Assessing HIV & Other STI Risk in American Indian/Alaska Native Communities

Participant's Manual

June 2005

Tribal BEAR Project
NW AIDS Education & Training Center (NW AETC)

ASSESSING HIV & OTHER STI RISK IN AMERICAN INDIAN/ALASKA NATIVE COMMUNITIES

PARTICIPANT'S MANUAL

Written by
Fransing Daisy, PhD and Lee F. Brown, PhD

Edited by
Christopher Behrens, MD

June 2005

The Tribal BEAR Project

Northwest AIDS Education & Training Center (NW AETC)

Funded by Health Resources and Services Administration (HRSA)

The publication's contents are solely the responsibility of the authors and do not necessarily represent the official view of HRSA.

The Tribal BEAR Project

The Tribal BEAR Project seeks to improve the capacity of tribal health care clinics in the Washington, Alaska, Montana, Idaho and Oregon (WAMIO) region to provide HIV care. The BEAR Project is a collaboration of the Northwest AIDS Education and Training Center (NW AETC) with the Salish Kootenai College (SKC) and the South Puget Intertribal Planning Agency (SPIPA). The project also works collaboratively with the Alaska Native Tribal Health Consortium's (ANTHC's) HIV/AIDS projects in Alaska.

The BEAR Project uses a longitudinal training model to develop clinic-specific HIV Response Teams, assist in the implementation of HIV-related policies and procedures, and coordinate resources between tribal and non-tribal entities. This project also encourages the building of bridges between traditional healing and western medicine.

Northwest AIDS and Education Training Center (NW AETC)
901 Boren Avenue
Suite 1100
Seattle, WA 98104
Phone: (206) 616-0391
Fax: (206) 221-4945
Email: nwaetc@u.washington.edu

http://www.NorthwestAETC.org

Table of Contents

Acknowledgements

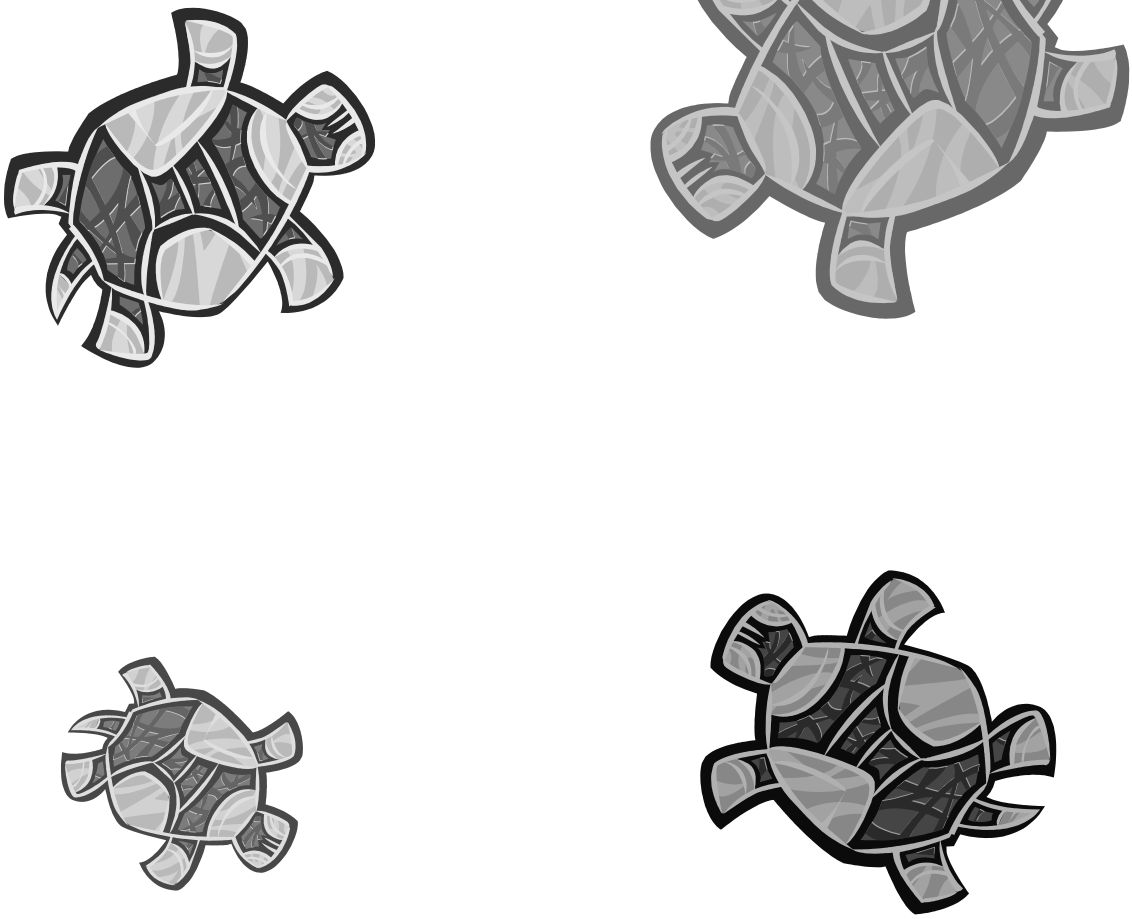
These training materials were developed for the Tribal BEAR Project by Native staff and consultants. They were developed over an 18-month time period. Initially, the writers compiled data and content material into a rough format. Reviewers provided input on cultural and clinical content. Three pilot trainings were conducted, and the materials were subsequently revised based on trainer and participant feedback. Three additional pilot trainings provided opportunities to make small changes prior to publication.

The project would especially like to thank the authors Fransing Daisy and Lee Brown for developing the risk assessment form and training materials. We also thank the following cultural reviewers: Ken Chester, MPH, SEARHC/CHS, Sitka, Alaska; Anno Nakai, MA (Saami), National Native American AIDS Prevention Center (NNAAPC), Oakland, CA; and Lori New Breast, BA, Amskapipikuni, Blackfeet Reservation, MT. For their clinical review, we thank Christopher Behrens, MD, NW AETC; Ann Kurth, RN, CNM, PhD, UW School of Nursing and Center for AIDS & STD; and Mary Van Bronkhorst, PA-C, NW AETC and Harborview Hepatitis and Liver Clinic. Thanks to Marie Agdamag, RN, Ron Baines, MA and Shelia St. Sebastian, MA, NW AETC, who also assisted in the development and review of these materials; and to Elaine Douglas, Amy Welton and Laurel Code of the Center for Health Education and Research (CHER) for proofing, formatting, and production.

We appreciate the willingness of the following sites to allow us to conduct pilot trainings in order to improve the materials: Nisqually and Skokomish Health Clinic, Nisqually Health Center; Lame Deer Clinic, Northern Cheyenne Reservation; Chief Redstone Clinic, Fort Peck Reservation; David C. Wynecoop Clinic, Spokane Reservation; Benewah Wellness Center, Coeur d'Alene Reservation; Nimiipuu Health, Nez Perce Reservation; and Kah-Nee-Ta Lodge, Warm Springs Reservation.

Session 1:

Introduction



Introduction of Facilitator and Participants

Name of participant

Where the participant works and professional/job title

Something we cannot know about the participant by just looking at him or her

Learning Objectives

After completing this workshop, participants will:

- Feel more comfortable with sexual and substance abuse history interviewing.
- Be able to understand and be cognizant of cultural sensitivity with delivery of services to Native patients.
- Recognize and understand the relationship between STIs and HIV transmission.
- Be able to identify sexual behaviors associated with risk for HIV transmission.
- Recognize the association of alcohol and drug abuse on high-risk sexual behaviors.
- Recognize the occurrence of IV drug use in Native communities.
- Recognize key factors associated with confidentiality related to successful patient sexual behavior interviewing.
- Be able to identify interview methods to increase effective use of the risk assessment form.

Introduction

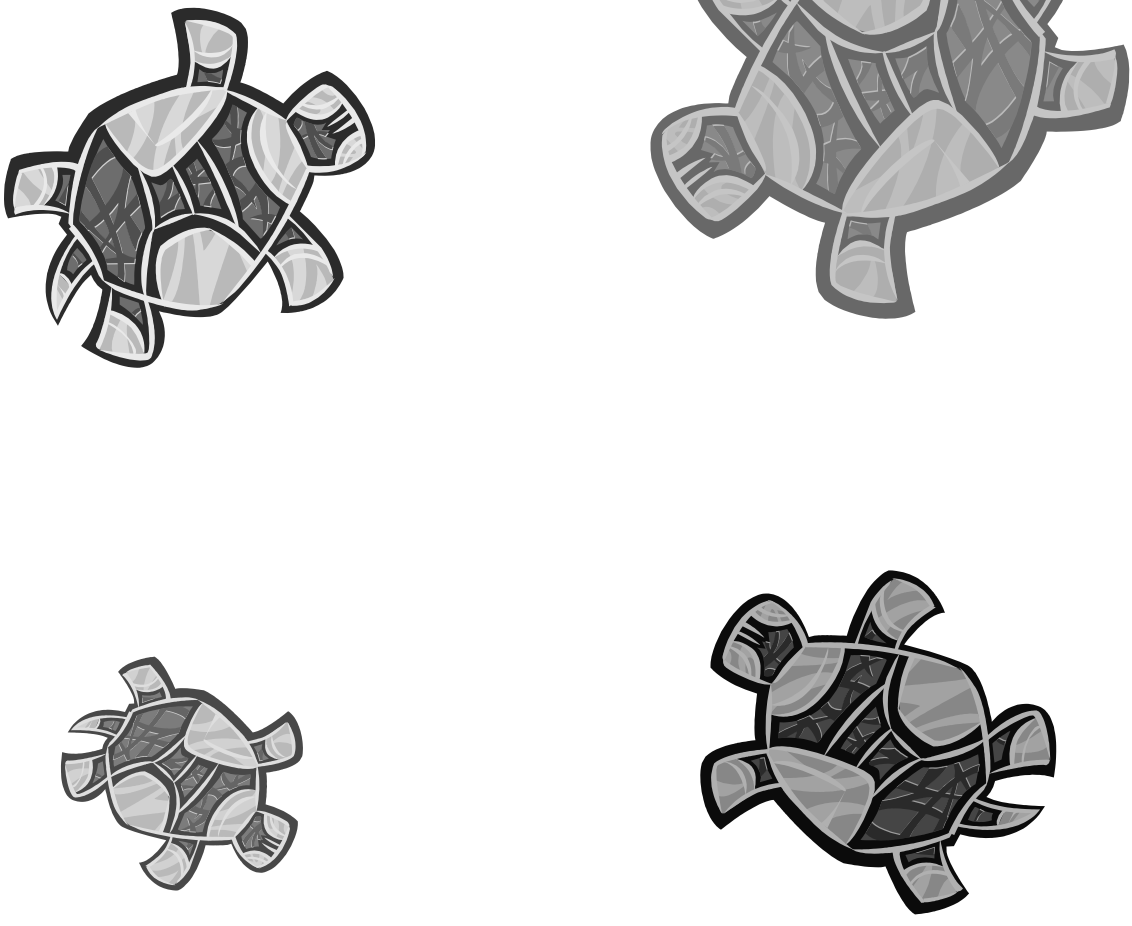
As of December 2003, 2,882 American Indians/Alaska Natives (AI/AN) from all states and territories had been diagnosed with AIDS as reported by the Centers for Disease Control (CDC, 2003). This data does not reflect the total number of Native people who are infected with HIV, and likely significantly under-represents the number that have been diagnosed with AIDS. Hence, while these numbers help us to estimate the prevalence of HIV, they do not reflect the full impact of HIV and AIDS upon Native American tribes and communities.

During the last 24 years of the AIDS epidemic, the majority of AIDS-related cases have been primarily found in large metropolitan areas of this country. Because reservations are commonly rural, most Native communities have had limited contact with HIV-specific training and service delivery. Other tribal health clinic priorities and community perceptions of a limited need for HIV service delivery preparation has resulted in many tribal health systems lacking the capacity to provide comprehensive HIV care for members of their communities. As a consequence, HIV-infected Natives are commonly referred to non-Native providers outside the reservation for medical management. HIV-specific training that does occur in tribal communities often lacks proper cultural orientation.

The HIV/STI Risk Assessment Trainer's and Participants' Manuals attempt to fill this void by offering culturally relevant training tools designed to improve the capacity of health providers working in tribal communities. Specifically, these manuals focus on developing the capacity of health workers in tribal health systems to assess their clients' risk of contracting HIV and other STIs.

Session 2:

American Indian / Alaska Native Health — Past and Present



Native Health — Past and Present

Colonization impact on Native health

- Colonizers' attempt to destroy traditional healers and ceremonies
- Introduction of new diseases
- Relocation
- Residential schools
- Family disruption

HIV/AIDS Prevalence among AI/AN

As of 2003, Native people constituted 1% of the total U.S. population, and represented 3% of reported cases of HIV/AIDS.

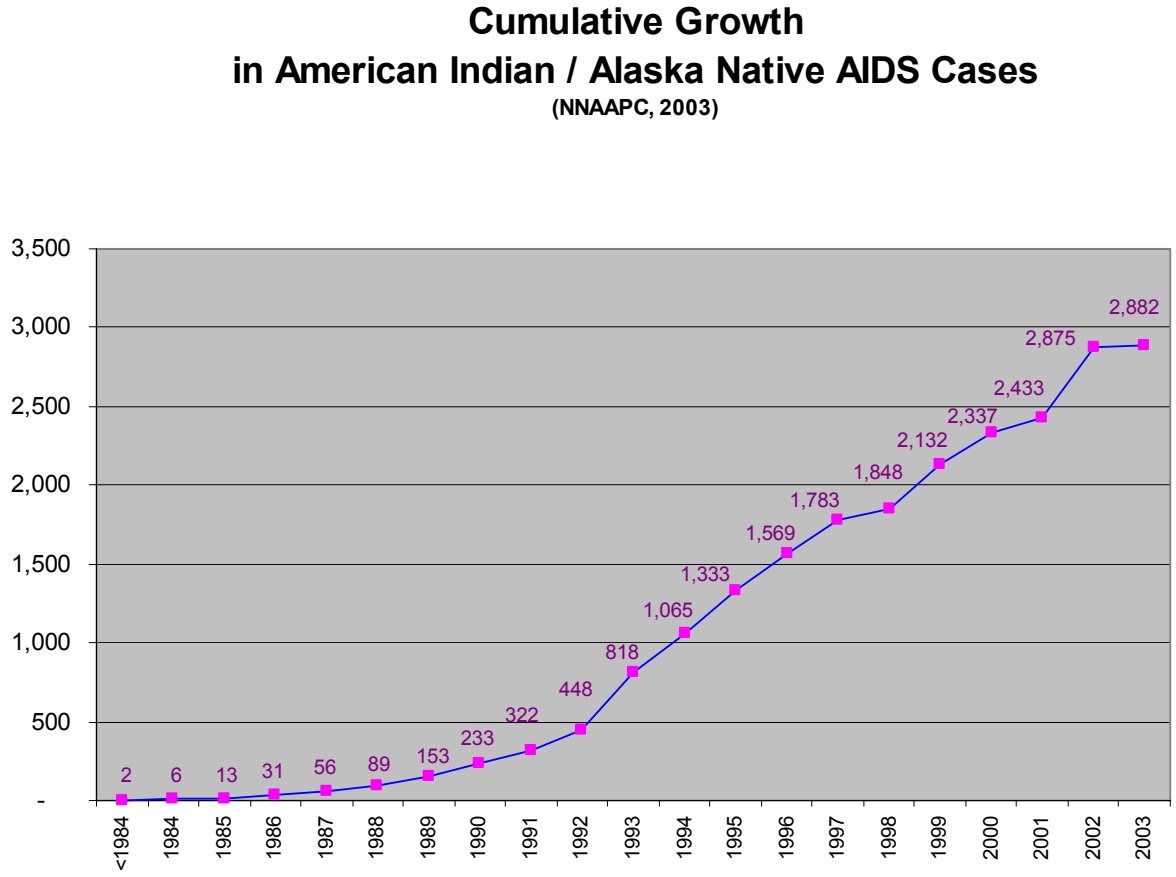
Furthermore:

- HIV infections among Natives could be significantly undercounted, due to under-reporting and AI/AN misclassification in terms of race/ethnicity on data collection forms.

- Social, behavioral, and economic factors associated with higher HIV risk are highly prevalent among Native communities, including:

    - Poverty and unemployment
    - Alcohol use/abuse
    - High rates of STIs and violence
    - Poor physical health

Cumulative Growth in AI/AN AIDS Cases



American Indian/Alaskan Native Health: Past and Present

HIV and AI/AN in historical perspective

As of December 2003, Native people represented 2,882 of the diagnosed AIDS cases in America. Native people make up approximately 1% of the total U.S. population, and represent approximately 3% of reported AIDS and HIV cases (CDC, 2003). While these numbers may appear small, underreporting and minimal HIV surveillance of Native people have probably resulted in significant undercounting of HIV infections (Rowell & Bouey, 2002). Accurate HIV surveillance may be further hampered by American Indian/Alaskan Native misclassification in terms of race/ethnicity on data collection forms, due to incorrect assumptions regarding surnames, residence, and perceived socioeconomic status associated with visual categorization of patients (Rowell, 1997). For example, as reported by Rowell and Bouey, 2002, a study of sexually transmitted disease (STD) data in Oklahoma found that 35% of Chlamydia cases and over 60% of gonorrhea cases among American Indian/Alaskan Native people were incorrectly attributed to Hispanic or Caucasian individuals.

HIV and AIDS must be viewed within the historical context of other diseases that have inflicted enormous suffering on American Indians. Native people have suffered disproportionately from several infectious diseases, including smallpox, measles, tuberculosis, and cholera (Conway et al., 1992). Major epidemics decimated American Indian populations, in some cases eliminating entire nations, and weakened many other nations to the point where they could not adequately defend themselves against European expansion and the theft of American Indian land (Duran & Duran, 1995).

The subsequent, prolonged oppression of AI/AN in the United States further devastated the health and well-being of Native people. This history, including colonization, legislation negating and prohibiting the use of Native languages and spiritual practices, and centuries of forced relocation, has created a justified mistrust of U.S. government programs and health institutions among Native Americans. This history continues to shape the experience of Native people who are disproportionately impacted by poverty, poor health, family violence (child physical & sexual abuse; neglect; domestic assault) and alcohol & drug abuse. AI/AN have the highest rates in school dropout, unemployment, suicide, and substance abuse of all peoples in North America (Niezen, 2000). Native women experience high rates of drug and alcohol use as well as high rates of STIs and violence (Morrison-Beedy et al., 2001).

Incorporating Native Customs and Values into HIV Treatment Programs

Effective treatment of HIV and other illnesses in Native communities, urban or rural, requires the involvement of both traditional and western medicine to return the mind, body, emotions and spirit to harmony (Guilmet & Whited, 1989). With the American Indian Religion Freedom Act, Native healing traditions gained legal recognition. One American Indian study confirmed that 74% of Natives prefer a health care system that includes traditional as well as western medicine, perhaps reflecting a renewed appreciation of ceremonial approaches to healing by American Indians reclaiming their heritage (American Red Cross, 1998).

The majority of AI/AN people live with respect for their environment and in harmony with themselves and the world around them (Trimble, 1982). Most Native people embrace the concept of balance in relationship to self, family, clan, tribe and nation. This represents the strong social structure of Native cultures. In tribal cultures, the family is the focal point of activity. In fact, traditional tribal healing practices often view illness as a family affair (Swinomish Tribal Community, 1991): if one person in a family has an illness, then the entire family has the illness. This affects the way illness is thought of and handled in traditional structures.

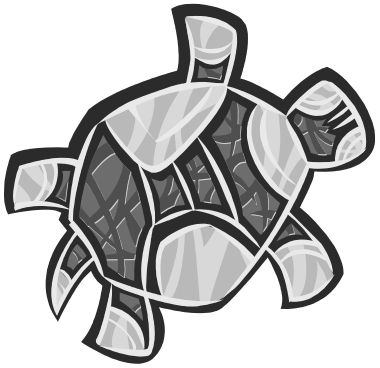
Consequently, the family is typically involved in the ceremonial healing process. In this context, elders (as well as children) are cherished resources and bring knowledge and experience to the healing process. The role of the elders is multifaceted and includes re-integration of adults into traditional "knowing" teachings as well as education of youth about tribal practices, histories and ceremonies that are important for the health and well being of the nation. Thus, each member of a family, including children, parents, and elders, should ideally be integrated into any ongoing health project.

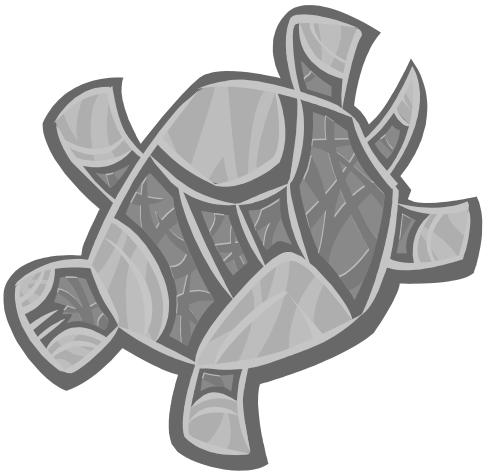
HIV and AIDS present a special challenge for the Indian Health Service (IHS). The IHS supports policies regarding the health care needs of Native populations but is often provided less than full funding for the designated delivery of services. Moreover, less than 1% of the IHS budget goes to urban populations, yet more than half of all AI/AN people in the United States live in urban areas. As a result, urban Native tribes and organizations are often denied funding opportunities by Indian Health Service policies which provide funding primarily to reservation Natives.

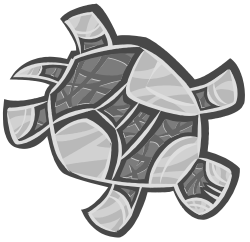
In summary, HIV/AIDS represent the latest of a long succession of infectious diseases that have ravaged Native Americans. A history of oppression of native populations has left a legacy of poverty and mistrust of federal programs and initiatives. Native people continue to suffer disproportionately from social, behavioral, and economic factors that are associated with a high risk of HIV transmission. Unfortunately, due to other severe and more obvious health and social problems such as alcoholism, diabetes and unemployment, denial of HIV as a significant problem is common in AI/AN communities (Rowell & Bouey, 2002). Recognition of the growing prevalence of AIDS in Native communities is critical to ensure adequate funding for innovative programs targeting the disease.

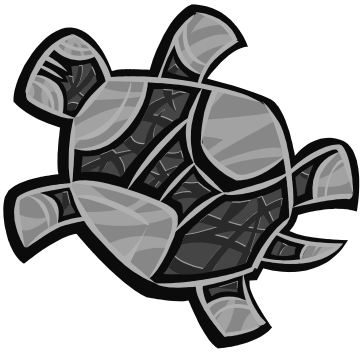
Session 3:

Cultural Sensitivity









Slide 3.1

Culture and the Health Care Provider

Antecedents of cultural self assessment:

- Emotional avoidance & cognitive restructuring.
- Assumption that all Americans have the same values.
- Different cultural values are de-valued.

All providers have a culture from which their values originate (ethnicity, area of country, religion, etc.).

Cultural heritage can include food preparation, celebrations, and family structure.

Slide 3.2

Cultural Sensitivity Questions

What was your first experience with feeling different?

What do you like about your identity (ethnic, spiritual, or profession)?

What are your earliest memories about people from cultural backgrounds or socioeconomic classes other than your own?

Cultural Values and Self-Assessment

Exercise

- Small groups (of 3 people)
- Each participant select one question from Cultural Sensitivity Questions
- Large group discussion

Cultural Sensitivity Questions

What was your first experience with feeling different?

What do you like about your identity (ethnic, spiritual, or profession)?

What are your earliest memories about people from cultural backgrounds or socioeconomic classes other than your own?

Cultural Sensitivity

The literature is clear that historical and cultural differences between the Native patient and the non-Native/allopathic medical provider create difficulties for Native people when accessing medical services. Culturally competent and responsive medical care requires that health care professionals be trained in cultural sensitivity which will enhance client retention and response to medical care. Greene and Hucles Sanchez (1994) define competence as:

> … [A] measurable professional standard that evaluates the incorporation of the differential historical, political, socio-economic, psychophysical, spiritual and ecological realities, their interaction, and its impact on individuals or groups. Here culture is used in its broadest sense to include race, ethnicity, gender, and sexual orientation and considers other dimensions of individual or group experiences that are salient to their understanding of the world and of themselves.

There are a number of strategies that contribute to becoming culturally competent (Dhooper & Moore, 2001) that include:

1. The provider's acknowledgement of diversity in race, culture and ethnicity.
2. The provider's awareness of his or her own values and beliefs and their willingness to do self-assessment of their values beliefs and traditions.
3. Recognizing the clinical dynamics created by cultural diversity.
4. The provider's knowledge of the patient and their Native community values.
5. The provider's willingness to adapt medical skills to the patient's culture.

Medical professionals may grasp the medical conditions of a Native client, but without an understanding of Native values they will lack the theoretical foundation to form appropriate healing strategies. McCormick (1994) states that, "In order to communicate with First Nations people, service providers must understand the traditional worldview of First Nations people".

To appropriately provide health services to Native patients, providers need to be knowledgeable of Native culture and comfortable with the local Native community. Providers may become comfortable with the Native culture and community by:

> Immersion in the culture, studying history and culture, participation in cultural activities, developing relationships with cultural members, learning cultural protocols, rituals, ceremonies, customs and respectful attitudes… (Peavy, 1993).

What is not acceptable is for providers, who have only superficial, little, or no knowledge of Native culture, to believe themselves above the need for acquisition of Native cultural knowledge.

Providers must be aware of the diversity to be found within a Native community. Patient variation within the group is determined by his/her relationship within the culture, level of acculturation, living situation, and personal preferences (Peavy, 1993). Providers must be wary of making assumptions about cultural orientation of Native patients because of the many variables involved. Palafox, Buenconsejo-Lum, Ka'ano'I, & Yamada (2001) suggest a process for gaining and maintaining cultural competence: becoming more aware of one's culture, acquiring knowledge about the patient's culture, and developing skills to apply acquired knowledge in clinical settings.

Self-Assessment

Being a member of the majority European-American population can block the ability of a provider to notice value variation between cultures. Requesting a self-assessment of values can be difficult with a resulting emotional reaction of distain and/or avoidance.

Comments, such as the following, can result from the introduction of the self-assessment exercise:

"Aren't we all living in America with the same values?"
"I'm a doctor (clinical provider) not a social worker."
"I don't notice race because we are all Americans."

It is recommended that these lines of thought be reviewed with the audience prior to introduction of an exercise.

Self-Assessment Exercise

Each provider has a culture from which their individual values originate. Assessing personal cultural attitudes, values, and beliefs is best facilitated through the use of an experiential exercise.

This exercise includes asking the audience to think about their cultural heritage be it food, celebrations, religious orientations, or family structure. Subsequently each audience member is asked to share thoughts with the larger group, or the larger group is divided into smaller groups and these smaller groups share their experiences. An exercise like this can be uncomfortable but also enlightening for audience members from the dominant culture who are not aware of their differences from and similarities to minority groups within American society. If the groups are divided into smaller units, this exercise needs to end by having each smaller group share with the larger group their cultural experiences. Such an exercise is more functionally beneficial if individuals not of European-American ancestry are encouraged to participate in the group exercise. This allows discussion on diversity beyond social class, religion, and education. It is recognized that some European-Americans continue to retain some cultural beliefs, values and language of their ancestral homelands.

Native Values and Health Care Delivery

As previously stated, the cultural and value differences of Native patients and the lack of understanding of these differences can create difficulties during the provider/patient relationship. Health care delivery must consider that the cultural process and failure to do so can result in greater illness for the patient. Sioui (1992) suggests that, values are a "portrait of a culture" and, argues that understanding cultural realities is fundamentally a question of understanding values. Values create the patient's sense of self. A provider's knowledge and awareness of the cultural differences between the provider and the patient, ensures a high degree of cultural competence that will be beneficial in moving the patient toward wellness. Awareness of values can lessen the difficulties involved with providing health care to Native patients.

Therefore, when providers are working with Native patients the most critical aspect of the helping relationship is an awareness of the values that exist in Native communities, families and patients. Native values have proved to be enduring despite acculturation.

An example of a primary Native value is relationship. The value of the relationship ties together all Native values including respect, cooperation, harmony, modesty, patience, spirituality, tolerance, non-interference, silence, relative time, present orientation, pragmatism, and observation. All Native values define the way in which relationships occur with other people, the creation and the universe. For instance, the value of harmony dictates that we need to be in harmony with our relationships.

The Swinomish Tribal Mental Health project (2002) suggests that the Native sense of empathy and kinship is the extreme opposite of the Euro-American, sense of separateness from and superiority over other forms of life. Providers that have an identity founded on separateness, nuclear family and individual achievement may need to reflect on their values when treating Native patients. Providers need to be aware that the European view of dominance toward creation is in conflict with the Native view of relationship to creation. Providers should be aware that Native patients might be very concerned with achieving balance and harmony with these forces during the healing process. Therefore, negative value judgments directed at any aspect of creation can affect the trust level in the healing relationship.

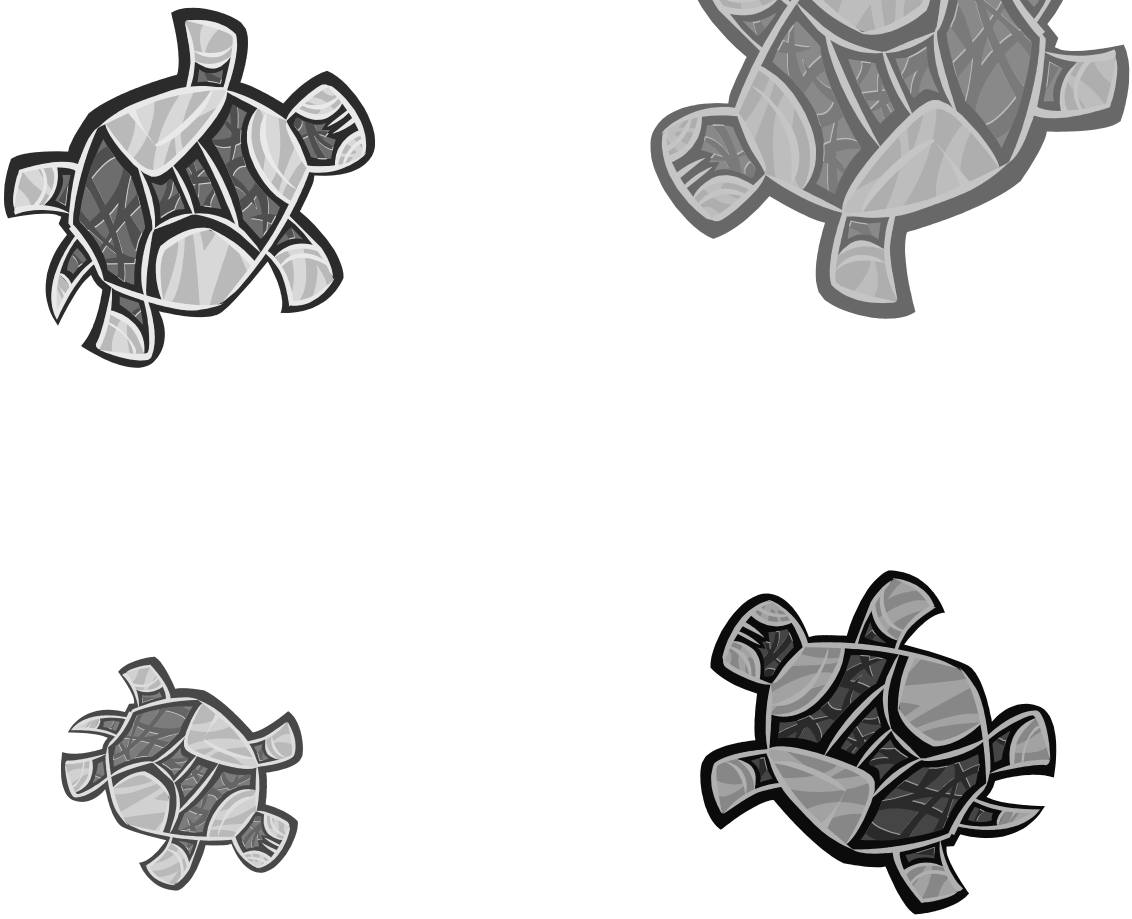
Providers can minimize formality and use a "friendly" approach that will offset power differentials and "official-ness" and thereby create more of a kinship setting in the clinical process. This may require additional time although development of the relationship and establishment of trust provides an opportunity for the Native patient to fully disclose their health concerns. Providers should be aware that questions that are viewed as too personal by a Native patient, or that are asked before relationship is established, can derail the healing process. Trust in the relationship can be enhanced through "genuine interest", patience, keeping commitments and participation in community activities. Personal questions and intake information may need to be postponed until a sense of relationship is established. The Native patient may need time to determine where the provider fits into their worldview.

Conclusion

Values define the way in which patients perceive the boundaries of their world and the way in which they communicate these perceptions. Providers who understand Native values will be better equipped to communicate across these boundaries and connect with the Native patient. Such skills reduce conflict of value differences and create cultural competency.

Session 4:

Cultural Ways of Viewing Relationships and Sexual Health



Native Cultural Values Chart

Values	Behaviors	HIV/STI Considerations
Cooperation	Cooperation is highly valued. Competition within the group is rare. Group concerns are put first. Agreement and consensus are very important. *Variance:* This value often conflicts with competition values.	Persons are not likely to answer questions that cause other people to lose face. In order for prevention strategies to work there may have to be a group consensus on their importance in the community
Group Harmony	Emphasis is placed on maintaining group harmony. There is a striving for anonymity resulting from a low ego level. Personal orientation is stressed over task orientation. The needs of the group are placed over the needs of the individual. *Variance:* This value often conflicts with individualism.	People may put group values above individual health concerns.
Modesty	It is unacceptable to boast about achievements. Boasting and loud behavior that attract attention to oneself are discouraged. Modesty regarding physical body is common.	Native patients may be reluctant to access medical services for reasons of personal modesty. Native patients may experience difficulty and embarrassment discussing medical problems.
Respect	Respect for people and their choices is valued. Respect for self is expressed with quiet personal dignity.	Non-Native health care professionals must be careful not to be perceived as disrespecting the patient.
Respect for Nature	Natives generally try to live in harmony with nature and therefore may not embrace progress for the sake of progress. Many Natives reject strict scientific explanations of the universe because it leaves out spiritual considerations. *Variance:* this value is sometimes at odds with the value of asserting control over nature.	Patients may find a strictly scientific explanation of their illness incomplete and non-holistic.
Spirituality	Native spirituality is contemplative rather than utilitarian and is a part of all areas of life. There is sometimes an emphasis on the mystical aspects of life. It is unacceptable in the Indian world to impose one's beliefs on another.	If spirituality or ceremonial healing is not part of the medical process the Native patient may feel the process is incomplete, inadequate and unnatural. Patients may feel that they are being disrespected by non-Native providers if their spirituality or dreams are not taken seriously.
Pragmatism	Most Natives converse in terms of concrete rather than abstract terms.	Non-Native health care professionals need to talk about concrete examples of healthy behaviors rather than theoretical models of behavior.

Tolerance	Harsh discipline, especially with children is considered demeaning. Criticism is usually communicated indirectly, often through another person.	Patients may respond negatively to direct criticism. Direct criticism may terminate conversation between the health care professional and the patient. Direct criticism of behavior may cause the patient to withdraw from services.
Non-interference	A person's individual autonomy and dignity are valued. It is considered rude to interfere in the affairs of another person. Noninterference is usually practiced including by parents. One does not interfere or give advice unless it is asked for.	Patients may resist involvement in their affairs if it is perceived as interference. Advice may be rejected if it is seen as given in a too forceful a manner.
Silence	Placidity, the ability to remain quiet and still is valued. Maintaining silence is acceptable and comfortable. Natives are slow to express action accompanied by strong emotions such as anger.	Patients may hide discomfort by maintaining silence. Non-Native health workers may mistakenly assume a patient is slow, backward or less intelligent because he or she is maintaining silence while considering what to do or say.
Patience	Patience and the ability to wait is considered admirable among Natives	Non-Native health care professionals may pressure Native patients to make rapid responses or decisions. Non-Native health care professionals may become impatient while the Native patient deliberates their response.
Generosity	Sharing is highly valued in Native communities. Ownership of too much material wealth is considered negatively. Avarice and greed are discouraged.	Not sharing of drug works may be a problem with injection drug users.
Relative Time	Time is viewed as flowing and in process, more like a movie than a picture. Time is flexible and relative to the task at hand. Many Native languages contain no word for time or a future tense.	Patients may be late for appointments or miss appointments altogether. Non-Native health care professionals may misinterpret the Native view of time as being irresponsible.
Present Orientation	There is a tendency toward immediate gratification of desires. Emphasis is on living one day at a time. Many Native languages contain no future tense.	Non-Native health care professionals may have a difficult time translating the need to forgo present desires for future considerations.
Respect for Elders	The wisdom and experience of age is highly valued. Signs of aging such as white hair are often not concealed.	Non-Native health care professionals may emphasize the attitudes of youthfulness and disrespect elder patients.
Relationship	Most Natives see themselves as related to creation and all people. Negative value judgments on any aspect of creation are avoided.	Non-Native health care professionals must respect the concept of relationship with Native patients.

AI/AN HIV & STI Risk Assessment Form

BRIEF VERSION

Introduction: *I am going to ask you some personal questions. I ask all of my patients these questions to help me provide the best possible health care. All your responses will remain confidential.*

Section 1 Piercing and Tattooing

1)	Could you please tell me if you have ever been pierced or tattooed for non-ceremonial reasons?	**Yes****	
		No	
	If *yes*, when?		
	If *yes*, could you say more about this?		
	Consider: *non-interference*—patient may resist divulging information if s/he perceives that questioning by health care provider is intrusive.		
2)	Could you please tell me if you have ever been pierced or made flesh offerings for ceremonial reasons?	**Yes****	
		No	
	If *yes*, when?		
	If *yes*, could you say more about this?		
	Consider: *silence*—patient may hide discomfort by remaining silent; *spirituality*—patient may feel disrespected by non-Native providers if perceived that their spirituality is not taken seriously; *respect*—patient may feel their spirituality may not be respected.		

Section 2 Substance Use

3)	Some people have sex when they drink too much alcohol or are under the influence of drugs. Has this ever been a concern for you?	**Yes****	
		No	
		Not Sure	
	Consider: *modesty*—patient might be embarrassed by this question; *silence*—patient may hide discomfort with silence.		

** Indicates significant risk for HIV infection; patient should be referred for counseling and testing at end of interview

Role Plays

ROLE PLAY 1

Linda, an unmarried 30-year-old mother of a 2-year-old girl and a 5-year-old boy, is in a casual relationship with a 45-year-old man who drinks and uses drugs on weekends. Linda's partner also has casual affairs during his weekend binges. Linda feels stuck because she has a minimum wage job and needs the financial assistance of her partner. She has had two cases of bacterial STIs within the last 6 months and knows that her partner is bringing the infections home after his weekends.

Linda arrives for an STI assessment and referral and you, the practitioner, would like to assess her using the risk assessment form.

Interview Linda and decide if she needs a referral for HIV testing and counseling.

ROLE PLAY 2

Carole, a 24-year-old woman, has had several past romantic relationships, each lasting for 6 months to a year. She describes herself as a dependent person who feels lost and alone without a relationship partner. Although several of her prior relationships had many problems and caused her unhappiness at the time, she considers them (at least in retrospect) as better than being alone. Carole describes a recent history of loneliness, having few friends, and says she often goes out to bars and parties hoping to meet someone special with whom a relationship might develop. What she often gets are "come ons" from men who pressure her quickly for sex - to which she agrees. These men are then out of her life a week later.

Carole comes into the medical clinic for an STI assessment. Interview her using the risk assessment form.

ROLE PLAY 3

Mark is 16 and was kicked out of the home of his mother and stepfather after frequent and violent conflicts. He now goes from house to house sleeping on the floor. Mark's life is in turmoil as he and a male teenage companion shift about finding places to stay and eat and ways to make money. Sometimes Mark does odd jobs that take him into the city. While in the city, Mark has also learned that he can hustle sex to older men for money. He has also found out that he can make more money by having sex without condoms. Mark's relatives are not aware of his hustling for money.

Interview Mark and refer him for HIV testing and counseling.

ROLE PLAY 4

Barbara, 15, is one of seven children from a single parent home. She dropped out of school at 13 years of age; she and her mother, brother and sisters are supported by welfare. Although she has considered looking for work, few places hire adolescents. Without school or a job, about the only thing Barbara sees in her future is her boyfriend, Bob. Bob runs with a gang, sells drugs, and uses methamphetamines. Although their relationship is chaotic, Barbara believes a child will give her something to live for, and 16 year old Bob would like to be a daddy.

Barbara arrives at the medical clinic for an STI screening and a pregnancy assessment. Interview her with the risk assessment tool.

ROLE PLAY 5

Bill is a 28-year-old man without a permanent girlfriend. He has frequent casual sexual encounters usually associated with heavy drinking and methamphetamine use. During the last year, he has tried working in the tribal casino but has not been able to hold a job longer than 3 months. He lives with his grandmother and does some light chores for her every once in a while. During the last year, he has come to the city for weeks at a time to visit his cousin and her family. While in the city he drinks at the Indian bar, gets in fights, and has many one-night-stands.

While back home, he visits the medical clinic due to a "personal" problem with a possible STI. Interview Bill and provide a referral for HIV testing and counseling.

ROLE PLAY 6

Gertrude has had a sexual relationship over the last 3 months with Jim, who is an injection drug user. She ended the relationship two weeks ago, not so much out of concern about HIV and Jim's reluctance to use condoms, but more because of other relationship conflicts they were having. Gertrude has been lonely since the breakup, and Jim calls occasionally just to talk.

Gertrude is shy and a non-drinker. Jim is not abusive but does have casual heterosexual affairs.

Take Gertrude through the risk assessment.

ROLE PLAY 7

Christine feels trapped in a relationship she does not really want. The man she lives with drinks, fools around with other women, and a day ago, Christine discovered that she may have contracted an STI. The only way she could have gotten it was from her partner.

Christine has a 2-year-old son and no job. She drinks heavily on weekends but doesn't run around. Her partner pays the rent and supports her and her son. This is not the first time she has contracted an STI.

Interview her with the sexual part of the assessment and try to convince her that she needs a referral for assessment of substance abuse.

ROLE PLAY 8

Jack is bisexual and has met a man he thinks is attractive while out at a bar in a nearby city. They get together and go to the other guy's apartment. After a few drinks they decide to have sex. Jack asks the guy if he has condoms and the guy says he doesn't. They go ahead and have unprotected anal sex.

Jack has a girlfriend on the reservation who is pregnant and lives with her mother. He frequently also lives with his girlfriend's family. The family does not know that he is bisexual and that he goes to the city a few times a month to meet guys and have sex.

Interview Jack and talk with him about high-risk sexual behavior. Offer a referral for HIV counseling and testing.

Cultural Ways of Viewing Heterosexual Relationships and Sexual Health

As Natives reclaim their heritage, it is important to understand the cultural context of healthy relationships. Native cultures have strong social and family structures that provide rules of conduct regarding heterosexual relationships (relationships between men and women). Traditionally, young men and women did not interact without the guidance of the family elders. Therefore, providing accurate information about cultural history and traditions regarding relationships and sexuality can be an effective method of teaching relationship principles, such as respect and kindness for the opposite sex, to Native youth.

There are many tribal teachings regarding the importance of proper conduct between men and women. One such traditional teaching, reiterated by a Native health educator, Brown (2001), has four parts:

I. Every human being is born with a gift. The purpose of life is to find your gift and use it wisely for the blessing and benefit of those around you. The knowledge that we have a gift gives our life meaning and purpose. Life is not meaningless. Every life has meaning and that meaning is achieved in our lifelong learning about our gift.

II. Everyone has both a masculine side and feminine side to their being. A man's gift is always on his feminine side and a woman's gift is always on her masculine side.

III. How men and women relate to the opposite sex determines the relationship they will have with their own gift.

IV. To have a good relationship with your gift requires one to be respectful, kind, honest and caring for the opposite sex.

As Native people reclaim their heritage and resume traditional parenting roles, it is important to remember that the first duty of a parent is to observe their children and notice their gifts. The second duty of a parent is to provide training for their children's gift. An important part of this training is the teaching of how to be respectful and kind to the opposite sex (Brown, 2001).

Brown (2001) further states that if a man is oppressive or abusive to women he will oppress and diminish his own gift and thereby lessen his own life. If a woman is dishonest or oppressive in her relations with men she will lessen her own gift and thereby lessen her own life. Therefore, how we relate to one another as men and women

is very important. When someone commits violence to another, physically or emotionally, they scar their own spirit and their own gift.

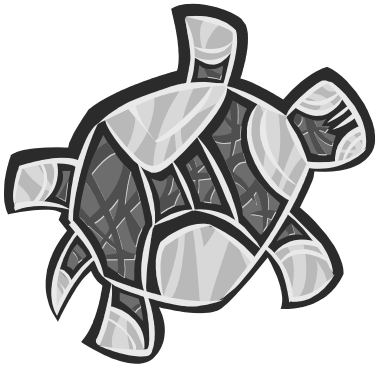
Many times, when men and women awake out of the violent reality of alcohol and drug addiction, they realize that they have not conducted themselves in the best possible manner toward those around them. All is not lost. It is possible to create a new relationship with others by making amends and embracing kindness (represented by the sweetgrass) and honesty. As relationships improve, the relationship with the gift will improve. When the relationships improve, the creativity often associated with one's gift comes alive. People begin painting, carving, singing, dancing or writing again. This creativity adds to the individual's healing. The more one can improve one's relationships and be creative, the more healing is accomplished and the greater the reconnection with the gift.

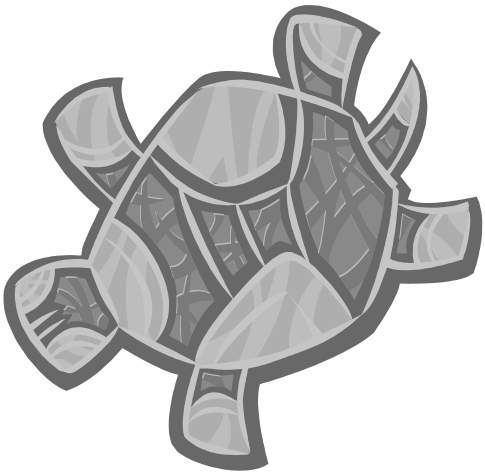
Native values are associated with modes of behavior that suggest ways of interaction with others. As part of a health curriculum targeting HIV prevention, an advisory committee of Southern Plains tribes (Cheyenne, Cherokee, Muscogee, Creek, Choctaw, Osage, and Kiowa), in conjunction with the local American Red Cross, developed a compilation of values common to the southern plains tribes. These values included cooperation, group harmony, modesty, respect, respect for nature, spirituality, tolerance, non-interference, silence, patience, generosity, relative time, present orientation, respect for elders, pragmatism, and relationship (American Red Cross, 1998). This session reviews some of the tribal values of the Southern Plains tribes that hopefully will provoke a discussion of the values, associated behaviors, and health practitioner communication considerations as relates to the HIV/STI risk assessment.

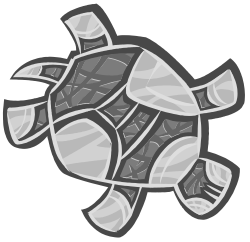
In summary, cultural recovery can increase self-esteem and create a strong identity based on Native tribal values. While differences obviously exist between the hundreds of tribes in America, common values exist among many of these tribes, such as cooperation, group harmony, modesty, generosity, autonomy and respect. These values, combined with the traditional emphasis on awareness of the feelings of others, encourage peaceful, non-abusive relationships. It is common for patients to expect their own tribal values to be understood by a health practitioner. If the health practitioner is not aware of these values and their corresponding behaviors, major problems with miscommunication can occur, compromising the patient/health practitioner relationship.

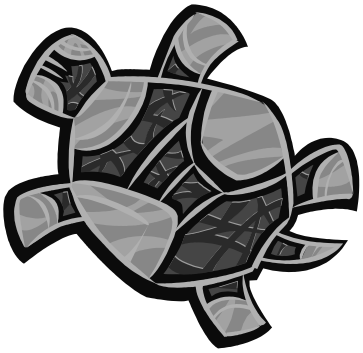
Session 5:

Confidentiality









Confidentiality and Privacy

Possible Problems:

- Rumors
- Relatives on staff
- Public location of free condoms and bleach
- Location of HIV testing and counseling office and waiting area

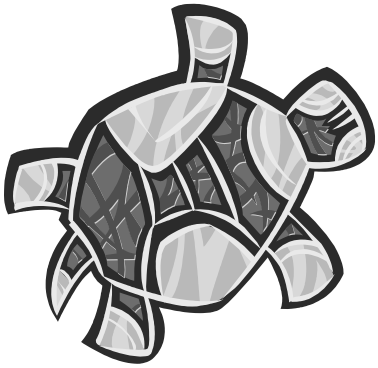
Confidentiality

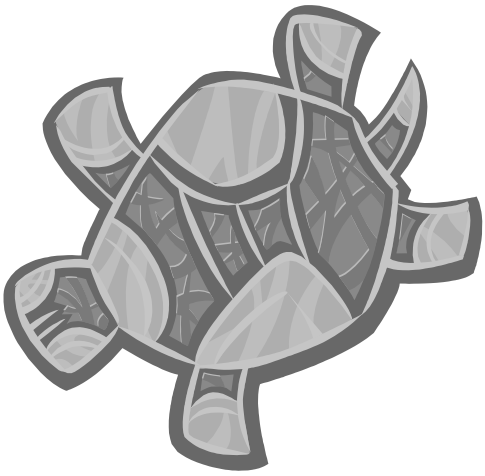
Confidentiality can be difficult to maintain in the small, closed communities that are typical of rural areas. Breaches of confidentiality are a serious issue in many Native clinics. This transgression often occurs in reservation or rural communities where rumors can spread quickly, although comparable problems also occur in urban clinics. In Native communities, it is not uncommon for a patient to have relatives, friends, or acquaintances who are employed at the Native clinic. These individuals may have access to confidential information about a patient. Any breach of confidentiality can lead to shame and isolation from the community, especially when the information is about a socially stigmatized problem such as HIV.

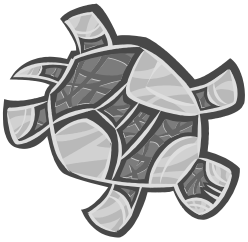
Breaches in confidentiality can also pose a barrier to important prevention activities, which include testing for HIV, discussing sexual practices with health care providers, obtaining drug treatment, or purchasing condoms in local stores. For Native bisexual and gay men, or MSM (men who have sex with men), issues related to confidentiality can negate the use of health care services due to community stigma and denial about homosexuality as a viable sexual orientation, particularly in rural Native communities (Oropeza, Bouey, Tight, & Bradley-Springer, 2001).

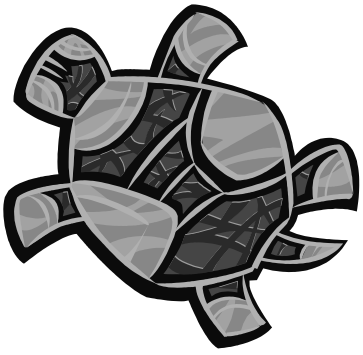
Session 6:

The Relationship Between HIV and Other STIs









HIV and Native Communities

HIV "invisible"

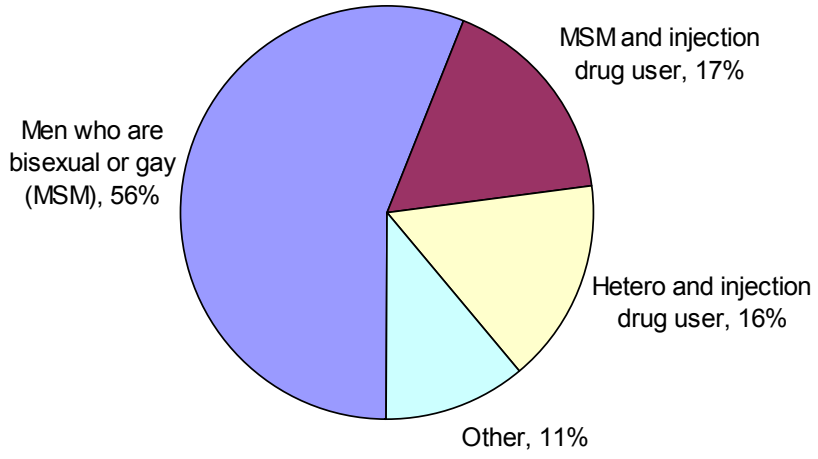
- **More obvious "visible" problems, such as poverty, violence, substance abuse**

HIV prevalence

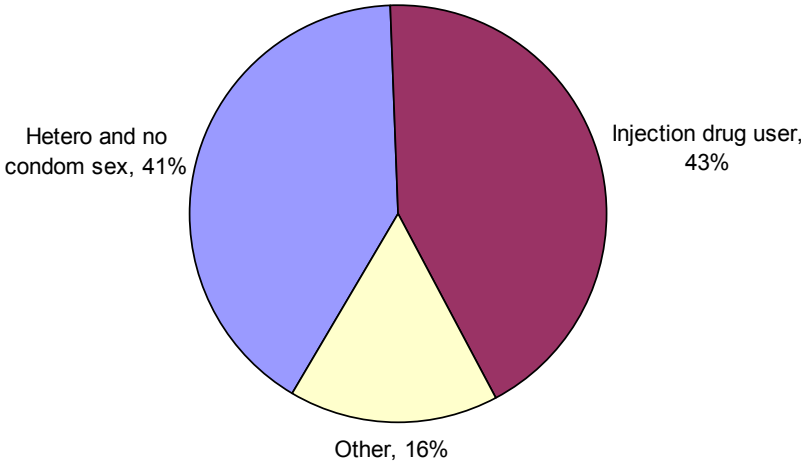
- **3% of HIV and AIDS**
- **Misclassification and under-reporting**

AIDS Exposure Categories (CDC, 2003)

Native Men



Native Women



STIs and HIV Risk within the Native Community

High incidence rate of STIs within the Native community

- Indirect measure of frequent high-risk sexual behavior
- Presence of other STIs increases the risk of HIV transmission

Risky Behaviors for HIV Transmission

- Vaginal or anal sexual intercourse without a condom
- Multiple sexual partners, especially if not using condoms
- Sharing injection needles
- Non-sterile piercing or tattooing

Zero Risk of HIV Transmission

(Activities that carry no conceivable risk of HIV transmission)

- Hugging
- Massage
- Abstinence
- Dry kissing
- Masturbating alone
- Dry humping with clothes on
- Masturbation without touching each other

Adapted from McIlvenna, T. (ed.) (1999). The Complete Guide to Safer Sex. New York: Barricade Books.

Very Low Risk of HIV Transmission

(Activities that could conceivably result in HIV transmission but are very low risk

- Deep wet kissing
- Mutual masturbation
- Use of sex toys with condoms or with sterilization between uses
- Oral sex on a man with a condom
- Oral sex on a woman with a dental dam
- Tattooing or piercing with sterilized equipment
- Injection Drug Use (IDU) using sterilized needles and equipment

Adapted from McIlvenna, T. (ed.) (1999). The Complete Guide to Safer Sex. New York: Barricade Books.

Low Risk of HIV Transmission

(Activities that carry a low, but definite, risk of HIV transmission)

- Sharing of sex toys without a condom or sterilization between uses
- Oral sex on women without a dental dam
- Oral sex on men without a condom (but without ejaculation)
- Vaginal sex with a condom
- Vaginal or anal fisting

Adapted from McIlvenna, T. (ed.) (1999). The Complete Guide to Safer Sex. New York: Barricade Books.

Medium Risk of HIV Transmission

(Activities that carry a well-documented, significant risk of HIV transmission)

- Insertive anal sex with a condom
- Oral sex on men without a condom and with ejaculation
- Tattooing or piercing without sterilizing the equipment between uses

Adapted from McIlvenna, T. (ed.) (1999). The Complete Guide to Safer Sex. New York: Barricade Books.

High Risk of HIV Transmission

(Activities whose average per-episode risk with an HIV-infected partner exceeds 0.1%)

- Receptive anal sex without a condom
- Receptive vaginal sex without a condom
- Injection drug use (IDU) needle sharing without sterilizing the equipment between uses

Adapted from McIlvenna, T. (ed.) (1999). The Complete Guide to Safer Sex. New York: Barricade Books.

AI/AN HIV & STI Risk Assessment Form

BRIEF VERSION

Introduction: *I am going to ask you some personal questions. I ask all of my patients these questions to help me provide the best possible health care. All your responses will remain confidential.*

Section 1 Piercing and Tattooing			
1)	Could you please tell me if you have ever been pierced or tattooed for non-ceremonial reasons?	**Yes****	
		No	
	If *yes*, when?		
	If *yes*, could you say more about this?		
2)	Could you please tell me if you have ever been pierced or made flesh offerings for ceremonial reasons?	**Yes****	
		No	
	If *yes*, when?		
	If *yes*, could you say more about this?		

Section 2 Substance Use			
1)	Some people have sex when they drink too much alcohol or are under the influence of drugs. Has this ever been a concern for you?	Yes**	
		No	
		Not Sure	

** Indicates significant risk for HIV infection; patient should be referred for counseling and testing at end of interview

Scenario for Desensitization Exercise

Roberta has had a sexual relationship for the last two months with Damon who is an injection methamphetamine user. Damon is bisexual and Roberta knows this. Damon "goes out" with guys when he visits the city and none of Roberta's or Damon's relatives are aware of his sexual identity.

Roberta describes their sexual risk behaviors as being very low risk. She describes behaviors that include oral sex on Damon without a condom and needle sharing. She goes on to provide a story of one of their sexual episodes to the interviewer.

The interviewer is provided sexual history information by Roberta without any hesitation. Roberta is comfortable with her sexuality and is quite graphic. Roberta isn't interested in further referrals today but may be when she next visits the clinic.

Interview and attempt to refer her for HIV testing.

STIs and HIV

In the United States, high rates of gonorrhea and syphilis have been found in states that have more than 20,000 American Indian/Alaska Native residents. High rates of STIs among Natives serve as an indirect measure of frequent high-risk sexual behavior. Studies have shown that Native adolescents are more likely to be sexually active and less likely to use contraceptives than non-Native adolescents (Weaver, 1999). Moreover, the presence of an STI can greatly increase the risk of HIV infection: **persons with STIs are more likely both to transmit HIV and to become infected with HIV upon exposure.**

What are STIs?

STIs are sexually transmitted infections. *STI* is a newer term for what are often called *sexually transmitted diseases,* or *STDs*. In addition to STDs such as gonorrhea and chlamydia, the term "STI" includes HIV and viral hepatitis infections, which technically are not diseases but rather are infectious agents that often result in disease. This training manual uses the term "STI". STIs are serious and can be life threatening. Most STIs predominantly infect the mouth, rectum, and/or sex organs, but some, such as HIV, hepatitis B, and syphilis, can infect other organ systems throughout the body. Often a person can have an STI with no signs or symptoms. Sometimes the symptoms go away on their own but the disease remains in the body until the person receives treatment. Most bacterial STIs can be cured with antibiotics. Other STIs such as HIV and herpes can be controlled by medications but can never be completely eliminated from the body.

How are STIs Spread?

STIs are generally spread through physical, sexual contact. HIV and hepatitis B are also spread by contact with infected blood and therefore can be transmitted through sharing of needles during drug use, contaminated tattooing or piercing equipment, or contaminated blood transfusions, though the risk of HIV transmission by blood transfusion is now extremely low due to required screening procedures.

What Should Happen if an STI is Suspected?

If a person thinks he or she may be infected with an STI, that person should have a medical examination as soon as possible. Without diagnosis and treatment, the STI will

typically remain in the body, where it can potentially damage that person's health and possibly be passed to others. It is recommended that the person visit the tribal clinic or county health department STI clinic. Local family planning clinics can usually assist with evaluation or referral as well.

Although patients may feel embarrassed about needing an examination for an STI, consulting with a medical professional is very important. The only way to get well and maintain health is to get treatment. Many STIs can be treated with an antibiotic. It is important to follow the treatment instructions of the medical practitioner and to take all of the medicine that is prescribed.

Partner notification is also critically important, so that potentially infected partners can be evaluated and treated appropriately. Patients may inform their partners themselves, or the treating clinician can arrange for the local health department to notify the partner(s) in situations where the patient wants to maintain anonymity.

Symptoms to Watch For:

Women
- An unusual discharge or smell from the vagina
- Pain in the pelvic area (the area between the belly button and sex organs)
- Burning or itching around the vagina
- Bleeding from the vagina that is not a regular period
- Pain deep inside the vagina when having sex

Men
- A drip or discharge from the penis
- Swelling or pain of the testicle(s) or scrotum

Women and Men
- Sores, bumps or blisters on or near the sex organs, rectum or mouth
- Burning and pain upon urination or when having a bowel movement
- Needing to urinate often
- Itching around the sex organs
- A swelling or redness in the throat
- Flu-like symptoms, with fever, chills and aches
- Swelling in the groin area around the sex organs

How Can Patients Protect Themselves?

- Abstinence: not having sex
- Having sex with only one uninfected partner who only has sex with the patient (monogamy)

- Discussion with one's partner about their sexual and drug use history, particularly their use of needles and injection equipment
- Knowing that birth control pills do not prevent infections
- Having fewer sex partners
- Learning the proper way to use a condom
- Using a new condom for every sexual encounter
- Not sharing IV street drugs, needles, or other drug equipment
- Getting checked for STIs regularly
- Knowing the signs and symptoms of STIs, and if an STI is suspected, making an appointment for a medical exam. (WA State Department of Health, 1996)

A Word about Hepatitis

The hepatitis B and hepatitis C viruses are also transmitted by sharing needles and drug equipment. Hepatitis B, like HIV, is also easily transmitted by sexual contact. There is increasing recognition that hepatitis C can also be spread by sexual contact, especially among men who have sex with men (MSM). All of the risky behaviors described for HIV are risky behaviors for Hepatitis B and Hepatitis C.

HIV and the Native Community

The Human Immunodeficiency Virus (HIV), the causative agent of the acquired immunodeficiency syndrome (AIDS), infects and can ultimately incapacitate the immune system whose function is to protect the body against a wide range of infections. HIV-induced immunosuppression results in a host defense defect that renders the body highly susceptible to 'opportunistic' infections and neoplasms (Oropeza et al., 2001).

Despite the steady increase of HIV and AIDS among the Native population, resources and services have been lacking. Many existing programs fail to target Native communities. Consequently Native communities are in need of culturally relevant programs. To become meaningful for Native people, HIV prevention, education, treatment and support must acknowledge Native realities.

HIV research among AI/AN people has a short history, which began in the late 1980's. Early studies primarily focused on identification of risky behavior (Morrison-Beedy et al., 2001). According to the CDC (2003), the leading HIV/AIDS exposure category for Native men is men who have sex with men (MSM) at 56%, MSM and injection drug use (IDU) 17%, and heterosexual IDU (16%) . Among women, the primary exposure risk is injection drug use at 43%, followed by heterosexual contacts at 41%.

Given the absence of an effective vaccine against HIV for the foreseeable future, behavioral change remains the only option for preventing further spread of the epidemic. Virtually all new HIV infections can be prevented if people can change their sexual and drug use practices that create risk for contracting HIV. Although the two

behaviors that represent highest risk for transmission of HIV (unprotected sex with a potentially infected partner and needle sharing by injection drug users) are very easy to identify, these behaviors are also very difficult for many people to change. Sexuality is among the most powerful and least understood of human motivations. It produces not only pleasure but also associations with love and affection; and it influences the expression of dating habits, relationships, self-concept, and self-esteem. Sex is strongly reinforced at levels ranging from physiology to fantasy to social pressure. Introducing change in sexual relationships and patterns can be very difficult (de Mauro & Patierno, 1990).

It is a common misconception that health education and prevention are equivalent, i.e., that by providing people with factual information regarding a health risk, behavior change will automatically follow. Unfortunately, however, a gap commonly exists between knowledge and behavior. Despite the increased awareness of HIV/AIDS among the general public, the incidence of new HIV infections in the United States has declined within some populations but not within the Native population (CDC, 2003).

Generally, it is not common knowledge that there are variations of sexual behavioral risk or that some sexual acts are less risky than others. When combined with other risk factors such as IDU and tattooing, the sexual risk is elevated. The following list of risk behaviors categorizes behaviors by their risk and association with HIV transmission.

Relative Risks of Sexual Behaviors

Zero Risk of HIV Transmission
(Activities that carry no conceivable risk of HIV transmission)

- Hugging
- Massage
- Abstinence
- Dry kissing
- Masturbating alone
- Dry humping with clothes on
- Masturbation with another person without touching each other

Very Low Risk of HIV Transmission
(Activities that could conceivably result in HIV transmission but are very low risk)

- Deep wet kissing
- Mutual masturbation
- Use of sex toys with condoms or with sterilization between uses
- Oral sex on a man with a condom
- Oral sex on a woman with a dental dam
- Tattooing or piercing with sterilized equipment
- Injection Drug Use (IDU) using sterilized needles and equipment

Low Risk of HIV Transmission
(Activities that carry a low, but definite, risk of HIV transmission)

- Sharing of sex toys without a condom or sterilization between uses
- Oral sex on women without a dental dam
- Oral sex on men without a condom but without ejaculation
- Vaginal sex with a condom
- Vaginal or anal fisting

Medium Risk of HIV Transmission
(Activities that carry a well-documented, significant risk of HIV transmission)

- Insertive anal sex with a condom
- Oral sex on men without a condom and with ejaculation
- Tattooing or piercing without sterilizing the equipment between uses

High Risk of HIV Transmission
(Activities whose average per-episode risk with an HIV-infected partner exceeds 0.1%)

- Receptive anal sex without a condom
- Receptive vaginal sex without a condom
- Injection drug use (IDU) needle sharing without sterilizing the equipment between uses

Adapted from McIlvenna, T. (ed.) (1999). The Complete Guide to Safer Sex. New York: Barricade Books.

Risks with Piercing, Tattooing, and Transfusions

Although unsafe sex and injection drug use (IDU) are the most common ways in which HIV is spread, piercing and tattooing of the body can also result in transmission of HIV or other infections if sterile equipment and needles are not used. Needles or sharp instruments used for tattooing or piercing should be sterilized between uses, and the practitioner administering the tattoo or piercing should wear gloves.

Tribal spiritual ceremonies can involve piercing and/or tattooing. In 1988, the Aberdeen Area Indian Health Service recognized the possibility of HIV transmission through piercing and flesh offerings that occur during the Sun Dance ceremony (Giroux, Takehara, Asetoyer, & Welty, 1997). Training was provided to spiritual leaders on the application of "universal precautions" which included:

- Avoiding piercing or cutting of a dancer by an assistant who has open cuts or sores
- Using latex gloves when piercing or assisting with flesh offerings
- Being careful to not cut the latex gloves while assisting with piercing or cutting
- Washing hands between assisting with piercing or cutting of dancers in a solution of three parts bleach and one part water
- Using a new scalpel or needle on each dancer

- Disposing of scalpels and needles in puncture-proof containers, labeled with the words "Hazardous Waste"
- Not sharing items exposed to the blood of another person (ropes and pegs)

With the assistance of the Indian Health Service, tribes located in the Plains area were provided assistance with public health posters and radio announcements regarding use of universal precautions for ceremonial piercing and cutting. The public health education campaign, in conjunction with personal visits to ceremonial leaders, effectively informed traditional tribal communities about this significant community health issue.

Blood transfusions represent another potential mechanism of HIV transmission. All blood in the United States is now tested for HIV before it is provided to another person, and the risk of HIV transmission via blood transfusion is now estimated to be extremely low (roughly one in 500,000) (Lackritz et al., 1995). However, in the past this risk was much higher, because prior to 1985, blood was not screened for HIV. Hence, if a patient received a transfusion prior to this date, there is a chance that he or she could have contracted HIV.

Health care workers are often accidentally exposed to blood or other body fluids. Though the risk is generally low, HIV transmission can occur in this fashion. Immediate medical assessment is indicated in such situations for possible intervention with post-exposure prophylactic medications. The National Clinicians' Post-Exposure Prophylaxis Hotline is available for consultation regarding occupational exposures to HIV at (888) HIV-4911.

Reducing HIV Risk for Women

Although more men than women have AIDS, recent data suggest that the prevalence of HIV infection among Native women in the United States is increasing significantly (Vernon, 2001; Morrison-Beedy et al., 2001).

In order to be effective, prevention programs targeting women need to be placed within the larger context of women's lives. It is imperative to recognize the ways in which economic dependence impinges upon the abilities of many women at high risk for HIV to protect themselves. The ways in which the dynamics of power and issues of trust are expressed within sexual relationships critically affect the opportunities for women to reduce their individual risk.

A woman's risk of contracting HIV through unprotected heterosexual sex is increased by having multiple sexual partners or by the presence of another STI in either herself or her partner (Rowell & Bouey, 2002). Unfortunately, rates of syphilis and gonorrhea infection among Native women have been increasing in recent years (Vernon, 2001). The risk of transmission among couples having unprotected vaginal or anal intercourse varies. Some individuals become infected with HIV after a single unprotected sexual encounter while others remain free from infection after hundreds of such encounters.

HIV transmission likely depends on multiple biologic factors involving the infected person, the virus, and the exposed person. Research indicates that the following factors increase the risk of sexual HIV transmission: high levels of HIV in the plasma (which generally, though not perfectly, correlates with high levels of HIV in genital secretions); genital lesions in either partner (e.g., due to syphilis, herpes, chancroid, or other STIs); intact foreskin (circumcision appears to reduce the risk of HIV transmission); and viral shedding in cervical and vaginal secretions (Williams, 2000).

A primary method for sexually active women to reduce their risk of HIV infection through heterosexual sex is for their partners to use condoms. Men may prefer to not use condoms for a variety of reasons (for example, because they interfere with the pleasure and spontaneity of sex). The most frequent reason women give for not using condoms is that their partners do not like them (Neron & Roffey, 2000).

The use of condoms also carries important symbolic meaning, particularly in regard to trust (Neron & Roffey, 2000). A woman asking her partner to use a condom can be construed as either a lack of trust in his faithfulness or an indication that she has not been faithful or is infected with HIV. The power structure of heterosexual relationships can make it very difficult for women to insist on condom use. This power dynamic is perhaps most relevant for women in abusive relationships, who may be unable to negotiate or enforce condom use safely.

Reducing HIV Risk among Bisexual and Gay Men (*Two-Spirit Men* or Men Who Have Sex with Men)

Available data suggests that approximately 56% of Native people who are HIV-infected are men who have sex with men (CDC, 2003). The term "men who have sex with men (MSM)" is preferred because many of these men, both among Native Americans as well as the general population, do not consider themselves to be 'gay', homosexual, or bisexual, especially if married or in a partnership with a woman. Many bisexual and gay men experience internalized homophobia due to societal prejudice and rejection by family and community. Those bisexual and gay men who acknowledge their sexual orientation are often exposed to rejection and experience feelings of isolation, depression, fear, loneliness, and shame. These combined factors of family and community rejection, as well as negative self-directed feelings, may result in self-destructive behavior such as substance abuse and/or high-risk sexual activities. Furthermore, Native MSM may avoid seeking out health care or counseling services out of fear of harassment by or alienation from family and community.

Unfortunately, the estrangement of bisexual and gay men from tribal communities has become a detriment to all community members. Research has shown that adolescent youth who express high levels of homophobia often demonstrate less perception of being at risk for HIV transmission and less precautionary behavior, i.e., heterosexual sex without condoms (Vernon, 2001).

Reducing HIV Risk among Adolescents

The number of adolescents with HIV/AIDS is relatively low. However there are a significant number of young adults with AIDS, suggesting that many of these individuals were likely infected with HIV as adolescents (CDC, 2003). Moreover, recent estimates suggest that one in four new HIV infections in the U.S. occur among people under the age of 20 years old.

A study of American Indian youth in over 200 reservation-based schools across the United States suggested that youth engaged in several high-risk behaviors, including the use of alcohol, tobacco and other drugs, risky sexual behavior, and suicidal behaviors. Drug use was most commonly associated with other risky behaviors (Potthoff et al., 1998). Many adolescents experiment with alcohol, drugs, and/or sex. This experimentation is often combined with perceptions of invulnerability. Rates of STIs are high among adolescents, which suggest that safer sex practices are not being consistently practiced. Overall most STIs occur among people between the ages of 20 and 29 years of age.

As with Native adults, a larger proportion of adolescents and young adults (aged 13-24) with AIDS were male (72%) rather than female (28%). Of the young males, most (59.6%) were exposed through sex with other men, followed by exposure through injection drug use (11.8%). 10% of male adolescents were exposed through the dual risk avenues of sex with men and injection drug use. For young women with AIDS, unprotected heterosexual sex accounted for over half of the cumulative AIDS cases through 1997 and about a quarter were exposed through injection drug use (CDC, 2001a).

Scenario for Desensitization Exercise

Roberta has had a sexual relationship for the last two months with Damon who is an injection methamphetamine user. Damon is bisexual and Roberta knows this. Damon "goes out" with guys when he visits the city and none of Roberta's or Damon's relatives are aware of his sexual identity.

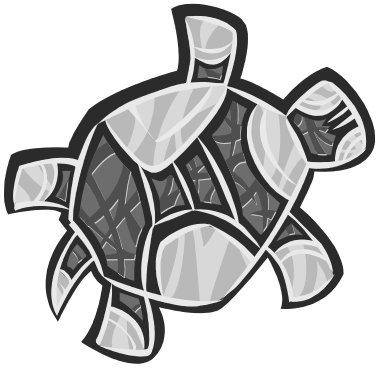
Roberta describes their sexual risk behaviors as being very low risk. She describes behaviors that include oral sex on Damon without a condom and needle sharing. She goes on to provide a story of one of their sexual episodes to the interviewer.

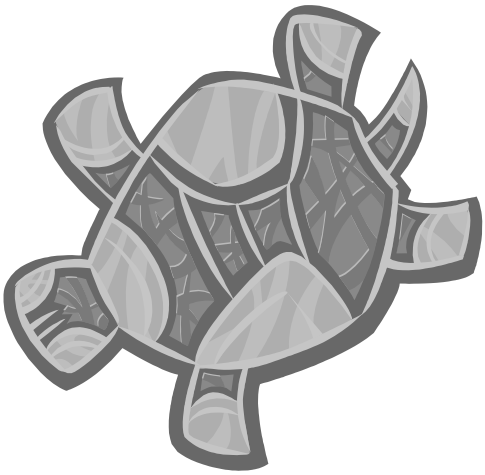
The interviewer is provided sexual history information by Roberta without any hesitation. Roberta is comfortable with her sexuality and is quite graphic. Roberta isn't interested in further referrals today but may be when she next visits the clinic.

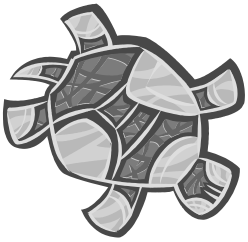
Interview and attempt to refer her for HIV testing.

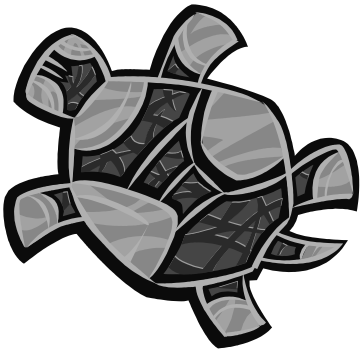
Session 7:

HIV / STIs and Substance Abuse









HIV/STIs and Substance Abuse within the Native Community

Native Youth

1998, reservation-based schools

- Drug use commonly associated with risky sexual behaviors (no condom use)
- High rate of STIs

Alcohol Abuse

Number one health problem in Native community

- Associated with high-risk sexual behavior by decreasing inhibitions with sexual decision making

Injection Drug Use

- HIV transmission through exposure to blood by use of contaminated injection equipment
- Injected substances may include anabolic steroids, vitamins, insulin, methamphetamine, heroin
- Intramuscular or subcutaneous ('skin popping') often used when veins no longer usable for injection

Drugs

Marijuana (smoke, joint, weed)

Methamphetamine (ice)

Ecstasy (x)

Cocaine and Crack (rock)

Inhalants (huffing)

GHB (gamma- hydroxybutyrate) (liquid ecstasy)

Rohypnol (roofie)

Ketamine (special K)

Heroin

LSD (acid)

Barbiturates

Steroids

HIV/STIs and Substance Abuse

Alcohol abuse arguably represents the single most important social and health problem in Native populations. The devastation of alcohol abuse, documented by many studies, includes child abuse, sexual abuse, domestic violence, fetal alcohol syndrome, accidents, homicide, and suicide. Though the age-adjusted alcoholism death rate for Native peoples has decreased 37% since 1979-1981, it remains unacceptably high at 37.2 deaths per 100,000, or 5.5 times the U.S. all-races rate of 6.8 in 1991 (Indian Health Service, 1997). Moreover, this statistic does not include alcohol-related mortality from accidents, suicide, or homicide (Indian Health Service, 1997). May and Hymbaugh (1989) report that within certain tribes, the prevalence of fetal alcohol syndrome and of fetal alcohol effects is much higher than in the non-Native population; Chavez, Cordero, & Becerra (1989) document a fetal alcohol syndrome rate 33 times higher for Native peoples than for non-Indians.

Facts About Alcohol and the Human Immune System

- **Alcohol abuse decreases white blood cell counts, causing the body to respond poorly to infection.**
- **Alcoholic liver disease inhibits the body's ability to form T-cells.**
- **Chronic abusers of alcohol have fewer T cells.**
- **Alcohol contributes to diabetes, high blood pressure and HIV/AIDS progression (Rowell, 1997).**

Alcohol also serves as an exacerbating factor in a number of other illnesses prevalent in Native communities, including high blood pressure, diabetes, gastritis, cardiomyopathy, and HIV/AIDS (Bouey, 1999). Baldwin, Maxwell, Fenaughty, Trotter & Stevens, (2000) found that alcohol use was the primary factor that placed Alaskan Native drug users at greatest risk for HIV. Many of the participants reported blacking out while drinking, and later learning that they had participated in unprotected sex with complete strangers or persons that they would not otherwise accept as partners. Neron & Roffey (2000) reported that drug-using Native women were at high risk for gonorrhea and HIV infection. Native women were more likely to inject drugs than any other ethnic group of women.

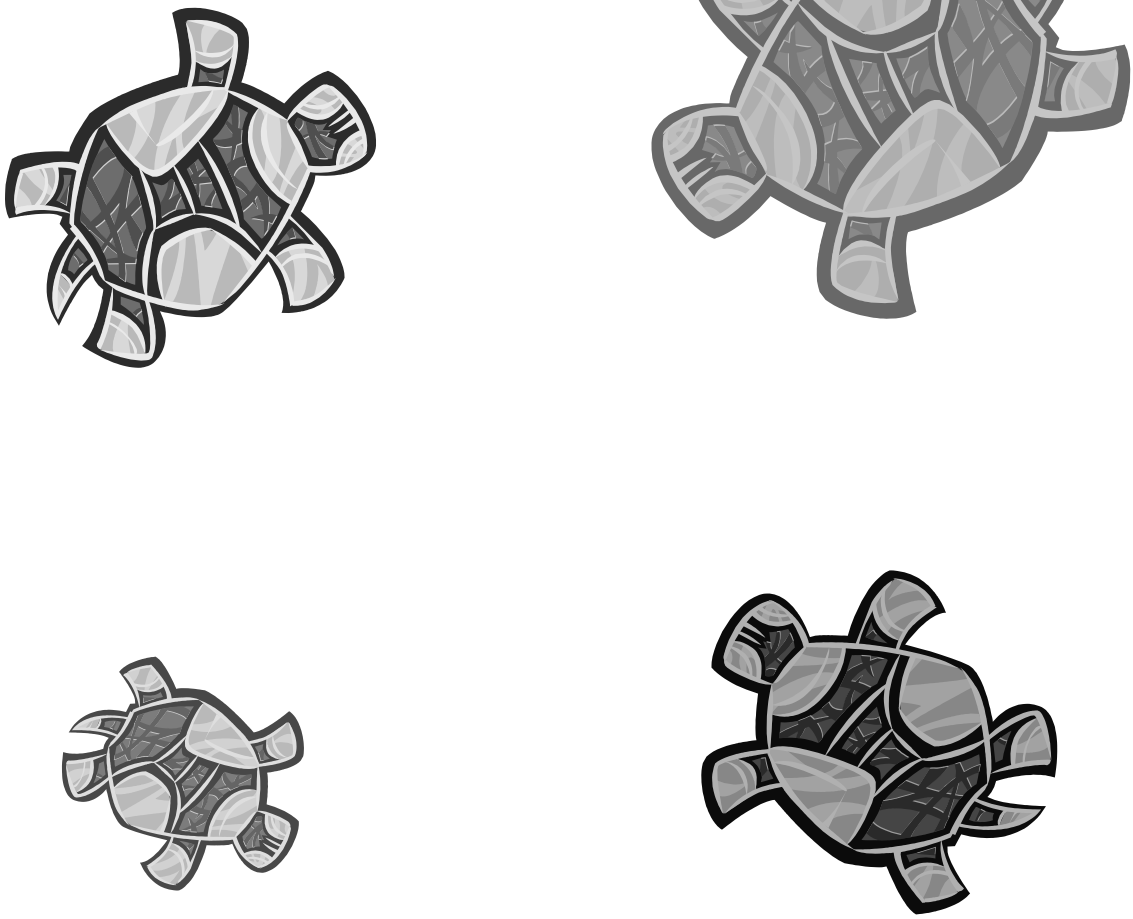
HIV transmission via injection drug use (IDU) occurs as a result of exposure to HIV-infected blood from a previous user of the injection equipment. Within the Native population, IDU-related HIV transmission is more common among men than women (Goldstone, Albert, Churchill, Schilder, Perry, Markowski, Hogg & McLeod, 2000).

What Can be Done to Promote Sexual Safety Awareness and Decrease Risk?

American Indian/Alaskan Native communities, although diverse in many ways, share a sense of pride, self-determination, spirituality, and resiliency that helps with prevention strategies that target and decrease the spread of HIV infection. HIV/AIDS must be recognized as a preventable illness. Recognition and acknowledgement of HIV by American Indian/Alaskan Native communities might be increased by ongoing reliable data collection of HIV/AIDS information, presentation of this information to tribes and communities, and the design and delivery of culturally relevant HIV prevention programs by and for the specific tribal communities.

Session 8:

Assessment of Sexual Risk Behaviors



Scenario Interview Format

To **begin** the interview with your patient using the HIV and STI Risk Assessment Form, read the following:

> ***Now, I am going to ask you some personal questions. I ask these questions to all my patients to help me provide the best possible health care. Anything you say will be confidential.***

This paragraph is located on the first page of the assessment tool.

After reading this, ask the patient if they are willing to complete the interview. If the answer is "yes", proceed with the interview. If the answer is "no", tell them you appreciate their opinion and continue with the interview.

To **end** the interview with your patient, refer to page 4 of the assessment tool. You will find Section V--Patient Feedback and Referral. This session provides:

- Directions for assessing your patient's level of risk for contracting HIV and other STIs;
- A script for recommending HIV testing and counseling for your patient; and
- A script for reviewing the content of a standard pre- and post-test HIV counseling session.

AI/AN HIV & STI Risk Assessment Form

Introduction: *I am going to ask you some personal questions. All my patients will be asked these questions as a means for me to provide the best possible health care. All your responses will remain confidential.*

Section 1 Piercing and Tattooing

1)	Could you please tell me if you have ever been pierced or tattooed for non-ceremonial reasons?	**Yes****	
		No	
	If *yes*, when?		
	If *yes*, could you say more about this?		
2)	Could you please tell me if you have ever been pierced or made flesh offerings for ceremonial reasons?	**Yes****	
		No	
	If *yes*, when?		
	If *yes*, could you say more about this?		

Section 2 Substance Use

3)	Some people have sex when they drink too much alcohol or are under the influence of drugs. Has this ever been a concern for you?	**Yes****	
		No	
		Not Sure	
4)	Do you drink alcohol?	**Yes**	
		No	
	If *yes*, how many days did you drink more than 5 drinks in the last month?		
	If *yes*, have you ever felt you ought to cut down?		
	If *yes*, have people annoyed you by criticizing your drinking?		
	If *yes*, have you ever had a drink first thing in the morning?		

** Means risk and patient needs a referral at end of interview

5)	**Do you smoke marijuana?**	Yes	
		No	
	If *yes*, how often during a week?		
	If *yes*, how often during a day?		
6)	Could you please tell me if you have used other street drugs in the last **6 months**? If *yes,* have you used:	**Yes**	
		No	
	Heroin (Opioids)?	**Yes****	
		No	
	How often during a week?		
	Month?		
	Crank/Ice/Crystal/Methamphetamine (Stimulants)?	**Yes****	
		No	
	If *yes*, how often		
	Cocaine?	**Yes****	
		No	
	If *yes*, how often?		
	Club Drugs?	**Yes****	
		No	
	If *yes*, Which types?		
	How often?		
	Huffing/Inhalant?	**Yes**	
		No	
	If yes, type of inhalant?		
	How often?		
7)	Have you injected any kind of drug within the last 6 months?	**Yes****	
		No	
	If *yes*, what type of drug?		
	How often?		
8)	Could you please tell me if you have ever shared needles with another person?	**Yes****	
		No	
	Could you please tell me if you have shared injection equipment (rigs, works) in the last 3 months?	**Yes****	
		No	
9)	Do you know how to inject safely? (If *no*, I can refer you to our community health education program.)	**Yes**	
		No	
10)	Do you know where to get clean needles? (If *no*, I can refer you to our community health education program.)	**Yes**	
		No	

Section 3 Sexual History

11)	Could you please tell me if you have had any kind of sexual relations with another person within the last six months?			**Yes****	
				No	
				Unsure	
	If *yes*, with how many different people? 1? 2-4?				
	If *no*, when was the last time?				
12)	Do you have sexual relations with:			**Men**	
				Women	
				Both	
13)	Have you ever been told that you had an STI?			**Yes****	
				No	
	HIV	Warts	Gonorrhea (Clap)	**Syphilis**	
	Chlamydia	Herpes	Trichomonas	**Other**	
	If *yes*, when?				
	Were you treated?			**Yes**	
				No	
	Have you been symptom free since then?			**Yes**	
				No	
14)	Have you ever had an HIV test?			**Yes**	
				No	
				Not sure	
	If *yes*, when?				
	If *yes*, what were the results?				
15)	Has your partner(s) ever had an STI?			**Yes****	
				No	
				Don't Know**	

16)	**Some people have different kinds of sexual relations with their partners. Within the last 6 months, could you please share your ways of being sexually intimate?**				
	Mouth-genital	Give	Receive	Protected	**Unprotected****
	Mouth-anal	Give	Receive	Protected	**Unprotected****
	Penis-vaginal	Give	Receive**	Protected	**Unprotected****
	Penis-anal	Give	Receive**	Protected	**Unprotected****
17)	**A. (*If applicable*), Could you tell me what you do to protect yourself from pregnancy?**				
	Condoms	**Hormonal****	**Other****	**Nothing****	Not applicable

	B. (*If applicable*), Could you tell me what you do to protect your partner from pregnancy?				
	Condoms	**Other**	**Nothing**	Not applicable	
18)	Could you please tell me what you do to protect yourself from HIV or other STI infections that can be spread by sex or sharing needles?			**Use condoms**	
				Use clean needles	
				Nothing**	
				Other	
19)	(*If applicable*), Have you ever had a partner refuse to wear a condom during sex?			**Yes****	
				No	
20)	(*If applicable*), Do you have options if your partner won't wear a condom?			**Yes**	
				No	
	If *yes*, what are your options?				
21)	**If you were to have sexual relations with someone, how would you protect yourself from sexually transmitted infections and pregnancy?**				

Section 4 Additional Exposures to Risk

22)	Do you recall ever having a blood transfusion prior to 1985 or more than 17 years ago?	**Yes****	
		No	
	If *yes*, have you talked with your medical provider about this information?		
23)	Have you ever been exposed to blood or bodily fluids by accident?	**Yes****	
		No	
	If *yes*, could you please say more?		

Section 5 Patient Feedback and Referral

Thanks for answering these screening questions.

Based on your answers to these questions, your risk for HIV or other sexually transmitted infections appears to be:
Lower_____ Higher_____
(If the patient has one ** they are in the higher range of risk.)

With your risk level in mind, my suggestions for you are:

Lower: **You appear to not be at high risk for HIV or other sexually transmitted infections at this time, continue with your current practices/behaviors.**

Higher: **Usually we recommend a referral for HIV counseling and testing for patients who have higher levels of risk for HIV transmission. Would you be interested?**

If yes, I can provide you with a referral to _____.

If not interested in a referral: **Thanks for your participation in this screening. Would you like more counseling on how you can reduce your risk of becoming infected with HIV and other sexually transmitted infections?**

If the referral is for HIV testing and counseling:
Let me tell you what an HIV testing and counseling session might involve. HIV testing and counseling typically consists of two visits, a pretest visit and a results visit.[1]

The pretest counseling visit would include additional questions regarding your behaviors that put you at risk for contracting HIV or other sexually transmitted infections. In your case, these risky behaviors include _____.

You would be asked to set up a risk reduction plan to help you decrease your risk. At this first visit, blood would also be drawn for an HIV test.

The second visit typically occurs 1-2 weeks after the first visit. You would receive your HIV test results at this visit, and we would review your risk reduction plan.

Thanks again for participating in this screening process.

[1] Since these training materials were written, rapid testing kits and protocol have been developed and received FDA approval. Counseling with rapid HIV tests should follow the recommendations of the Centers for Disease Control and Prevention (CDC).

Brief HIV Risk Assessment Form

Section 1	**Piercing and Tattooing**			
1.	Could you please tell me if you have ever been pierced or tattooed for **non-ceremonial** reasons?		☐ yes	☐ no
	If yes, when?			
2.	Could you please tell me if you have ever been pierced or made flesh offerings for **ceremonial** reasons?		☐ yes	☐ no
	If yes, when?			
	Say more?			
Section 2	**Sexual History**			
3.	Have you been sexually active within the last 6 months?		☐ yes	☐ no
4.	What does sexually active mean to you?			
5.	When you last had sex, was it your choice?		☐ yes	☐ no
6.	Do you know the drug-using habits of your partner?		☐ yes	☐ no
7.	Have you ever had sex with someone you don't know very well?		☐ yes	☐ no
	If yes, did you have protected sex (such as condoms)?		☐ yes	☐ no *
8.	Do you have sex with:	☐ men	☐ women	☐ both
Section 3	**Drug Use**			
9.	Do you take over-the-counter medication?		☐ yes	☐ no
10.	Do you take prescription drugs?		☐ yes	☐ no
11.	Do you use alcohol?		☐ yes	☐ no
12.	Do you use tobacco?		☐ yes	☐ no
13.	Have you ever used drugs from a non-medical source?		☐ yes	☐ no
14.	Have you ever injected drugs? Shared needles?		☐ yes *	☐ no
15.	Have you ever used substances to get high?		☐ yes	☐ no

* Means high risk and patient needs a referral for HIV testing at end of interview

Assessment of HIV/STI Risk Behavior

A thorough sexual and substance use history is an effective way to assess a patient's risk for HIV infection. The identification of a patient's risk behaviors related to HIV transmission also reveals information relevant to other sexually transmitted infections, substance use, and other issues that are useful in the broader context of a general clinical assessment. Unless experienced in both sexual behavior and substance use interviewing, health care professionals may be uncomfortable when inquiring about these behaviors. They may avoid important areas of concern and convey discomfort to their patients. It is essential that professionals who assess sexual behaviors attempt to become comfortable and non-judgmental in their approach to sexual and substance use risk interviewing. Although an HIV/STI risk assessment does not require the same level of detail as one might need in a comprehensive sexual history interview, it does require that the health professional be able to elicit accurate and reliable information regarding the patient's risk behavior practices.

A sexual history can be obtained as part of a patient's general health assessment, and is critical for identifying high-risk behaviors on which to base appropriate risk reduction plans and referrals for subsequent diagnostic and therapeutic interventions. Tribal clinic providers commonly do not solicit information regarding risk for HIV infection (Vernon, 2001). There are a number of possible reasons why clinicians do not perform HIV/STI risk assessments with their patients. Many practitioners are not aware of the new dynamics of HIV infection resulting in an increased prevalence of HIV infection among Native women, adolescents, and residents of rural areas. Practitioners may not feel prepared to address HIV/STI prevention issues due to a lack of training, or they may feel uncomfortable discussing sexual or drug related issues with their Native patients out of modesty. Clinicians may also have personal prejudices, fears or discomfort in talking about sexuality particularly with the elderly, disabled, men who have sex with men, and patients who are in multiple relationships (Oropeza et al., 2001). Providers may assume that patients will disclose risky behaviors or symptom history without being asked, or they may feel that they simply do not have the time to counsel patients thoroughly about HIV and other STIs, given other pressing needs within the clinic.

When taking a sexual history it is important to refer to behaviors, rather than labels such as gay or bisexual. In some cultures men do not consider themselves gay or bisexual when they are the sexually "insertive" partner with other men; only the "receptive" partner is viewed as gay. In other words, men and women engage in sexual behaviors that do not necessarily define their identities, and a person's self-image does not always relate to the labels that may be culture-specific. Hence, it is important to ask questions about specific behaviors in a direct but respectful manner. Because people are

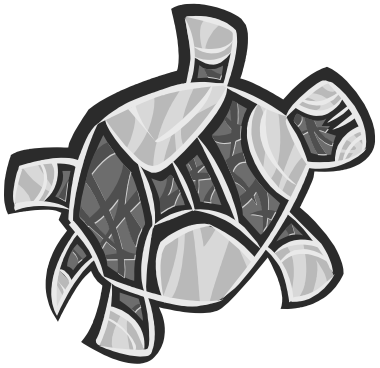
often uncomfortable talking about sexual issues, they may be tempted to avoid questions or to give evasive responses.

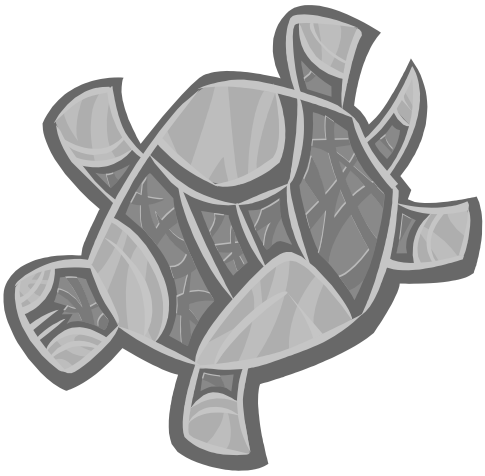
When discussing sexual behaviors, patients may not know the clinical terms for the behaviors they practice. It is appropriate to re-word terminology so that the patient understands the questions. It often helps to summarize the information provided by the patient as a method to avoid misunderstanding, which allows the patient an opportunity to clarify responses.

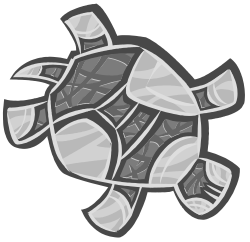
Assessment tools provide a mechanism to both obtain information from patients and to refer patients appropriately for further services. A high-risk behavioral assessment form facilitates an accurate, comprehensive review of a patient's recent and current risk behavior practices. While questioning people concerning their knowledge of HIV is relatively straightforward, obtaining accurate information about high-risk behaviors is often difficult for both patients and health professionals. Patients may be embarrassed when discussing intimate details of their sexual behavior and may be reluctant to disclose what are perceived to be socially undesirable behaviors. Furthermore, they may have concerns about the confidentiality of any information that is disclosed. Unless carefully handled, all of these issues are likely to result in an underestimation of risk and, perhaps, a misunderstanding of the degree of risk. For this training, the focus will be on the use of the risk assessment tool to identify those patients who require more intensive health related interventions and/or testing and counseling for HIV.

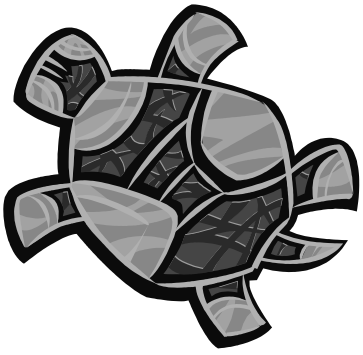
Session 9:

Implementation of the Risk Assessment









Slide 9.1

Time Frame

Bertha, today's date is February 1st. I'd like you to think back over the **past six months.** That's the time between September 1st and now. Think carefully about what you have done during that time period, **where** you've traveled, **what** you did during the three holidays (Thanksgiving, Christmas and New Years Eve), **whom you've met**, **whom you've dated**, and **how you've spent your time**. Now I'd like you to answer some questions about your sex life during the past six months. The **questions** will involve **how many times you have had sex** and the **types of sexual practices** that have taken place with your sexual partners. I'd like you to be as accurate as possible because this will let me know about your risk for HIV infection, and the best ways to help you be safe. So…think about the last six months, from August 1st to now, February 1st.

(Source: Kauth, St. Lawrence & Kelly, 1991)

Implementation of the Risk Assessment

Initially, the patient will be provided a time frame within which to assess his or her behavior. He or she will be asked to describe sexual behavior, use of alcohol or recreational drugs, piercing, tattooing, and any other potentially risky exposure occurring in that time frame. Kauth, St. Lawrence, & Kelly (1991) found that a retrospective time frame for sexual events occurring within the last 6 months was comprehensible for most patients, tended to yield counted "event" recollection rather than broad estimations or guesses concerning risk behavior frequency, and correlated well with self-monitoring recordings of behavior. An example of a possible structuring of the six month time period follows.

> *Bertha, today's date is February 1st. I'd like you to think back over the past six months. That's the time between August 1st and now. Think carefully about what you have done during that time period, where you've traveled, what you did during the two holidays (Christmas and New Years Eve), whom you've met, whom you've dated, and how you've spent your time. Now I'd like you to answer some questions about your sex life during the past 6 months. The questions will involve how many times you have had sex and the types of sexual practices that have taken place with your sexual partners. We'd like you to be as accurate as possible because this will let us know about your HIV risk and the best ways to help you be safe. So…think about the last 6 months, from August 1st and now, February 1st…*
> (Source: Kauth, St. Lawrence & Kelly, 1991)

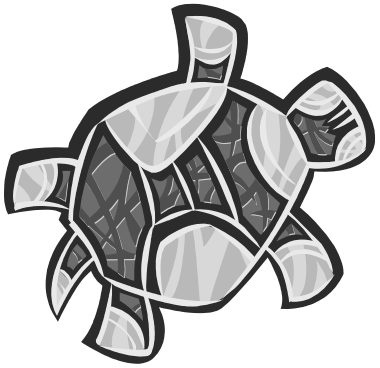
Information needed to complete the sexual component of the risk assessment includes the number of different sexual partners of each gender and type and frequency of sexual practices occurring with each partner.

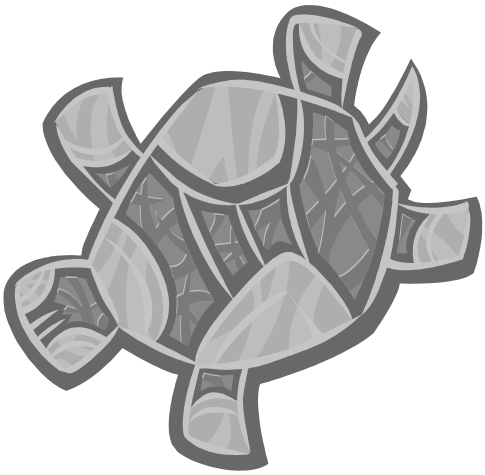
The complete risk assessment is divided into four sections that include sexual history, substance use history, piercing, tattooing, and additional exposures to risk. Each item will be reviewed and clarified with how it might relate to your tribal values. In conjunction with this, we will review use of the two motivational interviewing skills, affirmation and summarization.

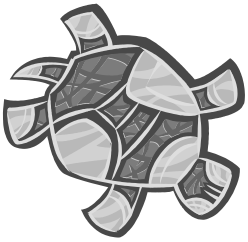
As is common with clinical interviews, sometimes it is not possible to use the entire assessment tool. For example, if a patient is fixated on their ensuing clinical visit, the practitioner may only be able to use the second section of the assessment, the sexual history section. If a patient is being seen for assessment of a possible STI, the sexual history section is a higher priority than the other sections. This section provides key information regarding risky sexual behaviors and consequent possible referral to HIV testing and counseling resources.

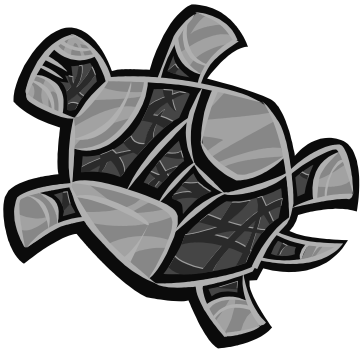
Session 10:

Communication Skills for Effective Interviewing









Open-Ended and Closed-Ended Questions

OPEN-ENDED QUESTIONS

Could you tell more about your concerns?

When do you think you started to be concerned about your partner's outside affairs?

CLOSED-ENDED QUESTIONS

Do you drink alcohol? Did you drink last weekend?

Do you use condoms?

Affirmation and Summarization

AFFIRMATION

I appreciate how hard it must be to provide this information to me today.

This must be very difficult for you.

SUMMARIZATION

You just mentioned… , now, does this seem right?

Let me see if I'm hearing you correctly. You said… Is that what you said?

You already mentioned this and that was… , so we already have an answer for this question, is that right?

Communication Skills

Communication between clinicians and patients is often difficult. When considering interviews of patients for their level of HIV/STI risk related to sexual behaviors and/or recreational drug use, communication becomes a primary process for either drawing the patient in or pushing the patient away. Open-ended questions often solicit more information from the patient, whereas closed-ended questions may discourage further communication.

Open-ended questions

Open-ended questions provide room for a patient to explain how they feel or think about their health concerns. Open-ended questions provide additional opportunities for a patient to think through their answer and possibly provide the answer within a story. Examples would include;

> *Could you tell more about your concerns?*
>
> *When do you think you started to be concerned about your partner's outside affairs?*

Closed-ended questions

Closed-ended questions limit a patient's need to provide additional information. Patients who engage in higher risk sexual behavior, do not protect themselves or others from contracting HIV, or use recreational drugs are less likely to be helped by the use of close-ended questions. Examples of closed-ended questions include:

> *Do you drink alcohol? Did you drink last weekend?*
> (Issue---How much did they drink last week or yesterday, and does this happen often?—When a patient tells you their story they are more apt to consider whether their behavior might be harmful to themselves or others.)
>
> *Do you use condoms?*
> (Issue—Does the patient know how to use condoms? If so, is the patient truly using them correctly?)

Two additional key counseling techniques may improve the risk assessment interview process for patients: *affirmations* and *summarization*.

Affirmations

When a clinician interviews patients regarding their health concerns, affirmations can provide a method of enhancing communication. An affirmation refers to use of compliments, statements of appreciation and acknowledgement by the clinician that he or she has "heard" the patient's story. For Native patients this experience of being "heard" assists development of trust in the clinician's ability to heal. Not feeling "heard" can limit the patient's desire to participate in a risk assessment interview. This feeling of not being heard can be magnified with adolescents and young adults who might be the patients most in need of a risk assessment. Some examples of affirmation include:

> *Thanks for answering all these questions.*
> *I appreciate how hard it must be to provide this (sexual) information to me today.*
> *This must be very difficult for you.*
> *I appreciate your observations and comments.*
> *That's a great question. I'll look into it.*
> *You certainly have to deal with a lot of problems right now-more than many people. I can understand how sometimes you want to escape from your worries and troubles* (Miller & Rollnick, 1991).

Summarization

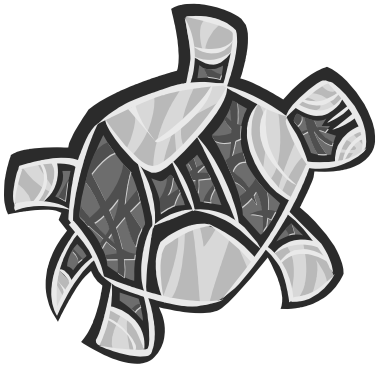
A summary statement can link comments together, clarify a patient's comments, or move the patient forward to the next question of a risk assessment interview. Periodic summaries reinforce what has been said, demonstrate that the clinician has been listening carefully, and prepare the patient to move on (Miller & Rollnick, 1991). The following statements are examples of summarizations.

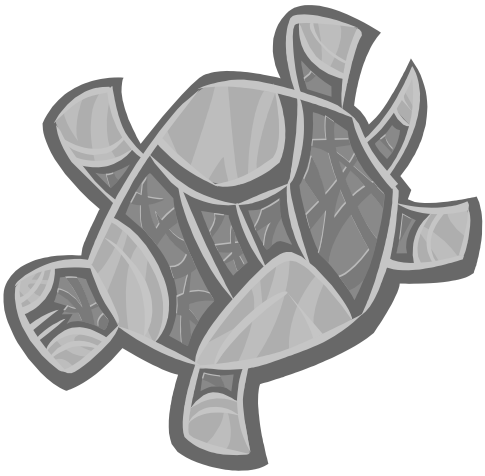
> *You've mentioned that you don't feel comfortable giving me this information today? Am I hearing you right?*

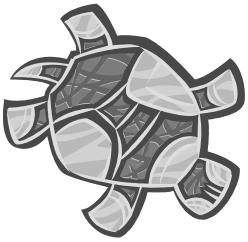
> *You've mentioned that you are scared to be tested for HIV because you think everyone in the community will think you are positive with HIV. Am I hearing you correctly?*

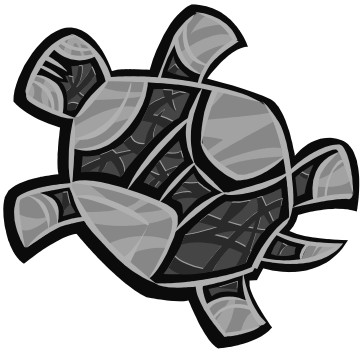
As we practice use of the risk assessment tool, we'll attempt to implement these techniques of affirmation and summarization. For many health practitioners the use of these two motivational interviewing techniques will be a review of presently used skills, while for others this may be a new experience.

References









References

American Red Cross. (1998). American Indians decision to survive. Tulsa, OK: American National Red Cross.

Baldwin, J., Maxwell, C., Fenaughty, A., Trotter, R., & Stevens, S. (2000). Alcohol as a risk factor for HIV transmission among American Indian and Alaskan Native drug users. American Indian and Alaska Native Mental Health Research, The Journal of the National Center, 9(1), 1-16.

Bouey, P. (1999). Chemical dependency and its specific effects on a person living with HIV/AIDS. In The Wind, 8(4), 3.

Brown, L. F. (2001). The four doorways. Unpublished manuscript.

Centers for Disease Control & Prevention [CDC] / National Center for HIV, STD and TB Prevention / Divisions of HIV/AIDS Prevention. (2003). HIV / AIDS surveillance report: HIV infection and AIDS in the United States, 15, Tables 19 & 21. Retrieved June 1, 2005, from http://www.cdc.gov/hiv/stats/2003SurveillanceReport.htm.

Centers for Disease Control and Prevention [CDC]. (2001a). HIV/AIDS surveillance report, 13(2).

Centers for Disease Control and Prevention [CDC]. (2001b). HIV and AIDS – United States, 1981-2000. Morbidity and Mortality Weekly Report [MMWR], 50(21), 430-434.

Chavez, G. F., Cordero, J. F., & Becerra, J. E. (1989). Leading major congenital malformations among minority groups in the U.S., 1981-1986. Journal of the American Medical Association, 261(2), 205-209.

Conway, G. A., Ambose, T. J., Chase, E., Hooper, E. Y., Helgerson, S. D., Johannes, P., et al. (1992). HIV infection in American Indians and Alaska Natives: Surveys in the Indian Health Service. Journal of Acquired Immune Deficiency Syndromes, 5(8), 803-809.

de Mauro, D., & Patierno, C. (1990). Communication strategies for HIV/AIDS and sexuality: A workshop for mental health and health professionals. New York: Sex Information and Education Council of the U.S.

Dhooper, S., & Moore, S. (2001). Social work practice with culturally diverse people. Thousand Oaks, CA: Sage Publications.

Duran, E., & Duran, B. (1995). Native American postcolonial psychology. Albany, NY: State University of New York Press.

Giroux, J., Takehara, J., Asetoyer, C., & Welty, T. (1997). HIV/AIDS universal precaution practices in sun dance ceremonies. The IHS Primary Care Provider, 22(4), 54.

Goldstone, I., Albert, R., Churchill, K., Schilder, T., Perry, T., Markowski, S., et al. (2000). HIV and injection drug use amongst First Nations in Vancouver: Outcomes of care and neglect. Native Social Work Journal, 3(1), 145-163.

Greene, B., & Hucles-Sanchez, J. (1994). Feminist visions new directions in education and training for feminist psychology practice. In Diversity: Advancing an inclusive feminist psychology. Washington, DC: American Psychological Association.

Guilmet, G., & Whited, D. L. (1989). The people who give more: Health and mental health among the contemporary Puyallup Indian tribal community. American Indian and Alaska Native Mental Health Research, The Journal of the National Center, 2(2).

Indian Health Service [IHS]. (1997). Trends in Indian Health, 1996. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Indian Health Service, Office of Planning, Evaluation, and Legislation, Division of Program Statistics.

Kauth, M. R., St. Lawrence, J. S., & Kelly, J. A. (1991). Reliability of retrospective reports of sexual HIV risk behavior: A comparison of biweekly, 3-month, and 12-month self-reports. AIDS Education and Prevention, 3(3), 207-214.

Lackritz E. M., Satten G. A., Aberle-Grasse J., Dodd, R. Y., Raimondi, V. P., Janssen, R. S., et al. (1995). Estimated risk of transmission of the human immunodeficiency virus by screened blood in the United States. The New England Journal of Medicine [NEJM], 333(26), 1721-1725.

May, P. A., & Hymbaugh, K. J. (1989). A macro-level fetal alcohol syndrome prevention program for Native Americans and Alaska Natives: Description and evaluation. Journal of Studies on Alcohol, 50(6), 508-518.

McCormick, R. (1994). The facilitation of healing for the First Nations people of British Columbia. Vancouver, B.C.: UBC Press.

McIlvenna, T. (Ed.) (1999). The complete guide to safer sex. New York: Barricade Books.

Miller, W.,& Rollnick, S. (1991) Motivational interviewing: Preparing people to change addictive behavior. New York: Guilford Press.

Morrison-Beedy, D., Carey, M. P., Lewis, B. P., & Aronowitz, T. (2001). HIV risk behavior and psychological correlates among Native American women: An exploratory investigation. Journal of Women's Health and Gender-Based Medicine, 10(5), 487-494.

Neron, C., & Roffey, R. (2000). HIV, sexual violence, and Aboriginal women. Native Social Work Journal, 3(1), 57-72.

Niezen, R. (2000). Spirit wars: Native North American religions in the age of nation building. Berkeley, CA: University of California Press.

Oropeza, L., Bouey, P., Tight, R., & Bradley-Springer, L. (2001). HIV/AIDS prevention, early intervention, and health promotion: A self-study module for health care providers serving Native Americans. Denver, CO: Mountain Plains Regional AIDS Education and Training Center [MPAETC].

Palafox, N.A., Buenconsejo-Lum, L., Ka'ano'I, M., & Yamada, S. (2001). Cultural competence: A proposal for physicians reaching out to Native Hawaiian patients. Pacific Health Dialog, 8(2), 388-392.

Peavy, R.V. (1993). Development of aboriginal counseling: A brief submitted to the Royal Commission of Aboriginal peoples. Retrieved January 10, 2005, from the Victoria, B.C., Canada, Ministry of Education Web site: www.bced.gov.bc.ca/ abed/ reports/subroyal.com.html/

Potthoff, S. J., Bearinger, L. H., Skay, C. L., Cassuto, N., Blum, R. W., & Resnick, M. D. (1998). Dimensions of risk behaviors among American Indian youth. Archives of Pediatric and Adolescent Medicine, 152(2), 157-163.

Rowell, R. M., & Bouey, P. D. (1997). Update on HIV / AIDS among American Indians and Alaska Natives. The I.H.S. Primary Care Provider, 22, 49-53.

Rowell, R., & Bouey, P. (2002). What are American Indian and Alaskan Natives HIV prevention needs? (Fact Sheet #43E). San Francisco: Center for AIDS Prevention Studies/University of California San Francisco.

Sioui, G. E. (1992). For an American history: An essay on the foundations of social ethic. Montreal, QC, Canada: McGill-Queens University Press.

Swinomish Tribal Community. (1991). A gathering of wisdoms, tribal mental health: A cultural perspective. Mt. Vernon, WA: Veda Vangarde.

Swinomish Tribal Mental Health Project. (2002). A gathering of wisdoms (2nd ed.). Lynden, WA: Proforma Mountainview Press.

Trimble, J. E. (1982). American Indian and Alaska Native mental health seminars. Seattle, WA: Seattle Indian Health Board.

Vernon, I. (2001). Killing us quietly: Native Americans and HIV/AIDS. Lincoln: University of Nebraska Press.

Washington State Department of Health. (1996). Sexually transmitted diseases. Olympia, WA: Office of STD.

Weaver, H. (1999). Through indigenous eyes: Native Americans and the HIV epidemic. Health and Social Work, 24(1), 27-34.

Williams, D. C. (2000). STD Wonderland. Seattle, WA: The Northwest AIDS Foundation.