Analysis of the Maryland American Indian Health and HIV/AIDS Needs Assessment

May 2004

Conducted by the Center for Health Program Development and Management
for the Maryland AIDS Administration

Contents

Executive Summary 1
Overview of Findings
Conclusions

Introduction 3

Methodology 3

Respondent Characteristics 4

Knowledge of HIV Transmission and Risk 6

Condom Knowledge 7

Attitudes Regarding HIV 9

Sexual Risk and Protective Factors

Assets and Skills to Reduce HIV Risk via Sexual Transmission 10

Sex Partners 10

Risky Behavior 11

Drug Use and HIV Risk Prevention Knowledge 13

Tattoos and Piercings 13

HIV Testing 14

Appendix 1: Powwows and Other Locations Where the Survey Was Administered 15

Appendix 2: Respondents' Tribal Affiliations 16

Executive Summary

From August 2003 through January 2004, the Center for Health Program Development and Management at the University of Maryland, Baltimore County conducted a needs assessment for the Maryland AIDS Administration. The assessment was performed in order to determine the knowledge, attitudes, and practices of Maryland American Indians concerning the issues of HIV/AIDS education, screening/testing, and treatment. The 20-30 minute, written assessment was conducted at seven powwows and through a community-based organization that works with American Indians in Baltimore City. There were 253 respondents overall, with 37 tribal affiliations.

This study allows some insight into which areas the Maryland AIDS Administration and Maryland American Indians might work together to improve efforts to decrease the spread of HIV/AIDS.

Overview of Findings

Every community has both strengths and weaknesses. The data from this study generally reveal a group of people who are well-informed about HIV/AIDS issues, knowledgeable about its transmission, concerned about its spread, and not involved in behaviors that risk acquiring or transmitting the virus to others. Specifically, most respondents:

- Have a main sex partner (77 percent)
- Know the primary routes of transmission
- Know how to get and use condoms appropriately
- Know where to obtain HIV/AIDS-related services such as family planning and reproductive health services, HIV/AIDS counseling and testing, STD counseling and testing, and substance abuse counseling and treatment
- Have positive attitudes about HIV/AIDS that support their capacity for taking positive steps to avoid the disease (most do not think that it is a gay or white man's disease that does not affect them, and most are not "burned out," "tuning out," or "tired" of hearing about the issue)
- Report high rates of self-esteem and self-worth
- Report low rates of drug use

Part of the purpose of the study, however, is to learn about the smaller segments of the respondents who put themselves and others at risk. The risk issues identified in the report include:

- Misunderstandings about modes of transmission and which body fluids carry the virus and
- Lack of knowledge about appropriate condom use
- Lack of knowledge about where to get important HIV/AIDS-related services

- Attitudes that AIDS is a “death sentence” and that sex is not as good with a condom
- Lack of comfort communicating with sexual partners regarding HIV, condom use, and previous sexual partners
- Casual sex partners among
- Risky behaviors of more than half of all respondents; 28 percent of these having never been tested

Introduction

It is well recognized in health care that no single method of outreach or service delivery will serve the needs of all segments of the population. Among the factors to be considered are the need to understand the cultural and social context in which individuals live, their knowledge, attitudes, and behaviors. Also important, is the need to acknowledge and understand the inherent assets, skills and protective factors that assist individuals and groups to maintain or regain health in the face of threats to health. In the case of HIV/AIDS, individuals' personal backgrounds and social/cultural milieus impact their behaviors and receptivity to information and use of health care services, etc.

In an effort to improve its planning for services to the Maryland American Indian community, the Maryland AIDS Administration contracted with the Center for Health Program Development and Management (Center) at UMBC to gather information about this population. To this end, the Maryland American Indian Health and HIV/AIDS Needs Assessment was conducted April 2003 through April 2004.

As a needs assessment, this report necessarily focuses on areas of deficit and need as a tool to understand and prioritize the interventions the AIDS Administration might undertake. However, the strengths in this community should be recognized and acknowledged as important elements in combating AIDS. It is evident from the enthusiastic cooperation of tribal leaders toward the survey, and the willingness of respondents to take the time to answer a lengthy questionnaire asking for highly personal information, that the community is interested in increasing its knowledge about HIV/AIDS and working with the AIDS Administration to reduce the spread of HIV/AIDS.

Methodology

Between August 2003 and January 2004, staff of the Center attended powwows throughout the state (see Appendix 1), soliciting the participation of Maryland residents who identified themselves as American Indian. A total of 253 respondents completed the needs assessment instrument.

More than 20 community-based and tribal organizations were initially contacted to seek advice about implementing the survey and/or to gain access to American Indian persons associated with or served by the organizations/tribes. There is no single source for identifying members of the American Indian community that would capture those not officially enrolled in the several federally unrecognized tribes in the state or involved with or served by community-based/tribal organizations. Thus, a convenience sample survey methodology was employed. It should be noted that a convenience sample does not afford generalizations to a group or population, but are often employed when a probability sampling approach is not feasible. This method does foster an understanding of the knowledge, practices, and attitudes about HIV/AIDS as an exploratory effort.

The instrument for this needs assessment was developed using items from the Maryland AIDS Administration's Planning and Evaluation instruments, as well as items taken from surveys of American Indians in two other states. These surveys are the North Dakota Native American HIV/AIDS Needs Assessment, conducted March 2002, and the Greater Houston Native

American/Alaska Native HIV Testing Survey, conducted December 2002. The instrument includes questions on several aspects of HIV/AIDS, including respondents' knowledge, attitudes and practices related to acquiring and transmitting the virus.

The instrument was reviewed by staff at both the AIDS Administration and the Center for question clarity and face validity. The instrument was revised based on comments and feedback from reviewers, and pilot test participants. Pilot testing showed the survey to take 20 to 30 minutes to complete.

The project was conducted under the auspices of the University of Maryland, Baltimore County Institutional Review Board. The purpose and sponsorship of the study was explained in an introductory statement inside the front cover of the survey. Respondents were required to read and signed an informed consent statement. To protect privacy, completed surveys were immediately placed in a sealed envelope after completion, and consent forms and surveys were kept separately.

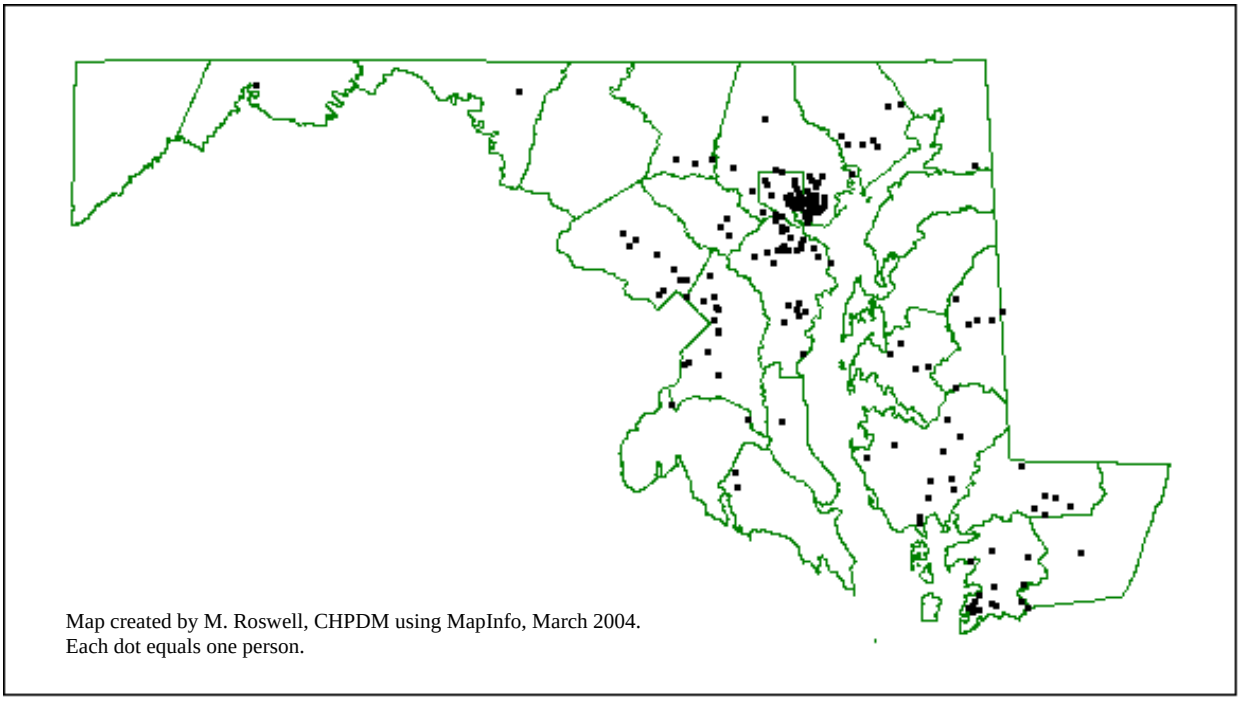
Respondents were allowed to identify themselves as American Indian Maryland residents age 18 or over. Tribal membership was not required, but those who questioned their eligibility were asked if they usually indicate, "American Indian" on forms asking for ethnic/racial category and/or if they grew up in a home where American Indian was the primary family identity. Incentives for completing the survey were the choice of a $20 gift card or a set of items including a cap, canvas bag, and tee shirt.

Respondent Characteristics

Of the 253 survey respondents, 85 (34 percent) were male, 159 (65 percent) were female, 2 respondents reported transgender status (female to male), and 7 did not indicate gender. Fifty-one percent are married, living as married, or living with their current sex partner.

Figure 1 shows the geographic distribution of respondents using their home zip code. The largest concentration of respondents is in the Baltimore metropolitan area. (See Figure 1.)

Figure 1: Map of Survey Respondents with a County Overlay



Regarding education, 27 percent of respondents completed high school or a GED, 38 percent received some technical training or attended some college, 19 percent are college graduates or have a graduate degree, and 17 percent did not complete high school. (See Figure 2.)

Seventy percent report being employed, and the same percent report having health insurance. Fifty percent have private insurance, 8 percent have Medical Assistance, and 10 percent have Medicare. (See Figure 3.) The majority of respondents (76 percent) receive health care from a private physician, 11 percent state that their usual source of health care is the emergency room, and 9 percent receive care from a government/veteran/military clinic.

Figure 2: Respondents' Education Level

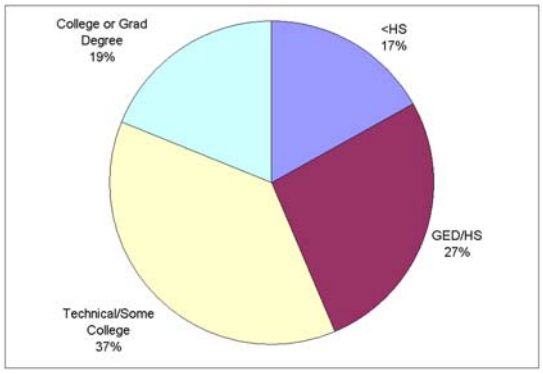
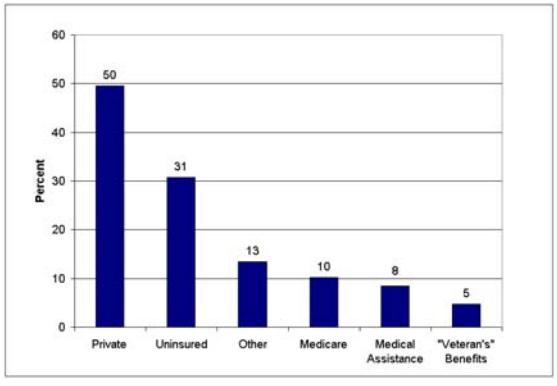


Figure 3: Health Insurance of Respondents*



Intrinsic to the survey design and protocol, only respondents who were American Indian/Native American (AI/NA) were solicited. Of the 223 respondents who designated themselves as AI/NA (there were 30 that did not respond to this question), the single most frequently first-mentioned tribe was Lumbee (n=101), followed by Cherokee (n=31). The

Nause Waiwash tribe was mentioned first 9 times, and the Assateaque, Accohannock, and Blackfoot were mentioned 5, 6, and 6 times, respectively. Thirty other tribes were mentioned as a first choice once or twice. Twenty-eight persons mentioned a second tribe, and there were 5 third mentions of tribal affiliation. (A list of respondents' entries is included in Appendix 2.)

Racial groups mentioned include White (n=28), African American/Black (n=13), and Native Hawaiian/Pacific Islander (n=4).

The final question of the survey asked respondents how frequently health care personnel classified them as an ethnic/racial group other than American Indian without asking them. The majority (56 percent) indicated that this occurred "always" or "more than half of the time." (See Table 1.)

Table 1: Frequency of Race Presumed as Non-Indian

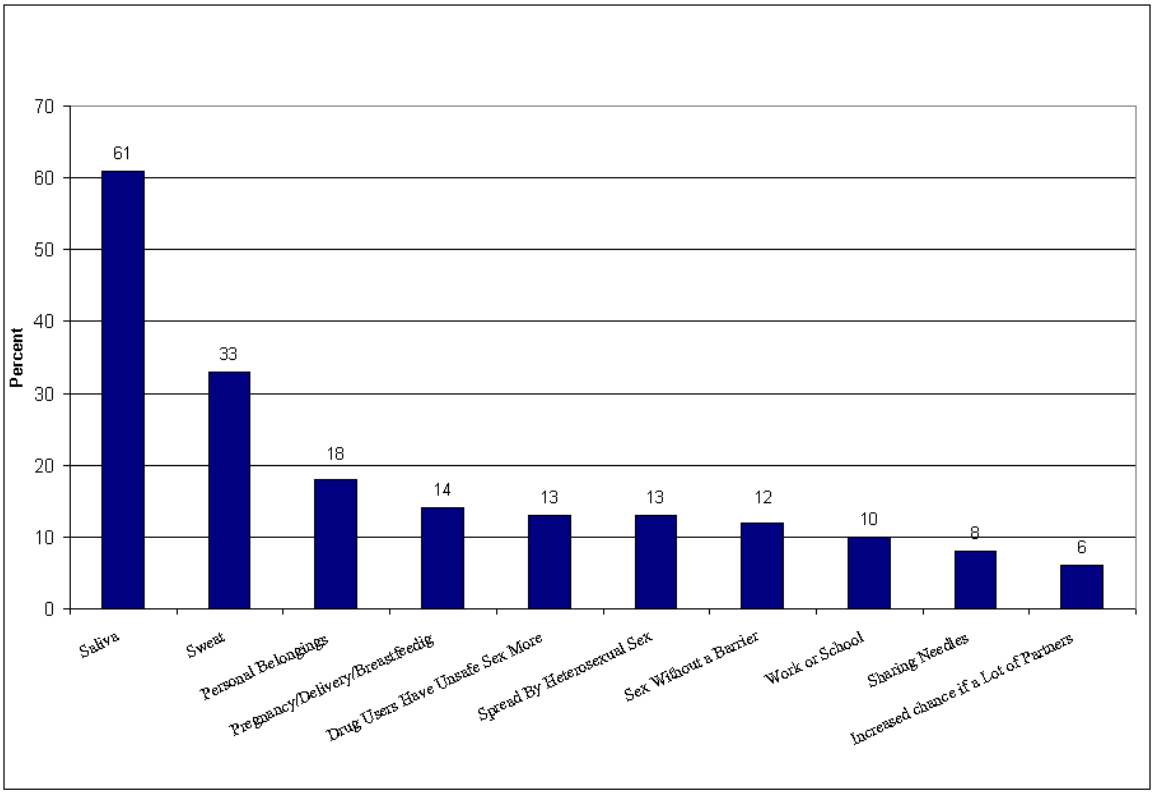
Frequency	Number	Percent
Always	83	35
More Than Half of the Time	49	21
About Half of the Time	21	9
Less Than Half of the Time	23	10
Never	22	9
Don't Know	37	16

Knowledge of HIV Transmission and Risk

While the vast majority of the respondents were knowledgeable about HIV transmission, common misunderstandings about which body fluids carry the virus and other modes of transmission indicate important areas of knowledge deficit. Specifically, there was a lack of knowledge about transmission via:

- Saliva (61 percent answered incorrectly or not sure)
- Sweat (33 percent responded incorrectly or not sure)
- Sex without a barrier (12 percent answered incorrectly or not sure)
- Sharing needles (8 percent answered incorrectly or not sure)
- "A lot of partners" (6 percent answered incorrectly or not sure) (See Figure 4.)

Figure 4: Knowledge of HIV Transmission: Percent of Incorrect or Unsure Responses

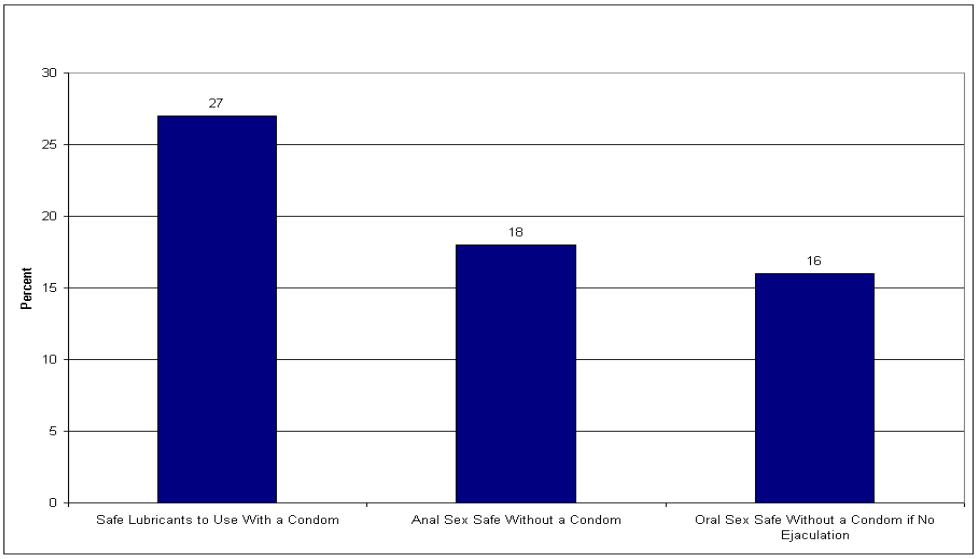


Condom Knowledge

As far as knowledge about condoms, most respondents answered correctly about the appropriate use of condoms; however, 12 percent state that they do not know whether or not a person can get HIV if they have sex without using a barrier method. Further, 27 percent answered incorrectly or were unsure about which lubricants were okay to use with condoms. When asked about oral sex, 16 percent feel that it is safe to have without a condom if there is no ejaculation. Concerning anal sex, 18 percent think that it is safe to have without a condom. Many respondents (40 percent) feel that requesting a partner to use a condom would indicate to the partner that they are not trusted. (See Figure 5.)

Twelve percent state that they do not know whether or not a person can get HIV if they have sex without using a barrier method.

Figure 5: Knowledge of Condom Use: Percent Incorrect or Unsure Responses



Almost all (99.5 percent) of those responding to the question say that they know where to get condoms, and 89 percent understand their correct use. However, 11 percent disagree or are unsure that they know how to *use* a condom. Part of the effort to empower the community to reduce their exposure to HIV and to lessen the impact of HIV/AIDS is to increase awareness of available services for reproductive health, HIV/AIDS testing and treatment, etc. Many report not knowing where to get services that are critical to limiting the spread of HIV. Most respondents knew where to get condoms (83 percent), but many *did not know* where to get substance abuse counseling and treatment (41 percent), family planning/reproductive health services (35 percent), HIV/AIDS testing and treatment (31 percent), sexual assault services (48 percent), dental dams (64 percent), or post-exposure prophylaxis (70 percent). The very low response on knowing where to get dental dams and post-exposure prophylaxis might be due to many who do not know what these are. (See Table 2.)

Table 2: Percent Knowing Where to Get Important HIV/AIDS-Related Services

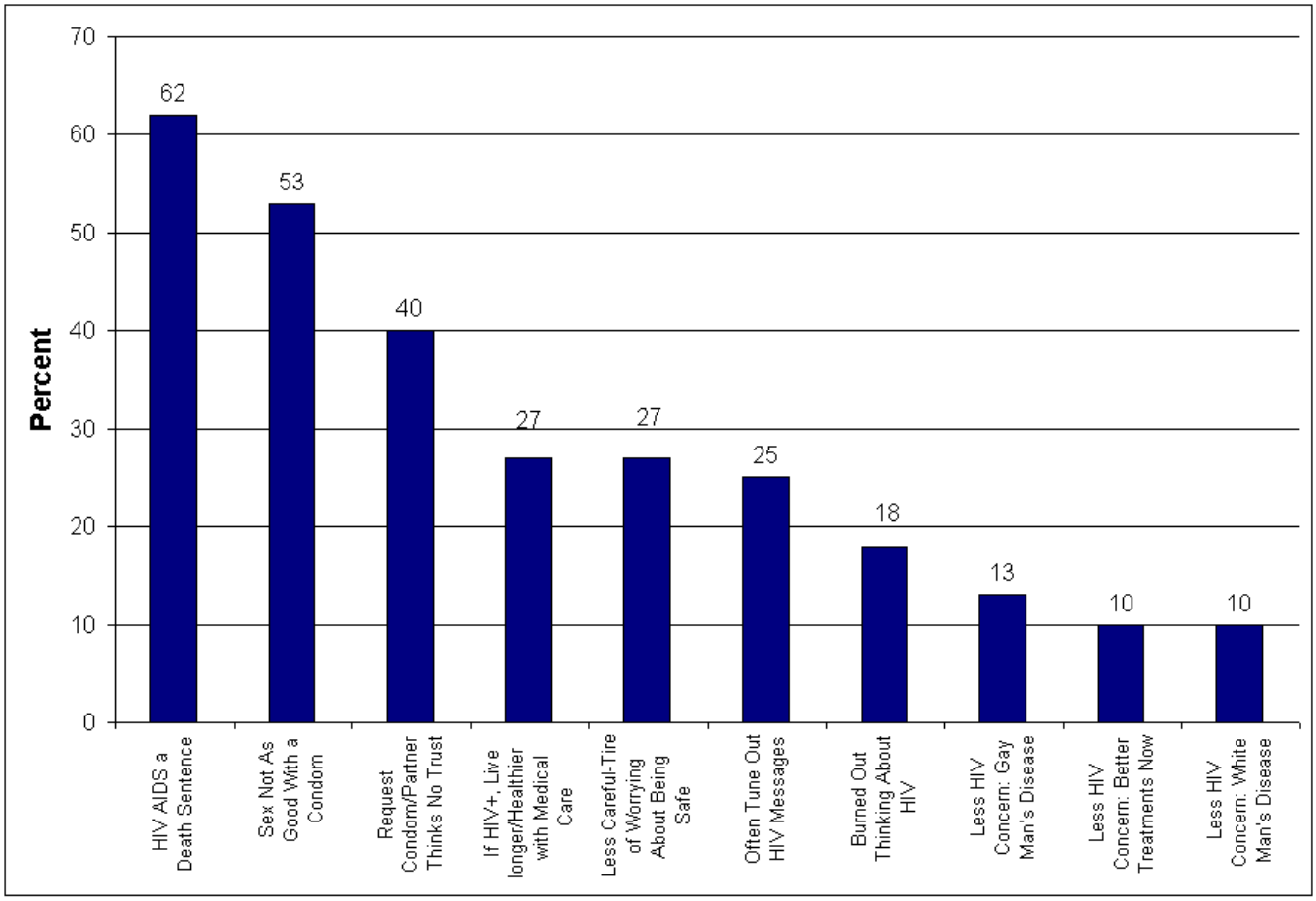
Service	Percent
Condoms	83
HIV/AIDS Counseling/Testing	69
Family Planning & Reproductive Health Services	65
Substance Abuse Counseling and Treatment	59
STD Counseling, Testing & Treatment	57
Sexual Assault Services	52
Dental Dams	36
Post-Exposure Prophylaxis (PEP)	30

Attitudes Regarding HIV

Several of the measured attitude variables indicate possible issues that place persons at increased risk. Fifty-three percent feel that sex is not as good with a condom, which may diminish the number of persons willing to use a condom. While most respondents have attitudes that would lead to behaviors that would minimize the spread of HIV. a number of questions indicated that *some* are giving HIV less consideration (see Figure 6):

- 25 percent say that they "tune out" messages about HIV
- 18 percent say that they are "burned-out" thinking about HIV
- 27 percent say that they are less careful about avoiding HIV because they are tired of worrying about being safe
- 20 percent say that they are unsure of how they feel about "being safe"

Figure 6: Negative Attitudes Regarding HIV-Related Issues



Among the 13 percent who feel that HIV is less of concern for them because it is a "gay man's" disease, and the 10 percent who feel it is a "white man's" disease, risk could be greater as they do not identify with the population that they feel is at risk.

Sexual Risk and Protective Behaviors

Assets and Skills to Reduce HIV Risk via Sexual Transmission

Of all respondents, 25 percent expressed that they could not or were not sure if they could avoid risky HIV situations. (Sixty percent of these are respondents who report one or more risky behaviors. See p.8.) Self-efficacy is a major component of achieving behaviors that require interaction and/or negotiation with another individual, and can be affected by self-esteem. While most respondents display high levels of self-esteem (92 percent report having a positive attitude about themselves, and 90 percent feel that they are a person of worth), the balance of respondents who do not score highly in these areas may be individuals who are less able to be proactive in their HIV avoidance behaviors.

Three percent said that their behavior had put them "very much" at risk. Eight percent said that their behavior had put them "somewhat" at

While most respondents do not think that they have recently (in the last 30 days) been at risk for acquiring HIV, 3 percent said that their behavior had put them "very much" at risk, and 8 percent said that their behavior had put them "somewhat" at risk.

When asked how difficult it would be to address the issue of HIV with a partner, respondents reported that it would be ***somewhat or very difficult*** to:

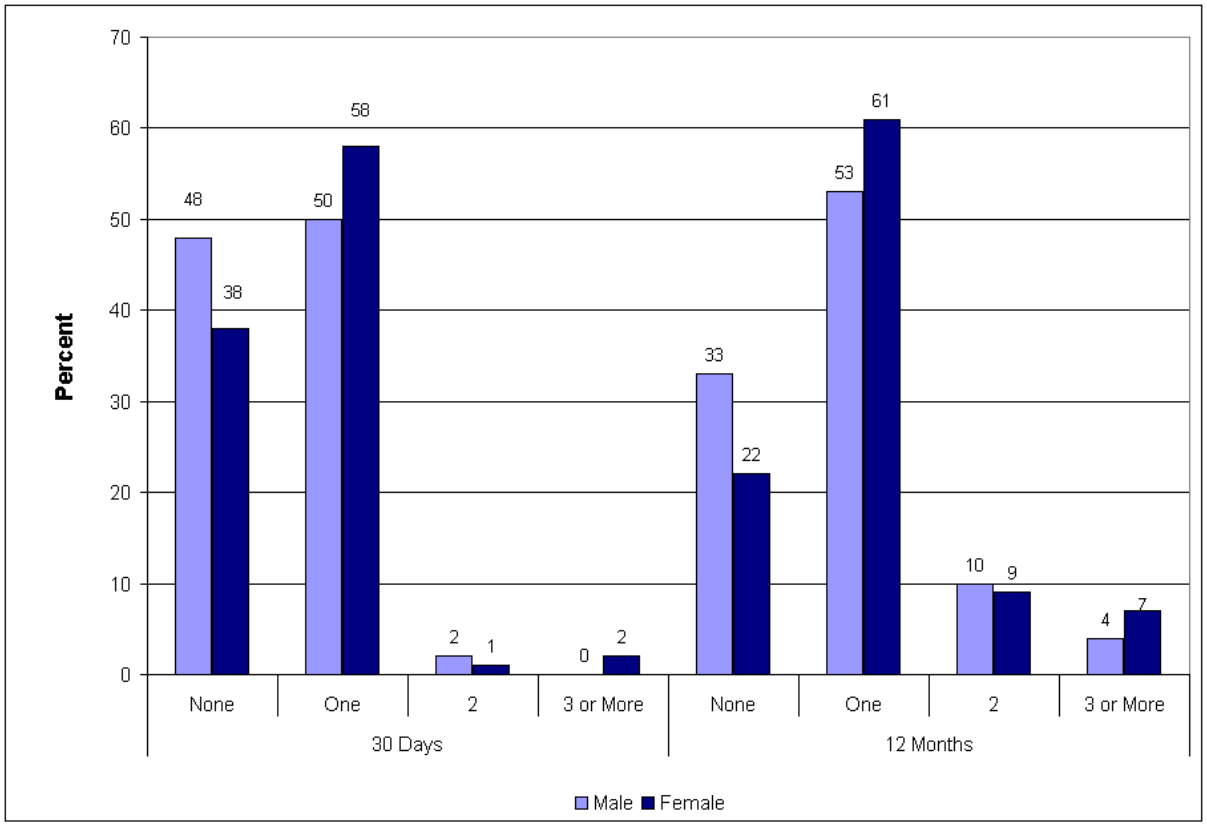
- Ask partner to use a condom (15 percent)
- Insist on condom use (17 percent)
- Refuse to have sex without a condom/barrier (22 percent)
- Talk about HIV/AIDS (16 percent)
- Ask if their partner has other sexual partners (15 percent)
- Ask if a partner had been tested (18 percent)

Men and women found it nearly equally difficult to ask or insist that a partner use a condom. Men were 43 percent more likely than women to say that it was somewhat or very difficult to refuse sex if no barrier protection was available.

Sex Partners

Of the survey participants, 77 percent report that they currently have a main sex partner, while only 10 percent say they currently have casual sex partners. In the past 12 months, seven men and seven women report same sex partners, and seven report bisexual activity. In the past 30 days, 48 percent of men report no sexual contact, 50 percent report contact with only one partner, and 2 percent report having two partners. In the past 12 months, men report 33 percent, 53 percent, and 10 percent, respectively. Among women in the past 30 days, 38 percent report no sexual contact, 58 percent report only one partner, 1 percent report two partners, and 2 percent report more than two partners. For women over the last 12 months, reports are 22 percent, 61 percent, 9 percent, and 7 percent respectively. (See Figure 7.)

Figure 7: Number of Sexual Partners by Gender in the Past Thirty Days and the Past Twelve Months



Three percent of both men and women report that their sex partner either has HIV or that the HIV status of their sex partner is unknown. Sixteen percent report that in the past year they had at least one sex partner who had been incarcerated. Seventeen (7 percent) of the respondents had been incarcerated themselves.

Responding about sexual contact in the last 30 days, 68 of 118 (58 percent respondents reported using condoms or other barriers during vaginal intercourse.

Risky Behavior

Eleven items were selected from among assessment questions that indicate direct behavioral risk leading to possible HIV infection (see Table 3).

Table 3: Behaviors of Respondents with Direct Risk of Acquiring HIV

Risky Behaviors	Number	Percent
Sex while high on drugs/alcohol	66	26
Having sex with someone who had been incarcerated	38	15
Having casual sex partners	25	10
Having had an STD in the past year	21	8
Having been incarcerated in the past year	17	7
Having unprotected sex with an intravenous drug user in the past year	14	6
Using intravenous drugs in the past year	13	5
Trading sex for drugs or money	9	4
Injecting steroids, drugs, or other substances with a previously used needle	8	3
Using needles or other sharp implements (such as in tattooing) that were used previously by others	4	2
Having a positive HIV test	2	1

Nearly half of the respondents, and slightly more women than men, report no risky behaviors (see Figure 8). Risky behaviors decrease with age, with only 30 percent of younger respondents (age 18-34) reporting no risky behaviors, compared to 58 percent age 35-64, and 80 percent age 65-80 (see Figure 9).

Figure 8: Percent of Respondents Reporting Risky Behaviors By Sex

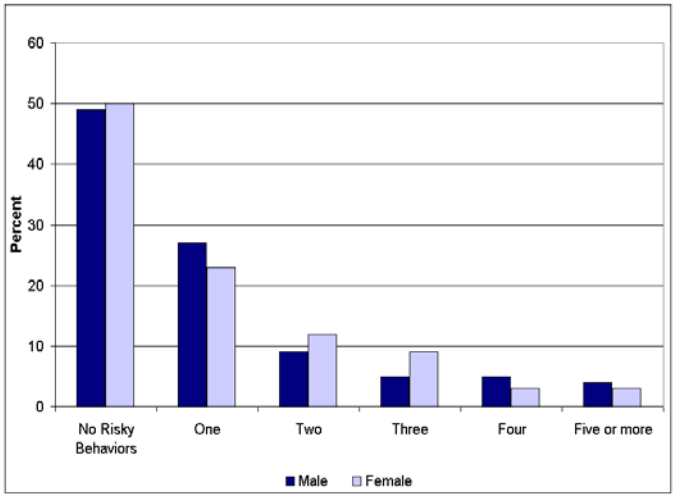
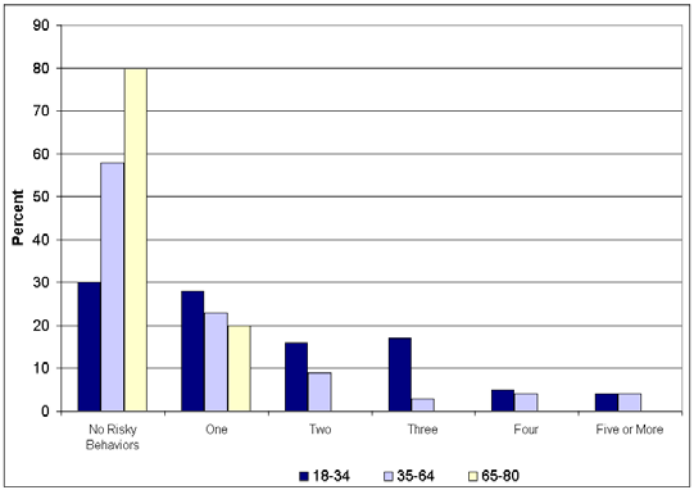


Figure 9: Percent of Respondents Reporting Risky Behaviors By Age

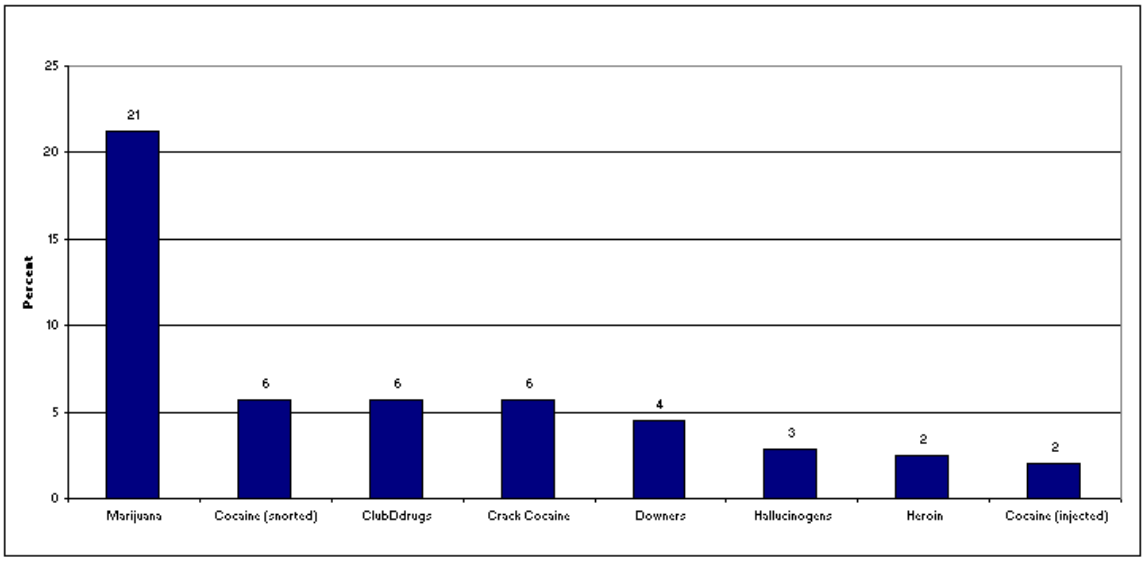


Drug Use and HIV Risk Prevention Knowledge

Marijuana is the most reported drug used (21 percent). Six percent or less reported using other drugs. (See Figure 10.) Twenty-eight percent report having sex while high on drugs or alcohol. Four percent report having given or received sex for drugs, shelter, or money in the past year. Five percent report having sex with injecting drug users in the past year, and 5 percent are injecting drug users themselves. Ten persons (4 percent) stated that they either did or weren't sure if they had used needles used by others.

Twenty-eight percent report having sex while high on drugs or alcohol.

Figure 10: Drug Use in the Last Twelve Months



Of all respondents, 74 (30 percent) reported receiving information about AIDS or supplies to reduce their risk from someone in their community. Of these, 14 persons were referred for a drug treatment, and 13 for a needle exchange program.

Tattoos and Piercings

Historically, tattooing and piercing are prominent in many cultures, including American Indians. Today, it is very popular among all age groups of the general population. Use of contaminated equipment (sharp implements such as needs or knives) for either of these processes is means for spreading a number of blood borne diseases, including HIV. Among the respondents to this survey, 38 percent report having either tattoos or body piercings.

Of the 57 respondents who have piercings, 65 percent have one or two piercings, 32 percent have three to six piercings, and 4 percent have more than six. Of the 79 persons who report having tattoos, 53 (67 percent) have one or two, 21 (27 percent) have three to six, and 5 (6 percent) have more than six. Ten percent of those with tattoos or piercings report that either the needle/knife was used on someone prior to their own cutting (4 percent) or that they do not know if there was prior use (6 percent).

HIV Testing

Nationally, prevention efforts are being refocused on secondary prevention, with renewed efforts to prevent the spread of HIV by intervening with infected persons. Unknown serostatus is a major risk in the spread of HIV. Testing of persons at risk is critical in this effort.

Respondents report having ever been tested from 1 to 20 times with an average of 3 tests per individual. Among those tested, 77 percent report being tested one to three times. The primary reasons for testing the last time were that the subject "wanted to know" (29 percent) or it was suggested by their doctor (20 percent). Fifteen percent were tested due to "possible" sexual exposure (11 percent) or a known HIV+ partner (4 percent). Other reasons health care was sought include routine exam/STD check/health problem (18 percent) or pregnancy (11 percent). (See Table 4.)

Table 4: Reasons Respondents Last Sought Testing

Reason	Percent
Wanted to Know	29
Doctor Suggestion	20
Part of STD Check or Routine Exam	14
Other	12
Possible Sexual Exposure	11
Self/Partner Either Pregnant or Seeking Pregnancy	11
Partner's Request	8
Insurance Exam or Military Court Order, Etc.	6
Friends/Family Suggestoin	6
To Initiate Care if HIV+	5
Possible Exposure Through Drug Use	4
Health Problem Possibly HIV-Related	4
Outreach Worker	4
HIV+ Partner	3
Blood Donor	1

Of the 91 persons who report never having had an HIV test, 34 report behaviors that put them at risk for acquiring HIV.

Appendix 1: PowWows and Other Locations

Where the Survey Was Administered

Date	Location	Contact
August 27-29, 2003	30th Annual Baltimore PowWow Catonsville, MD	Baltimore American Indian Center Dennis Seymour, PowWow Chair dennis@baltimorepowwow.com
Sept 13-14, 2003	Nause-Waiwash Band of Indians 11th Annual Native American Festival Vienna, Dorchester County.	Chief Sewell E. "Winterhawk" Fitzhugh at the Nause-Waiwash Tribal Office, 410-376-3889.
Oct 11-12, 2003	Drums on the Pocomoke Native American Festival and Pow Wow. Cypress Park, Pocomoke City, Worcester County.	Gail Fox 1-757-331-2188 or e-mail at: :midnightstar002@msn.com; or Diane Baldwin 1-757-824-3060 or e-mail at firewolf@intercom.net
Oct 18-19, 2003	Accohannock Indian Tribe Tenth Annual Festival and Pauwau. Bending Water Park, Marion, Somerset County.	Chief Rudy Hall Phone: 410-623-2660 E-mail: Accohannock Indian Tribe
Nov 1-2, 2003	The Four Bay Winds. The Lock House Havre de Grace, Harford County.	Amy Paul (Blessing Bird) 410-942-0542
November 8, 2003	Veterans Powwow November 8, Anne Arundel County, Md.	(301) 869-9381
November 17, 2003	Third Annual American Indian Festival Rockville, MD	Indian Health Service www2.his.gov/heritage Heritage@hqe.his.gov
January 22 and 27, 2004	LifeLines Foundation 106 West Clay Street Baltimore, MD 21201	Susan Roth, Director 410-837-2258 lifelines.cnap@verizon.net

Appendix 2: Tribes First* Mentioned by Respondents** ***

*Respondents were asked to mention up to three tribal affiliations. Only the first affiliation is reported here. Not every respondent mentioned a tribal affiliation.

**Unduplicated.

***Spelling according to respondents' entries in most cases, without correction.

A.A.I.W.V.A.	1
Accohannock	6
Algonquin	1
Andirondack	1
Anwawea	1
Apache	1
Assateaque	5
Blackfoot	6
Cherokee	31
Chickahominy	1
Comanche	1
Croatan	1
Haliw-Sapoin	1
Kadipan	1
Kaw	1
Lakota	4
Lumbee	101
Metis	1
Mohawk	1
Montaukett	1
Nanticoke/Lenape	1
Nause Waiwash	10
Northern Indian	1
NWBOI	1
Occaneechi (Eno)	1
Oglala	1
Piscataway	3
Pocomoke	1
Pohatan	1
San Gabrieleno	1
Saponi	1
Seminole	1
Shawnee	2
Sioux	2
Taino	2
Tuscarora	2
Yaqui	2