Infertility Prevention Project

American Indian/ American Native (AI/AN) Population in Region II Summary Report

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A. INTRODUCTION

This report will provide a description of the development of and findings associated with the implementation of a standardized tool used to gather data intended to describe systems available to support chlamydia (CT) and gonorrhea (GC) screening and treatment services provided to American Indian and Alaskan Native (AI/AN) populations in Region II.

B. BACKGROUND AND NEED

Significant disparities are observed at the national level in the burden of Chlamydia (CT) and Gonorrhea (GC) infections in American Indian and Alaska Native (AI/AN) populations. According to recent surveillance data from the CDC[1], in 2007, AI/AN had the second highest CT rate (after African Americans) at 732.9 cases per 100,000 population- 4.5 times higher than the rate among whites (162.3 per 100,000 population). Similarly, AI/AN populations had the second highest GC rates in 2007 at 107.1 cases per 100,000 population - 3.1 times higher than the rate among whites (34.7 per 100,000 population). Although, from 2002-2006, GC rates increased by 22.9% among AI/AN, the rate decreased by 21.8% between 2006 and 2007 (compared with a 0.7% decrease for the US overall). More information is needed to fully understand the significance of these trends. From a national perspective, the majority of STDs among the AI/AN population is predominant among young people from ages 15-25 years.

C. OVERVIEW IN REGION II

Region II is comprised of 5 project areas, New Jersey, New York State, New York City, Puerto Rico, and the US Virgin Islands. Information about American Indian or native populations in Puerto Rico or the US Virgin Islands is not available at this time and remains unknown. For this reason, assessment activities were focused within New York City, New York State and New Jersey.

It should be noted that urban American Indians face unique challenges when it comes to accessing health care. According to the 2000 US Census Data, 87,241 AI/AN live in New York City alone. New York City contains the largest urban Indian population in the United States but with no tribal entity or access to tribal health facilities. In fact, across the nation nearly

[1] DHHS/CDC Indian Health Service. *Indian Health Surveillance Report, Sexually Transmitted Diseases 2007.* http://www.cdc.gov/std/stats/IHS/IHS-SurvRpt_Web508Nov2009.pdf

seven out of every 10 American Indians – 2.8 million – live in or near cities, and the number is yet growing.

Across Region II, there is a huge diversity in the AI/AN population and relatively few federally recognized tribes. Further, the inability to understand and address STD related disease burden and access to care for AI/AN population is due to the lack of data. This poses a great concern locally and nationally and results in being unable to describe disease burden and health care seeking behaviors among AI/AN. At the same time formal linkages and collaborations between health department STD divisions and tribal entities in New York City, New York State and New Jersey appear to be limited further exasperating our ability to work to understand the system of care.

According to the IPP Prevalence Monitoring Database (PMD), there is little CT/GC prevalence monitoring data available for AI/AN. In the IPP Prevalence Monitoring database, only 0.2% of all CT/GC tests (394,809) were reported as AI/ANs in CY 2010. Table 1 below shows number and percentage of CT/GC tests for individuals reporting race as ***AI/AN*** in each project area in CY 2010. As seen below, the CT and GC prevalence monitoring data for the AI/AN population is virtually non-existent in Region II.

Table 1: Number and percentage of CT/GC tests reported, Region II IPP PMD, CY 2010

Project Area	Total Number of CT/GC Tests	Numbers of CT/GC Tests in AI/AN Population Only	Percentage of CT/GC Tests in AI/AN Population Only
New Jersey	85,273	157	0.2%
NYC	114,361	169	0.1%
NYS	159,618	403	0.3%
PR	30,450	-	0.0%
VI	4,664	6	0.1%
Total	**394,809**	**735**	**0.2%**

D. DEVELOPMENT AND IMPLEMENTATION OF TOOL

In an effort to collect information that would allow the region to better understand the system for the delivery of chlamydia and gonorrhea screening and treatment services along with practices associated with case reporting, a Region II IPP workgroup was created to develop a methodology for analyzing AI/AN morbidity and prevalence-monitoring data. This workgroup also evaluated the validity of CT and GC morbidity data for race/ethnicity in order to assess undercounting of STD cases reported among AI/AN. The work group created

a standardized approach for the review and analysis of AI/AN morbidity and prevalence monitoring data that takes into account the need to include AI/AN in combination with any other race/ethnicity.

All project areas within the region provided a description of the AI/AN community within their jurisdiction specifying AI/AN population, morbidity, and information regarding access to STD-related health care services. Summary findings include:

- **New York City** has a large AI/AN population but no tribal entities. The measures of AI/AN population are greatly affected by inclusion of individuals who indicate multiple race and Hispanic ethnicity which can dramatically affect disease rate calculations.
- **New York State** provides a considerable amount of funding to tribal entities but has very little information from those programs about how they implement their STD/HIV/TB programs or morbidity data. There are nine IHS health centers in the state, and eight of the nine provide health services. Four are federally funded and five are state funded. However, in any given year less than 100 cases of STDs [including CT/GC and Syphilis] reported to the state health department through their surveillance systems are identified as AI/AN.
- **New Jersey** has no federally recognized tribal entities but has AI/AN population. Reported STD/HIV/TB morbidity for AI/AN populations is virtually non-existent.
- **Puerto Rico** an**d the US Virgin Islands** have no AI/AN population nor tribal entities.

Based on these preliminary findings, the AI/AN survey tool was only implemented in project areas that had tribes that were recognized by state or federal entities which included New York State and New Jersey. To complete the survey, New York State and New Jersey pulled CT and GC morbidity data from two sources - state surveillance systems and the IPP prevalence monitoring database (PMD). One limitation of the IPP PMD is that reported CT/GC cases are only representative of those tests received by AI/AN persons who received services at a site that reported data to the PMD.

E. RESULTS

OVERARCHING THEMES

The discussion below provides overall themes based on findings from the AI/AN survey for New Jersey and New York State.

Estimated State Population and Burden CT/GC for AI/AN

At the time this survey was implemented, population estimates for CY 2010 were not available. Project areas reported estimated state population for CY 2009. In New Jersey and New York State, the AI/AN population was approximately 1% of its state population. The burden of CT and GC data was derived from their individual state surveillance system. The burden of CT reported for the AI/AN population is extremely small in males and females from CY 2008 to CY 2010. This finding is consistent with reports from project areas on STD/HIV/TB morbidity for AI/AN population being extremely low or nonexistent.

Chlamydia (CT) and Gonorrhea (GC) Positivity

CT and GC positivity data was derived from the IPP prevalence monitoring database. Trends in CT and GC positivity are difficult to interpret due to significantly low volume in AI/AN clients. The low number of CT/GC tests and positivity report could also be attributed to missing information or misclassification of race/ethnicity in morbidity data. This is not surprising since there is no or low CT and GC prevalence monitoring data available for AI/AN in the annual prevalence monitoring report.

Tribal Health Care Delivery System

New Jersey has no federally recognized tribes while New York State has four federally recognized tribes. New Jersey has one tribal center and New York State has 13 tribal centers but both states do not have any existing collaboration with their tribal health programs or centers.

Chlamydia and Gonorrhea Screening Services

The CT/GC screening criteria for AI/ANs in New Jersey and New York State is for females less than 26 years of age.

Partnerships Across Health Department Divisions and Programs

The Title X Program within the NYS Health Department independently reported having contact with at least one federally recognized tribe to explore opportunities to provide family planning services within the tribal health system. They did not partner with any other division in this effort. In addition, when queried about their relationships or partnerships

with State health Native American Liaison all survey respondent indicated that they had no existing relationship with these resources.

PROJECT AREA FINDINGS

New Jersey

New Jersey provided data using AI/AN ***in Alone or in Combination*** which refers to individuals reporting race as AI/AN regardless of other race(s) and/or Hispanic ethnicity, and ***AI/AN Alone*** refers to individuals reporting only one race as AI/AN (not Hispanic). New Jersey's data was derived from their Public Health Environmental Laboratory.

Estimated Population of AI/AN**:**

Estimated state population, all ages, of AI/AN population was 1.1% (94,325) of its total population of approximately 8.7 million in CY 2009 which is relatively small (see appendix, Table 1a). State population of AI/AN stratified by age group was not reported. At the time this survey was implemented, estimates for CY 2010 were not available. New Jersey reported estimated state population for CY 2009 instead.

Burden (Cases) of Chlamydia and Gonorrhea for AI/AN – Case Report Data

Chlamydia**:**

Table 2a (see appendix) shows CT case reports for individuals reporting race as ***AI/AN Alone or in Combination*** from CY 2008 to CY 2010 in New Jersey. Among AI/AN, the number of CT cases reported in males and females from CY 2008 to CY 2010 is very low. In the total male population, there were 6 CT cases reported in CY 2008 and no reported case in CY 2009 and CY 2010. In total female population, there were 10 CT cases reported in CY 2008, 11 cases in CY 2009 and 9 cases in CY 2010. The number of reported cases is low that it is difficult to examine trends associated with burden of infection in the community.

Table 2b (see appendix) shows CT case reports for individuals reporting race as ***AI/AN in Alone*** from CY 2008 to CY 2010. In total male population, there were 10 CT cases reported in CY 2008, 7 cases in CY 2009 and 6 cases in CY 2010. In total female population, there were 22 CT cases reported in CY 2008, 21 cases in CY 2009 and 10 cases in CY 2010. As seen in the other racial group, the number of reported cases is so low that it is difficult to examine trends associated with burden of infection.

Gonorrhea:

Table 2a (see appendix) also shows GC case reports for individuals reporting race as ***AI/AN Alone or in Combination*** from CY 2008 to CY 2010 in males and females (see Appendix, Table 2a). In this racial group, there was a low or no burden of GC cases reported in both males and females from CY 2008 to CY 2010. In total male population, there were 3 GC cases reported in CY 2008 and no reported case in CY 2009 and CY 2010. In the total female population, there was 1 case reported in CY 2008 and CY 2009, and 2 cases in CY 2010.

Table 2b (see appendix) also shows GC case reports for individuals reporting race as ***AI/AN Alone*** from CY 2008 to CY 2010 in males and females. In the total male population, there were 5 GC cases reported in CY 2008 and CY 2009, and 2 cases in CY 2010. In total female population, there were 2 GC cases reported in CY 2008 and 1 case in CY 2010. There was no reported GC case in CY 2009. As seen in the other racial group, the number of reported cases was extremely low that it is difficult to examine trends associated with burden of infection.

Chlamydia and Gonorrhea Positivity Data for AI/AN

Chlamydia

Table 3a (see appendix) shows CT positivity for individuals reporting race as ***AI/AN Alone or in Combination*** in males and females from CY 2008 to CY 2010. In the total male population, there was a CT positivity of 14% (7 CT tests; 1 CT positive test) in CY 2008, CT positivity of 100% (1 CT test; 1 CT positive test) in CY 2009 and no CT positivity in CY 2010. In the total female population, there was a CT positivity of 12% (25 CT tests; 2 CT positive tests) in CY 2008 and no CT positivity reported in CY 2009 and CY 2010.

In appendix, Table 3b shows CT positivity for individuals reporting race as ***AI/AN Alone*** in males and females from CY 2008 to CY 2010. In the total male population, there was a CT positivity of 13% (8 CT tests; 1 CT positive test) in CY 2008, CT positivity of 50% (2 CT tests; 1 CT positive test) in CY 2009 and no CT positivity in CY 2010. In the total female population, there was a CT positivity of 11% (54 CT tests; 6 CT positive tests) in CY 2008 and no CT positivity reported in CY 2009 and CY 2010.

Gonorrhea:

Table 3c (see appendix) shows GC positivity for individuals reporting race as ***AI/AN Alone or in Combination*** in males and females from CY 2008 to CY 2010. In the total male population, no GC positivity was accounted for individuals in this racial group from CY 2008 to CY 2010. In the total female population, there was a GC positivity of 3.9% (26 GC tests; 1 GC positive test) in CY 2008, and no GC positivity reported in CY 2009 and CY 2010.

Tribal Health Care Delivery System

New Jersey has only one Indian community which does not receive NJDHHS and Title X funding. The CT/GC screening criteria is for females less than 26 years of age. The Public Health Environmental Laboratory is used for CT/GC testing with the use of NAAT AT/Tigres technology. New Jersey has a state liaison in the Office of Minority and Multicultural Health in NJDHSS but no relationship has been established**.**

New York State

New York State only provided data for ***AI/AN Alone or in Combination*** because of the size individuals reporting race as either ***AI/AN Alone or Combination*** or ***AI/AN Alone*** *is not likely to be different.* In the New York state's surveillance system*,* the number of cases with multiple race indicated is very low overall and it will likely be lower for AI/AN.

Estimated Population of AI/AN

Estimated state population, all ages, of AI/AN population was 0.7% (129,322) of its total population of approximately 19.5 million in CY 2009 which is relatively small (see appendix, Table 1a). At the time this survey was implemented, estimates for CY 2010 were not available. New York State reported estimated state population for CY 2009 instead.

Burden of Chlamydia and Gonorrhea for AI/AN – Case Report Data

Chlamydia:

Table 2a (see appendix) shows CT case reports for individuals reporting race as ***AI/AN Alone or in Combination*** from CY 2008 to CY 2010 for males and females in New York State. Among AI/AN, the number of CT cases reported in males and females from CY 2008 to CY 2010 is very low. In the total male population, there were 30 cases reported in CY 2008, 23 cases reported in CY 2009 and 28 cases

reported in CY 2010. In total female population, there were 86 CT cases reported in CY 2008, 115 cases in CY 2009 and 113 cases in CY 2010. The number of reported CT cases is extremely that it is difficult to examine trends associated with burden of infection in the community.

Gonorrhea:

Table 2a (see appendix) also shows GC case reports for individuals reporting race as ***AI/AN Alone or in Combination*** from CY 2008 to CY 2010 in males and females. The number of GC cases reported in males and females from CY 2008 to CY 2010 is very low among AI/AN. In the total male population, there were 5 GC cases reported in CY 2008, 4 GC cases reported in CY 2009 and 3 GC cases reported in CY 2010. In the total female population, there were 22 GC cases reported in CY 2008, 13 cases in CY 2009 and 7 cases in CY 2010. The number of reported GC cases is low making it difficult to examine trends associated with burden of infection in the community.

Chlamydia and Gonorrhea Positivity Data for AI/AN

Chlamydia

Table 3a (see appendix) shows CT positivity for individuals reporting race as ***AI/AN Alone or in Combination*** in males and females from CY 2008 to CY 2010. In the total male population, there was a CT positivity of 7% (55 CT tests; 4 CT positive tests) in CY 2008, CT positivity of 8% (72 CT tests; 6 CT positive tests) in CY 2009 and a CT positivity of 5% (54 Ct tests; 3 CT positive tests) in CY 2010. In the total female population, there was a CT positivity of 8% (51 CT tests; 4 CT positive tests) in CY 2008, CT positivity of 12.5% (56 CT tests; 7 CT positive tests) in CY 2009 and a CT positivity of 8% (52 CT tests; 4 CT positive tests) in CY 2010.

Gonorrhea

Table 3b (see appendix) shows GC positivity for individuals reporting race as ***AI/AN Alone or in Combination*** in males and females from CY 2008 to CY 2010. No GC positivity was reported for individuals in this racial group from CY 2008 to CY 2010.

Tribal Health Care Delivery System

New York State has four federally recognized tribes that provide health services funded by IHS and eight AI/AN state tribes funded by the NYSDOH through the Maternal and Child Health Funds. However, the New York State has no existing relationship with these existing tribes.

The CT/GC screening criteria is for females less than 26 years of age in the four Indian communities. One of the four Indian communities use the Southampton Hospital Lab for CT/GC testing with the implementation of NAAT technology while in the other three Indian communities, the laboratory and laboratory technology varies depending on the provider. The health services provided to these four Indian communities include - Reproductive, immunization and STD/HIV/TB/Hepatitis screening and treatment (see appendix, Part II.C).

F. CONCLUSION

It should be noted that a major limitation encountered during the implementation of the survey included that IPP representatives completing the survey were simultaneously addressing local priorities associated with state budget cuts, health department re-organizations and layoffs and an increased focus, on the national level, on GC resistance. Given the relatively small population of AI/AN in the surveyed communities project areas did not see this effort as a priority thereby delaying the process of survey completion and including large gaps in completion of survey results.

There are very few tribal health programs within the region that could help increase CT/GC prevention and control services with the AI/AN community. Also, the lack of information about AI health care delivery systems beyond state and local health departments demonstrates a need and opportunity for states to forge partnerships and collaborations with tribal health centers. The high level of morbidity data in the AI/AN population viewed nationally is not consistent with the morbidity seen in Region II which is caused by lack of data. This is one of the major challenges related to addressing the needs of this population. Although federal, state and local public health institutions collect some health data on AI/ANs, these data are rarely disaggregated, separately analyzed or reported. Furthermore, existing data are replete with problems, including racial/ethnic misclassification. Since many decisions about public support are based on data, sub-populations with little or no data can easily be overlooked.

Given the apparent gaps in both our knowledge and services available related to CT and GC prevention control in the AI/AN population throughout Region II, there is need to more effectively work across programs to both plan for and address the needs of the AI/AN population in both NYS and NJ. There is a need to explore potential future opportunities for collaborations in an effort to expand and enhance STD prevention services among AI/AN, and particularly among Urban Indians in Region II. These collaborations will help STD/Family Planning/Laboratory state partners to gain a better understanding for the needs of the AI/AI

community and to begin exploring potential future opportunities. The Infrastructure continues to pursue AI activities in Region II and is working to promote adoption of the Native STAND curriculum among at least one project area in Region IV to encourage healthy decision making and responsible behavior among AI youth.