

PERCEPTIONS OF HEALTHCARE PROVIDERS ABOUT HIV/STD
PREVENTION EDUCATION AMONG AMERICAN INDIAN
POPULATIONS: A QUALITATIVE DESCRIPTIVE SURVEY STUDY

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ABSTRACT

Background: Unmet healthcare education needs of American Indian and Native Alaskan (AI/NA) adults remain significant in the United States. Disparities have been identified in healthcare access, health status, and preventative care. HIV/STD's disproportionately affect AI populations compared to Caucasians but remain lower than African American and Hispanic/Latino races in the US. However, American Indians have poorer survival rates of HIV and face significant cultural based stigma and poverty. Understanding the perception of HIV/STD prevention education from a community perspective is important to develop comprehensive educational programs.

Purpose: The purpose of this study is to examine the perceptions of healthcare providers about HIV and STD/STI prevention education among AI/NA tribal populations.

Theoretical Framework: This project is based upon the community-based participatory research model (CBPR), which integrates education and social action to improve health and reduce health disparities. The major tenets of this framework highlight community involvement in the research process and understanding the historical context of the population to include culture, beliefs, and norms that may be critical in designing preventative health educational initiatives.

Methodology: We will conduct a qualitative descriptive exploratory study to examine the perceptions of healthcare providers who care for adult AI/NA men and women. We will conduct face-to-face interviews and online surveys using a purposive sample design. The estimated sample size is approximately 15 participants. Interviews will be recorded and content analysis will be conducted to identify categories and themes perceived as important to providing culturally appropriate HIV/STD education in the future.

Findings: The study remains open for data collection until May 31, 2014.

Conclusion: HIV and STD's remain a significant health threat to American Indian populations. The information elicited from this study will be used, with data collected in future studies with key AI/NA tribal leaders and members, to develop a culturally appropriate HIV/STD intervention to increase knowledge and prevention strategies to ultimately decrease the incidence and prevalence of HIV and STDs.

Introduction

INTRODUCTION

Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), and sexually transmitted diseases (STDs) are significant health issues for American Indians and Native Alaskans (AI/NA). Rates of HIV/AIDS and sexually transmitted diseases/sexually transmitted infections (STDs/STIs) disproportionately affect American

Indian men and women in the United States as compared to Caucasians but remain lower than African American and Hispanic Latinos (Centers for Disease Control and Prevention CDC, 2011). In addition, mistrust, stigma, cultural taboos, and confidentiality concerns remain significant barriers to receiving healthcare and education related to these diseases in the AI/NA populations (Kaufman, et al., 2007; Pacheco, Daley, Brown, Filippi, Greiner, & Daley, 2013)

RESEARCH AIMS

Specific Aim: The specific aim of this qualitative descriptive exploratory survey study is to examine the perceptions of healthcare providers about HIV and STD/STI prevention education among AI/NA tribal populations.

Research Questions:

1. What are healthcare providers' perceptions about HIV & STD/STI educational needs among their AI/NA patient populations?
2. What are healthcare providers' methods of HIV & STD/STI prevention education for AI/NA patients?

BACKGROUND

Although in 2011, American Indian/Alaska Natives ranked fifth in the estimated rates of HIV infection diagnoses, HIV disease remains a significant health issue among this population. HIV/AIDS is the ninth leading cause of death among AIs. AIs/NAs have the shortest survival time with disease and progress to AIDS diagnosis (CDC, 2011). In AI men diagnosed with HIV, Male-to-male (MSM) contact accounts for 84% of the infections

followed by MSM and injection drug use (IDU) (6%), heterosexual contact (6%) and IDU at 4%. In women, the leading cause of HIV infection is from heterosexual contact (83%), followed by IDU (15%) (CDC, 2011).

Sexually transmitted diseases are a significant health problem for American Indian populations. In a study by Kaufman, et al (2007), the STD prevalence in the North Central Plains AI/NA was 6 times higher than the overall US rates. Rates of STD's range from 2.7-7.8 times higher in a sample of AI as compared to non-Hispanic white (NHW) individuals presenting the continual burden of STD's in the AI/NA population (Winscott, Taylor, & Kenney, 2010). Risk factors for high STD such as chlamydia, HPV, Gonorrhea, and Syphilis rates in AI include young age of first sexual encounter, multiple sex partners, lower socioeconomic status, multiple sexually transmitted disease diagnoses, smoking, poor nutrition, multiple childbirths, and lower age (Bell, Schmidt-Grimminger, Jacobsen, Chauhan, Maher, & Buchwald, 2011; Dicker, Mosure, Kay, Shelby, Cheek, 2008). Significant delays in treatment of STD's in AI populations have been noted (Winscott, Taylor, & Kenney, 2010) placing the individual at significant risk for long-term health problems such as cancer and infertility (Dicker, Mosure, Kay, Shelby, & Cheek, 2008). The disproportionate number of young AI/NA diagnosed with HIV/and/or STDs suggests that current primary and secondary prevention interventions are not effective. Tribal and state laws governing screening and treatment of minors pose many challenges to prevention activities (Kaufman, et al., 2007).

Effective educational interventions utilizing tribal and cultural beliefs to promote education, screening, diagnosis and treatment of HIV/STD in AI are needed (Kaufman, et

al., 2007; Markus, 2012; Winscott, Taylor & Kenney, 2010; Vernon & Jumper-Thurman, 2002). Kaufman, et al (2007) from the Task Forces on STD Prevention and Control among American Indians and Alaska Natives suggests that using the local cultural and context specific knowledge such as understanding sexual health in AI/NA's be used to guide research and interventions to reduce the burden of HIV/STD's in this population. The use of culturally-appropriate education and materials has been shown to be effective in a smoking cessation program for AI (Makosky Daley, et al., 2010) and in a HIV/AIDS prevention intervention for AI and NA youth (Kaufman, Litchfield, Schupman, & Mitchell, 2012). Furthermore, by including providers and tribal leaders' views in assessing the perspective of the AI population can offer insight into the community views on healthcare needs (Daley, et al., 2012).

This is an interprofessional collaborative research study between nursing, social work, and medicine to understand healthcare providers' perceptions of the educational needs regarding HIV and STD's. The information elicited from this study will be used, with data collected in future studies with key AI/NA tribal leaders and members, to develop a culturally-appropriate HIV/STD intervention to increase knowledge and prevention strategies to ultimately decrease the incidence and prevalence of HIV and STDs.

THEORETICAL FRAMEWORK

Community Based Participatory Research (CBPR) is "an orientation to research that focuses on relationships between academic and community partners, with principles of colearning, mutual benefit, and long-term commitment and incorporates community theories, participation, and practices into the research efforts" (Wallerstein & Duran,

2006). This methodology applied to Indian American (AI) populations has included working within the historical and cultural framework of the population with an emphasis on community inclusion. Fisher and Ball (2003) note that the values and beliefs of the community form the central core of intervention. Therefore the researcher should obtain formal consent from the Tribal Council and work closely with cultural, religious, and spiritual leaders, elders, and relevant individuals from tribal programs. CBPR may also include seeking facilitators who can encourage clear communication between researchers and tribal members, and including community members at all levels of the research project. Lastly, researchers have noted that focus groups are means to obtain feedback about interventions. Evidence indicates that these empowerment strategies can improve health among different subpopulations particularly at risk for social exclusion, including those at risk for HIV/AIDs (Wallerstein & Duran, 2006).

Daley et al. (2010) have utilized CBPR in colorectal cancer screening, breast cancer screening, and Internet health information initiatives for AI's in Kansas and Missouri. Methods of community involvement included forming the American Indian Health Research and Education Alliance, presence at a number of community pow wows, dinners and symposiums, and offering free health information and screenings. They additionally conducted in person interviews to determine community member interest in health topics. Presence and input from the community will likewise guide this initiative.

METHODS

DESIGN

The proposed study will use a qualitative descriptive design. This inductive approach provides an in-depth understanding of a phenomenon of concern in nursing and healthcare (Sullivan-Bolyai, Bova, & Harper, 2005). It also allows the researcher to describe the phenomenon of interest with minimal interpretation of data (Sandelowski, 2000). A key benefit of the methodology is the ability to obtain an in-depth subjective view into the perceptions HIV/STD education among healthcare providers. Qualitative description was used to provide a preliminary understanding of this scarcely researched phenomenon (Sandelowski, 1999).

SAMPLING AND PROCEDURES

A purposive sampling design will be used to target healthcare providers who care for adult AI/NA men and women. The recruitment flyer (appendix A) will be distributed at the March Conference hosted by the Kansas AIDS Education and Training Center (KAETC) and sent to clinics that provide direct care to American Indian populations in Kansas through the KAETC email list serve. If persons wish to be contacted about the survey at the KAETC meeting, we will collect their email addresses and send them the link to the survey via Survey Monkey or they may call or email the PI of the study to obtain the survey link.

Inclusion criteria include: older than 18 years of age, the ability to read and speak English, and provides health care and healthcare services to the American Indian population.

Written consent will be obtained if providers elect to be interviewed in the audiotaped face-to-face format.

The face-to-face interviews will be conducted using a structured interview guide (appendix B) and will be audio-taped for transcription. Basic demographic information (appendix C) will be collected prior to focus group or one-on-one interviews. Researcher notes will be taken immediately after the session.

If participants elect to complete the survey in the online format, they will be asked to read the information sheet prior to answering the survey questions. Consent is assumed if the participants fill out the demographic data sheet and the survey questions.

DATA ANALYSIS

The study personnel will transcribe the transcripts verbatim. The transcripts will be de-identified to uphold confidentiality of the participants. The research team will read the transcripts while listening to the audio recordings to ensure accuracy of the transcripts. The researchers will use content analysis to examine the data. Qualitative content analysis uses a systematic format to develop codes, or labels to describe data from careful reading of the interview transcripts (Knafl, & Webster, 1988; Morgan, 1993).

The research team will read through the transcripts, and listen to the audiotapes to ensure the accuracy of the transcripts. The online responses to the survey questions will be read and reviewed. Initial impressions of the interview will be noted in a reflexive journal. A codebook will be created to list, organize and arrange codes. The purpose of coding is to cluster large pieces of data into a smaller number of focused descriptive themes (Miles & Huberman, 1994; Morgan, 1993). Codes will then be consolidated where possible, and

ongoing attempts will be made to compare and contrast patterns across the data (Creswell, 2003). Codes will be used to develop themes and that describe the perceptions HIV/STD education among the three groups. Descriptive statistics will be used to describe the sample demographic data.

RESULTS

The sample consisted of three participants so far. Because the survey is still open to participants, data saturation has not been reached. We disclose that one of the surveys is incomplete. Respondents were all female and all from the Midwest. Participants had on average 7.5 years (range 1-15) of experience working with AI populations and included an RN, APRN, and social worker. Preliminary findings suggest that caring for members of the AI population is very rewarding and very challenging. Barriers include: trust, geographical distance to healthcare, substance abuse, myths and traditional beliefs, and family crises. Survey results also recommend the following education methods: talking circles, handouts, talking with every visit, various formats, phone applications, online materials, and native specific materials. One respondent noted that it might be hard to address each individual tribal belief culture and recommends fundamentally providing information about contracting diseases regardless of beliefs. From the provider prospective one should be very forthcoming with every disease and diagnosis. She stated, "Because you believe you cannot contract it does not make it so."

DISCUSSION

These findings correlate with current research that factors such as trust, access, active substance abuse, travel time, and family dynamics are barriers to AI populations (Kaufman,

et al., 2007; Pacheco, Daley, Brown, Filippi, Greiner, & Daley, 2013). These also reconfirm the utility of culturally specific education methods (Makosky Daley, et al., 2010; Kaufman, Litchfield, Schupman, & Mitchell, 2012). A novel recommendation is the use of talking circles. “The circle process establishes a safe non-hierarchical place in which all present have the opportunity to speak without interruptions” (Umbreit, 2003, pg. 1). This technique has been widely used among hundreds of tribes of AI in this country (Umbreit, 2003; Struthers, Hodge, Geishirt-Cantrell, & De Cora, 2003). An additional new insight is that technology based education may be beneficial to AI youth. Kaufman et al. (2012) have similarly developed computer-based versions of an HIV/AIDS prevention intervention for American Indian and Alaska Native youth.

We are anticipating approximately 12 future survey results. Therefore the projected total sample size is small but appropriate for a qualitative descriptive study. Results may be limited to a certain geographical area thus we could not make assumptions about provider perceptions in regions outside of the Midwest. The data may not be transferrable to populations outside of this particular group and the themes that emerge from the participants may not be representative of the other providers AI populations outside of this region.

CONCLUSION

HIV and STD's remain a significant health threat to American Indian populations. Data confirm barriers to HIV/STD prevention education among AI populations. Data also confirm the need for interventions utilizing tribal and cultural beliefs and further suggest the utility of talking circles and technology as educational tools. The information elicited

from this study will be used, with data collected in future studies with key AI/NA healthcare providers, tribal leaders and members, to develop a culturally appropriate HIV/STD intervention to increase knowledge and prevention strategies to ultimately decrease the incidence and prevalence of HIV and STDs. We propose to interview the community members and tribal leaders in addition to healthcare providers as part of this ongoing project.

APPENDIX A

RECRUITMENT FLYER

PERCEPTIONS OF HIV/STD PREVENTION EDUCATION AMONG HEALTHCARE PROVIDERS: A QUALITATIVE DESCRIPTIVE SURVEY STUDY

We invite you to participate in a study if you are a healthcare provider for persons of American Indian/Native Alaskan heritage and would like to discuss your perception of HIV/STD education in this population.

If you are interested in participating in this study: please contact Lisa Ogawa (study PI) at 617-851-1508 or email at logawa@kumc.edu

You may participate in the online secure survey through Survey Monkey at the following link:

<https://www.surveymonkey.com/s/2NNGVHL>

Thank you!

KUMC IRB: STUDY00000994



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APPENDIX B

FACE-TO-FACE AND ONLINE SURVEY QUESTIONNAIRE

HealthCare Provider Questions
What is like caring for the AI population?
Do you provide care to individuals with HIV and STD's in your practice? If so, will you describe the population you care for and approximately how many persons do you see per month.
What cultural beliefs do you encounter in providing care to the AI population? How do these beliefs impact health care overall and how do they impact HIV and STD education and prevention?
What cultural barriers exist when providing education related to HIV and STD prevention?
How do you educate your patients about prevention of HIV and STD's in your practice?
What strategies could be helpful in providing prevention education to the AI population about HIV and STD education?
Do you have any other suggestions as a healthcare provider about providing prevention education to the AI population that might be helpful?

APPENDIX C

DEMOGRAPHIC WORKSHEET

Gender	Male Female
Type of Provider: MD/DO, APRN, PA	MD DO APRN PA RN Social Work Mental Worker Public Health Professional Other Please List
Years working with AI population	
Geographical area in which you work:	Midwest West Northeast

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