**JVA webinar 10/08/2019**

**“Engaging tribal populations throughout the vulnerability assessment”**

Questions:

1. How are you engaging with tribal populations?

State participant: The Cherokee Nation has been undergoing an HCV elimination project over the last couple of years which has been a joint effort with the Cherokee Nation, the health department and researchers at X University. This project has been important, because it is an example of “the more you look, the more you find.” The Cherokee Nation knew that there was an issue with HCV, however the rates may be artificially high or in other counties may be artificially low. The researchers did find high rates of HCV infection both acute and chronic within the counties in the Cherokee Nation. X University has been meeting with the Tribal project leaders to make sure they were working in tandem and to be sure that the messaging was correct. They wanted to be sure to provide results that help, but don’t reinforce stereotypes.

Michelle (CDC) – When you did note the differences in the rates particularly for the counties that overlap Cherokee Nation, did you separate them out from your analysis? How did you work through the potentially artificially high level of rates compared to other areas of the state?

State participant: They have not addressed this issue formally with the analysis. When they met with their partners with the state health department, their next steps were to focus on pilot projects for education, prevention, and treatment services. The focus was on identifying counties and partners for these pilot projects and to deemphasize the predicted rates or the size of the problem.

Michelle (CDC) – It sounds like you’re in line with the asset-based approach to community engagement that Dr. Massoudi talked about on the last webinar. Rather than looking at the predictive risk you looked at the opportunities for partnerships.

1. What other activities are you engaged in with tribal populations?

State participant – This is on the “to-do” list. In my state there are three very large nations and 38 federally recognized tribes and sometimes the medium and small nations will join together to share resources. They would like to build partnerships with each of the nations based on their infrastructure and needs. There are many players in these areas, and one is the Tribal Health Board which has a Tribal Epidemiology Center (TEC). There is a history of working with these partners. One example outside of JVA, our university is currently working on a project that is addressing concurrent use of opioids and marijuana in the HIV infected population in the entire state. Medical marijuana is legal in my state. They are working with the TEC to do a similar study in the tribal population because they know that our state is one of the states where there is an increase in the incidence of HIV and that’s affecting the rural and tribal populations. It takes time to build these relationships, so they partner with other colleagues within X who have stronger relationships to help build his relationships with the tribes. This strategy has worked very well for my state.

1. What are some of the challenges or lessons learned in working with tribal populations?

Michelle (CDC) – A challenge other states have talked about is related to what the state participant was talking about earlier is how to address the data issues in higher rates or incomplete information that show artificially lower rates. It is helpful to do a lot of engagement early on to determine what those data mean with regards to data quality and data completeness so that the data can be better determined. De-emphasizing the predictive values as the state participant mentioned earlier is a good way to understand the data and move away from the risk perception. One specific jurisdiction ran into challenges with dissemination of what predictive risk means how it will be perceived by the community.

State participant – The vulnerability analysis has provided an opportunity to talk about issues like a needle exchange program which is illegal in my state. There is a direct link to being able to tie different pieces together so that it is a little less threatening to the state legislators to discuss issues like needle exchange programs. There is a greater focus on the evidence instead of the politics. The analysis has allowed them to broaden their stakeholder groups and if there had been a bit more time, he would have expanded the stakeholders even more.

Michelle (CDC) – Who are some of the other stakeholders that you would have engaged in the project if you had more time?

State participant– The Infectious Disease Institute which are two clinics in my state that receive Ryan White funding. Also working with the Tribal Epi Centers would have been very helpful.

Micelle provided a link to additional resources for SSP programs: [www.cdc.gov/ssp/index.html](http://www.cdc.gov/ssp/index.html)

1. Which other states are working their tribal populations that my state can learn from?

Michelle (CDC) – South Dakota is one of the other states that early on realized the importance of engaging with their tribal populations early on. She also heard similarly from Minnesota and how they simplified their analysis and communications. Getting good feedback from the tribes early on helped alleviate potential roadblocks down the road. Arizona and North Dakota would also be good to speak with.