen Area, 90% of clinicians reported having received STD and HIV/AIDS- specific training and 76% indicated that it was sufficient for their needs. Future training needs included:

Northwest Portland Area:
- STD Treatment Guidelines
- STDs and Women's Health

Aberdeen Area:
- Strategic planning and capacity building
- STDs and Women's Health

Clinic Education and Counseling: On average, about 70% of clinicians in the Northwest Portland Area and 74% in the Aberdeen area reported that patients receive STD/HIV-related education during reproductive health exams. In the Portland Area, about 80% of tribal health clinics provide STD pre- and post-test counseling, and nearly two-thirds provide HIV pre- and post-test counseling. Among IHS facilities in the Aberdeen Area, 95% reported providing pre- and post-test counseling for STDs and 76% for HIV.

Prevention Priorities: Respondents were asked to report on tribal health clinic prevention priorities by rating the extent to which prevention activities were a priority for the clinic.

Northwest Portland Area:
- Increase access to services for adolescents
- Increase access to services for adults
- Increase community awareness of STDs and HIV

Aberdeen Area:
- Increase access to services for adolescents
- Increase community awareness of STDs and HIV
- Increase STD and HIV testing and treatment rates

Results: Community STD/HIV Efforts

Community Health Staffing: Like clinicians, the majority of community health personnel reported having several years of experience working with their local tribe. Ninety-seven percent of Northwest Portland Area respondents and 50% of Aberdeen Area respondents indicated that they spent fewer than 10 hours dedicated to STD-related activities per week.

Community Outreach and Intervention: To prevent STD and HIV transmission among community members, NW Tribal health programs most often distribute condoms (94%), provide education (81%), and promote clinic-based screening (69%). A majority of community health personnel in Aberdeen area reported that STD and HIV education (64%) and condom distribution (55%) are available in their community to prevent STD and HIV transmission.

Community Health Personnel Training in STDs and HIV: Nearly all (93%) of the health directors, health program managers, and health educators surveyed by Project Red Talon had received training on STD and HIV issues, yet nearly one-third indicated that the training was not adequate for their needs. Sixty-seven percent of Aberdeen Area community health personnel reported having received training in STDs and HIV, and 57% indicated that their training had been adequate.

Future Training Needs: Both regions identified "youth prevention and intervention" as their greatest training need.

Prevention Priorities: Respondents were asked to report on tribal priorities by rating the extent to which prevention activities were a priority.

Northwest Portland Area:
- Increase youth outreach
- Decrease rates of injection drug use
- Increase age of first intercourse
- Increase knowledge about screening and treatment

Aberdeen Area:
- Increase outreach to youth
- Increase outreach to pregnant women
- Decrease rates of injection drug use
- Increase outreach to injection drug users

Abstract:

I. Background / Introduction:

In the U.S., American Indians and Alaska Natives (AI/AN) experience a disproportionately high burden of sexually transmitted diseases (STDs). As is true among other ethnic populations, chlamydia and gonorrhea rates in Indian Country are typically highest among those aged 15-29 years. Given that the "young" demographic distribution in many AI/AN communities, this disparity is troubling to IHS prevention programs. Research shows those infected with STDs are 2 - 5 times more likely to acquire HIV when exposed through sexual contact. Consequently, elevated STD rates among AI/ANs put them at heightened risk for HIV transmission. Thus, STD testing and treatment programs can serve as an effective tool to help prevent the spread of HIV.

In order to understand the types of STD and HIV prevention services available within NW and Aberdeen Area tribal communities, Project Red Talon (PRT) and the Northern Plains Tribal Epidemiology Center (NPTEC) collaborated to develop a comprehensive Tribal STD/HIV Capacity Assessment Survey. The survey was administered to 38 tribes in Idaho, Oregon, Nebraska, North Dakota, South Dakota, and Washington.

II. Method / Experience:

Two survey tools were developed to encapsulate the various prevention efforts available at the clinic and community level. The "provider" survey targeted STD screening and treatment practices among Indian Health Service (IHS) & tribal clinicians. The "community" survey targeted STD prevention efforts of tribal health directors, health program managers, and community health educators. Each survey sought information regarding systems for promoting STD awareness, populations needing services, barriers to access, service utilization, and prevention priorities and training needs.

After obtaining approval from each Area's IHS IRB (Portland and Aberdeen), the survey tools were pre-tested with key informants to assure comprehension and to identify potential problems. Following pre-test revisions, both surveys were self-administered using paper-based and internet formats (via SurveyMonkey.com). Each respondent was sent a packet with a cover letter, a paper copy of the survey form, and a self-addressed stamped envelope. This message was also sent via email with links to the survey imbedded in the message.

III. Results / Best Practices:

In May 2005, PRT administered the surveys to the 43 Northwest (NW) tribes. PRT obtained over 44 "provider" surveys and 45 "community" surveys. NPTEC administered the surveys in August 2005. 30 provider surveys and 30 community surveys were sent out to the 18 communities of the Northern Plains.

Data collected with the assessment tools were compiled and analyzed by PRT's external evaluator, Frank Mondeaux, Ph.D, and by NPTEC staff. Using SPSS, basic descriptive statistics were used to analyze responses to each question, as appropriate. Final analysis described each tribe's screening, treatment, and prevention services, and identified programmatic strengths and weaknesses for the Northwest and Northern Plains regions.

IV. Conclusions / Recommendations:

Survey results from the Northwest Tribes were included in the Northwest Tribal STD Profile, which is now being used by NW tribes to identify prevention priorities and by the Red Talon STD/HIV Coalition to develop an Inter-tribal STD Action Plan. NPTEC is currently preparing an aggregate report summarizing the survey findings from the Northern Plains tribes, which will be distributed back to tribal communities to stimulate discussion among healthcare providers and tribal communities and for guiding the development and implementation of prevention programs.

The Tribal STD/HIV Capacity assessment tool is an effective survey instrument for obtaining information about tribal STD and HIV screening, treatment, and prevention activities. This information can help identify programmatic strengths and weaknesses, and can significantly improve program planning and evaluation.

Recommendations:

The results of the comprehensive STD/HIV capacity assessment were used to develop the following recommendations:

Priority #1: Increase community awareness about STDs.

- Develop and implement a comprehensive media strategy using consistent messages and images. Use the STD/HIV media campaign to increase community knowledge about STDs and available treatments, reduce stigma around testing, increase willingness to participate in screening efforts, and improve attitudes about accessing services.
- Identify and mentor peer-to-peer educators that can extend the reach of outreach messages to high risk populations (youth, injection drug users, MSM, social/sexual networks, etc.).
- Improve and broaden community access to native-specific and culturally relevant educational materials – fact sheets, brochures, risk reduction kits, etc.
- Increase outreach and education at community events.
- Present fact sheets to Tribal Council members to increase awareness about sexually transmitted diseases.

Priority #2: Strengthen local capacity to prevent STDs.

- Develop and/or strengthen skill- and behavior-based intervention programs targeting high-risk populations.
- Increase training among tribal health advocates, particularly addressing youth prevention strategies and culturally appropriate interventions.
- Propose a tribal resolution providing support for STD and HIV prevention initiatives.
- Work with State and County health departments and partner agencies to increase tribal funding for STD and HIV initiatives.

Priority #3: Improve STD screening and treatment in Tribal clinics.

- Develop clinic-based policies to improve tribal screening rates, increase case reporting to the state or county registry, reduce test result wait-times, improve the confidentiality/anonymity of testing, improve service access for adolescents and intravenous drug users, and reduce partner-to-partner transmission.
- For most clinics, STD treatment rates lag well behind screening and testing rates. Establish a workgroup to identify actions that can be taken to improve STD treatment rates at tribal clinics so that testing and treatment for all STDs, including HIV are available in every facility.

Project Red Talon: Working with Tribes in the Pacific Northwest to prevent Sexually Transmitted Diseases.

The Northwest Portland Area Indian Health Board is a tribal, non-profit organization located in Portland, Oregon. The Board is comprised of all 43 federally recognized tribes in Oregon, Washington, and Idaho. The NPAIHB was formed in 1972, "to assist Northwest tribes to improve the health status and quality of life of members/tribes and Indian people in their delivery of culturally appropriate and holistic health care." NPAIHB has a 34-year history of providing health service support to the Northwest tribes, particularly addressing health promotion, disease prevention, and health research. Many of the projects have National reach, serving Tribes throughout the US.

Among these, Project Red Talon has provided education, training, technical support, research, and capacity building assistance for over ten years to support the prevention and treatment of STDs and HIV/AIDS among NW Tribes. The activities of Project Red Talon are currently funded by the Centers for Disease Control and Prevention through a three-year grant, which began in September 2004. (Award Number: U83/CCU024369-01).

To reduce the prevalence of STDs among Natives in the Pacific Northwest, Project Red Talon is working to:

- Improve STD testing, screening, and treatment services among NW tribal clinics.
- Strengthen the capacity of tribal health educators, program managers, and clinicians to provide STD prevention services.
- Increase community awareness about Sexually Transmitted Diseases.

Aberdeen Area Tribal Chairmen's Health Board:

Hecel Oyate Kin Nipi Kte — So That The People May Live
Northern Plains Tribal Epidemiology Center

The Aberdeen Area Tribal Chairmen's Health Board (AATCHB) was established in order to provide the Indian people of the Aberdeen Area with a formal representative Board as a means of communicating and participating with the Aberdeen Area Indian Health Service and other health agencies and organizations on health matters. The Northern Plains Tribal Epidemiology Center, part of the AATCHB, provides leadership, technical assistance, support, and advocacy to Northern Plains tribal nations and communities in order to eliminate tribal health disparities that currently exist in the area.