

Master of Public Health

Integrative Learning Experience Report

Leveraging tribal strengths in response to the syphilis epidemic in the Great Plains Area

by

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MASTER OF PUBLIC HEALTH

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Abstract

The syphilis epidemic in the Great Plains Area and Indian Country has delivered a continued and devastating toll on the American Indians/Alaska Natives Relatives that the Great Plains Tribal Epidemiology Center serves. Within the Great Plains Tribal Leaders Health Board and Great Plains Tribal Epidemiology Center “Relative” is used in place of traditional language such as “patient” or “client”. “Relative” will be capitalized in all cases of this usage and distinguished from the familial usage of the word with no capitalization. Additionally, to emphasize Tribal sovereignty, Great Plains Tribal Leaders Board and Great Plains Tribal Epidemiology Center capitalize all uses and variations of “Tribe”. American Indians/Alaska Natives have been disproportionately impacted by syphilis and continue to see the highest rates amongst any other racial group in the Great Plains Area. A multitude of systemic and structural barriers exist that prohibit state and federal governments from being able to effectively address this crisis in a meaningful way. In response to this public health crisis, a need for Tribally trained Disease Intervention Specialist was established, and the Great Plains Tribal Epidemiology Center’s Tribal Disease Intervention Training Center was formed. My role as a Disease Intervention Specialist Trainer was to enhance Tribal public health infrastructure capacity through workforce building and Tribal Disease Intervention Specialist trainings.

During my Applied Practical Experience, I created a multitude of education and training products for the Tribal Disease Intervention Training Center with two primary pieces: Great Plains Tribal Epidemiology Center Tribal Disease Intervention Specialist Certification Student Manual Module 2: Sexually Transmitted Infection Basics and a medicine bag health education collection. These two products delivered a culturally tailored reference tool and empowering health education pieces to enhance a Tribal Disease Intervention Specialist’s ability to conduct case investigations and provide health education. Interweaving clinically grounded resources from the Centers for Disease Prevention

and Control and the American Public Health Association with indigenous-based knowledge led to materials that provided meaningful training of Tribal and Tribal serving public health professionals and gave them the tools to effectively educate their community members.

As the Tribal Disease Intervention Specialist training program becomes more developed, the ever-evolving need for data access becomes increasingly apparent. The Great Plains Area Tribal Nations and Great Plains Tribal Epidemiology Center continue to work together to advocate for data sovereignty to allow for the best delivery of Tribal Disease Intervention Specialist and other Tribal public health services. The two products provide infrastructure for the continued development of the Tribal Disease Intervention Specialist training program and, in turn, allow for increased advocacy for data and Tribal sovereignty. Tribal Nations and Tribal Epidemiology Centers having access to their data as public health authorities is a vital component to continued successful infectious and chronic disease prevention that the Tribal Disease Intervention Training Center seeks to provide.

Subject Keywords: American Indian/Alaska Native, Syphilis, Disease Intervention Specialist

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Chapter 1 Literature Review

Rationale and Background

Health Care in Indian Country

For one to understand the syphilis epidemic in Indian Country and in the Great Plains, they first must explore the state of health care within Tribal Nations. Tribal Nations are served by a patchwork of service providers and funding bodies, including the federal government, state and local governments, private entities, and the Tribal Nations themselves. To provide a simplistic description of a deeply scarred and bloody history of broken treaties and trust, one can understand the relationship between Tribal Nations and the United States (U.S.) government as follows. In a post-colonial environment, Tribes began entering into various treaties with the U.S. government, often under coercion or force. These treaties resulted in the birth of the legal precedent of the U.S.'s trust responsibility (United States Department of the Interior, n.d.). This trust responsibility can most plainly be understood as a legal obligation the U.S. has to provide services to protect and uphold Tribal rights (Calabrese, 2024). However, the U.S.'s trust responsibility has often been acknowledged in name only, if at all. Adequate funding for the needed oversight for the fulfillment of these trust responsibilities or the material and labor support to ensure that Tribal rights were upheld was often, and continues to be, lacking or nonexistent (United States Commission on Civil Rights, 2018).

The enactment of U.S. federal health policy in Indian Country is flawed and nuanced, but an overview of some of the most influential pieces of legislation is helpful to understand the frustrations and mistrust that Tribal Nations often have in federal health care systems (Jaramillo and Willging, 2021). The Act of November 2, 1921 (Snyder Act) is the first meaningful piece of legislation to ensure that congressional funding was appropriated towards American Indian/Alaska Native (AI/AN) people and served as the beginning attempt of a more adequate delivery of health services in line with the U.S.'s

trust responsibilities (Calabrese, 2024). The implementation of the Snyder Act, though, is another failed step in the U.S.'s federal AI/AN policy that is most clearly documented in the 1928 report *The Problem of Indian Administration* (Meriam Report). The Meriam Report delivered the American public and legislators a harsh reality of the standard of living conditions, health care, financial capacity, and general well-being of the Tribal Nations. The findings of the Meriam Report surmised that, amongst other solutions, a marked increase in funding for the Bureau of Indian Affairs must be provided (Olson & Mendoza, 2015). The U.S.'s federal policy follows a distinct trend of slow moving and often inadequate addressment of the dire needs of Tribal people and is hallmarked by the 1955 enactment of the Indian Health Transfer Act of 1954, which consolidated clinics across Indian Country to be under one operational body, the Indian Health Service (IHS) (Indian Health Service [IHS], 1997). Indian Health Service is divided into 12 service areas across the U.S., one of which is the Great Plains Area (GPA) that includes Tribal Nations in Iowa, Nebraska, North Dakota, and South Dakota (IHS, 2023). IHS, after review in 1957, was tasked with missives to increase funding, develop relationships with Tribal Nations to tailor the delivery of health care, and diffuse care through state and local initiatives (IHS, 1997). These goals have been achieved at varying levels of success with each of the 574 federally recognized Tribal Nations that IHS serves (United States Commission on Civil Rights, 2018).

Tribal Nations throughout the entirety of post-colonial history have strived towards federally recognized sovereignty and for the U.S. to acknowledge that the best people to serve the Tribal Nations are the Tribal citizens themselves. The birth of the *Indian Self-Determination and Education Assistance Act (ISDEAA)* of 1975 marks the first formal policy recognition by the U.S. of the right to Tribal sovereignty, but does not negate the trust relationship between Tribal Nations and the U.S. (Indian Self Determination Act, 1975). This act is what marked a movement of Tribal sovereignty that is more commonly referred to as a Tribe "being 638". A Tribal Nation possessing the status of 638 indicates that they have entered into a contract with the federal government and will now serve as the deliverer of the

services that the U.S. has traditionally provided in line with its trust relationship (*Indian Self-Determination and Education Assistance Act*, 1975). Tribal self-determination or being a 638 can take on a multitude of forms, but for this paper, we will examine its role in health care services and delivery only. The process of a Tribal Nation assuming the role of health care deliverer from IHS is a lengthy process that often takes years to achieve, including many steps of auditing and evaluation to receive IHS accreditation (IHS, 2017). North Dakota State University American Indian Public Health Resource Center divides this process into four key stages: Assessment of feasibility and tribal leadership decision, Preparation of ISDEAA proposed agreement, Negotiation of Indian Self Determination Act agreement with IHS, and finally Development of Intergovernmental Personnel Agreement/Memorandum of Agreement for federal employees (*Six Thirty Eight*, 2020). An additional consideration is that Tribal Nations do not have to assume 638 status for all health care services. A Tribal Nation may feel adequately equipped to take one or many components of their healthcare delivery but recognize that they are not yet equipped to assume the responsibilities of all areas of care IHS provides in their community. This is commonly referred to as a Tribal Nation's clinic being "partially 638". Within the GPA, three facilities are fully 638 Great Plains Tribal Leaders Health Board, Spirit Lake Health Center, and Winnebago Comprehensive Health Care System (IHS, 2025).

The late 1970s brought forth several pieces of relevant AI/AN U.S. federal health policy, one of which was the Indian Health Care Improvement Act (IHCIA) of 1976. IHCIA became a foundational piece of legislation after a 1992 amendment that authorized and funded through IHS the creation of Tribal Epidemiology Centers (TECs) (Tribal Epidemiology Center [TEC], n.d.a). Tribal Epidemiology Centers serve as public health authorities (PHA) within the 12 IHS service areas with seven core functions. These functions are established to ensure that Tribal Nations are provided with the needed public health infrastructure and resources so that Tribal Nations can make data driven decisions on behalf of their people. The seven core functions are: collecting data and monitoring health, evaluating data and

programs, identifying health priorities, making recommendations for health service needs, making recommendations for improving healthcare delivery systems, providing epidemiologic technical assistance, and providing disease surveillance (TEC, n.d.a). TECs serve as a key service provider to the Tribal Nations in their service area by providing either direct public health infrastructure and public health workforce development opportunities or by awarding subawards to Tribal Nation grantees. TECs work in tandem with the Tribal Nations and are organizations grounded in Tribal sovereignty.

After the 1992 amendment to IHCA, Indian Country is directly served by IHS, 638 Tribal Clinics, and TECs. Tribal Nations and TECs, alongside their mandated IHS funding, are also eligible to receive grants and funding streams through other federal agencies, state governments, local governments, and non-profit groups. State and local public health departments, as well as federal public health agencies, can also be service providers for Tribal Nations. This vast and varied network creates a tangled web of care that continuously changes as federal, state, and local administration priorities change, and in turn so does the flow of funding. It is in this environment that the syphilis epidemic took hold in the GPA and has leveled devastating consequences on AI/AN people.

American Indian and Alaska Native Barriers to Health Care

It is vital to understand the makeup of the public health and healthcare systems operating in Indian Country, but recognizing the barriers that prevent AI/AN people from successfully using them is an even larger component to addressing the syphilis epidemic. For this report, disparities specifically impacting Tribal Nations in South Dakota will be examined; similar disparities impact the Tribal Nations in the other GPA states and across the U.S. Three overarching barriers to health care in South Dakota and Indian Country can be explored through the availability of care, trust in healthcare, and competing needs with the understanding that additional unique barriers to healthcare in every Tribal Nations exist and that Tribal Nations are not homogenous entities but rather distinct sovereign nations. These

barriers while not all encompassing serve to address some of the most prevalent concerns in Indian Country that have tangible implications on health care access.

Geographic factors and the availability of health care providers play a large role in the health and wellness of AI/AN populations in South Dakota. Public health professionals within the South Dakota Department of Health (SDDOH) analyzed health care access between January and July of 2024 and reported that Tribal lands have only 10.3 Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs) per 100,000 square miles compared to the 19.3 FQHCs/RHCs per 100,000 square miles in non-Tribal lands (South Dakota Department of Health [SDDOH], 2024a). AI/AN Relatives living on sovereign Tribal lands simply have farther to travel and fewer health care options than their white counterparts, making health care less attainable by way of distance alone. Even when comparing Tribal lands with very rural communities, this disparity exists, as very rural communities reported 57.2 FQHCs/RHCs per 100,000 square miles (SDDOH, 2024a). Additionally, SDDOH found in its report that most residents residing on sovereign Tribal land need to travel over two hours to access an IHS hospital facility (SDDOH, 2024a). At its core, health care is difficult to access for many simply due to the distance between care facility or provider and the Relative needing care.

Physical access alone, though, is not the only barrier to care. In minority populations, historic trauma and mistrust serve as powerful and at times unmovable barriers to care, and this is especially true in AI/AN communities (Powder, 2022). Compounding the issue is the sensitive and vulnerable nature of sexual and reproductive health care. One of the leading causes of distrust in federally provided reproductive health care was revealed through report HRD-77-3. HRD-77-3 reported the following

Between the 1973-76 fiscal years, 3,406 sterilization procedures, primarily on child bearing age women, were done under coercion or without obtaining informed consent. The Aberdeen,

South Dakota IHS facility is one of the four sites named in this report and primary location where these practices occurred (Comptroller General of the United States, 1976).

It must be recognized that currently, many elders in the GPA Tribal Nations have direct ties to victims or are themselves victims of these practices. This is a recent event for many Relatives in South Dakota and beyond, and for some, trust in federal and non-Tribal healthcare providers has been lost forever.

Beyond the more horrific and blatant examples of medical abuse, many Relatives doubt the quality of services provided by IHS. These doubts are not unfounded, as in 2017 an oversight report found that four of the nine GPA IHS facilities were “out of compliance with the minimum standards required to participate in the Medicare and Medicaid programs” (United States Government Accountability Office, 2017). In many cases, even Relatives who have access to care choose not to utilize it due to mistrust and frustrations with the federal health care system.

One of the most significant contributing factors outside of direct flaws with IHS is the competing needs of many Relatives that often supersede seeking healthcare. Examining census data for the three largest tribes in South Dakota provides a helpful perspective on the lives of Relatives in the GPA. The United States Census Bureau provides the following insights

The Oglala Sioux Tribe (OST) reports that 18,758 people live on Tribal lands, with 48.1% of the population falling below the poverty line and an unemployment rate of 14.1%. The Rosebud Sioux Tribe (RST) reports a population of 10,180 on its tribal lands, with 42.2% of the population falling below the poverty line and an unemployment rate of 19.6%. The Cheyenne River Sioux Tribe (CRST) reports a population of 7,582 on its tribal lands, with 29.6% falling below the poverty line and an unemployment rate of 17.4% (United States Census Bureau, n.d.).

Understanding the financial factors that impact Relatives in South Dakota provides a window into their needs. Relatives who do not have adequate resources to provide housing and food are often not or

cannot prioritize seeking healthcare. As previously discussed, distance to healthcare facilities can be great, and so decisions on how to allocate time and resources are deprioritizing healthcare for many Relatives.

This combination of systemic and situational barriers to healthcare creates an environment that does not support successful uptake and usage of the services that the U.S.'s trust responsibility dictates that it must provide. It is essential to understand that the lack of utilization is not a failure of the Relative, but a failure of the system to correctly and adequately meet the needs of the population it is federally mandated to serve.

Syphilis Explained

Syphilis is a sexually transmitted infection (STI) that has proliferated the GPA and disproportionately impacted the AI/AN communities who reside there. *Treponema pallidum*, a bacterial spirochete, is the causative agent for syphilis that can quietly wreak havoc on a Relative's body and leave them in the dark about their infectious status or health decline (American Public Health Association [APHA], 2022). Syphilis is a preventable, treatable, and curable infection (APHA, 2022) that, with public health bodies and health care systems working in tandem, is an easily addressed condition. Benzathine penicillin administered intramuscularly in differing regimens depending on the stage of syphilis infection is the standard treatment recommendation that clears the infection and cures a patient (Centers for Disease Control and Prevention [CDC], n.d.). The 21st edition of the Control of Communicable Diseases Manual (CCDM) explains that a syphilis infection can be broken down into three stages: primary, secondary, and tertiary, with "variable stages of latency" (APHA, 2022). Staging syphilis is a nuanced art that falls on the shoulders of public health professionals, such as Disease Intervention Specialists (DIS) and clinical staff, and relies on obtaining accurate sexual and needle sharing histories

along with correct interpretations of the often-misleading clinical manifestations. “The Great Imitator”, a nickname for syphilis attributed to Sir William Osler (Hermarajata, 2019), has permeated the public health and medical vernacular as syphilis’ symptoms can mimic a multitude of lesser and greater infections that can leave clinicians who are unfamiliar with it in the dark as to their patient’s condition. Syphilis lays largely asymptotically in the body with distinct but short-lived physical presentations most commonly observed during the primary stage as a chancre lesion at the site of infection (in or on the anus, in or on the vagina, on the penis, and or in the mouth) and during the secondary stage as a bilateral rash presented on the chest during (APHA, 2020). These symptoms are often painless and resolve without treatment, but the infection is still present. The primary and secondary stages of the infection are a public health professional and clinician’s best time for intervention and the most infectious stages of syphilis, as the lesions shed *T. pallidum* at high rates (APHA, 2020). While primary and secondary lend themselves to be the most infectious, their health threats pale in comparison to tertiary and congenital syphilis.

Tertiary syphilis produces some of the most notable but rarer manifestations of the infection, as many individuals do not progress to this stage. Adding to the difficulty in a clinician’s job of identifying and distinguishing syphilis, tertiary symptoms can begin between five and 20 years after the initial infection (APHA, 2020). Tertiary symptoms at their most extreme can range from cognitive decline to gummas (tumors) on organs to blindness and deafness (APHA, 2020). These are life-altering conditions that stem from a lack of diagnosis or lack of connection to care. Congenital syphilis, however, is one of the most harmful outcomes of an untreated case of syphilis and occurs when an untreated syphilis infection vertically passes to a fetus during pregnancy (APHA, 2020). This occurrence demonstrates a fundamental public health and healthcare failure to both the pregnant individual and their unborn baby. Stillbirth is the most devastating effect of congenital syphilis, and babies who are born with syphilis are at an extremely high risk of being born with or later developing various bone and cartilage

malformations, blindness, deafness, and additional central nervous system abnormalities (APHA, 2020).

A stillbirth or birth defect caused by congenital syphilis is an occurrence caused by a preventable, treatable, and curable infection. It is with this in mind that one must examine the syphilis epidemic in Indian Country.

Syphilis in South Dakota and Indian Country

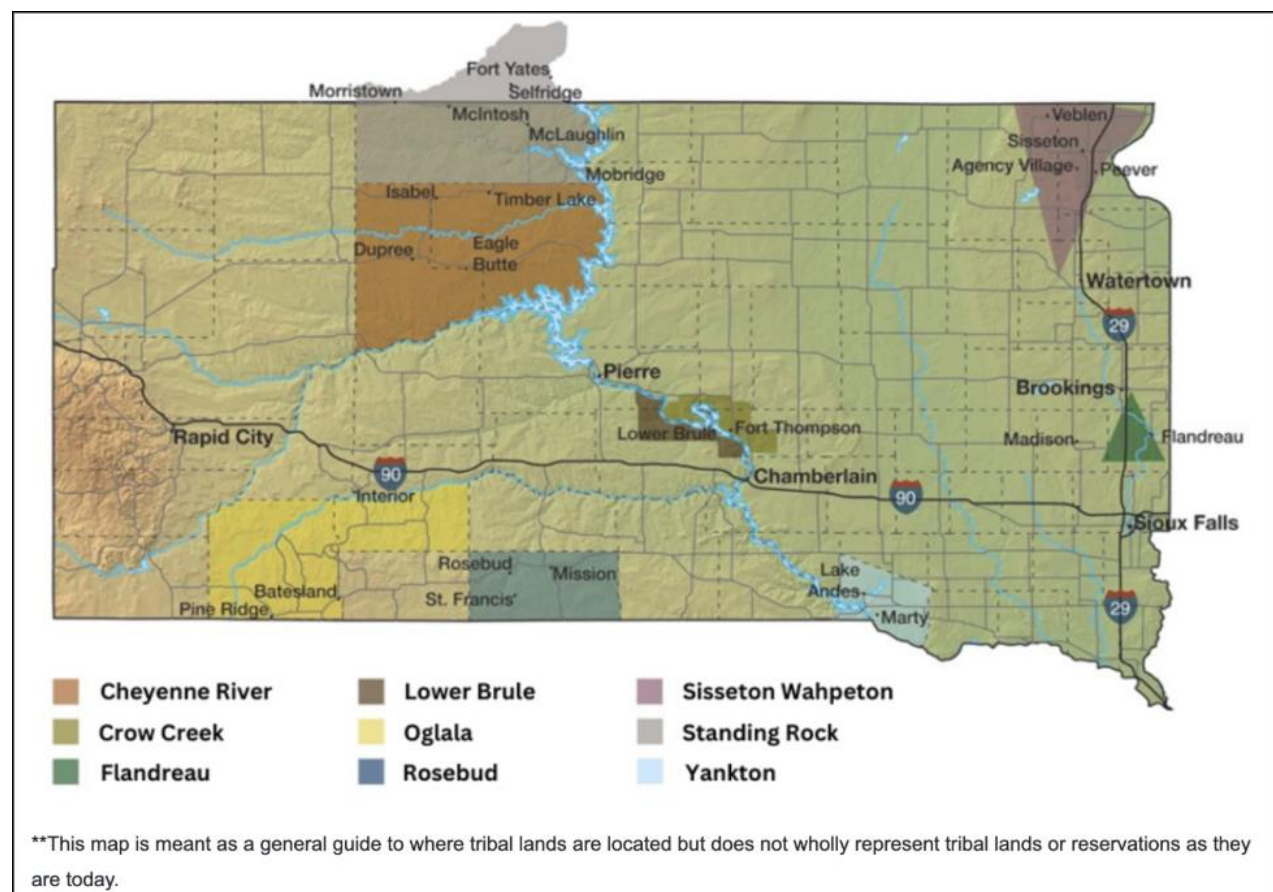
Syphilis took hold in the GPA, most notably in South Dakota, amid the COVID-19 pandemic, and caught the public health and healthcare world by surprise. South Dakota has seen staggering rates of syphilis that were first identified in 2021, with a 3081% increase to 668 cases in comparison to the previous 5-year median of 21 cases (Olson, 2022). This increase in cases in a region where clinicians rarely, if ever, encountered the infection and public health professionals had a competing priority of COVID-19 left South Dakota and the GPA at large unprepared for what was to come. In 2022, South Dakota continued this upward trajectory and was ranked first in the nation with a rate of 84.3 primary and secondary (early) syphilis cases per 100,000 people; New Mexico was ranked second with a rate of 36.0 early syphilis cases per 100,000. The U.S. in total reported a rate of 17.7 early syphilis cases per 100,000 in 2022 (CDC, 2023). Early syphilis rates are most helpful to examine as they reflect a syphilis case that is less than a year old and are vital in understanding the increase of new cases in a given period. South Dakota's rates reflect a sexual and reproductive health crisis that public health professionals have been triaging ever since.

The first sight of hope was documented in 2023 when South Dakota's rate of early syphilis cases fell modestly to 73.4 per 100,000 people (CDC, 2024). This decrease, though, was not felt evenly amongst different racial groups, and AI/AN were impacted more drastically than most. While the rate of early syphilis in South Dakota fell between January and July of 2023, and the case count of early syphilis dropped to 810, AI/AN made up 86% of these early syphilis cases; white South Dakotans made up only 9% (SDDOH, 2024b). These data points indicate a clear health disparity between AI/AN and their white

counterparts. Looking at the geography of South Dakota alone also tells an obvious story. Figure 1.1 lays out the distribution of sovereign tribal lands in the state of South Dakota, while Figure 1.2 reflects the syphilis case rates by South Dakota county in 2024. When first looking at Figure 1.1 and then Figure 1.2, there is a clear correlation between the counties with the highest rates of early syphilis and Tribal sovereign land. These figures alone identify that a public health crisis is occurring, and that a barrier to health care exists for AI/AN communities and Tribal Nations in South Dakota.

Figure 1.1

Tribal Lands in South Dakota

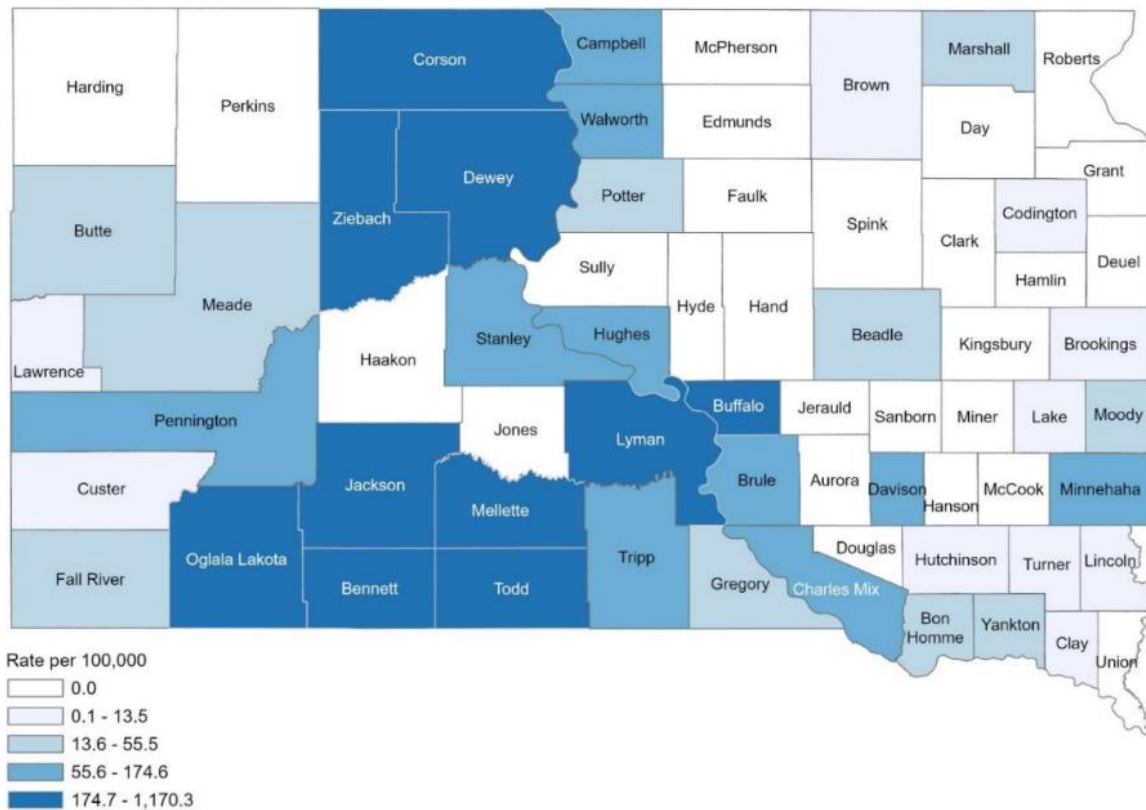


Note. South Dakota Department of Tribal Relations (n.d.) The Tribes of South Dakota.

<https://sdtribalrelations.sd.gov/tribes/nine-tribes.aspx>

Figure 1.2

January to June 2024 Rates of Early Syphilis in South Dakota



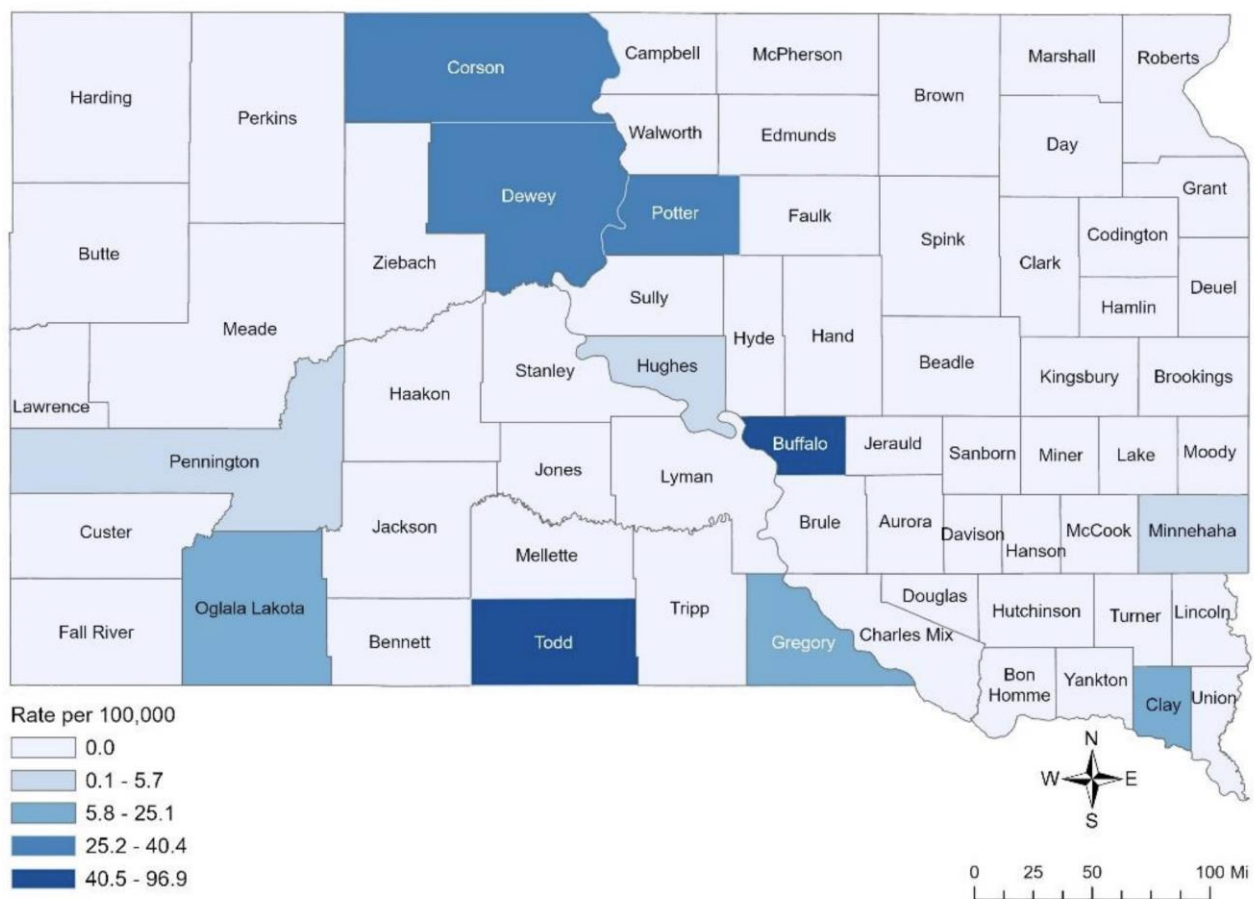
Note. From *Early Syphilis*. South Dakota Department of Health. (2025). Reducing an Unprecedented Rise in Syphilis Rates by Enhanced Screening and Testing. <https://doh.sd.gov/media/i2thr1nj/healthcare-guidance-document-622025-all-stages.pdf>

Early syphilis is not the only point of concern, though, as exponential congenital syphilis rates are found in South Dakota and the Tribal communities within the state. Congenital syphilis rates in South Dakota in 2023 were 482.1 cases per 100,000 live births, while the national average was 105.8 cases per 100,000 live births (CDC, 2024). In 2019, South Dakota observed a rate of only 17.5 cases per 100,000 live births (CDC, 2024). When taking in these rates, it should again be emphasized that congenital syphilis is a preventable, treatable, and curable condition that, through timely intervention,

could have resulted in no adverse health outcomes. When further examining South Dakota's syphilis data between January and July of 2023, it was found that AI/AN made up 92% of congenital syphilis cases while their white counterparts only represented 4% of cases (SDDOH, 2024b). When looking again at sovereign Tribal lands in Figure 1.1 and then comparing to Figure 1.3, the same relationship that was observed with early syphilis cases is seen in congenital syphilis cases as well.

Figure 1.3

January to July 2023 Rates of Congenital Syphilis in South Dakota



Note. From Congenital Syphilis Rates by County, EDSS, SD, January-July 2023. South Dakota Department of Health. (2024). American Indian Health Data Book Full Report.

https://doh.sd.gov/media/htxbhvmu/american-indian-health-data-book_2024.pdf

It is well documented that AI/AN populations are experiencing higher rates of syphilis in South Dakota than their white counterparts, and despite decreasing rates, AI/AN still make up the majority of cases (SDDOH, 2024b). A public health crisis is occurring, and work to address it must occur in tandem with the Tribal Nations, whose citizens are most at risk. This is where the work of a Tribal DIS (TDIS) comes into play.

Who are Disease Intervention Specialists?

DIS are public health professionals who do contact tracing to work case investigations for communicable and reportable conditions. DIS got their origins in an effort by the U.S. Surgeon General to curb syphilis spread in the 1930s, and in the modern era, syphilis and other STIs make up the majority of a DIS's case load (Dill, 2025). Additionally, a DIS is responsive to emerging disease outbreaks such as measles, pertussis, COVID-19, and others as the community burden of these infections ebb and flow. A DIS's primary workflow after a notification of a new positive syphilis case is to conduct case investigation interviews to elicit names and contact information of sexual and needle sharing partner(s) of the Relative during the infectious window and conduct handoffs to care providers and other support services as needed. After contacts have been identified, the investigation has progressed, and the DIS is now on the hunt to get all contacts tested and connected to the necessary partner services. These cases can span many people and infections, as STIs are prone to coinfections (Lin et al., 2021), and what started as a syphilis case can quickly evolve into a more complex investigation and larger sexual and needle sharing networks. It is vital that a DIS obtains the trust of the community they work in (Correia, 2024), as they are asking Relatives deeply personal questions that inquire into someone's sexuality, sex practices, and drug usage. DIS must uphold confidentiality practices and navigate their role for disclosure to PHAs and direct care providers involved in a Relative's case, all the while ensuring that the Relative understands that only those directly involved in their care will learn this information (Dill, 2025). It takes empathetic tact and competency for a DIS to walk into a room of sometimes a stranger,

but in small tribal communities, often that of someone they know and ask, “Could you describe the type of sex you usually engage in?” or “How many sexual partners do you recall having in the last 30 days?”

DIS provide a vital public health service that assists in mitigating the spread of infections to improve the overall health of a community while also providing partner services and direct support to improve the health of an individual Relative.

Current and Past Public Health Action

The work of the Tribal Disease Intervention Training Center (TDITC) began in response to the GPA syphilis epidemic and was initiated by the Great Plains Tribal Epidemiology Center’s (GPTEC) application for the Native Public Health Resiliency (NPHR) grant funded through IHS. Upon securing funding, the TDITC began consultations to develop the Tribal DIS (TDIS) training curriculum and course materials. Once Christy Hacker and I were both brought on as TDIS Trainers, a concerted in-house development began. Recognizing the principles of Tribal sovereignty and understanding the nuanced relationship between Relatives, IHS, and state governments, the TEC and the TDITC team were equipped to provide a meaningful Tribal public health workforce development course. Our primary goal is to provide indigenously competent and practical training that will enable the mobilization of the current Tribal public health workforce to perform DIS work. This work will allow for a more targeted effort to prevent syphilis and other reportable disease spread while also enhancing a Tribal public health department’s ability to connect Relatives to further care. TDIS trainings are grounded in Tribal sovereignty to build up Tribal public health workforce capacity and to serve as a way to improve the public health outreach in communities where state DIS are unable to effectively reach due to distance or lack of trust by the community.

Prior to the TDITC’s genesis, GPTEC’s Epidemiology and Disease Prevention program conducted community wide testing events in partnership with Oyate Health Center’s public health nurses and a Rapid City, South Dakota, non-Tribal healthcare facility. A targeted effort by GPTEC from December 2022

to June 2024 of providing free community-based testing and gift cards to those who elected to be tested resulted in 76 Relatives who were positive for syphilis, with 61 of those Relatives getting connected to care within a year of their positive result (Curry O'Connell et al., 2025). This testing event, along with mobilization into many of the GPA Tribal Nation communities, has been a targeted deployment strategy that has helped to turn the tide and stop the rise in syphilis rates and cases. Community outreach alone has not been GPTEC's only mode of action, though, as Great Plains Tribal Leaders Health Board GPTLHB in partnership with the GPA Tribes urged the U.S. Secretary of Health and Human Services in February of 2024 to declare syphilis a public health emergency in the GPA (Rowland, 2024). While this declaration of emergency has never come, the U.S. Department of Health and Human Services did take action almost an entire year later. On December 26, 2024 formal notification was given that the U.S. Public Health Service (USPHS) would deploy up to 45 officers from January 5 to May 31, 2025 (Tso & Levine, 2024). Other Tribal organizations have also started to mobilize, and the Southern Plains Tribal Health Board has put out some capacity building information establishing TDIS programs as well (Southern Plains Tribal Health Board, n.d.). The Tribal public health field has mobilized and is continuing to develop programs to meet the needs of our Relatives, and the GPTEC TDIS training plays a significant role in this landscape.

Purpose

My work within GPTEC to address the syphilis epidemic through the TDITC and TDIS curriculum is grounded in enhancing and creating competent education and reference material. Producing both the TDIS Student Manual's Module 2: STI Basics and the medicine bag health education collection worked to leverage my knowledge of reportable infectious diseases and the needs of Tribal communities to improve my ability to create tailored trainings to strengthen the health of a community by building Tribal public health workforce capacity.

Great Plains Tribal Epidemiology Center

GPTEC is one of the 12 congressionally mandated TECs within the U.S. Residing in Rapid City, South Dakota, it serves 17 federally recognized Tribal Nations and one Tribal service area throughout Iowa, Nebraska, North Dakota, and South Dakota. GPTEC has three focuses: public health, epidemiology, and research (Great Plains Tribal Leaders' Health Board [GPTLHB], n.d.) to improve the health and wellness of the Relatives they serve. GPTEC is housed within the GPTLHB, and both organizations are a continued assertion of Tribal sovereignty, and their work can best be described through their respective mission and vision statements: "Advancing excellence in tribal health through culturally guided service, innovation, and advocacy," and "All tribal nations and citizens thrive in wellness." GPTLHB was born in 1986 in Aberdeen, South Dakota, to act as Tribal representatives and advocates on behalf of the 17 Tribal Nations and one service area to the GPA regional IHS. Growth has been continuous since then, and in 2003, GPTEC gained its origins through its original iteration of Northern Plains TEC. These two foundational events have paved the way for future generations of Tribal public health professionals to advance Tribal sovereignty and advocate for the health and wellness of all Relatives in the GPA and beyond.

A special thanks to my preceptor, John Godoy, MPH, and mentor and fellow TDIS Trainer, Christy Hacker, MPH. Godoy serves as the Program Manager of the TDITC and has been with the program since the start of its funding in 2024. Godoy obtained his MPH at Creighton University in 2023 and has served in various roles with his home Tribal Nation, the Rosebud Sioux Tribe, before coming to GPTEC. Hacker and I are the first two TDIS Trainers for GPTEC, but she has served in a multitude of roles with GPTLHB's public health programs for 15 years, most notably as the Director of Maternal Child Health for 8 years, and cut her teeth in public health as a state DIS with South Dakota. Hacker obtained her MPH in 2011 at Benedictine University. Both Godoy and Hacker passionately serve the Tribal Nations in the GPA. As a team, Godoy, Hacker, and I have shaped the TDIS Manual, and Godoy and Hacker have served as irreplaceable consultants as I developed the presentation of the TDIS Student Manual Module

2: STI Basics and medicine bag health education collection. Godoy's leadership as program manager and preceptor alongside Hacker's mentorship have been deeply meaningful in shaping my public health career and foundational to the work of my Applied Practical Experience and Integrated Learning Experience.

Chapter 2 – Learning Objectives, Project Description, Methods

Objectives

My time at GPTEC was grounded in uplifting and supporting Tribal Nations and their rights to sovereignty through public health infrastructure building. The NPHR team is a program founded on the idea that empowering Tribal public health workers to increase their capacity to serve our Relatives is the best path to decreasing syphilis and increasing overall health and wellness in the GPA. In line with this mission and belief are the two objectives established for my APE.

- **Objective 1.** I will produce the GPTEC TDIS Certification Student Manual - Module 2: STI Basics by 11/07/2025 to improve my ability to create tailored trainings to strengthen the health of a community by building tribal public health workforce capacity.
- **Objective 2.** I will produce a “medicine bag” health education collection by 11/07/2025 to enhance my ability to provide relevant education strategies that lead to meaningful increases in health literacy and positive health changes for specific populations.

Objective 2 was originally structured to incorporate an evaluation of the GPTEC TDIS Module 2: STI Basics. Due to scheduling conflicts with a Tribal partner, a delivery of the GPTEC TDIS course was not given during the duration of my APE, and an evaluation was not completed. The medicine bag health education collection serves to complement the TDIS curriculum and act as supplemental material for a TDIS to use during health education with Relatives.

Methods and Activities

Objective 1: GPTEC TDIS Certification Module 2: STI Basics

When first tasked with organizing and designing the GPTEC TDIS Certification Module 2: STI Basics (Mod 2), the immediate first need was to think about the user. A firm understanding of who would be and when they would be using and referring to Mod 2 was foundational to the layout and implementation. TDIS will often be out in rural Tribal lands where cell service is unreliable or nonexistent, so they are relying on print or downloaded resources to serve as a tool. In DIS work, it is preached that to work an effective case investigation, you need to have a comprehensive understanding of the Relative whose case you are working and the infection they have. This principal, while key, must allow for the understanding that new TDIS will likely not have an all-knowing understanding of STIs and other conditions that they are investigating. It is with this background that Mod 2 was drafted.

Mod 2's layout needed to be accessible by providing practical information that would facilitate a case investigation but not overwhelm a TDIS. My personal copy of the CCDM 21st edition houses a textbooks' worth of text into just under an 800-page "pocket manual" that, while a wealth of knowledge, is cumbersome to use. Utilizing the CDC's resources and the CCDM, information was compiled on syphilis; human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS); chlamydia; gonorrhea; and hepatitis A (HAV), B (HBV), and C (HCV). Partnerships were established with South Dakota DIS and Tribal public health professionals to assess what specific infections were priorities in their communities to inform what material should be presented. This combination of STIs was chosen as a reflection of their high prevalence in GPA DIS caseloads.

The other goal that Mod 2 sought to address was how this can be a resource that not only informs a TDIS on a specific STI, but also gives them information that can be presented back to a Relative. A DIS's primary job after contact elicitation for disease tracing is to ensure that the Relative receives health education to inform healthy decision making surrounding their sexual practices or drug

use and getting the Relative connected to testing and treatment services. This is an area where the CCDM and CDC are lacking. There is often not a clear transition of communication from material that is presented in a high-level medical manner to inform a DIS to relatable, digestible material for a Relative. A key feature I included in Mod 2 and throughout the GPTEC TDIS Certification Student Manual is margins that include “when talking to a Relative...”. Additional information, such as “tips for using a condom correctly” and “U=U,” was provided as well to give TDIS tips and language to help articulate health education to a Relative. These margin notes served to pair the traditional, more scientifically geared presentation of information with practical communication style tips for a TDIS to use in an interview.

The aesthetic layout of Mod 2 is also something that I spent significant time contemplating. A concerted effort was made to present visuals that tied to natural landscape and wildlife in the GPA and GPA Tribal cultural components in Mod 2 and the GPTEC TDIS Certification Student Manual as a whole. Indigenizing content was a priority that sparked the idea of a reinvention of a STI health education package.

Objective 2: Medicine Bag Health Education Collection

In the sea of health education, minority populations often do not see themselves or their cultures represented. When representation is presented, it often can be in the form of a cartoon figure with a similar skin tone, and I strove to expand beyond that. In Lakota culture, smudging is an important spiritual practice that allows for sage, sweetgrass, or cedar to be burned (Furst, 2023). GPA Tribal Nations are not homogeneous, and this practice varies between tribes, but it is common for smudging to be done to cleanse negative thoughts and energy, where the smoke is pulled towards the body and inhaled (Hazlett et al. 2025). Within GPTLHB, it is a daily practice in the morning to have a team member bring around an abalone shell holding sage for those who wish to smudge. This is a traditional medicinal practice that is well recognized amongst Relatives and that promotes mental and spiritual well-being that transcends to overall health. Traditionally, these types of spiritual medicines were kept in a small

medicine bag that one would always keep on oneself to have available. This was the framing that I used to create our medicine bag health education collection.

Hacker and I had noticed that at all GPTEC's health education tabling events, the health education provided was often clunky and quite clinical looking, as if it belonged in a doctor's office. Hacker's idea that sparked my creation of these pieces was that we needed a small card that would be discreet and only provide a Relative with actionable information to improve their health. As I became more familiar with GPTEC and Lakota culture, smudging became a meaningful part of my day, and the association between smudging and health and wellness was firmly established for me. This connection of sage and smudging as good medicine started to prompt me to explore how we could visualize the relationship between safe sex and utilization of condoms as good medicine, too. Linking traditional Lakota values with modern infection prevention became a clear need, and the medicine bag health education collection was born.

I prioritized Hacker's suggestion of giving the Relative only information that they could turn into an actionable behavior change, and phrases like "snag safer", being a common AI/AN phrase for "hooking up", were implemented. All three pieces address STIs of high prevalence or concern in the GPA and gave additional advice such as "know your status", "get treated", and "get tested" or offer answers to questions like "how is HCV spread?". These facts are situated on 5-6" by 2-3" foldable and scented cards (to smell like what the card is depicting) that are new, discrete, culturally relevant, and provide vital health education to increase healthy decision making when engaging in sex. Many Relatives, though, are already concerned about their health, and being told to use a condom is not a new concept, and for those who want more information, a QR code to additional information is also found inside the card.

The QR code linked flyer was made to provide a Relative with still relatively fast facts on syphilis, HIV/AIDS, and HCV, respectively, that would allow a Relative to understand what they should protect

their body against. The flyers underwent an extensive review process with GPTLHB's Chief Public Health Officer, Meghan Curry-O'Connell, and Hacker to ensure that the language was precise while also being digestible for a Relative. The digital flyers serve as a companion piece to the foldable cards and allow for consistent changes and updates to be made to allow for changes in treatment guidelines or any other new findings related to the STIs. Both Mod 2 and the medicine bag health education collection worked to bridge clinical knowledge of STIs and traditional medicine and learning, for a Relative.

Chapter 3 – Products and Results

Within my APE, the two products produced were Mod 2 and the medicine bag health education collection. These pieces are blends of clinical knowledge of STIs from the CDC and APHA's resource libraries and traditional Lakota knowledge used to engage both the TDIS and a Relative in their respective health learnings. Both products serve as a toolkit resource for a TDIS, whether they need refreshers to improve their own understanding of STIs or if they need support in effectively articulating to a relative the nuances of their infection.

Mod 2 aims to be the travel companion of a TDIS while they are on the road and acts as a practical resource. Many individuals who are doing TDIS work are community health workers (CHW) or public health nurses (PHN) who wear many hats and have expertise in places that often lie outside of STIs. These embedded Tribal public health workers, though, know their communities and are experts in connecting with Relatives. This is a skill much harder to teach than the latency period of syphilis or the nuisances of an HIV infection. By providing TDIS with materials like Mod 2, they are being set up for success to conduct a case investigation in a meaningful way that builds rapport with the Relatives to strengthen their relationship with public health professionals while also giving accurate and effective health education messaging.

Both products were well received by my colleagues at GPTEC, with special favor being placed on the medicine bag health education collection. Within GPTEC the medicine bag health education pieces underwent internal review and were provided to health educator and program coordinator staff to give comments on prior to printing. Additional feedback was provided from our Chief Public Health Officer, Dr. Meghan Curry O'Connell. Dr. Curry O'Connell and I worked together to ensure that the verbiage language used by the Relatives out in our communities and that the pieces-maintained faithfulness to APHA and CDC guidelines. The pieces are currently being printed now to be provided to Relatives in community events throughout the GPA at the end of March. This health education collection served as a

new way to combine cultural values and medicinal practices with clinical education that engaged Relatives effectively. The medicine bag health education collection is used with “snag bags” that include condoms, dental dams, insertive or female condoms, lubricant (lube), and various other supplies. When the Relative opens the snag bag to retrieve the STI prevention materials, they will first see the health educator to peruse. The emphasis is wholly placed on the association between smudging materials being good medicine for the mind and STI prevention materials being good medicine for the body.

Chapter 4 - Discussion

The first question most public health professionals are posed to ask is “Why is there a need for Tribal DIS?” This question is easily answered, though, when understanding the role of Tribal and data sovereignty. Tribal Nations have always fought for their right to self-governance and to govern and access the necessary data to support their people. DIS caseloads are never small, and state DIS must serve huge swaths of the states they serve and are often situated in the urban centers that are large enough to support a regional or state public health office. In many cases, this means that they are a significant distance away from rural Tribal communities that are experiencing the highest rates of syphilis. This is not a strategic setup to effectively combat the syphilis epidemic that the GPA and Indian Country are facing. Additionally, state DIS are often unfamiliar with the values held in Tribal communities. They come onto the reservation in state plated vehicles, with often no ties to the community, with the mission to triage as many cases in the time they have, as they are often unable to make the regular visits that are needed. This sense of urgency and otherness often demonstrates a lack of cultural competency that, in most cases, does not stem from a disregard or apathy for the health of our Relatives, but results in the same harmful effect of worsening the relationship between Relatives and PHAs. The current dynamic makes it easy for a Relative to not feel that the state DIS, often an effective newcomer to a Tribal community understands or appreciates their health concerns and what choices or situations have led to their positive status. Creating TDIS seeks to address this issue.

TDIS by design are already embedded community members in Tribal communities and are often enrolled members of the Tribal Nation they are serving. This inherent identity and tie to the community increases trust and emphasizes the collective goal of keeping a Tribal Nation healthy. Tribal DIS understand the cultural practices of a Tribal Nation and can better recognize and integrate traditional healings and practices to increase uptake of healthy sexual behaviors and promote testing and treatment for STIs. Whether the TDIS is a CHW, PHN, or Tribal public health professional simply looking

to expand their knowledge on STIs, they step into the room understanding their Tribe's needs and priorities of the Relatives they serve more innately than any state or federal provider. By training and mobilizing TDIS into Tribal Communities, we are creating a workforce that is sustainable and builds trust amongst our Relatives. A TDIS's inherent identity and tie to the community increases trust and emphasizes the collective goal of keeping a Tribal Nation healthy. Tribal DIS understand the cultural practices of a Tribal Nation and can better recognize and integrate traditional healings and practices to increase uptake of healthy sexual behaviors and promote testing and treatment for STIs. To develop this enhanced workforce, there must be supported trainings provided.

There is currently no formal or standardized DIS certificate program required for a public health professional to assume the title of DIS or to ensure consistent education across public health jurisdictions. The CDC provides free asynchronous online training modules in a curriculum series titled Passport to Partner Services that covers topics from the biology and mechanisms of infectious causative agents of reportable infections to the necessary steps of an interview and the practicalities of conducting a case investigation. Passport to Partner Services does not address any of the intricacies of working in rural Tribal communities or with AI/AN populations. This training consists of 72+ hours of material for a DIS to watch and read, which, depending on a DIS's familiarity with infectious diseases, could take significantly more time to work through. While Passport to Partner Services is a robust resource, it does not deliver a practical training option for Tribal partners who are often serving in a multitude of roles and do not have 2 work weeks or more to dedicate to an online training module that does not address concerns faced in rural Tribal communities.

The GPTEC TDIS Certification course served to address the shortcomings of Passport to Partner Services. It was identified that Tribal partners need a comprehensive, but concise, training that could deliver actionable skills for Tribal public health professionals who were already working in their communities. Within the GPTEC TDIS Certification course, there are three modules: Confidentiality and

Data, STI Basics, and Sensitive Dialogue Training. The modules aim to deliver in a two-day course the basics of DIS work and what a public health professional needs to know to successfully and meaningfully limit infectious disease spread to improve the health of an individual, Relative, and an entire community. While I assisted in the development of all three modules, Module 2: STI Basics showcases the integration of clinical knowledge of STIs and the delivery of material tailored to promote best learning for Tribal partners.

The idea of creating a comprehensive resource package for a TDIS was also born from the manual creation. While the training itself is designed to provide a foundational knowledge of STIs, I recognized that no two-day course could answer all questions or ensure that the information presented is completely learned. The student manual serves to address this issue. The student manual is meant to be carried and kept by the TDIS and used as a reference guide in the field or in their offices to quickly answer questions and serve as a refresher. Module 2: STI Basics and the entirety of the GPTEC TDIS Certification Student Manual is thought of as a field guide that, in rural Tribal lands where there is often limited or no cell service, is the resource that a TDIS can use to ensure they understand a STI comprehensively enough to educate a Relative without internet access. These parameters challenged me to place myself in the shoes of a boots on the ground public health professional and critically think about how, individually, a TDIS and a Relative would need to have the same information explained.

The medicine bag health education serves as an additional resource for a TDIS. During a case investigation interview, a TDIS is talking about potentially life changing information with a Relative, and this is often overwhelming and confusing. When working a syphilis case investigation, I often spend the first 10 minutes of an interview explaining to the Relative that this is a curable condition that can lead to adverse health outcomes if left untreated, but that they have the power to get treated and avoid these complications. This atmosphere of shock and fear can leave the Relative unfocused and unable to process the information that the TDIS is telling them. Having culturally competent and easily digestible

health education to leave the Relative with allows them to regain power and have the information to empower them to make healthy decisions. Training a TDIS means that you are not only guiding them in how to conduct a case investigation and conduct sensitive interviews but also providing the resources to allow them to have meaningful interactions with a Relative, and the medicine bag health education collection allows them to successfully do this.

Through my work creating the products for my APE and time with GPTEC, the issue of what a TDIS and Tribal public health department need most would come up: data. Data access is a complicated beast to tackle, as the data pipelines are coming from health care facilities, local public health departments, and lab facilities that state and federal public health agencies have access to as PHAs. In this vein, the various TECs and Tribal Nation public health departments should also be plugged into this data exchange, but in most cases, they are not. GPTEC, other TECs, and Tribal Nations have all been campaigning and working with their respective jurisdictions to gain access to their Relatives' data. This seek and find mission, though, has shed light on issues that have been readily apparent in the Tribal data space for years. Racial misclassification plagues most federal and state databases, and in turn, if data is turned over to the Tribal Nation or TECs, it is often incomplete as it is done by race sorting, and many Relatives are excluded due to identifying as "other" or "more than one race". Additionally, some data streams will only release data to TECs of AI/AN that are members of a federally recognized Tribal Nation that the TEC directly serves. This also excludes Relatives' data from being accurately sent over, as federal recognition status and enrollment into Tribes can mean that some AI/AN aren't accounted for. Some Relatives are not enrolled in a Tribal Nation either due to a lack of their Tribe's federal status or being unable to enroll in a Tribal Nation due to their heritage being split between a multitude of Tribal Nations or other races and not meeting enrollment requirements of one singular Tribal Nation. This resulting lack of data means that TDIS have an incredibly difficult time tracking cases and completing case investigations.

GPTEC has been working with the state of South Dakota for many years and established a data sharing agreement that allows for a flow of data on infectious reportable condition cases. However, this is only one state in the GPA, and racial misclassification can still act as an issue. The solution to this has been to create their own electronic disease surveillance system (EDSS) that is under construction now and is working to provide all GPA tribes with an EDSS that will capture Tribal data and allow it to be mobilized for case investigation and emerging outbreak responses. This is the forefront of the Tribal public health field and is ever evolving to meet the needs of our GPA Tribal Nations.

Conclusion

Tribal Disease Intervention Specialists can only be as successful as their training and data access allow them to be. By providing a comprehensive resource package for a TDIS to use in the field for their own reference and to support a Relative's health education, they will be more effective in their role of reducing disease spread. The emerging focus on data accessibility will continue to drive the work of TDIS forward and allow for increased Tribal and data sovereignty amongst our GPA Tribal Nations.

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Appendix 1 – Synthesis and/or Integration of Competencies

Competency MPH 1: Apply epidemiological methods to the breadth of settings and situations in public health practice

Within my time at GPTEC, I was afforded the opportunity to assist in the development of an in-house EDSS that was designed and brought to life by GPTEC. To successfully conduct TDIS work, one must have access to reliable data streams that support case investigations. A TDIS needs to know information on when the Relative tested positive, if they tested positive or were named as a sexual/needle sharing contact, if the Relative has had prior infections, and if adequate treatment has been provided and completed. All of these questions state DIS have answered through state and at times inter-state EDSS data access and sharing. Due to syphilis and other STIs falling under the reportable condition requirements, state and federal entities have access to this data if it exists. Tribal Nations and their public health departments, along with TECs, are not automatically tapped into this pipeline despite the fact that they are considered PHAs and are entitled to this data share. Individual Tribal Nations and at times coalitions of Tribal Nations alongside TECs have been advocating and negotiating data sharing agreements with the states that they fall under the service area of. GPTEC has successfully established a data sharing agreement with the state of South Dakota and an independent lab facility that will share their data on reportable conditions of AI/AN in the state of South Dakota, and in the case of the lab facility, all GPA states.

This data needs a cyber secure home for it to be routed to, and the GPTEC EDSS serves as that. My role has been to provide insight and direct development support to build out the EDSS. One of the key priorities I have had has been to engage with Tribal public health stakeholders who are either already conducting TDIS work or are interested in starting to collect and assess what they will need the EDSS to perform for them. This has translated to my work in disease modeling to create what the user interface will look like for each specific reportable condition, ranging from STIs to mumps to lead

poisoning and more. My job has served to construct an interface that makes sense to a TDIS user who has potentially never interacted with an EDSS before and allows them to conduct meaningful case investigations for disease mitigation and response work. While this work has had a direct tie to my work as a TDIS trainer with a focus on STIs, it has also broadened my knowledge on the public policy and data infrastructure needs of Tribal Nations and TECs to effectively serve their Relatives through public health services informed by accurate data. Disease surveillance and response mobilization through an EDSS is a foundational component of state and federal public health entities, and through my work with GPTEC, I have been able to assist in designing and implementing this core epidemiological strategy in our Tribal communities.

Competency MPH 8 Apply awareness of cultural values and practices to the design or implementation of public health policies or programs:

The insight that allowed for the successful development of my products was gained through practical TDIS work that I performed in partnership with the South Dakota state DIS and through traveling to different GPA Tribal Nations to help perform DIS work during community testing events. When I observed the State DIS conduct their work, it was noticeable that at times there was a cultural disconnect between the state and the Relatives they had been sent to serve. Through continued consultations with Tribal public health professionals and leadership, I was able to learn what priorities these communities had and what they felt was necessary to ensure that culturally competent training could be provided for TDIS. I do not come from a Tribal or Tribal public health background, and the insight that the existing workforce provided helped me to assess and interpret what was critically needed for a successful TDIS training program. Additionally, I had the opportunity to attend South Dakota state public health calls and conferences that highlighted the tensions between the State and Tribal Nations, as the state often failed to provide adequate resources or equitable funding opportunities to Tribal public health programs. This combination of experiences and insights

demonstrates the need to provide and support self-sustaining Tribal public health department initiatives through designing culturally competent public health capacity building course.

Competency IDZ 1: Evaluate modes of disease causation of infectious agents

My time as a TDIS trainer also allowed me to serve as a TDIS for Tribal Nations during community testing events. As a TDIS, I was a direct resource when a positive case of syphilis was identified at a testing event and provided case investigation services for the Tribe. During a case investigation, it's a TDIS's role to learn and assess what a Relative's health or environmental risk factors are that likely led to their positive status. It is vital that a TDIS has a comprehensive understanding of whatever reportable condition they are investigating and understands if the condition is infectious, how the Relative obtained it, and potentially transmitted it to others. I worked to interpret a Relative's sexual history and behaviors to understand where the infection stemmed from, most often, either horizontal transmission from an unprotected sexual encounter or vertical transmission to a fetus during pregnancy. It was vital to be able to compose an accurate sexual history from the Relative and, with that information, estimate when the infection first occurred and how many, if any other individuals were exposed. Effective staging through interpreting the Relative's retelling of clinical symptoms was key, as syphilis is most infectious during its early stage when a chancre sore is present. Syphilis also puts Relatives at a high risk for coinfections, the most dangerous of which is HIV. The chancre sores provide an ideal route of entry into the body for HIV, which emphasized the need for me to connect Relatives to partner services for further STI testing if it had not been previously done. Managing a case investigation required me to have a comprehensive understanding of syphilis and its interaction with a Relative's body.

Table A.1 Synthesis and Integration of Competencies

Number and Competency		Description of Synthesis and Integration
MPH 1	Apply epidemiological methods to the breadth of settings and situations in public health practice	Assisting the GPTEC informatics and data coordinating units to construct and enhance an internal EDSS system for enhanced Tribal public health response capacity to infectious diseases and emerging outbreaks by integrating Tribal public health workers' needs and state and federal reporting guidelines.
MPH 8	Apply awareness of cultural values and practices to the design or implementation of public health policies or programs	Assessing the relationships between non-Tribal DIS during statewide calls and conferences and while supporting Tribal Nations during community testing events allowed me to create the best strategies for educating both TDIS and the Relatives they serve by integrating clinical knowledge of infectious diseases and values of the Tribal communities GPTEC serves.
IDZ 1	Evaluate modes of disease causation of infectious agents	Conducting TDIS work in tandem with or entirely for Tribal public health departments throughout the GPA allowed me to better analyze the various causative factors of STIs and to integrate how social drivers of health influence and allow for STI spread.

Appendix 2 – Demonstration of Competency Attainment

Competency MPH 8: Apply awareness of cultural values and practices to the design or implementation of public health policies or programs

The medicine bag health education collection is a product grounded in cultural responsiveness. Most health education that exists for STIs is in brochures, posters, or rack cards that often look like they were pulled straight from a display in a health clinic. This clinical and often physically large health education is often uninviting or outright off putting as it lacks discretion and frequently provides overly dense information. With this health education collection, I aimed to create a digestible, culturally relevant, and practical piece of health education that includes actionable pieces of information that a Relative can use to make healthy decisions when engaging in sex acts.

The shape alone is a reference to items used to smudge with that are good pieces of medicine for mental and spiritual health that Relatives in the GPA are familiar with. This shape creates an inherent association between culturally known traditional medicine and potentially new or reemphasized information to increase uptake in safe sex practices and encourage testing for and treatment of STIs. The die cut cards are also designed to be discreet as they are between 5-6" long and 2-3" tall when folded to allow for a Relative to not broadcast to those around them that they are learning about an STI or seeking out that information, as in tight knit and small Tribal communities, that can be an uncomfortable encounter. The collection presents health education in a new format that I have never seen before and sparks interest amongst Relatives as it is something that is interactive and unique. The cards are also printed on scented paper that smells earthy and similar to the items that the cards depict. Most importantly, I chose verbiage that calls the Relative to action or poses and answers questions that the Relative might be asking when learning about items like HIV or HCV. If the Relative wants to learn more or get connected to care, they can scan the QR code and are directed to a linked flyer that provides more in-depth information that is presented in a clear way that lacks medical jargon to

enhance learning. This health education was formulated to revise existing information that, at times, served as a barrier and disengaged Relatives from learning more about how they can protect their health.

Competency MPH 19: Communicate audience-appropriate public health content, both in writing and through oral presentation

Creating targeted communication strategies for the health education for both public health professionals and the Relatives they serve was the primary work I did as a TDIS trainer. TDIS have the job of learning clinical basics of STIs themselves and ensuring that they understand this information well enough to communicate to Relatives how they can improve and protect their health. When arranging Mod 2, I worked to create moments of pause where the TDIS could be presented with the clinical information of an STI and then be pulled directly to a margin that discussed how this knowledge could be imparted to a Relative. Learning that you have tested positive for an STI and that your health and the health of your partner(s) could be at risk is an overwhelming time for a Relative, so information specific to their infection must be presented clearly.

Developing tailored health education for a Relative to have after the TDIS has left was something that was important due to high levels of stress the Relative is under during the interview. It is impossible for the Relative to remember everything that the TDIS has communicated to them during their interview, so reference material for a Relative is just as important as it is for a TDIS. With the medicine bag health education collection, I worked to create an integration of clinical information with cultural values and references that would allow the Relative to be presented dense information in a demystifying and destigmatizing way. The size of the printed materials was also designed to be discreet so that Relatives not wanting to disclose their health status to others they live and interact with was something I focused on, as the cards are able to fit comfortably in a pocket or folded into a wallet. My primary goal was supporting the entire breadth of a TDIS's work, from their own education to their

ability to connect with and educate the Relatives in their community to create a prepared and engaged Tribal public health workforce.

Competency MPH 20: Describe the importance of cultural competence in communicating public health content

Both Mod 2 and the medicine bag health education collection aim to provide culturally competent deliveries of health education in two different settings, Tribal public health workforce trainings and Relative education. It has readily been established that a public health crisis is occurring in the GPA and that the syphilis epidemic is disproportionately impacting AI/AN communities. GPTEC's public health response has been deployed through a multitude of education campaigns, testing events, and the development of the TDIS curriculum. DIS services already exist in the region, though delivered through state public health departments and federally through the CDC. However, due to historic traumas and lack of cultural understanding, these deliveries have not best served our Relatives. In a quarterly HIV centered state meeting of public health agencies and community members, a South Dakota state DIS remarked that "it is hard to do DIS work on the reservations because native people do not care about their health". While an extreme example, this exemplifies the lack of connection between non-Tribal entities and the Relatives that they are meant to serve. Health and wellness are vital parts of Tribal Nations, and in many across the U.S., it is deeply prioritized through spiritual and cultural practices. To claim that AI/AN do not care about their health is an opinion founded in ignorance of Tribal culture and disregard of the social drivers of health that have played a role in this epidemic. A Tribal public health workforce of mobilized TDIS ensures that infection prevention and control are implemented while also culturally and meaningfully supporting a Relative during what can be one of the most difficult times of their life.

My arrangement and creation of Mod 2 sought to integrate cultural connections into the most foundational aspect of TDIS training. I worked to integrate cultural competency at the most basic level

by using Relative rather than client or patient and using images of a traditional Lakota dancer and drums while also incorporating GPA nature scenes and wildlife. During more clinical explanations, the reader is also pulled to the margins, where there is guidance on how to explain the material to a Relative and IHS specific guidelines. I organized Mod 2 to always center the Relative and promote the central idea that improving a singular Relative's health directly improves the health of a community and strengthens a community's trust in public health services.

The medicine bag health education also served as an interpretation of cultural values and traditional medicine practices to increase uptake in healthy decision-making surrounding sex acts and drug usage. Health education that is representative of the community it seeks to inform increases uptake and works to grow the health literacy of a community. As I compiled information on syphilis, HIV/AIDS, and HCV, I thought back to the questions asked and concerns expressed to me while I tabled at community events, assisted community testing deployments, and conducted TDIS work. I worked to decode and destigmatize clinical health information that, for many Relatives, acts as a barrier to learning. Constructing both products allowed me to deepen my own understanding of the STIs I provided education and training on, and also allowed me to further my learning of the GPA Tribal Nation's cultures to best support our Relatives and strengthen Tribal sovereignty work.

Competency IDZ 1: Evaluate modes of disease causation of infectious agents

The bulk of my work when creating both products was ensuring that I could effectively explain the clinical basics of STIs to a TDIS or Relative and assist both in understanding what the risk factors are for these infections. The CCDM 21st edition and the CDC's resources played an integral role in my learning as I worked to adapt their clinical explanations into meaningful education materials. It is vital for a TDIS to understand how the various STIs can be transmitted. This understanding allows them to conduct effective contact tracing and identify the partner(s) of a Relative who has been exposed and is at risk of contracting the infection. I compiled this information in Mod 2 to allow for the TDIS to learn

these mechanisms and have a field guide that can quickly reeducate them as needed. The medicine bag health education collection served to explain to Relatives information on the clinical manifestations and mechanisms of syphilis, HIV, and HCV in a way that would mobilize them to make healthy decisions during sex acts and drug usage. The same analysis of clinical STI information occurred for this health education, but as I organized it, I did so in a way that Relatives would be able to understand and feel empowered by.

Competency IDZ 4: Analyze disease risk factors and select appropriate surveillance.

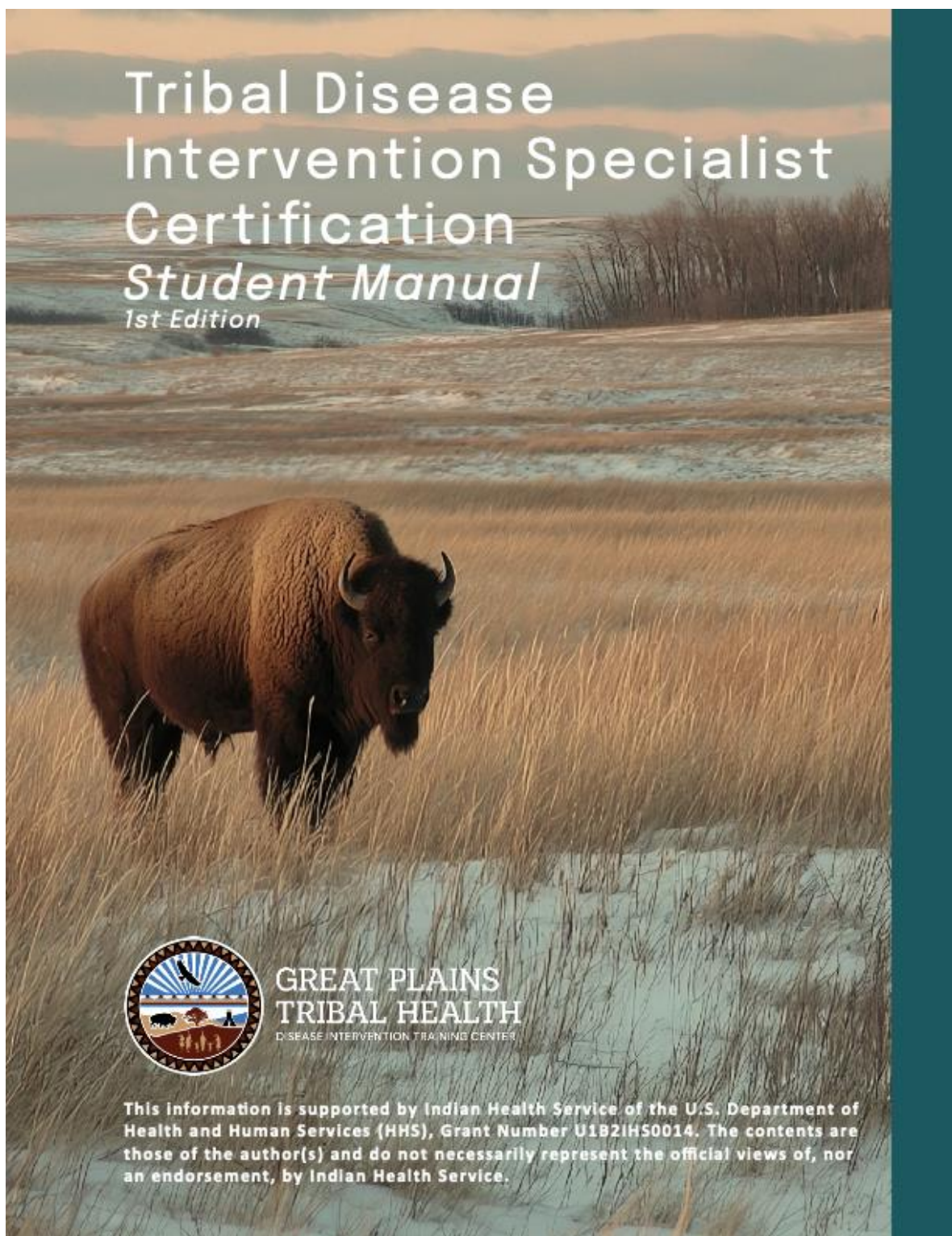
Mod 2 is the learning resource and field guide for TDIS to educate them on the clinical realities of various STIs and instruct them on the risk factors so that they can effectively mobilize to respond to cases reported in an EDSS. TDIS are the public health workforce responding to reportable conditions and emerging outbreaks through EDSS and the statutes that require reporting to determined PHAs. This dynamic is the framework that I centered my organization of Mod 2 on. The emphasis on how to utilize the known risk factors of STIs throughout Mod 2 is designed to prepare TDIS to conduct interviews where they will learn what risk factors a Relative has engaged in. In turn, that information informs the TDIS of the partner(s) of a Relative who has been exposed to the STI(s). The case investigation a TDIS conducts initiates their contact tracing as they act as the surveillance mechanism for partner(s) who have not presented to a health clinic to receive testing and treatment. As I constructed Mod 2, I worked to form a resource that clearly articulates the risk factors for the respective STIs, as understanding what an infection does is essential, but knowing how it is transmitted is what allows for effective infection control and response.

Table A.2 Attainment of Competencies

Practice-based products that demonstrate competency attainment		
Specific products	Competency Number	Competency
Medicine Bag Health Education	1. MPH 8	Apply awareness of cultural values and practices to the design or implementation of public health policies or programs
GPTEC TDIS Certification Student Manual Module 2: STI Basics and Medicine Bag Health Education	3. MPH 19	Communicate audience-appropriate public health content, both in writing and through oral presentation
GPTEC TDIS Certification Student Manual Module 2: STI Basics and Medicine Bag Health Education	3. MPH 20	Describe the importance of cultural competence in communicating public health content
GPTEC TDIS Certification Student Manual Module 2: STI Basics and Medicine Bag Health Education	4. IDZ 1	Evaluate modes of disease causation of infectious agents
GPTEC TDIS Certification Student Manual Module 2: STI Basics	5. IDZ 4	Analyze disease risk factors and select appropriate surveillance

Products

GPTEC TDIS Certification Student Manual Module 2: STI Basics





GREAT PLAINS TRIBAL HEALTH EPIDEMIOLOGY CENTER

The Great Plains Tribal Epidemiology Center's (GPTEC) mission is to provide leadership, technical assistance, support, and advocacy to Tribal nations and communities in the Great Plains in order to eliminate the disparities in health that currently exist for Tribal people in the area.

Module 2: STI Basics

*By the end of this module,
you will learn:*

- What an STI is and which STIs are most common
- How STIs are passed from one person to another, also called "transmission"
- How STIs can be prevented

What is an STI?

Sexually transmitted infections (STIs) are infections spread via sexual contact. STIs pass from one person to another through vaginal, oral, and anal sex. They also can spread through close sexual contact, though this is not very common. In addition to sex and sexual contact, some STIs can be spread through sharing needles used for intravenous (IV) drug use. This is from coming into direct contact with infected blood.

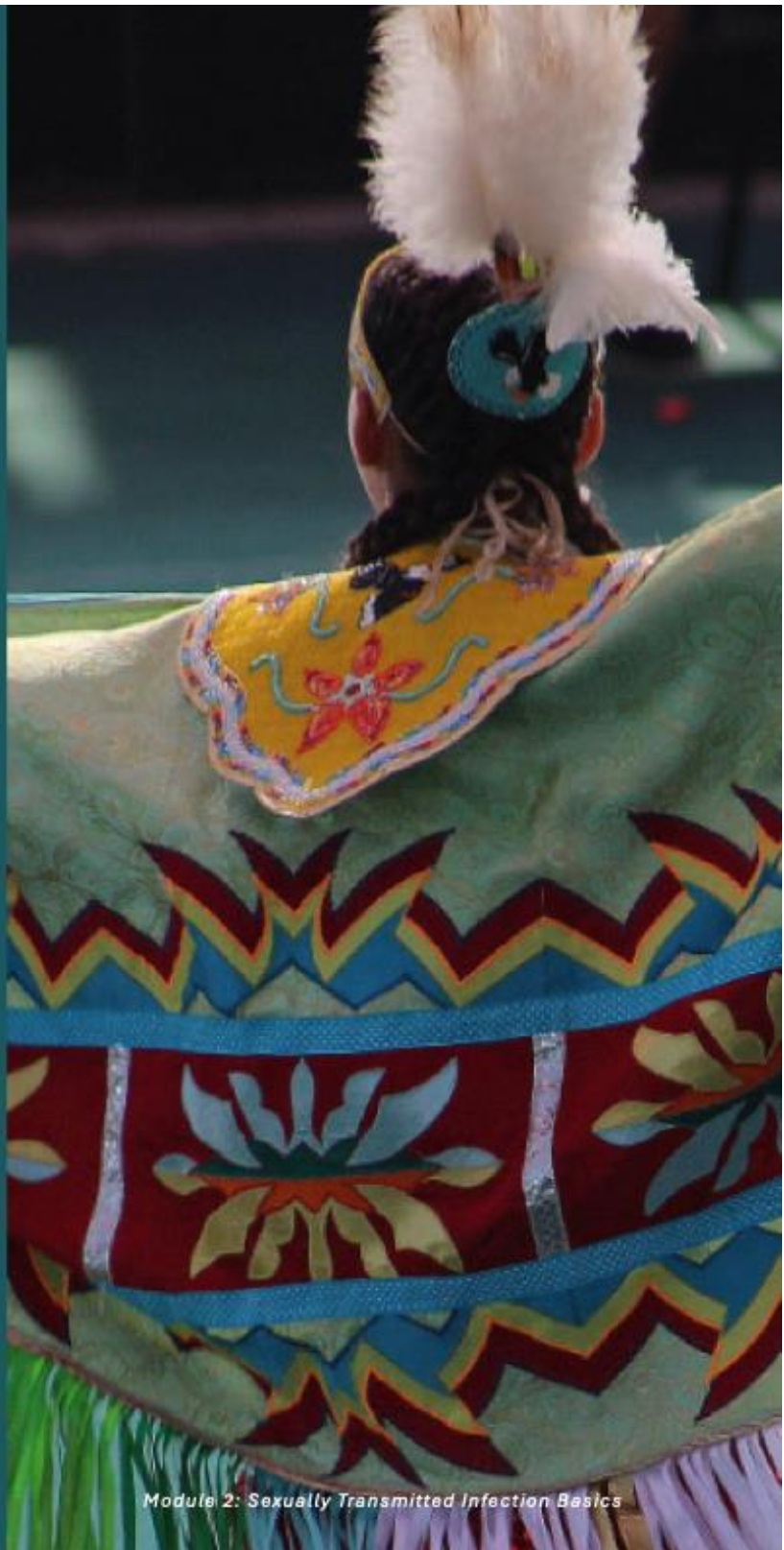
Some people refer to them as STDs (sexually transmitted diseases). STI is more appropriate because sometimes people can have an infection without it developing into a disease. For example, someone could be infected with HIV and experience no symptoms. This stage can often last 10 years or longer.

There are dozens of STIs. They can be caused by bacteria, viruses, parasites, and fungi. This module provides information on some of the STIs caused by bacteria or viruses. Each STI includes a description of the infection, common symptoms, testing, treatment protocol (i.e., procedure), and methods of prevention.

Fast facts about STIs

- STIs may not have **symptoms** (signs that you are sick) or may only cause mild symptoms. This means it is possible to have an infection and not know it.
- **Getting an STI test** is the only way to know for sure if you have an STI.
- All STIs are treatable with medicine, and some can be cured entirely.
- You are at risk for STIs if you:
 - Have vaginal, anal, or oral sex (risk is higher if no condom is used)
 - Share needles or syringes when injecting drugs, medications, or vitamins
 - Share needles for tattoos or body piercing

To provide services to Relatives DIS should become familiar and comfortable with words used to discuss STIs, have a general understanding of what they are, how they are passed from one person to another, and how they can be prevented.



STI Testing

There are several different ways to get tested for STIs, including: blood tests, urine tests, pelvic and physical exams, genital (penile/vaginal) and anal swabs. Accurate testing depends on **anatomical** site of exposure and the STI **incubation period**, or the time between exposure and when symptoms appear. This varies by STI. Since many STIs don't have any symptoms, the **window period** is also referred to. This is the time between exposure and when a screening test can reliably detect the infection and turn positive. In general, individuals should typically wait to get tested until after the incubation period for the STI they might have. This is because testing too early could result in a false negative (meaning a negative test result even if they really do have an infection). However, it is important to provide Relatives with STI education during this wait, emphasizing the importance of testing and monitoring of symptoms.



When talking to a Relative...

It can be helpful to say "on the body" rather than **anatomical**

The **incubation period** is about symptom onset, while the **window period** is about test accuracy.



STIs Caused by Bacteria

Syphilis

What is syphilis?

Syphilis is a bacterial infection caused by *Treponema pallidum*, a spiral shaped (spirochete) bacteria. Syphilis is spread by coming into contact with syphilis sores during early stages of the infection. This can happen through sex (vaginal, oral, or anal) or close sexual contact.

- The sores (may be hard to see, painless, and go away on their own, so someone might not know they have them).
- An infected pregnant person can spread the infection to their unborn baby during pregnancy or delivery (called "vertical transmission"). This is known as congenital syphilis.
- Infection from syphilis can also spread other parts of the body. This includes the central nervous system (brain and spinal cord), which is known as neurosyphilis, the eyes, which is known as ocular syphilis, and the inner ear, known as otosyphilis.

Symptoms

There are four stages of syphilis. Each stage has different signs and symptoms:

- **Primary Stage:** Single or multiple sores (chancres, pronounced "shankars") where the virus entered the body (usually the genitals, anus, rectum, and/or the lips or mouth) appear anywhere from 3 weeks to 3 months after exposure. This makes it hard to connect the sore to earlier sexual contact. It is often just a single sore and may be hard to see since they are typically inside the vagina, back of the throat, or even on the underside of the penis. Sores are usually painless and go away in about 3-6 weeks, even without treatment. But without treatment, syphilis will move on to the next stage, secondary syphilis.

The sore (chancre) is very contagious!

Syphilis and HIV

Syphilis chancres create an open wound making it easier for HIV to enter the body. This means individuals with syphilis are more at risk for HIV.



Figure 1
Primary stage syphilis sore (chancre) on tongue*



Figure 2
Primary stage syphilis sore (chancre) on penis head*



Figure 3
Primary stage syphilis sore (chancre) on vaginal opening*

<https://www.cdc.gov/syphilis/hcp/images/index.html>



Figure 4
Secondary stage
syphilis rash/sores on
the palms of the hands*



Figure 5
Secondary stage
syphilis rash/sores on
the bottoms of the feet*



Figure 6
Secondary stage
mucous patch on
tounge

<https://www.cdc.gov/syphilis/hcp/images/index.html>

- **Secondary Stage:** Rashes or sores (known as the "syphilis rash") can develop on the face, vagina, anus, or other parts of the body, such as the palms or bottoms of the feet (Figures 4 & 5) approximately 6-12 weeks after exposure. The rash is usually reddish brown and can be very faint. A painless, white or grayish patch called a "syphilis mucous patch" (Figure 6) can also appear on the tongue or inside the mouth. Other symptoms may include wart-like growths on the genitals (called "condyloma lata"), flu-like symptoms, patchy hair loss, headaches, weight loss, achiness, or fatigue. The symptoms of secondary syphilis will go away and usually last between 2-6 weeks (and up to 3 months). Without treatment, syphilis will move on to the next stage, latent syphilis.

- **Latent Stage:** Someone with latent syphilis is infected but does not have any symptoms ("latent" means it's not obvious or causing symptoms). The latent stage is broken into early latent syphilis (where infection occurred within the past 12 months) and late latent syphilis (where infection occurred more than 12 months ago. Syphilis can stay latent for life. It can also move to late syphilis.

Testing

The incubation period for syphilis is around 21 days on average (but can be up to 90 days), but the window period for testing is typically 3 months. This means individuals should be tested again after 3 months after potential exposure if the initial test was negative.

Syphilis can be tested via a blood draw, with two tests performed on the blood sample. The first one is a screening test to look for antibodies that aren't specific to *T. pallidum*. If the test is positive, the second test looks for antibodies that are specific to *T. pallidum*. Sometimes you can take a blood test at home by pricking your finger to collect a sample of blood. This is then sent to a laboratory for analysis.

Treatment

Syphilis can be cured with medication (antibiotics) and is easiest to cure in the early stages of infection. This is typically penicillin unless there is a known allergy. For primary, secondary, and early latent syphilis, a single injection is used.

Syphilis Testing Considerations

The Indian Health Service (IHS) recommends annual syphilis testing for people aged 13 and older who are sexually active. This includes people who don't have symptoms.

Additionally, pregnant people should be tested three times: at the first prenatal visit, during the third trimester, and at delivery.

Individuals with late latent or tertiary syphilis typically need three injections, one week apart. While the infection itself can be cured, the medical problems it can lead to — such as dementia, artery damage, or blindness — usually can't be cured.

During treatment, a syphilis titer (i.e. the amount of antibody formed in response to syphilis) is used to monitor if treatment is successful. After successful treatment, a syphilis titer should decrease by at least fourfold (Figure 7, Example 2). If the syphilis titer increases fourfold (Figure 7, Example 1), this suggests there is a new syphilis infection.

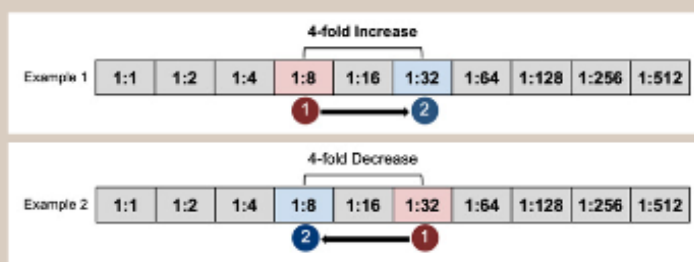


Figure 7

Prevention

While the only way to fully prevent syphilis and other STIs is to not have sex (oral, vaginal, or anal),. Individuals can take several steps to reduce their risk if they are sexually active. This includes correctly using a latex condom during every sexual encounter and regularly getting STI testing.

Tips for Using a Condom Correctly

- *Use a new condom for EVERY sexual encounter.*
- *Before sex - Place condom on the head of penis. Pinch air out of the tip of the condom. Unroll condom all the way down the penis.*
- *After sex - Before pulling out, hold the condom at the base, then pull out while holding the condom in place.*

Determining Syphilis Stage During a Disease Investigation Interview

Do you have any signs or symptoms present?



Gonorrhea

What is gonorrhea?

Gonorrhea is a bacterial infection caused by *Neisseria gonorrhoeae* bacteria and spread through sex (vaginal, oral, or anal) with someone who has the infection. It can also be passed from a pregnant person to their baby via vertical transmission.

Symptoms

Many people with gonorrhea have no symptoms. They can spread the infection to others without knowing it.

Someone with gonorrhea may have:

- Discharge from the vagina, penis, or anus
- Pain in the lower belly
- Pain when peeing
- Rectal pain, especially when having a bowel movement (pooping)
- For individuals with a penis/testes, pain in testicles
- For individuals with a uterus, vaginal bleeding between periods

Testing

The incubation period for gonorrhea is around 2-8 days on average, but the window period for testing is typically 2 weeks. This means individuals should be tested again after 2 weeks after potential exposure if the initial test was negative.

Gonorrhea can be tested for via a urine sample (i.e., urinating in a cup in order to insert a test strip) or a swab of all body parts used in sexual activity, i.e., a cotton swab is gently swiped inside the penis, vagina, anus, or throat.

It is recommended to perform multi-site testing for gonorrhea, which means testing multiple body sites (such as urethra, anus, and throat) in addition to the genitals. Testing only one site can miss infections that occur elsewhere. This approach is especially important for individuals who may have exposure through anal or oral sex or who have multiple sexual partners, and may not feel comfortable disclosing more information.

Treatment

Healthcare providers treat gonorrhea with antibiotics. This can be done via a single dose injection in the doctor's office or, as an alternative, a single dose injection in combination with a single dose oral (by mouth) antibiotic. Follow up testing may be recommended in some cases.

All sexual partners from the past 2 months need treatment too, even if they don't have signs of gonorrhea. If someone still has symptoms after treatment, they may need treatment with different antibiotics. Or they may have been infected with gonorrhea again.

Notes:



*When talking
to a Relative...*

It can be
helpful to
describe what
are included in
the in the
**reproductive
system.**



*When talking
to a Relative...*

It is important
to describe the
body in ways
that the
Relative will
understand.
Consider
calling the
urethra "the
tube that
carries urine
from the
bladder out of
the body".

35

If it's not treated, gonorrhea can lead to:

- For individuals with a uterus: pelvic inflammatory disease (PID), which can damage the **reproductive system**, making it hard or impossible for an individual to get pregnant later on
- For individuals with a penis/testes: swelling in the testicles and tubes at the back of the testicles, possibly sperm fertilization of an egg later on
- Problems peeing due to scars in the **urethra**
- Infection of the blood that can lead to joint problems and other problems

Prevention

While the only way to fully prevent gonorrhea and other STIs is to not have sex (oral, vaginal, or anal), individuals can take several steps to reduce their risk if they are sexually active. This includes correctly using a latex condom during every sexual encounter and regularly getting STI testing.

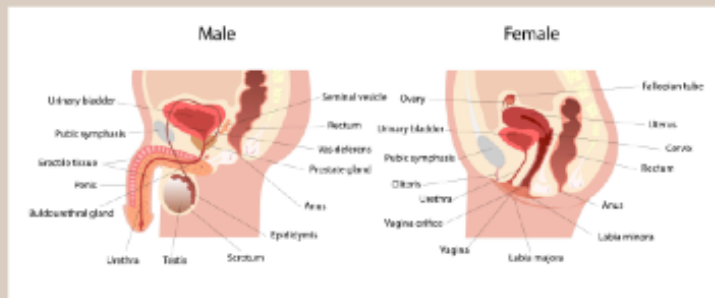


Figure 8

Chlamydia

What is chlamydia?

Chlamydia is a bacterial infection caused by *Chlamydia trachomatis* bacteria and spread through sex (vaginal, oral, or anal) with someone who has the infection. It can also be passed from a pregnant person to their baby. Most people with chlamydia don't have symptoms. They can spread the infection to others without knowing it. It is the most frequently reported bacterial infectious disease in the U.S.

Symptoms

Chlamydia usually doesn't cause symptoms. If it does, they can include:

- Discharge from the vagina, penis, or anus
- Pain in the lower belly
- Fever
- Pain when peeing

Testing

The incubation period for chlamydia is around 1-3 weeks on average, but the window period for testing is typically 2 weeks. This means individuals should be tested again after 2 weeks after potential exposure if the initial test was negative. During the window period, DIS should provide Relatives with STI education, emphasizing the importance of testing and monitoring of symptoms.

Chlamydia can be tested for via a urine sample or a swab of all body parts used in sexual activity, i.e. penis, vagina, anus, or throat. Self-collected swabs (done by the individual) are an option if a healthcare provider isn't available or if self-collection is the preferred method.

Treatment

Healthcare providers treat chlamydia with antibiotics. Individuals may take an oral form of the antibiotic by mouth for seven days (once or twice a day depending on the medication), or a single dose. If untreated, chlamydia can lead to

- In individuals with a uterus: pelvic inflammatory disease (PID), which can damage the reproductive system, making it hard or impossible for to get pregnant later on
- In individuals with a penis/testes: swelling in the testicles and tubes at the back of the testicles, possibly preventing them from getting someone pregnant later on

Prevention

While the only way to fully prevent chlamydia and other STIs is to not have sex (oral, vaginal, or anal), individuals can take several steps to reduce their risk if they are sexually active. This includes correctly using a latex condom during every sexual encounter and regularly getting STI testing.

STIs Caused by a Virus

Viral hepatitis (A, B, C)

What is viral hepatitis?

Viral hepatitis is a disease of the liver caused by a virus. The three most common viruses that cause hepatitis are hepatitis A, hepatitis B, and hepatitis C. The liver performs hundreds of functions, including: storing nutrients; removing waste from the blood; filtering and processing chemicals in food, alcohol, and medications; and producing bile, a solution that helps digest fats and eliminate waste products. If it is inflamed or damaged, it can't do its job properly.

Symptoms

Symptoms of all types of viral hepatitis are similar and can include one or more of the following:

- Dark urine or clay-colored stools
- Diarrhea (hepatitis A only)
- Feeling tired
- Fever
- Joint pain
- Loss of appetite
- Nausea, stomach pain, throwing up
- Yellow skin or eyes (jaundice)



HAV and HBV Immunization

The best way to prevent HAV and HBV is through immunization. HAV and HBV vaccination is recommended by the Advisory Committee on Immunization Practices (ACIP) as part of the pediatric immunization series for infants and children. These vaccines are not only safe, but extremely effective in preventing HAV and HBV.

Hepatitis A

Hepatitis A is caused by the hepatitis A virus (HAV). It spreads through the feces (poop) of infected individuals. This can happen by eating, drinking, or touching something (such as doorknobs or toilets) that's been contaminated by poop (feces). It usually causes a mild, short-term illness.

- **Treatment**—There are no specific medicines used to treat hepatitis A. A doctor will usually recommend that you rest, eat a well-balanced diet and make sure you get enough fluids.
- **Getting the Hepatitis A vaccine** is the best way to prevent it. Proper hand washing can also help prevent the spread of the hepatitis A virus.

Hepatitis B

Hepatitis B is caused by the hepatitis B virus (HBV). It is mostly spread through bodily fluids. This can include having sex (vaginal, oral, anal) with an HBV-infected person or sharing contaminated needles or syringes for injecting drugs. It can also be passed from HBV-infected people who have given birth to their newborn babies. It can result in a short or long-term illness.

- Hepatitis B can be tested via a blood draw in a healthcare provider's office and results are typically available within a few days. The incubation period is around 6 weeks but can be up to 6 months. The window period for testing is 3-6 weeks. This means individuals should be tested again after 6 weeks after potential exposure if the initial test was negative.
- Treatment for hepatitis B depends on whether it is a short (acute) or long-term (chronic) illness. If it is acute, doctors usually recommend rest, eating a well-balanced diet and getting plenty of fluids. For chronic hepatitis B, there are some medications that can help it, but they are not a cure for hepatitis B. Other ways to prevent the spread of hepatitis B through infected blood and other body fluids include:
 - Not having sex (oral, vaginal, or anal)
 - If sexually active, correctly using latex condoms every time you have sex (oral, vaginal, or anal)
 - Avoiding contact with an infected person's blood
 - Not using intravenous drugs or sharing needles or other drug tools
 - Not sharing things like toothbrushes or razors
 - Finding tattoo and piercing places that do not reuse needles without properly sterilizing them

Notes:

Hepatitis C

Hepatitis C is caused by the hepatitis C virus (HCV). It is spread by direct contact with an infected person's blood and less commonly other body fluids. This can happen through: sharing drug needles and intranasal (snorting) drug devices, getting a tattoo or body piercing with unsterilized tools, sexual contact (although this is less common), passing of the infection from a pregnant person to their unborn child. Many people with hepatitis C don't look or feel sick, so they might not know they have the virus. It can lead to serious liver problems if left untreated.

- Hepatitis C can be tested via a blood test in a healthcare provider's office and results may be available within a few days to weeks. The incubation period is around 2-6 weeks but can be up to 6 months. The window period for testing is 2-6 months. This means individuals should be tested again after 6 months after potential exposure if the initial test was negative.
- Most treatments involve just 8–12 weeks of oral medication (pills). Treatment cures more than 95% of people with hepatitis C, usually without side effects.
- There is no vaccine for hepatitis C, but it can be cured with oral pills.
- The best way to prevent getting hepatitis C is to avoid behaviors that can spread the disease, like sharing or reusing needles or other personal items that might come into contact with blood that is infected with the virus.

HIV and AIDS

What is HIV?

HIV (human immunodeficiency virus) is a virus that attacks the immune system. HIV attacks cells in the immune system called CD4 cells (or T cells). CD4 cells are white blood “helper” cells that help the body fight off infections and some kinds of cancer by telling other immune cells to attack harmful pathogens. HIV binds to and enters CD4 cells, replicating and spreading throughout the body, destroying the CD4 cell in the process. This makes it difficult for the body to fight off infection, making the individual more at risk for other infections.

HIV spreads when infected blood or body fluids (such as semen or vaginal fluids) enter the body. This can happen:

- During sex (especially anal sex and vaginal sex)
- Through sharing needles for injecting drugs or tattooing
- By getting stuck with a needle that has an infected person's blood on it
- HIV also can pass from a pregnant person to child during pregnancy, childbirth, or breastfeeding

HIV does NOT spread through:

- pee, feces, spit, throw-up, or sweat (as long as no blood is present)
- coughing or sneezing
- holding hands
- sharing eating utensils or drinking glasses



What is AIDS?

AIDS (acquired immune deficiency syndrome) is a late stage of HIV infection. Think of AIDS as a status, not the infection itself. Over time, HIV kills more and more CD4 cells, and this leads to AIDS. In AIDS, the immune system is severely weakened. This means bacteria or viruses that are normally harmless in healthy individuals can cause serious infections and health problems in individuals with AIDS, including pneumonia, tuberculosis, and salmonella infection.

Symptoms

Symptoms depend on what stage of HIV infection someone has.

- *Acute HIV infection:* This is when someone is first infected with the virus. Symptoms usually start about 2–4 weeks after infection and last a few days to a few weeks. They can include fever, headache, muscle aches, swollen glands, and a rash. Some people have very mild symptoms or don't notice any symptoms.
- *Chronic HIV infection:* During this next stage, a person may have no symptoms or mild symptoms. People can stay in this stage for 5–10 years, but some move to the next stage (AIDS) faster.

Module 2: Sexually Transmitted Infection Basics

- *AIDS* is the most severe stage of HIV infection. Symptoms can include:
 - very fast weight loss
 - fever
 - extreme tiredness
 - swollen glands
 - a lung infection called pneumocystis pneumonia
 - diarrhea
 - sores of the mouth, anus, and genitals
 - some types of cancers
 - skin problems

Testing

There are several different ways to get tested for HIV, including:

- **HIV Blood Test:** Blood is drawn. Results are usually ready within a few days to 2 weeks.
- **Rapid HIV Test:** A blood sample is drawn or a finger prick is done and then tested immediately.
- **Oral Test:** The inside of the mouth is rubbed with a cotton swab. Results are usually ready within a few days to 2 weeks.
- **Rapid Oral Test:** The inside of the mouth is rubbed with a small plastic comb. Results are available within 20 minutes. Must be reconfirmed with another test if positive.
- **Home Test:** A blood sample is taken at home and sent to a lab by mail. Results are usually ready by phone within a few days.
- **Rapid Home Test:** This is an at-home rapid oral test that will provide results at-home within 30 minutes. Must be reconfirmed with another test if positive.

U=U

“U=U” is an acronym for “undetectable equals untransmittable.” It means that people with HIV who take antiretroviral therapy (ART) as prescribed and maintain an undetectable viral load cannot pass HIV to others through sex.

Treatment

Most people with HIV can stay healthy by taking medicines called antiretrovirals. Antiretrovirals help lower the viral load (how much HIV is in the body) so that the CD4 count can go up. The goal of treatment is for the viral load to be undetectable (this means there is too little virus to show up on blood tests). It takes at least 3–6 months on medicine to get to an undetectable viral load. Continuing to take the medicine can keep the virus at undetectable levels. If medicines are stopped, the virus levels will go up.

Prevention

To lower their risk of getting HIV, people should:

- Avoid sharing any kind of needle.
- Avoid sharing razors or other personal objects that may touch blood.
- Not touch anyone else's blood (such as from a cut or sore).
- Correctly using a latex condom every time they have sex (including oral, vaginal, or anal).

While there's no vaccine for HIV, there are medications that can help prevent HIV infection. PrEP (Pre-Exposure Prophylaxis) is a daily medication for people who are HIV-negative but at risk of HIV infection. PEP (Post Exposure Prophylaxis) is medication that someone takes within 3 days (72 hours) of being exposed to HIV. In general, someone may benefit from PrEP if they have tested negative for HIV but are at high risk of exposure to HIV and NOT currently pregnant or breastfeeding. This includes people who:

- Have a sexual partner with HIV
- Have a drug injection partner with HIV
- Have not used condoms regularly
- Have been diagnosed with an STI in the past 6 months
- Share drug injecting equipment
- Frequently change partners
- Have sex with people with unknown HIV status
- Work in sex industries
- Inject drugs
- Have sex when drinking alcohol and/or taking recreational drugs

Relatives should be encouraged to talk to their health care provider to find out if PrEP is right for them.

Notes:

STI Screening Recommendations

Since STIs often have no symptoms, it's important to encourage
Relatives to have routine testing to avoid serious health problems.

Who should be tested?

- Everyone ages 13 to 64 years should be tested at least once for HIV.
- All sexually active women younger than 25 years should be tested for gonorrhea and chlamydia every year.
- Women 25 years and older with risk factors should be tested for gonorrhea and chlamydia every year. Risk factors include having new partners, multiple partners, or a partner who has an STI.
- Pregnant women should be tested for syphilis, HIV, hepatitis B, and hepatitis C starting early in pregnancy. Repeat testing may be needed.
- Pregnant women at risk should also be tested for chlamydia and gonorrhea starting early in pregnancy. Repeat testing may be needed in some cases.
- Sexually active men who are gay or bisexual and men who have sex with men should be tested:
 - For syphilis, chlamydia, and gonorrhea at least once a year. Those with multiple or anonymous partners should be tested more frequently (e.g., every 3 to 6 months).
 - For HIV at least once a year and may benefit from more frequent HIV testing (e.g., every 3 to 6 months).
 - For hepatitis C, at least once a year, if living with HIV.
- Anyone who shares injection drug equipment should get tested for HIV at least once a year.
- People who have had oral or anal sex should talk with their healthcare provider about throat and rectal testing options.

Concurrent infection screening

In some cases, a concurrent infection screening model can be useful to simultaneously screen for other potential STIs at the same time. This model aims to identify multiple infections occurring concurrently in a single patient during a single visit. It can be particularly important for high-risk populations where co-infection rates (i.e. the presence of more than one STI and or other infection) are likely to be high.

Notes:



Summary

- Most STIs are not passed from one person to another from casual contact, such as using a public toilet, shaking hands, playing team sports, hugging, or sharing food (unless it is oral herpes).
- While many STIs can be fully prevented by avoiding sex (oral, vaginal, or anal), there are additional steps individuals can take to reduce their risk:
 - Ensuring sexual partner(s) have been tested and do not have an STI (and that they get treatment if they do)
 - Correctly using condoms every time someone has sex (oral, vaginal, or anal)
 - Avoiding sex when someone has a rash or sore outside of where a condom can cover
- Some STIs can be prevented by taking medicine (HIV), getting a vaccine (HPV, HAV, HBV), and/or avoiding unsterilized needles (HIV and Hepatitis B and C).
- Many STIs will not show symptoms. Without visible symptoms, a person may not know they have an STI and can pass it to other people, or it can develop into something more serious and harmful to their health.

- If people DO show symptoms, symptoms may include:
 - Discharge from the genitals
 - Burning sensation when peeing
 - Pain or swelling in the testicles
 - Rectal pain, discharge, or bleeding (when an infection is in the rectum)
 - Bumps, warts, sores, or rashes on or near the genitals, mouth, or where sexual contact occurred
- People should get tested regularly (even if they feel fine!) and get treatment right away if they have a positive test. Why?
 - Some STIs can be cured with antibiotics. But if STIs are not treated, they can cause serious health issues, even if there are no visible symptoms.
 - Some STIs can be managed, even if they can't be cured. Managing STIs means better health and less chance of transmission to others.

Medicine Bag Health Education Collection

HCV Education

Cedar Card



Stay Protected Against Hepatitis C (HCV)

- ***How is HCV spread?***.... direct contact with an infected person's blood
- ***How does that happen?***... most frequently through sharing drug needles
- ***Can I get treated?***... yes, most people are cured after completing their treatment

For more info on syphilis or to get connected with care scan the QR code or email...

GPTEC.healthed@gptchb.or





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HCV Fast Facts

What is HCV?

Hepatitis C Virus, or HCV is spread by infected blood when sharing needles and other equipment during drug use, tattooing, piercing and unprotected sex. ***HCV can also be spread to baby during pregnancy and birth.***

Get Tested

A blood test in a doctor's office can tell you if you have HCV, and if the test is positive you may need additional blood tests.

Lasting Impact

HCV can cause serious liver problems like cancer without medication.

How to Prevent

HCV can be stopped by never sharing **ANY** drug usage equipment and using condoms, internal condoms, or dental dams during **ALL** sex acts.

Treatable and Curable

HCV is treatable and can be cured. Most treatments involve 8-12 weeks of oral medication (pills).

Connect to Care

For questions about testing and treatment please reach out to your local health care provider. For health education related questions email GPTEC.healthed@gptchb.org.

This information is supported by Indian Health Service of the U.S. Department of Health and Human Services (HHS), Grant Numbers U1B2IHS0014, U1B1IHS0007, and H1H9IHS0016. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by Indian Health Service.

Syphilis Education

Sage Card



Be a Good Partner and ...

- **Snag Safer** - use a condom, internal condom, or dental every time and the right way.
- **Get Tested** - the only way to know if you have syphilis or any other STI is to get tested
- **Get Treated** - syphilis is CURABLE with a common

For fast facts on syphilis
or to get connected
with care scan the QR
code or email...

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Syphilis Fast Facts

How is syphilis spread?

Syphilis is usually spread by sores during sex: oral (mouth to penis, vagina, anus, or mouth), vaginal, or anal (butt).

- Sores are usually painless and **can be hard to see** because they can be inside your mouth, vagina, or anus. They can also be on the penis (these are the easiest to see).

How to Prevent

Syphilis can be stopped by using a condom, internal condom, or dental dam during **EVERY** sex act.

"The Great Imitator"

Syphilis sores can look like warts and rashes. The sores will go away on their own, **BUT** syphilis does not go away until it is treated.

Lasting Impact

If left untreated syphilis can cause serious problems with sight, hearing, and brain function.

Congenital Syphilis

Syphilis can be passed to a baby during pregnancy or birth. Syphilis can cause death, serious birth defects, and life long health problems for babies. Congenital syphilis can be prevented by syphilis testing and treatment during pregnancy. **ALL** pregnant moms **AND** their partners should be tested.

Treatable and Curable

Syphilis is treated and cured with a common antibiotic. **You can get syphilis after you are treated if you have unprotected sex again with someone who has syphilis.**

Connect to Care

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HIV Education

Sweet Grass Card



Fight Against HIV

- **Snag Safer** - use a condom, internal condom, or dental every time and the right way.
- **Syringe Safety** - never share needles or use unsterilized needles for piercings or tattoos
- **Know your Status** - get tested for HIV at your healthcare provider's office or at community events

For fast facts on HIV or to get
connected with care scan the QR
code or email...

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**GREAT PLAINS
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EPIDEMIOLOGY CENTER**

HIV Fast Facts

What is HIV?
Human Immunodeficiency Virus, or HIV is spread through infected blood or body fluids. HIV can be spread during **ALL** sex acts or shared drug equipment. *It can also be spread to baby during pregnancy, birth, and breast feeding.* HIV damages the body's immune system and makes it hard for the body to fight off other illnesses and some cancers.

Get Tested
HIV can be tested for by a blood draw, finger poke, or oral swab.

HIV and AIDS?
Testing positive for HIV means that the virus is inside your body. Acquired Immune Deficiency Syndrome, or AIDS is the last and worst stage of an HIV infection. AIDS is when body has a very hard time or can't fight off infections. AIDS can be stopped or slowed with medication and medical care.

How to Prevent
Use condoms, internal condoms, or dental dams during **EVERY** sex act. Never use shared drug equipment. HIV is **NOT** spread through sharing utensils, kissing, coughing or sneezing, pee, poop, spit, throw up, or sweat as long as there is no blood in them.

If you are worried about getting HIV, talk to your doctor about PrEP medication. Taking PrEP as prescribed can **GREATLY** lower your chance of getting HIV even if you are exposed. ***If you think you have been exposed to HIV talk to a doctor right away.***

Treatable
HIV is treatable, but not curable. There is medication that can keep your HIV levels very low and keep your immune system healthy. Medication can also prevent you from spreading HIV to others.

Connect to Care
For questions about testing and treatment please reach out to your local health care provider. For health education related questions GPTEC can be reached at GPTEC.healthed@gptchb.org.

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