# "Our Relatives Go Everywhere"

## Key Learnings and Recommendations from the American Indian (AI) and Alaska Native (AN) Sexual Health Convening

NACCHO[SM]
National Association of County & City Health Officials

*On June 6 and 7, 2023, the National Association of County and City Health Officials (NACCHO) supported by the Centers for Disease Control and Prevention's Division of STD Prevention (CDC/DSTDP), brought together public health representatives at the federal, state, local, and tribal level from across the country to discuss the extreme disparities in sexually transmitted infection (STI) rates in American Indian (AI) and Alaska Native (AN) communities. We gathered in Tulsa, Oklahoma, and the agenda can be found in Appendix 1.*

# Purpose

The goal of this meeting was to promote collaboration between city, county, and state health departments and the CDC with tribal health departments, Indian Health Service (IHS), Urban Indian Health Centers (UIHC), and 638 clinics[1] to provide the best possible STI prevention, treatment, and care to AI/AN people. We gathered to understand how STIs are being addressed in AI/AN communities, where there are unmet needs, and how partnership and collaboration can better move us forward to address STIs. The two-day meeting was designed around collaborative information sharing sessions to generate clear ideas for future partnership and next steps.

# Background

American Indians and Alaska Natives experience significant health disparities originating from historical trauma suffered through violent colonialism, including war, displacement from ancestral lands, family separation, and bans on cultural and religious practices. Such trauma contributes to elevated risk of substance use, depression, and suicide, as well as learned stigma around sexuality and sexual health. Currently, many AI/AN individuals continue to experience racism, impoverishment, and lack of access to care, particularly for those many AI/AN people living in rural communities. These social determinants of health contribute to disparities in many health conditions, including for HIV, STIs, and for viral hepatitis. For example, in 2021, AI/AN showed the greatest increase in primary and secondary syphilis of any race/ethnicity in the U.S. since 2020, and now has the highest rate in 2021.[2] In 2020, the rate of reported new syphilis cases among AI/AN persons was nearly four times the rate among non-Hispanic White persons (26.9 versus 6.9 cases per 100,000, respectively). The rate was particularly alarming for AI/AN females, at over seven times greater than the rate among non-Hispanic White females (21.3 to 2.9 per 100,000). Nationally, from 2016 to 2020, the rate of reported congenital syphilis increased over 400% among AI/AN babies (37.7 to 190.6 cases per 100,000 live births) in 2020. In 2021, AI/AN populations were the only ones experiencing an increase in number of HIV diagnoses[3]. And national data indicates AI/AN people have the highest incidence of acute HCV infection and the highest HCV-related mortality rate of any race/ethnicity.[4]

Treaty relationships between sovereign tribes and the United States include every level of government (federal, state, local). In addition, American Indians and Alaska Natives, as citizens of the United States, are eligible to participate in all public, private, and state health programs available to the general population. Therefore, all jurisdictions have a responsibility to be engaged in providing care to tribal communities and AI/AN individuals—and to do so with cultural humility.

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[1] 638 Clinics are also known as tribal contract or compact health centers, funded by Indian Health Service and operated by Tribes or Tribal organizations. Like Urban Indian Health Centers, they are outpatient health care programs and facilities that specialize in caring for American Indians and Alaska natives.

[2] https://www.cdc.gov/std/statistics/2021/default.htm

[3] https://www.cdc.gov/hiv/statistics/index.html

[4] https://www.cdc.gov/hepatitis/statistics/2020surveillance/hepatitis-c.htm

# Key Learnings

**Health Service and Systems**

- While IHS and other tribal facilities serve members of federally recognized tribes, sexual health networks are not determined by race/ethnicity. Prevention and care efforts for AI/AN communities are most effective when coordinated across jurisdictions and communities. Local health departments, especially those that border tribal communities and reservations, have an active role to play in providing these communities with high quality sexual healthcare.
- Sexual health and sexual health services are stigmatized across the AI/AN community, and stigma presents a barrier to care, especially in small, tightly knit communities where anonymity for those seeking services cannot be maintained.
- At the same time, midwives, doulas, and other traditional birth workers and healers have a potential role to play in STI prevention and treatment and especially for syphilis.
- Because so many AI/AN communities are rural and remote, models of service delivery outside of the clinic setting are needed: "street" medicine brings outreach workers and licensed clinicians out into the community to administer tests, treatments, and referrals where clients live and congregate; telehealth allows clients to access a clinician remotely via phone or videoconference; and self-collection or self-test kits can be made available via pharmacies, retail health clinics, or mail order.
- Similarly, such models are most effective if they are integrated and syndemic, with a panel of STI/HIV tests being offered if risk is identified.
- Fear of involvement by the authorities (police and child protective services) and possible child removal undermines a desire to engage in prenatal care for pregnant people who use drugs in AI/AN communities just like every other community.

**Data Sovereignty/Sharing**

- With state, local, tribal, and IHS agencies often overlapping in their mandate and service area, the question of "public health authority" is complex, particularly in terms of data reporting and sharing. In response, tribal epidemiology centers (TECs) have been established with authorization to access data collected by the U.S. Department of Health and Human Services (DHHS), including from CDC, and IHS. However, access to such data has been found to be variable[5].
- At the local level, too often, even though tribes report mandated health data to state health departments, they are unable to access AI/AN specific data sets and analyses. And data that is held by tribal health departments may not be shared with states or IHS systems.
- Access to real-time patient level data across jurisdictions is critical to conduct effective case investigation and contact tracing to interrupt infectious disease transmission and assure treatment.

On the second day of the convening, the breakout groups (focusing on Data, Community Activities/Education, Clinical Services) offered recommendations, and presentations were delivered from the rapporteurs who represented several groups at the meeting (IHS, NACCHO, CDC, health departments, National Network of Prevention Training Centers, and tribal care providers). Based on these two sessions and what was heard over the course of the convening, the following recommendations were identified.

[5] https://www.gao.gov/products/gao-22-104698

# Recommendations

**Syphilis (including congenital syphilis)**

- Syphilis, and especially congenital syphilis, in AI/AN populations should be declared a public health emergency by the DHHS/CDC which would allow for more timely data-sharing.
- The AI/AN community must be included in congenital syphilis taskforces, review boards, and coordination meetings, and their provider communities and leaders must be included and engaged in times when actions like a "Dear Colleagues" or "Dear Provider" letters are being issued by state and local health departments/government. All relevant jurisdiction health departments should be sending "Dear Tribal Leader" letters about the emergency of syphilis in AI/AN communities.
- Access should be provided to syphilis registries by state and local health departments and until that is in place, there should be a solid, pre-determined contact to a live person within the relevant health departments to communicate syphilis data to tribes so that they can quickly conduct partner services.
- Testing for syphilis, especially syphilis in those who may be pregnant, must not be based on perceived "risk factors" and instead all individuals should be tested.
- Increases in funding must occur to be able to have enough staff to correctly address syphilis and do partner services.
- Continuing education on sexual health and specifically syphilis should be offered in person and virtually— including in settings targeting AI/AN providers (e.g., Association of American Indian Physicians (AAIP) Annual Conference) and with providers that serve AI/AN communities (e.g., health departments and emergency rooms in "border communities" outside of reservations).
- Direct funding to tribes to address STI rates is essential. This should include funding to allow for universal screening for syphilis (tailored to the specific Native community in need).
- The stigmatization of sexual health services must be combated collaboratively across all communities and legislatures.

**Health System/Delivery**

- Support integration of services by leveraging HIV and other routine health screenings/visits to co-locate STI testing. Staff must be cross trained in HIV and STI testing, and facilities should be able to braid funding to test for both.
- For STIs overall, conversation should not focus on "risk factors" of an individual to determine when to test for STIs and which STIs to test for. Instead, conversation should focus on the impact of STI impact on the community and the need for proactive screening to occur to mitigate the impact.
- If a sexual history cannot be obtained, STI testing should be conducted in all settings. Without a sexual history, there is no ability to determine behaviors that would increase or decrease risk, so multi-site STI testing should be offered in clinical and non-clinical settings.
- Increase use of:
    - Mobile units and field-based activities where multiple health services are offered to decrease stigma associated with the delivery of sexual health services.
    - Syndemic care teams which allow for hiring of peers/community health workers/ Disease Intervention Specialists (DIS) that can connect clients to one-shop services for HIV/STI/hepatitis/harm reduction services.
    - Express STI testing at tribal clinics, pharmacies, and in lab settings—this should be offered to clients who self-referred and for referrals made by clinicians, pharmacists, and nurses.
    - DIS with standing orders to bundle STI testing including gonorrhea, chlamydia, trichomonas, syphilis, and HIV.

    - Field treatment for syphilis as well as field services allowing for testing and treatment for any partners also present on site. This should be available from as many types of staff as possible, including pharmacists, clinicians, and DIS.
    - Mail-order STI/HIV testing options—especially those designed specifically for AI/AN communities.
    - Telehealth for HIV, STI, PrEP services especially in rural areas and allow for those visits to be conducted over the phone rather than needing internet access.
    - Three-site STI testing.
- Hire AI/AN staff at all levels and to do all work.
- There should be designated staff to confirm completion of treatment, and to provide support if needed for referrals for prenatal care and STI treatment.
- Local and state health departments should promote STI/HIV testing in emergency rooms—guidance should be given that if pregnancy or other relevant tests are being done, full STI testing should also be completed.
- State and local health departments, especially those that border tribal areas, must be engaged in providing health services for tribal communities and doing so with cultural humility. They should also be sharing recommendations and funding opportunities with those tribes and offering access to any best practices that have already been developed.
- There must be an increase in rapid testing across all healthcare settings but especially in health departments, emergency rooms, and in correctional facilities, so that treatment can be provided before an individual with an STI leaves the premises. Providers in these settings must be trained on syphilis staging so that they can determine whether a patient needs one or more bicillin shots.

**Data Sovereignty/Sharing**

- Data sovereignty is a necessity—tribes must have the ability to keep, own, access, and analyze data from their tribes.
- State and local health departments must provide data access to tribes/IHS/Urban Indian Health Centers/638 clinics. It must be a priority for state and local health departments to give access to line-level data on syphilis and congenital syphilis to tribes and IHS as a public health emergency. There should be clarifications issued on 25 USCA 1602 and who is a "public health authority." All tribal epidemiology centers should have access to Epi Data Mark. There should be an ECR or EHR mechanism which shares data back to the tribal communities from which it came.
- CDC should require states to share data with tribes; CDC could make state epidemiology funding contingent on developing data-sharing agreements. CDC's data modernization should be leveraged for IHS/tribal data access. CDC ELC funding mechanism should require the reporting of data to tribes as a condition of eligibility for supplemental funding.
- There should be intergovernmental training on epidemiology needs for state and local governments and their tribal/IHS/UIHC counterparts, highlighting the importance of race/ethnicity markers, how data is shared, etc. IHS data should be used for matching to correct race misclassification.

**Inter-governmental Collaboration**

- There is an essential need for state and local health department officials and their staff to better understand how AI/AN individuals can and do receive care via the IHS, urban Indian health organizations, and tribal health systems.
- It cannot be, and is not, only the responsibility of IHS, urban Indian, and tribal health systems to provide care for AI/AN individuals, especially when it comes to sexual health care.
- Local and state health departments should have disease investigation staff imbedded in tribal communities/health organizations. Those individuals should be from the communities that they are serving. They should also be representative of gender diverse communities.

- True collaboration/partnership is needed and should include:
    - Regularly scheduled meetings between tribal health directors and clinical managers, and staff of state and local health departments that serve the communities.
    - Support for field/clinic staff to speak to local or bordering tribal leaders, health directors, and clinical staff.
    - Regular meetings between state and local health departments and tribal epidemiology centers, tribes, and 638 clinics to best understand the health states of the communities. Data access is key to this partnership.
    - Financing—a reciprocal care model should be developed that would allow individuals in tribal communities and those counties surrounding them to go to county, state, or tribal public health providers and those entities should be able to be paid for providing those services.
    - Tribal communities being included in the development and execution of all community health plans.
    - Communities of practice which engage tribes, IHS, locals, and states together to tackle issues such as syphilis/congenital syphilis.

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# Appendix 1: Agenda

## Tuesday, June 6

| | | |
|---|---|---|
| 8:00am | **Breakfast (provided)** | |
| 9:00am | **Welcome** | Cherokee Nation |
| 9:10am | **Why Are We Here: Panel Presentation**<br>• Who is here and why?<br>• Health Disparities in AI/AN communities, and how AI/AN access sexual health services<br>• Indigi-HAS | Facilitator: Lucy Slater, NACCHO<br>Presenters:<br>• Rebekah Horowitz, NACCHO<br>• Jessica Leston, Northwest Portland Area Indian Health Board (NPAIHB)<br>• Rick Haverkate, Indian Health Service (IHS) |
| 10:20am | **Break (snack provided)** | |
| 10:35am | **Situational Awareness: Large Group Discussion**<br>• How are state and local health departments working with AI/AN populations and AI/AN healthcare providers to address sexual health?<br>• How ARE local/state HDs working well with AI/AN communities? (i.e., success stories)<br>• What are some barriers/challenges experienced by AI/AN communities in working with state and local health departments?<br>• Proposed solutions (i.e., how SHOULD jurisdictions work with AI/AN communities?)<br>• Are there special considerations for working with specific populations within your communities that need to be kept in mind?<br>  • Justice-involved<br>  • Pregnant people<br>  • Adolescents<br>  • PWUD<br>  • Rural | • Facilitator: Rebekah Horowitz, NACCHO |
| 11:30am | **Breakout Groups: What is happening now? What are the current challenges? Where do you see opportunities?**<br>1. Clinical Services<br>2. Community activities/education<br>3. Data | 1. Clinical Services Facilitator: Andrew Yu, IHS<br>2. Community Activities and Education Facilitator: Michelle Singer, NPAIHB<br>3. Data Facilitator: Carla Britton, Alaska Native Health Consortium (ANHC) |
| 12:30pm | **Lunch (provided)** | |
| 1:15pm | **Partner Services: Large Group Discussion** | Facilitator: Cody Knight, Southern Plains Indian Health Board (SPIHB) |
| 2:00pm | **Overview of Syphilis/CS in Indian County and Large Group Discussion** | Facilitator: Cody Knight, Southern Plains Indian Health Board (SPIHB) |
| 3:30pm | **Break** | |
| 3:45pm | **Point-of-Care (POC) Testing: Large Group Discussion** | Facilitator: Andrew Yu, IHS |
| 4:15pm | **Breakouts [Regional]**<br>• What are successes and challenges in your region around addressing sexual health?<br>• Are there special considerations based on geography, populations, politics?<br>• How could state/local HDs support/collaborate with you?<br>• What have you learned today so far that you want to take back with you? | • Region 10 (AK, WA, OR, ID)<br>• Regions 9 and 6 (CA, NV, AZ, NM, TX, OK)<br>• Regions 8, 7, and 5 (MT, ND, SD, WY, CO, NE, IA, KS, MO, MN, WI, IL, IN, MI, OH<br>• Regions 1, 2, 3, and 4 (all remaining states) |
| 5:00pm | **Adjourn** | |

## Wednesday, June 7

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| 8:00am | **Breakfast (provided)** | |
| 9:00am | **Concurrent Sessions: What are our recommendations?**<br><br>1. Data<br>2. Community Education/Awareness and Partner Services<br>3. Clinical Services | 1. Data Facilitator: Ashley Hoover, NPAIHB<br>2. Community Education/Awareness and Partner Services Facilitator: Becki Jones, Planned Parenthood of the Rocky Mountains<br>3. Clinical Services Facilitator: Allison Finkenbinder, Denver Prevention Training Center |
| 10:30am | **Break (snack provided)** | |
| 10:45am | **Report Back** | Facilitator: Sonia Almonte, NACCHO |
| 11:30am | **Rapporteur presentations** | • Amy DeLong, Ho-Chunk Nation<br>• Oskian Kouzouian, IHS<br>• Melinda Salmon, CDC<br>• Kamala Stiner, Alaska HD<br>• Joseph Cherabie, St. Louis Prevention Training Center<br>• Julia Zigman, NACCHO |
| 12:30pm | **Technical Assistance and Closing** | Facilitator: Lucy Slater, NACCHO |

# Appendix 2: Participant Invite List

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|---|---|---|
| Kristi | Aklestad | Montana DPHHS |
| Sonia | Almonte | National Association of County and City Health Officials (NACCHO), HIV, STI, Harm Reduction Program |
| Sarah | Alsop | Washington University STI/HIV Prevention Training Center (PTC) |
| Christy | Altidor | National Coalition of STD Directors (NCSD) |
| Teri | Anderson | Denver PTC |
| Tranita | Anderson | CDC, National Center for HIV, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), Division of STD Prevention (DSTDP) |
| Elizabeth | Antone | Gila River |
| Kevin | Ard | Ratelle PTC |
| Faith | Baldwin | Arizona Department of Health Services |
| Lindley | Barbee | CDC/NCHHSTP/DSTDP |
| Nicolas | Barton | Southern Plains Tribal Health Board |
| Meggin | Bean | Muscogee Creek Nation Department of Health |
| Kurt | Begaye | Albuquerque Area Indian Health Board, Inc. |
| Taleisa | Benally | Changing Woman Initiative |
| Gina | Benson | St. Croix Tribal Health Clinic |
| Cheryl | Bighorn-Savior | Fort Peck Tribal Health |
| Sally | Bouse | Oklahoma State Department of Health |
| Robbie | Bright | Southern Plains Tribal Health Board |
| Scott | Brill | Maricopa County |
| Carla | Britton | Alaska Native Tribal Health Consortium/Alaska Native Epidemiology Center |
| Tyler | Broghammer | Oyate Health Center/Great Plains Tribal Chairmen's Health Board |
| Zandt | Bryan | Washington State Department of Health |
| Aaron | Bull | Navajo Nation Department of Health |
| Karen | Buller | Southern Indian Health Council, Inc. |
| Donald | Chee | National Native HIV Network |
| Joseph | Cherabie | St. Louis STI/HIV PTC |
| Donna | Clampitt | Ft Peck Tribal Health |
| Ryan | Close | Whiteriver Service Unit |

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| Alexandra | Coor | CDC/NCHHSTP/DSTDP |
| Dana | Cropper | California Prevention Training Center |
| Martha | Curry | National Council of Urban Indian Health |
| Shawnell | Damon | Navajo Area IHS |
| Amy | DeLong | Ho-Chunk Nation |
| Maxine | Delorme | Turtle Mountain Public Health Department |
| Stephanie | Devlin | Maricopa County Department of Health |
| Whitney | Dickson | Cass Lake IHS |
| Linda | Drach | Oregon Health Authority |
| Anathea | Edleman | Tuba City Regional Health Care Corporation (TCRHCC) |
| Mason | Emert | Choctaw Nation Health Services Authority |
| Mark Anthony | Faustino | Tuba City Regional Health Care Corporation |
| Molly | Feder | Cardea Services |
| Allison | Finkenbinder | Denver Prevention Training Center |
| Shannon | Fleg | Changing Woman Initiative |
| Cassandra | Fonseca | Turtle Mountain Public Health Department |
| Jessica | Frasure-Williams | California Department of Public Health |
| Keanu | Frazier | Winslow Indian Health Care Center |
| Julia | Freimund | Infectious Diseases Education & Assessment Program (IDEA), UW |
| Victoria | Freire | NACCHO, Rural Health |
| Kevin | Gaines | Navajo Area IHS |
| Andrew | Gans | New Mexico Department of Health |
| Richard | Haverkate | Indian Health Service |
| Priscilla | Haynes | Tulsa City-County Health Department |
| Ashley | Hoover | Northwest Portland Area Indian Health Board |
| Jeanee | Hoover | STD/HIV Prevention Training Center at Johns Hopkins |
| Rebekah | Horowitz | NACCHO, HIV, STI, Harm Reduction Program |
| Staceee | Hoye | Oklahoma City-County Health Department |
| Katherine | Hsu | Mass. Dept. of Public Health / Boston Univ. Med. Ctr. |
| Christin | Hullinger | Cherokee Nation Public Health |
| Jonathan | Iralu | Indian Health Services |
| Rose | James | Urban Indian Health Institute/SIHB |
| Stephanie | Jay | Turtle Mountain Public Health Department |
| Mattee | Jim | First Nations Community HealthSource |
| Rebecca | Jones | Planned Parenthood of Rocky Mountains- Native Community Health Network |
| Destiny | Kelley | National Network of STD Clinical Prevention Training Centers (NNPTC) |
| Jolene | Keplin | Tribal Health |
| Joshua | Knight | Southern Plains Tribal Health Board |
| Oskian | Kouzouian | Indian Health Service |
| Kelsey | LaCoote | Passamaquoddy Indian Township Health Center |
| Jane | Langemeier | Winnebago Public Health |
| Rikki | LaRoche | Choctaw Nation |
| Rickey | Lawson | Tuba City Regional Health Care Corporation |
| Jessica | Leston | Tuba City Regional Health Care Corporation |
| Philana | Liang | Washington University in St. Louis |
| Jodie | Liebe | Iowa HHS Division of Public Health |
| Bradah | Littlefield | Muscogee Creek Nation |
| Lachyna | Locklear | National Indian Health Board |
| Michael | Lopez | Pima County Department of Health |
| Evelina | Maho | National Council of Urban Indian Health (NCUIH) |

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|---|---|---|
| Yuleta | Marta | Wind River Family and Community Health Care |
| Stella | Martin | New Mexico Department of Health |
| Kayla | Mason | Navajo Department of Health |
| Kimberly | Matulonis Edgar | Idaho Department of Health and Welfare, Division of Public Health |
| Candice | McNeil | Southeast STI/HIV PTC |
| Daniel | Molina | Chickasaw Nation Department of Health |
| Mayra | Mollo | Arizona Department of Health Services |
| Lector | Morales | Urban Indian Health Institute |
| Rachel | Morse | Oklahoma State Department of Health |
| Michelle | Murtaza-Rossini | Tulsa City-County Health Department |
| Wendy | Nakatsukasa-Ono | Cardea |
| Jodene | Nerva-Chee | Changing Woman Initiative |
| Lavinia | Nicolae | Centers for Disease Control and Prevention |
| Melanie | Ogleton | Cardea |
| Meghan | O'Connell | Great Plains Tribal Leaders Health Board |
| William | Patterson | Oklahoma State Dept. of Health |
| Arika | Perry | Navajo Area Indian Health Service |
| Laura | Potter | Cardea |
| Amy | Radford | University of Washington STD PTC |
| Terra | Raxter | Tsalagi Public Health |
| Amanda | Reed | Muscogee (Creek) Nation Department of Health |
| Hilary | Reno | St. Louis STI/HIV PTC |
| Ashley | Ringwood | New Mexico Department of Health |
| Kaitlin | Ritchie | Southern Plains Tribal Health Board |
| Anne | Rompalo | Johns Hopkins School of Medicine |
| Judith | Rosenberger | Hennepin County Public Health |
| Melinda | Salmon | CDC/NCHHSTP/DSTDP |
| Olivia | Scott | Oklahoma State Department of Health |
| Rebecca | Scranton | Arizona Department of Health |
| Rachel | Sharber | Oklahoma State Department of Health |
| Aimee | Shipman | Idaho Department of Health and Welfare |
| Michelle | Singer | Northwest Portland Area Indian Health Board- NW Tribal Epi Center |
| Bobbi | Six | Oklahoma State Department of Health |
| Lucy | Slater | NACCHO, HIV, STI, Harm Reduction Program |
| Dollie | Smallcanyon | Tuba City Regional Health Care Corporation |
| Krishanya | Smith | Tuba City Regional Health Care Corporation |
| Atonbara | Sowemimo | Oklahoma State Department of Health |
| Amanda | Spencer | Cherokee Nation Public Health |
| Jessica | Steinke | New York City STD/HIV Prevention Training Center |
| Kamala | Stiner | State of Alaska Department of Health |
| Jolianne | Stone | Oklahoma State Department of Health |
| Melanie | Taylor | CDC, Division of HIV Prevention |
| Lisa | Toahty | Oklahoma City Indian Clinic |
| Terrance | Todome | Southern Plains Tribal Health Board |
| Maria | Vega | Indian Health Service, Fort Peck |
| Hannah | Warren | Alaska Native Tribal Health Consortium |
| Katherine | White | Southeast Prevention Training Center |
| Erinn | Williams | Oklahoma State Dept. of Health |
| Samantha | Williams | CDC/NCHHSTP/DSTDP |
| Jennifer | Williamson | Alaska Native Tribal Health Consortium |
| Jamie | Wilson | Tuba City Regional Health Care Corporation |

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|---|---|---|
| Michelle | Womack | Cherokee Nation Public Health |
| Melissa | Wyaco | IHS-Navajo Area Office |
| Marilyn | Yellowman-Baloo | Phoenix Indian Medical Center |
| Andrew | Yu | Indian Health Service |
| Julia | Zigman | NACCHO, HIV, STI, Harm Reduction Program |
| Trinity | Guido | Southern Plains Tribal Health Board |