PROJECT RED TALON

A Case Study of STD and HIV Capacity Building Among Idaho, Oregon, and Washington Tribes

2005-2007

The activities of Project Red Talon are funded by the Centers for Disease Control and Prevention through a three-year grant, which began in September 2004. This project is designed to provide tribes in Idaho, Oregon, and Washington with education, training, and technical assistance for the prevention and treatment of STDs and HIV/AIDS. Award Number: U83/CCU024369-04

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Project Red Talon

A Case Study of STD and HIV Capacity Building among Idaho, Oregon, and Washington Tribes

2005-2007

Red Talon STD/HIV Coalition

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Project Red Talon - Program Rationale

American Indians and Alaska Natives (AI/AN) are disproportionately impacted by high rates of sexually transmitted diseases (STDs). In 2004, American Indians were nearly five times more likely than whites to be diagnosed with chlamydia, were four times more likely to be diagnosed with gonorrhea, and were twice as likely to be diagnosed with syphilis.

When compared to other populations in the U.S., the American Indian population is typically younger, making them particularly vulnerable to adolescent health concerns. During the 2000 census, about one-third of the AI/AN population was under the age of 18. With a higher percentage of the population within the age group most at risk, AI/ANs are disproportionately affected by teen pregnancy, sexually transmitted infections (STD), and HIV acquired in adolescence.

By age 24, nearly one in three sexually active people have had an STD. These infections compromise not only individual well being, but the well being of the community as a whole. The long-term health consequences of undiagnosed STDs are serious, particularly for young women. Untreated chlamydia and gonorrhea can lead to chronic pelvic pain, pelvic inflammatory disease (PID), ectopic pregnancy, infertility, and increased risk for HIV infection. Because of their anatomy, women are biologically more susceptible than men to becoming infected if exposed to an STD, and STDs are more likely to remain undetected in women.

Most chlamydia and gonorrhea cases occur among adolescents and young adults. In the Northwest, over eight-hundred American Indian and Alaska Native youths age 10-24 years were diagnosed with chlamydia in 2005. Because chlamydia often causes no signs or symptoms, it is likely that many more cases occurred without being diagnosed.

1 out of 4 sexually active teens will get an STD this year.

High rates of STDs indicate both high-risk behavior and vulnerability to HIV. People infected with an STD are 2 to 5 times more likely to become infected with HIV if exposed.

The number of American Indians and Alaska Natives diagnosed with AIDS has grown more rapidly than in any other ethnic group. When compared by ethnicity, AI/ANs had the third highest HIV/AIDS rate in 2005. Among males, the HIV/AIDS rate increased over 2% from 2001 to 2004, the most significant increase observed among any racial or ethnic group. Because of factors such as rural geography, early sexual debut, close-knit sexual networks, and high endemic rates of hepatitis C, substance use, and sexually transmitted diseases, many experts now believe that HIV/AIDS could be a “time bomb” among Native communities.

Unfortunately, many people are not regularly screened for STDs and HIV. It is recommended

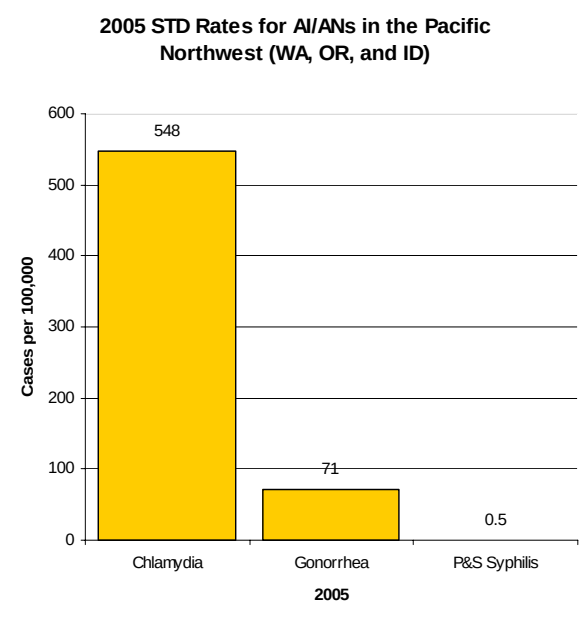
Project Red Talon - Program Rationale

that all sexually active women age 10-24 be screened annually for chlamydia and gonorrhea. The CDC also recommends that opt-out HIV screening be performed routinely in all healthcare settings, for all patients aged 13 to 64 years.

Federal Response

Recognizing the need for a targeted response to this problem, in 2004 Senator Daschle secured $500,000 in the Senate-passed Labor-HHS Appropriations bill for a competitive grant program administered by the Centers for Disease Control and Prevention to bolster the capacity of American Indian communities to “screen for and treat sexually transmitted diseases and to educate local populations about such diseases and their consequences, as well as how transmission of such diseases can be prevented” (H. Rept. 108-401, p. 762). This mandate was carried out, and two tribal organizations received approximately $200,000 per year to carry out project activities, from September 2004 to August 2007.

This paper will focus on one of the two “capacity-building” recipients - Project Red Talon. The purpose of this paper is to describe the social and political context in which capacity development has taken place in the Pacific Northwest, discuss the activities and lessons learned by Project Red Talon, and provide guidance to those who are interested in replicating elements of the project in their own communities or regions.



Most chlamydia cases diagnosed in the U.S. occur among young people between the ages of 15 and 29. In the Northwest, over 800 American Indian and Alaska Native youths age 10-24 years were diagnosed with chlamydia in 2005. Over half of these cases occurred among 15-19 year olds.

Data Included in this Case Study

This case study was developed using four principle data sources:

- Quantitative data synthesized from community capacity surveys
- Qualitative data generated from key informant interviews
- Participant observation of Red Talon STD/HIV Coalition meetings
- A variety of informational documents and reports generated by Project Red Talon

Surveys

In 2005, Project Red Talon and the Northern Plains Tribal Epidemiology Center collaborated to develop a comprehensive Tribal STD/HIV Capacity Assessment Survey, which was first administered to tribes in Idaho, Oregon, and Washington in May 2005.

Two survey tools were developed to encapsulate a variety of prevention efforts taking place 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 carried out by tribal health directors, health program managers, and community health educators. Each survey sought information on tribal systems for promoting STD awareness, populations needing services, barriers to access, service utilization, prevention priorities, and training needs.

In 2005 the surveys were completed by over 90 NW tribal respondents. Since then, portions the two surveys have been replicated annually, with over 60 respondents in 2006 and over 30 respondents in 2007. (For a complete discussion of the survey’s findings, the results of the 2005 survey were published in the Red Talon STD Profile report, available through PRT).

Interviews

To capture the diversity found within tribal communities and organizations that utilized services provided by Project Red Talon, phone interviews were conducted in the second and third years of the project using a purposeful sampling design. Key informant interviews were conducted with individuals representing four Northwest tribes.

Participating tribes were intentionally selected to include high, medium, and low capacity STD/HIV programs or services, and were geographically dispersed throughout Oregon, Washington, and Idaho. Interview questions focused on the extent to which Project Red Talon’s services were accessed and utilized, the degree to which those services translated into measurable changes in outcomes of interest (e.g. STD screenings and treatment rates), and how the community was affected by the Project’s activities.

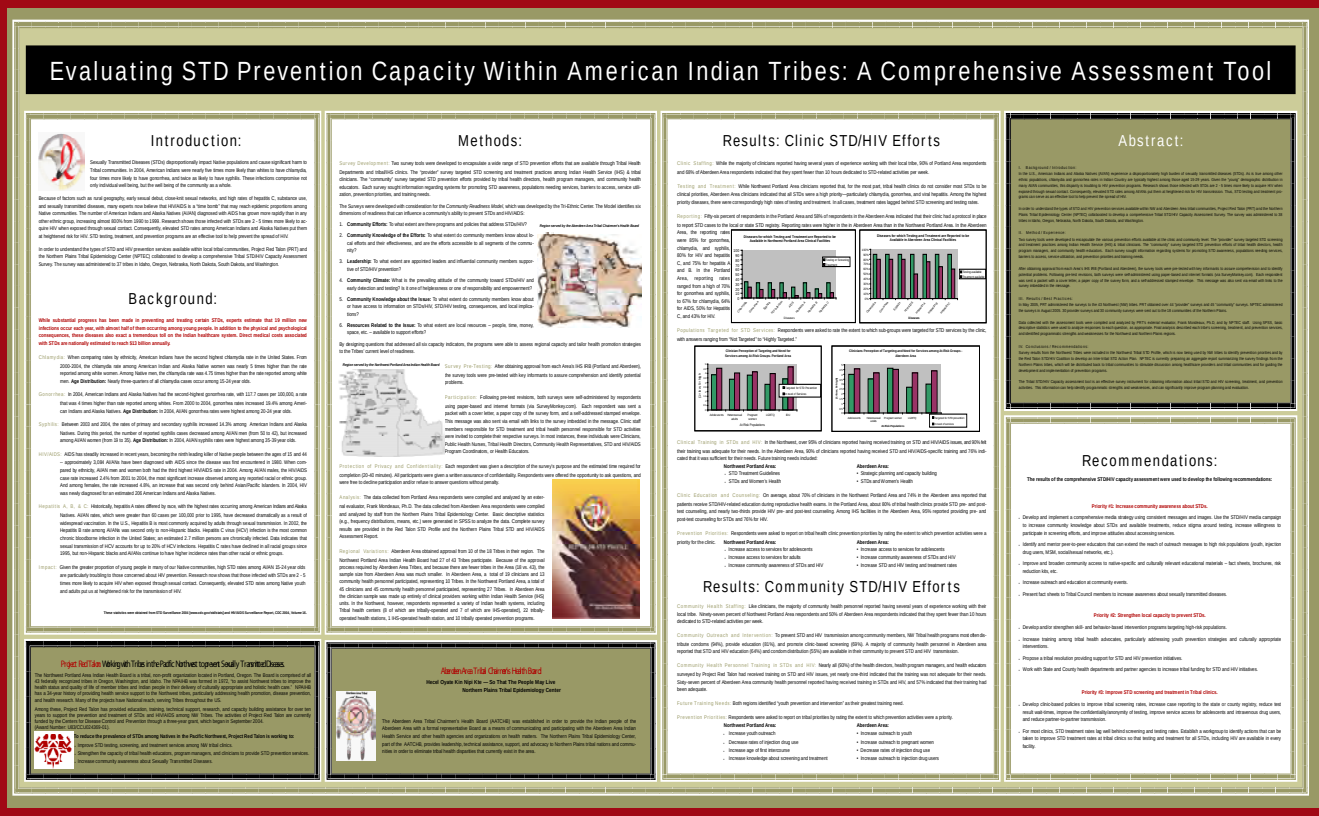
Data Included in this Case Study

Documents

Additionally, the Red Talon STD/HIV Coalition met on a quarterly basis from 2005-2007, and detailed notes were taken by Red Talon staff members documenting meeting proceedings, community representation and participation, follow-up action items, and attendance over time. These notes and additional site visits were used to generate and refine emergent outcomes and themes.

Project Red Talon and the Northern Plains Tribal Epidemiology Center collaborated to develop a comprehensive Tribal STD/HIV Capacity Assessment Survey. Together, the survey was administered to 37 tribes in Idaho, Oregon, Nebraska, North Dakota, South Dakota, and Washington. Additional information about the 2005 survey results can be found at:

http://www.ihs.gov/medicalprograms/hivaids/docs/RedTalon.pub



The Social and Political Climate for Tribal STD Prevention

Tribal STD Resources at the National Level

It is exceedingly difficult to quantify the amount of money available for STD/HIV prevention and control activities in Indian Country, and the federal agencies responsible for administering those initiatives.

Nationally, less than $1 million dollars were dedicated by the CDC to fund STD prevention and capacity development in Indian Country in 2006, the only agency, to our knowledge, involved in such efforts. In contrast, several federal agencies fund HIV-related activities in Indian Country, including CDC, SAMHSA, the Minority AIDS Initiative, and Ryan White. While there are quite a few programs and organizations throughout the U.S. that provide tribe-specific HIV capacity-building assistance and resources, outside Project Red Talon there are relatively few tribal organizations that specifically address STD prevention and treatment issues.

In addition to the two CDC capacity-building grantees (which includes Project Red Talon), two CDC field staff work full-time in the Indian Health Service's National Sexually Transmitted Disease Program, as does a part-time medical epidemiologist. By this count, fewer than ten full-time public health personnel are employed nationally to address STD prevention and surveillance specifically for American Indians and Alaska Natives.

The Northwest Tribes

Over 190,000 American Indians and Alaska Natives reside in Idaho, Oregon, and Washington, representing 6.3% of the nation's American Indian population. Forty-three federally recognized tribes are dispersed across immense distances in the Northwest, most typically in isolated areas with sparse populations. Ranging from under 220 to over 8,800 tribal members, and from the Coast to the Northwest Plateau, the tribes of the Northwest vary significantly in population size, culture, and geographic location.

Local Tribal Health Projects Responding to STDs and HIV/AIDS

Established in 1972, the Northwest Portland Area Indian Health Board (NPAIHB or the Board) is a non-profit tribal advisory organization that serves the forty-three federally recognized tribes of Oregon, Washington, and Idaho. Each member tribe appoints a delegate via tribal resolution, who meets quarterly to direct and oversee all activities of the Board. The NPAIHB is unique among other regional Indian Health Boards, in that all federally recognized tribes in the region are contributing members of the NPAIHB.

The NPAIHB's strategic plan contains four main functional areas: health promotion and disease prevention, training and technical assistance, legislative and policy analysis, and surveillance and research. To meet these objectives, NPAIHB houses several health promotion and disease prevention projects, a tribal epidemiology center

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(The Northwest Tribal EpiCenter), and is active at the state and national levels in shaping and advocating for Indian health policies.

Project Red Talon has worked on STD and HIV prevention activities with the Northwest tribes for over 20 years.

Among its many health promotion and surveillance projects, Project Red Talon (PRT) has worked on STD/HIV prevention with the NW tribes for over 20 years. The first project started in 1988 with an AIDS Knowledge, Attitude, and Behavior survey, which was followed by a CDC-funded HIV/STD prevention project. Over the years, NPAIHB has been instrumental, both regionally and nationally, in making HIV and STD prevention a priority issue at regional and national Indian health meetings.

From 2005-2007, the core activities of Project Red Talon were carried out by a full-time Project Director and a half-time Administrative Assistant. The Project's activities significantly benefited from having no staff turn-over throughout the duration of the project.

From 2004-2007, the bulk of Project Red Talon's activities were funded by the CDC's capacity building grant. Benefiting from this focused attention on tribal STD capacity development, this grant allowed PRT staff to successfully leverage additional dollars to fund a number of different STD Coalition activities. Among them, Project Red Talon received a grant to develop culturally appropriate media materials, a memoranda of agreement to support school-based chlamydia screening events, and a contract to develop culturally appropriate resources to improve adolescent reproductive health.

The SPIPA Tribal B.E.A.R. Project works with 14 Tribes in Washington and Oregon, providing clinical training on treating Hepatitis C and HIV+ patients.

Also in this region, the South Puget Intertribal Planning Agency (SPIPA) manages the Tribal B.E.A.R. Project, which provides medical update training to tribal healthcare providers who serve Native Americans at high risk of HIV and Hepatitis C infection.

From 2002-2007, SPIPA administered a Special Project of National Significance (SPNS) grant

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that allowed them to provide culturally competent HIV outreach and rapid testing services to 3-5 small rural tribes. This funding significantly contributed to HIV capacity building among the five participating tribes, and allowed a part time HIV advocate to be hired and trained at each site.

From 2002-2007, the core activities of the Tribal BEAR and SPNS projects were carried out by a full-time Program Coordinator and a full-time Training Coordinator. Likewise, SPIPA's activities significantly benefited from having no staff turn-over throughout the duration of the project.

A History of Effective Partnerships

Contributing to the development of effective prevention efforts in the Pacific Northwest, the tribes in this region have substantial experience building collaborative relationships among tribes, states, federal agencies, and health advocacy organizations. This has been facilitated by the development of a uniquely positive working relationship between the states and tribes, based on mandated government-to-government consultation policies.

Unlike other IHS regions, most of the tribal clinics in the Northwest are 638 facilities that provide self-directed healthcare to its members, a factor that has motivated tribal council members to get intimately involved in health policy consultation. Federally recognized tribes in Idaho, Oregon, and Washington now use multiple conduits to engage in health program policy consultation.

The many benefits of this model include:

- ***Efficiencies in Planning and Implementation.*** The inclusion of Tribes in State agency planning has helped to ensure that management plans are realistic and comprehensive. By involving Tribes early in formulating priorities and identifying resources, efficiencies are achieved in project planning and implementation. Tribes in the Pacific Northwest now have early input into the development of state health budgets, policies, and programs. This model has been widely successful, and is now being used for State-Tribal discussions in non-health related areas.

- ***Mutually-Beneficial Goal Attainment.*** This proactive, participatory approach has increased inter-agency understanding and trust, and has allowed health programs to make steady progress on mutually-beneficial goals.

  Prior to the emergence of these practices, few partnerships successfully emerged between tribal health programs and external agencies in the region, largely due to a lack of capacity within tribes to engage in such partnerships.

  Tribal health personnel typically focused on a broad array of health outcomes. Without staff members dedicated to specific health topics, external agencies did not know who to contact to establish effective partnerships, and tribal

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leaders and program managers were often hesitant to pursue relationships with outside agencies, citing distrust, conflicting agendas or a history of unsuccessful relationships with non-tribal entities. Unstable partnerships were further perpetuated by fluctuating acknowledgement of and respect for tribal sovereignty by state and county health departments.

- ***Non-Competitive Funding.*** The creation and disbursement of non-competitive state funds to tribal health programs has enabled many to initiate and develop internal capacity for tribe-specific, culturally appropriate health programs, and has helped to establish personnel who are distinctly responsible for particular health topics, facilitating collaborative work in those areas.

  This relationship has been particularly true in the fields of tobacco control and breast and cervical cancer, where the Northwest states have funded tribes and the NPAIHB to improve inter-agency collaboration. Unfortunately, the fields of STD and HIV/AIDS have not yet benefited from such arrangements.

Tribal Consultation Policies

In response to social and political shifts in American Indian policy at the national level, and increasing demand by tribes to advance Native self-determination, the Federal government has issued a series of laws, amendments, judicial decisions, and executive orders over the last forty years that increasingly instruct federal agencies to interact with Tribes on a government-to-government basis (Hutt & Lavallee, 2005).

Most recently, President Bush issued an Executive Memorandum, "recommitting the federal government to work with federally-recognized Native American tribal governments on a government-to-government basis" (U.S. General Services Administration). Reinforced by treaty rights and constitutional provisions, these mandates require that federal agencies consult with federally-recognized tribes in a meaningful way, in good faith, as independent but dependant nations.

To honor the directives set forth by the federal government, many state governments have ratified their own consultation policies, including Idaho, Oregon, and Washington.

Tribal Readiness for STD Prevention

The Community Readiness Model was designed by the Tri-Ethnic Center for Prevention Research to respond to the unique culture, resources, and readiness levels of different tribes for various health promotion and disease prevention initiatives.

This model identifies six critical dimensions that can influence a community's ability to take action to prevent STDs and HIV/AIDS, including:

1. Existing community efforts and activities
2. Community knowledge about these efforts
3. Supportive tribal leadership
4. Healthy community climate and social attitudes
5. Community knowledge about the topic
6. Resources dedicated to the issue

As conceived by the Community Readiness Model, tribes can display varying levels of readiness within each of the six domains:

1. **No Awareness** - STD/HIV is not recognized by the community or leaders as a problem.
2. **Denial / Resistance** - At least some community members recognize that STD/HIV is a concern, but there is little recognition that it might be occurring locally.
3. **Vague Awareness -** Most feel that there is local concern, but there is no immediate motivation to do anything about it.
4. **Preplanning** - There is clear recognition that something must be done, and there may be a group addressing it. These efforts are not focused or detailed.
5. **Preparation** - Active leaders begin planning in earnest. Community offers modest support of efforts.
6. **Initiation** - Enough information is available to justify efforts. Activities are underway.
7. **Stabilization** - Activities are supported by community decision makers. Staff are trained and experienced.
8. **Confirmation/ Expansion Efforts** - Community members feel comfortable using services. Local data are regularly obtained.
9. **High Level of Community Ownership** - Detailed and sophisticated knowledge exists about STD/HIV prevalence, causes, and consequences. Effective evaluation guides new directions.

Plested, B.A., Jumper-Thurman, P., & Edwards, R.W (2006, July). Community Readiness: Advancing HIV/AIDS prevention in Native communities (Community Readiness Model handbook). Fort Collins, CO: Center for Applied Studies in American Ethnicity.

Project Red Talon: Capacity Building Strategies

Intended to bolster the capacity of American Indian communities to screen for and treat sexually transmitted diseases, the primary objectives of Project Red Talon were to:

1. Strengthen the capacity of tribal health educators, program managers, and clinicians to provide STD prevention services to the Northwest tribes.
2. Improve STD testing, screening, and treatment services among Northwest tribal clinics.
3. Increase community awareness about sexually transmitted diseases.

To meet these objectives, the project's annual scope of work included providing: STD training to tribal medical providers, health professionals, and community health advocates; STD technical assistance to support improvements in local STD programs and services; access to culturally appropriate STD prevention interventions; and access to information about effective STD prevention, screening, and treatment strategies, including the development of culturally appropriate materials.

Training

From 2004-2007, Project Red Talon provided introductory STD training to over 180 tribal health educators, nurse practitioners, and local health advocates, representing thirty Northwest tribes and five partnering agencies. Additionally, PRT covered registration and travel expenses for eleven tribal clinicians who attended STD clinical updates provided through the Seattle STD/HIV Prevention Training Center.

Technical Assistance

From 2004-2007, Project Red Talon provided technical assistance to over 525 tribal medical

Tribal STD Prevention Capacity - To determine the baseline STD capacity of the NW tribes, a comprehensive capacity survey was conducted in 2005, and was used to generate index scores related to: 1) participation in prevention activities, 2) existence of clinical protocols, and 3) breadth of screening and treatment services. These scores were then averaged to derive a total *STD Capacity Rating* for each tribe. Based on the methods used, capacity ratings could range from 0-9.

At the onset of the project, participating tribes had an average capacity and prevention rating of 5.42, slightly above the midpoint on the scale. By dividing the scale into three segments, the majority of tribes (85%) were found to be at moderate to high STD prevention capacity, with 22% of the tribes scoring 7.0 or above. Four tribes (15%), received a capacity and prevention rating below 3.0, averaging only 1.75 on the capacity and prevention scale. In total, 41% of the tribes received capacity and prevention ratings below the group average.

Project Red Talon: Capacity Building Strategies

providers, health professionals, and community health advocates. Requests came from tribal health advocates located throughout the U.S., and most typically included requests for: tribe-appropriate educational materials and media campaign products, AI/AN STD fact sheets or brochures, PowerPoint slides for community presentations, Tribal Advocacy Kits, clinical training resources, access to lower-cost STD laboratory services, assistance with STD intervention projects, grant writing assistance, and access to AI/AN STD-related data.

Site Visits and Community Outreach Events

From 2004-2007, Project Red Talon attended sixteen community outreach events, providing STD/HIV information to over 3,000 Northwest tribal members.

Resource Development and Dissemination

To improve community awareness about STDs, Project Red Talon developed and disseminated a variety of culturally appropriate promotional materials, including over 1,500 native-specific fact sheets, 9,500 native-specific brochures, 14,000 condoms, 5,000 snag bags, 150 STD resource directories, 250 leader advocacy kits, 150 health clinic policy check-lists, thousands of media campaign products, and monthly informational emails. To ensure cultural appropriateness and utility, all materials developed by PRT were reviewed by Red Talon Coalition members for their feedback and input prior to mass dissemination.

Websites

Each year, Project Red Talon's online resource page received over 5,250 page hits and resource downloads, and Project Red Talon's community awareness page [www.StoptheSilence.org], which was unveiled in March 2007, received over 1,800 page hits in its first nine months.

All PRT resources are available at:
http://www.npaihb.org/epicenter/project/project_red_talon/

Project Red Talon: Capacity Building Strategies

Red Talon STD/HIV Coalition

The Red Talon STD/HIV Coalition was formed in 2005 at the request of several local tribal health advocates, shortly after receiving the CDC's three-year STD capacity-building grant. The mission of the Coalition is to "*reduce the prevalence of STDs among American Indians and Alaska Natives in the Pacific Northwest by uniting to share wisdom, data, and resources; identify and address common priorities; and develop strategies to eliminate STD-related disparities*."

From 2005-2007, Coalition meetings were held quarterly - in January, April, July, and October. The Red Talon Coalition served the dual purpose of engaging tribes in joint STD prevention planning and outreach, while providing direction to Project Red Talon staff members on desired goals and activities for the project as a whole.

Participants in the Red Talon Coalition included tribal health advocates (typically Health Educators, CHRs, RNs, Youth Prevention staff, or Health Program Managers) and representatives from State and County Health Department STD/HIV programs, regional and national Indian Health Service programs, regional tribal planning groups, the Seattle STD/HIV Prevention Training Center, the AIDS Education and Training Center, the Northwest Portland Area Indian Health Board, Center for Disease Control and Prevention, and a number of other local community-based organizations.

Attendance at each meeting fluctuated, with five to ten "core" participants and many other "occasional" participants, depending on the location of the meeting. Meetings usually had ten to fifteen attendees, but attendance was as low as five on one occasion, and as large as thirty-five on several other occasions. To ensure all partners (Tribal, State and NGO) were aware of Coalition activities, detailed meeting minutes were circulated by email to about 150 contacts after each meeting. This allowed tribes who were unable to attend meeting to benefit (to some extent) from the activities and resources developed by the Coalition.

To increase participation and tribal turnout, meeting locations alternated between tribal and urban locations in Oregon, Washington, and Idaho. Meetings were held in-person, and took place from mid-morning to early afternoon to allow for participant travel. In April of each year, the Coalition meeting was held in conjunction with a two day training, which specifically addressed issues of interest to coalition members. Training topics included: STD updates for non-clinicians, Women's peer education, and adapting STD/HIV interventions for cultural appropriateness.

Facility and meeting arrangements were coordinated by Project Red Talon staff, and all travel expenses for tribal participants were reimbursed by Project Red Talon within two-weeks. When requested, support was also provided in making travel arrangements.

Project Red Talon: Capacity Building Strategies

The decision-making process for the Coalition was most typically achieved through consensus, but was democratic when necessary. Meeting agendas were developed by Project Red Talon staff, but were kept intentionally flexible to address any emerging topics of interest to participants.

Meetings usually began with a blessing, introductions, and tribal project updates. This was usually followed by time to discuss the three-year STD/HIV Tribal Action Plan and any upcoming deadlines. When available, partnering agencies also provided presentations on available resources or activities open to collaboration. To encourage networking and social-cohesion, all meetings also involved a working lunch provided by Project Red Talon.

Meetings typically concluded with a discussion of any new funding opportunities available, desired proposals, and possible joint-applications. Based on this feedback, Project Red Talon staff members submitted two to three grant applications on behalf of the Coalition each year. Resources were also discussed for upcoming STD/HIV observance days, and any Coalition "next steps."

STD/HIV Tribal Action Plan

The STD/HIV Tribal Action Plan was the product of a collaborative, year-long planning process initiated by members of the Red Talon STD/HIV Coalition. It was designed to be actively used by members of the Northwest Portland Area Indian Health Board to guide program planning, catalyze community outreach, and foster a coordinated inter-tribal response to STDs and HIV/AIDS. The Action Plan was presented to the 43 delegates of the NPAIHB in January 2006, and a resolution in support of the plan was unanimously passed. The Plan spans from 2006 to 2008.

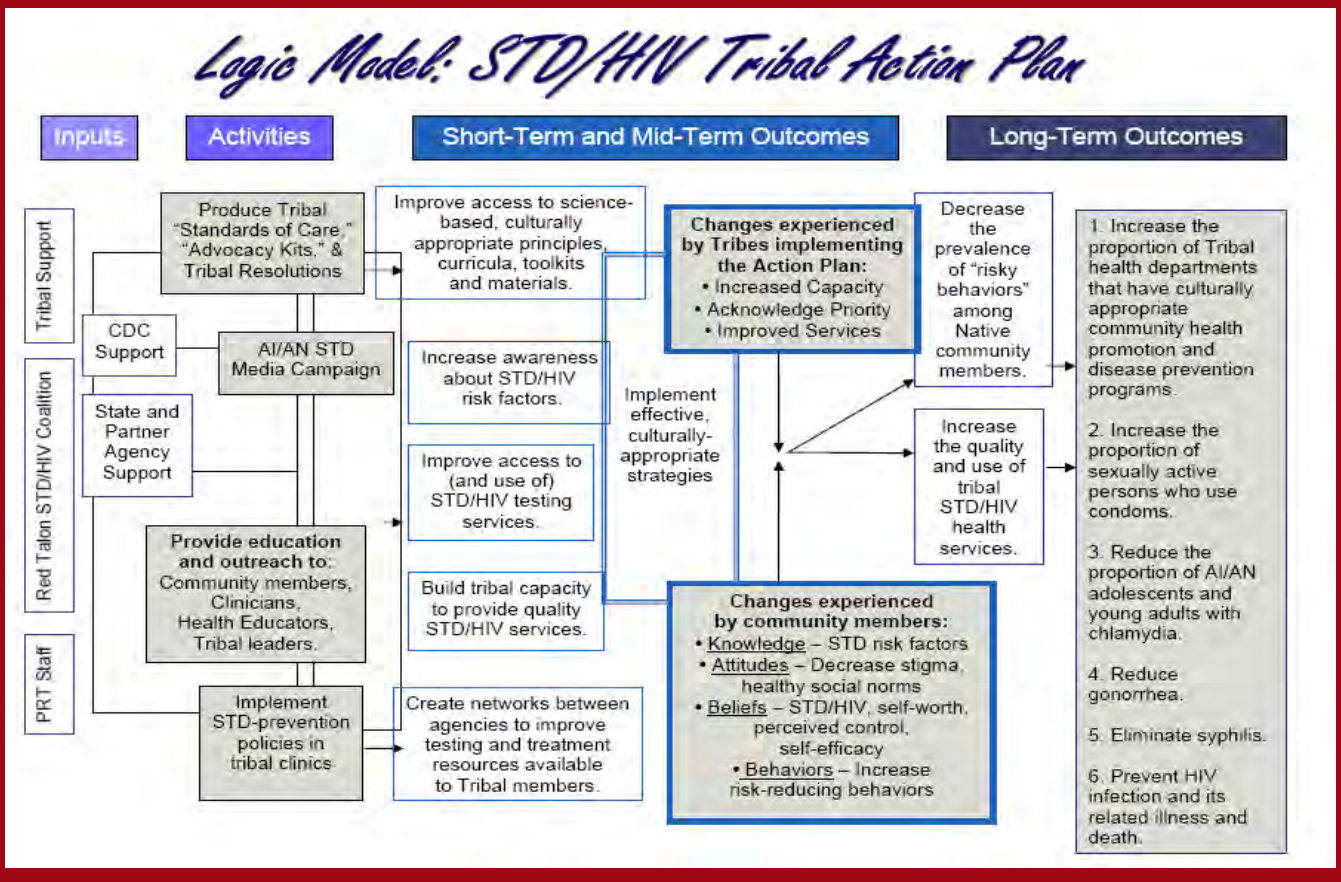
The strategic planning process was facilitated by external consultants from the Center for Applied Studies in American Ethnicity (CASAE), through a request for Native HIV/AIDS Capacity Building Assistance. Reflecting on the process, Coalition members voiced that this strategic planning process was instrumental in their development of a cohesive, usable Action Plan.

In each of the six capacity domains outlined by the Community Readiness Model (see pg. 13),

Project Red Talon: Capacity Building Strategies

members of the Red Talon Coalition felt in 2005 that their existing levels of readiness were:

- Supportive tribal leadership: *Denial/ Resistance*
- Community knowledge about STD/HIV issue: *Vague Awareness*
- Healthy community climate and attitudes: *Vague Awareness*
- Community knowledge about existing prevention efforts: *Vague Awareness*
- Existing community efforts and activities: *Preplanning*
- Resources dedicated to the issue: *Preparation*



Project Red Talon: Capacity Building Strategies

Based on this information, the Red Talon Coalition strategically selected a variety of intervention activities to incrementally increase the readiness of Northwest tribes to prevent sexually transmitted diseases. By collecting information about these capacity indicators in subsequent Capacity surveys, the Coalition has been able to tailor their health promotion strategies in response to identified needs.

Coalition Advisory Role

Because the Coalition is comprised of tribal health educators, nurses, youth prevention specialists and other community-based advocates, their feedback and guidance substantially influenced the development of PRT products and media.

This group was aware of community norms, appropriate messages, and was familiar with effective strategies for reaching high-risk groups. The wisdom and experience of the Red Talon STD/HIV Coalition thus guided the development of a variety of resources, by brainstorming messages and prioritizing outreach strategies. By fostering these discussions, materials developed by the Coalition and Project Red Talon sought to increase community awareness while remaining sensitive to traditional teachings.

National Partnerships

To maximize tribal access to resources derived from STD-networking, Project Red Talon participated in a number of local and regional conferences, planning groups, and training events, including: the National AI/AN STD Research Group, Oregon's Statewide Planning Group (SPG) for HIV Prevention, the National Coalition of STD Director's American Indian/ Alaska Native Sexual Health Workgroup, the Native School-Based STD Screening Guidelines Workgroup, and attended quarterly Region X Infertility Prevention Project (IPP) meetings with Oregon, Washington, and Idaho State's STD Program Directors. Each year, Project Red Talon attended ten to twenty-five meetings with regional STD prevention partners, and gave presentations at five to ten regional and national conferences.

Changes in Tribal Capacity for STD/HIV Prevention and Treatment

Working together, members of the Red Talon STD/HIV Coalition and Project Red Talon made great strides towards improving tribal capacity to prevent STDs in the Pacific Northwest. Among the Project's many successes were:

Improved STD/HIV surveillance for American Indians in the Pacific NW.

By conducting the annual comprehensive Tribal STD/HIV Capacity Assessment Survey, interested parties now have a greater understanding about the types of STD and HIV testing, treatment, and prevention services provided by the Northwest tribes. This process has allowed Project Red Talon to track changes in STD prevention capacity, guided the development of the STD/HIV Tribal Action Plan, and helped identify training and technical assistance needs. Beyond this region, the STD Capacity Survey tool has also been used by several other tribes and tribal organizations to evaluate their own communities.

Additionally, Project Red Talon worked closely with the region's State Health Departments and the CDC to obtain up-to-date AI/AN STD data. In the 2007 Capacity Assessment Survey, 57% of respondents indicated that progress had been made in recent years in the tribe's STD/HIV surveillance and data management capacity.

Improved clinical services related to STD screening and treatment at NW Tribal clinics.

According to the 2007 Capacity Assessment Survey, 81% of clinical respondents reported that progress had been made in the tribe's STD/HIV medical and laboratory services in the last three years, with one third of respondents noting significant improvements. Additionally, three-quarters of respondents reported that improvements had been made in the tribe's STD/HIV partner notification services, and 63% reported an increase in the community's access to risk reduction resources (such as condoms and bleach kits).

In 2007, 81% of clinical respondents reported that progress had been made in the tribe's STD/HIV medical and laboratory services in the last three years.

Increased knowledge about STD/HIV issues among tribal staff.

In the 2007 Capacity Assessment Survey, 53% of respondents reported that improvements had been made since 2005 in the tribe's STD/HIV training and professional capacity.

Improved community awareness about STDs among NW Tribal community members.

To improve community awareness about sexually transmitted infections, Project Red Talon developed and disseminated a wide variety of promotional materials that were both culturally appropriate and tailored to the "level of readiness" present in the target population. Prior to this project, very few culturally-specific or

Changes in Tribal Capacity for STD/HIV Prevention and Treatment

readiness-targeted STD materials were available in Indian Country.

New STD educational materials developed by Project Red Talon included brochures, fact sheets, PowerPoint presentations, Advocacy Kits, and resource directories. Likewise, the "Stop the Silence" Media Campaign was designed by the Red Talon Coalition with significant input from NW tribal youth. Campaign materials included Teen STD/HIV Magazines and Teacher's Guides, posters, print Adult Public Service Announcements, an Adult Tip-Sheet for talking to teens about sex and STDs, promotional T-shirts and logos, and an informational community website [www.stopthesilence.org].

Tribal interviewees for this Case Study consistently reported that Project Red Talon's Native-specific materials and technical assistance were especially valuable in their outreach work. Guided by the Coalition, respondents felt that Project Red Talon produced meaningful and appropriate educational materials.

As a result, 58% of respondents to the 2007 Capacity Assessment Survey reported an increase in the tribe's ability to provide STD/HIV prevention education, 53% reported an increase in outreach targeting youth, and 63% indicated that the community's knowledge about STDs and HIV had increased in the last three years.

Increased inter-agency collaboration in grant writing and receipt of awards.

With the support of the Red Talon STD/HIV Coalition, Project Red Talon submitted eight grant applications to funding agencies between 2005 and 2008. Four of these applications were awarded, totaling $160,000 to fund additional STD/HIV-related activities for tribes in the Pacific Northwest.

Improvements in STD/HIV networking and regional partnerships.

The Red Talon STD/HIV Coalition has successfully fostered a coordinated response to STDs and HIV among Northwest tribal communities. Prior to this endeavor, tribes were working largely in isolation on these topics, with little interaction between state health departments, tribes, and relevant service agencies. This newfound inter-tribal and inter-agency collaboration on STD/HIV topics has led to the development of new culturally appropriate educational materials, tribal-specific training opportunities for clinicians and tribal health advocates, new program funding opportunities, reductions in laboratory expenses, and better utilization of limited resources.

In the 2007 Capacity Assessment Survey, nearly half of tribal respondents indicated that progress had been made in the last three years in developing a strategic plan for local STD/HIV prevention.

Challenges to Meaningful Social Change

Coalition Funding

Despite the success of this project, and significant and ongoing needs in Indian Country, the CDC does not intend to provide future support for STD prevention capacity-building among American Indian and Alaska Native communities. In a 2007 letter from Dr. Gerberding, the Director of the CDC, it was acknowledged that "as with other capacity-building initiatives, the intent was to build local capacity to implement ongoing programs after three years of focused assistance from CDC. No further congressional appropriations were received to continue this initiative for capacity building, and there are no current funds to support it."

Unfortunately, short-term capacity building projects fail to reflect what is already known about the duration and intensity of health promotion interventions needed to make lasting change in community norms and complex social behaviors. Short-term capacity-building grants are only effective if other funding sources are available to sustain them. To date, no long-term resources have emerged for Project Red Talon. While most of the STD and HIV-related funding announcements created by the CDC in 2007 addressed high risk ethnic populations, all of them neglected to include American Indians and Alaska Natives as possible recipients.

Project Sustainability

Recognizing the limited duration of the original 2004-2007 "capacity building" funding, the staff of Project Red Talon intentionally sought to develop structures and resources that could be functional beyond the funding period, and that could be sustained with less direct involvement from PRT staff. For this reason, focus was placed on developing strategic plans, strengthening clinic-based policies, and creating media and outreach materials that could be accessed and printed from the internet.

While the material products of this project will remain available, it appears less likely that the Coalition itself has become institutionalized by participants such that it will continue to function beyond the presence of Project Red Talon. Tribal participants are highly dependent on travel scholarships to attend Coalition meetings, and attempts to host remote meetings (via conference call or virtual meeting software) have produced very low turnout. Already overworked, it seems unlikely that attendees will choose to take-on the responsibility of coordinating meetings without the involvement of PRT staff.

Tribal Funding

When asked what additional assistance would best support their STD prevention efforts, tribal programs overwhelmingly request funds to support local prevention activities. There is often an assumption by federal agencies, that health promotion funding adequately flows through State and County health departments to benefit the tribes in their region. For a variety of reasons, this is rarely the case. To truly develop internal

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capacity for STD and HIV prevention and control, tribes must be funded to provide culturally appropriate services and to engage in local and regional planning and partnership.

Local STD/HIV Advocates

Consistent with tribal funding limitations, many tribes do not have a staff-person designated to coordinate the tribe's STD prevention and treatment services. As a result, insufficient manpower was the most significant barrier to the use of technical assistance provided by Project Red Talon. Many tribes did not have the ability to reach out for technical assistance, actively participate in Coalition initiatives, or engage in PRT's services. Because PRT staff were kept thoroughly busy responding to requests, very little time and proactive attention was given to those tribes who were not requesting assistance. Assuredly, these are the tribes that could benefit most from PRT's services.

Adding to this challenge, several tribal HIV advocates that had been funded through SPIPA's 5-year SPNS grant lost their funding to promote rapid testing in early 2007. As a result, tribal attendance at Coalition meetings dropped immediately, confirming the importance of external funding and designated personnel for HIV/STD work to occur at the tribal level.

Data Accuracy

To improve the identification and reporting of infectious diseases, the Council of State and

Social barriers preventing healthy behavior change were repeatedly mentioned by those who were interviewed for the PRT Case Study. Stigma about STD and HIV testing persists in many communities, despite community awareness campaigns. Stigma continues to prevent many community members from accessing available services.

Territorial Epidemiologists has recommended that tribally-operated and urban facilities receive training in disease surveillance and reporting, case investigation and follow-up, and surveillance coordination. Additional steps must also be taken to improve STD screening and reporting rates. High laboratory costs have inhibited the application of recommended STD and HIV screening policies in many tribal clinics. And unlike other facilities, Tribal clinics are not required to report STD cases to state and country surveillance registries.

Low rates of STD/HIV screening and case reporting at tribal clinics, and racial misclassification in state disease registries, all contribute to a significant underestimation of the true burden of disease in Indian Country. Progress must be made in each of these areas to improve the accuracy of AI/AN STD data.

Conclusion

Taken together, Project Red Talon and the Red Talon STD/HIV Coalition offer a culturally appropriate model for STD prevention capacity building in American Indian and Alaska Native communities. While Indian Country is culturally, politically, and geographically diverse, lessons from Project Red Talon can no doubt inform the STD/HIV capacity building efforts of indigenous peoples in other regions of the U.S. Most importantly:

- Projects designed to increase tribal capacity to test for, treat, and prevent STDs are critically needed, and are an effective strategy for increasing regional STD awareness and coordination, disseminating relevant training and technical assistance services, and creating much-needed educational products.
- Inter-tribal coalitions can foster coordination and sharing, produce valuable partnerships, and create a unified response to STD/HIV issues. This both stretches limited resources and generates a sense of unity among members who were otherwise working in isolation with few external supports.
- Comprehensive capacity surveys and community readiness assessments offer health advocates effective tools for identifying existing program strengths and weaknesses, and for generating strategic responses.
- Small tribes and tribes without a designated STD/HIV advocate often do not have the underlying capacity needed to fully benefit from collaborative activities. Unique strategies must be developed to build capacity in these under-supported tribes.

Several key features ought to be considered before replicating this Project. The Northwest tribes function in a social and political climate that may be unlike other regions. All federally-recognized tribes in Oregon, Washington and Idaho are members of the Northwest Portland Area Indian Health Board and have a long history of working together on behalf of Indian health. This history reveals a commitment to sharing and partnership, which may be conducive to the collaborative spirit that was developed in the Red Talon Coalition.

Also unique, the vast majority of tribal health programs in the Pacific Northwest are self-directed. Other regions have a greater reliance on the Indian Health Service to provide their health services. This management experience in the NW might have lead to particular skill in developing public health infrastructure and resources, instilling proactive health leadership among the Northwest Tribes.

Recommendations

A great deal remains to be done to significantly reduce STD disparities among American Indians and Alaska Natives.

To improve planning and resource allocation, steps must be taken to improve the accuracy of AI/AN STD data. This will require improvements in STD screening and reporting at tribal clinics, and improvements in the accurate identification of ethnicity by providers in non-tribal settings.

There remains a significant need for STD educational resources that are both culturally-targeted and readiness-relevant to American Indian and Alaska Native communities. To truly make progress, individuals must develop risk reduction skills, families must enhance communication between generations and partners, and communities must embrace new social norms. Research is needed to better understand STD/HIV knowledge, attitudes, and behaviors among tribal community members, and the unique cultural context in which sexual decisions are made.

Inequalities in STD morbidity and HIV mortality will continue to persist among our Native populations until adequate health services are made available and social norms are positively changed. This manner of change will not occur quickly or without cost; a sustained effort is needed. Comprehensive, culturally-relavent programs must continue to facilitate this process to protect the health and wellbeing of future generations.

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