

# Region IV

## Infertility Prevention Project

American Indian / Alaska Native (AI/AN)  
Summary Report

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**Special Report**

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**Special Report****A. BACKGROUND AND NEED**

Significant health inequities 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 the CDC's recently released 2010 Sexually Transmitted Disease Surveillance Report<sup>1</sup>, AI/AN populations nationally continue to have the second highest rate of CT and GC (after African Americans) in 2010: 592.8 cases per 100,000 population for chlamydia (an increase of 7.8% from 2009) and 105.7 cases per 100,000 population (4.6 times the rate among whites) for gonorrhea. Additionally, surveillance data from the CDC's Indian Health Surveillance 2007 Report of STDs demonstrate the high prevalence of disease among young AI/AN females. According to this report, the rate of chlamydia among AI/AN females age 15 – 19 in the Nashville IHS Area<sup>2</sup> was 2,322.3 per 100,000 population, and 2,439.6 per 100,000 population among AI/AN females age 20 - 24. Gonorrhea rates were 460.5 per 100,000 population among AI/AN females age 15 – 19, and 348.5 per 100,000 population for AI/AN females at 20 -24 in the Nashville IHS Area.

Region IV is home to six federally-recognized tribes: the Poarch Creek Indians (AL), Seminole Tribe of Florida (FL), Miccosukee Tribe (FL), Mississippi Band of Choctaw Indians (MS), Eastern Band of Choctaw Indians (NC), and the Catawba Indian Nation (SC). There are also 33 state-recognized tribes throughout the region, and numerous other unrecognized tribes.

**B. OVERVIEW IN REGION IV**

A major challenge related to addressing the needs of the AI population is a lack of data at the state and local levels. Although federal, state and local public health institutions collect some data on the health of American Indians they rarely include data related to chlamydia and gonorrhea. Because many decisions about public support are based on data, sub-populations such as AI tribes with little or no data can be easily overlooked. In Region IV, discussions with IPP project area partners and attempts to collect chlamydia and gonorrhea data for AI populations have demonstrated a general lack of knowledge and/or relationship

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<sup>1</sup> CDC. *Sexually Transmitted Disease Surveillance, 2010*. <http://www.cdc.gov/std/stats10/default.htm>

<sup>2</sup> Includes 24 tribes among 112 counties in 13 states (AL, CT, FL, LA, ME, MA, MS, NY, NC, PA, RI, SC, TX). See Centers for Disease Control and Prevention and Indian Health Service *Indian Health Surveillance Report – Sexually Transmitted Diseases 2007*, Atlanta, GA: US Department of Health and Human Services, September 2009.

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with tribes in their jurisdictions. The small number of chlamydia and gonorrhea cases among AI reported to Region IV states (often due to missing or misclassified race/ethnicity data) may explain why they do not view AI populations as a priority and thus have not actively pursued relationships or collaborations with tribal entities (with the exception of Mississippi's State Department of Health which has a partnership with a representative from the Choctaw Health Center). This creates significant barriers and challenges to accurately describing disease burden and health care seeking behaviors among AI in the Southeast.

According to the IPP Prevalence Monitoring Database (PMD), there are few CT/GC prevalence monitoring data available for AI/AN. In the IPP Prevalence Monitoring database, only 0.2% of all CT/GC tests (1,046,456) were reported as AI/AN in CY 2010. The table below shows the number and percentage of CT/GC tests for individuals reporting race as AI/AN in each project area in CY 2010. As seen below, availability of CT and GC prevalence monitoring data for the AI/AN population is virtually non-existent in Region IV.

**Number and percentage of CT/GC tests reported, Region IV IPP PMD, CY 2010**

<b>Project Area</b>	<b>Total Number of CT/GC Tests</b>	<b>Numbers of CT/GC Tests in AI/AN Population Only</b>	<b>Percentage of CT/GC Tests in AI/AN Population Only</b>
AL	117624	235	0.2%
FL	284232	322	0.1%
GA	154830	208	0.1%
KY	90577	29	0.0%
MS	91093	108	0.1%
NC	112204	969	0.9%
SC	80856	72	0.1%
TN	115040	86	0.1%
<b>Total</b>	<b>1046456</b>	<b>2029</b>	<b>0.2%</b>

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**Special Report****C. REGIONAL ACTIVITIES & DEVELOPMENT OF AI ASSESSMENT TOOL**

In efforts to address the National IPP priority of assessing AI/AN health care delivery systems the Region IV IPP Infrastructure has engaged Region IV IPP Advisory Board (AB) members in discussing and sharing their experiences and activities with tribal communities. Discussions over the course of several regional AB meetings have revealed that Region IV IPP AB members share a general lack of knowledge and relationship or contact with their AI populations despite some self-identified AI clients seen in state and local family planning clinics. The Infrastructure initiated a partnership with CDC IHS STD Program Director Scott Tulloch and Program Analyst Lori de Ravello to engage the Region IV IPP in becoming more familiar with and addressing AI needs. Mr. Tulloch and Ms. de Ravello provided an overview on the AI community in Region IV along with local resources and contact lists for states at the May 2009 AB meeting, and Mr. Tulloch attended the May 2010 AB meeting to present on STI-related programs implemented in AI communities. Additionally Mr. Tulloch introduced the Infrastructure and Region IV IPP to Christine Compher, Epidemiologist, United South and Eastern Tribes Tribal Epidemiology Center, who also attended the May 2010 AB meeting. Ms. Compher gave an informative presentation on CT/GC trends among AI populations in the region and discussed barriers and challenges associated with accessing AI communities and forming partnerships.

A regional AI Work Group was formed which included AB representatives from each of the five states in Region IV with federally-recognized tribes (AL, FL, MS, NC, and SC). Only Mississippi had a direct contact with a provider in a tribal health center (Choctaw Health Center). Ms. Compher and Mr. Tulloch were helpful in providing recommendations about who to contact and how to move forward, but states were reluctant to follow up, citing limited resources and lack of authority in decision-making. Additionally, Ms. Compher emphasized that developing relationships with AI tribes is often a long process as tribes can be slow to respond, and tend to be suspicious of state and federal entities. Cultivation of relationships may require long periods of time to allow for sufficient trust-building.

At the November 2010 AB Meeting the Infrastructure engaged the Region IV AI Work Group in drafting and finalizing an AI assessment tool to describe the burden of CT/GC infections and surveillance activities among AI communities in Region IV. The AI Work Group agreed upon several measures of data that should be included on the assessment tool including state AI population, CT/GC cases reported among AI, CT/GC positivity by sex and age group, screening criteria, test technology and special screening initiatives. The tool was then developed by the Infrastructure and distributed back to the AI Work Group for completion.

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**Special Report****D. OVERARCHING THEMES AND CHALLENGES**

This section provides overall themes based on findings from the AI/AN assessment tools submitted by South Carolina, North Carolina, Mississippi, Florida and Alabama (see **Appendix 1**). Challenges encountered with implementation of this survey are also highlighted.

The number of CT and GC cases among AI is very small across all states: AI cases made up less than 1% of all cases reported statewide in all Region IV states except NC, which had 1% AI cases for CT and 1% for GC in 2010. CT/GC positivity among AI screened at IPP sites is extremely high, although the number of tests performed is relatively low. Trends in CT and GC positivity are difficult to interpret due to a significantly low volume of AI/AN clients, which is not representative of the AI/AN population in the region.

Some of the challenges experienced during completion of this assessment include difficulty among states in obtaining data from tribal health centers outside of state/local health department jurisdictions, or in ensuring documentation of race/ethnicity for data from health departments and private labs (tribal health centers do not send tests to state public health labs). Project areas were also unable to provide tribe-specific population data (except NC) and screening criteria and test technology used in tribal health centers was unknown. These incomplete AI assessments submitted by AI Work Group members may indicate the low priority of AI populations among Region IV IPP project areas.

**E. PROJECT AREA FINDINGS****ALABAMA**

**Estimated Population of AI/AN:** Estimated state population of AI/AN (all ages) was 0.6% (28,218) of its total population of approximately 4.8 million in CY 2010 (see **Appendix 1** for Alabama AI/AN profile).

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

**Chlamydia:** Per the Alabama AI profile, there were 36 CT cases reported in CY 2006; 35 CT cases in 2007; 30 CT cases in 2008; 48 CT cases in 2009 and 53 cases in CY 2010. The number of reported cases is extremely low making it difficult to examine and interpret trends associated with burden of infection in the community.

**Gonorrhea:** The number of GC cases reported is lower than CT cases reported; however, interpretation of trends is difficult due to the low number of reported cases. According to

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the Alabama AI profile, there were 16 GC cases reported in CY 2006; 6 GC cases in 2007; 5 GC cases in 2008; 14 GC cases in 2009 and 13 cases in CY 2010. As stated above, it is difficult to interpret any trends due to the low number of GC cases reported.

**Chlamydia and Gonorrhea Positivity Data for AI/AN:** This project area did not report CT positivity data due to inability to access data from tribal health centers. The project area noted that the total number of AI/AN screened can only be derived from visiting reservations and manually extracting data from their lab logs.

**Tribal Health Care Delivery System:** Alabama has one federally recognized tribe. The state tribes use other health departments primarily in Baldwin and Mobile counties. Very few report as AI, so the numbers are very small. Mobile County has a reservation but anyone within the community is able to utilize it. Alabama has AI/AN reservations in Escambia County and the Poarch Creek Indian Health Department conducts CT/GC screening. The laboratory used for testing is Labcorp but test technology is unknown.

**FLORIDA**

**Estimated Population of AI/AN:** Project area did not provide state AI/AN population data.

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

**Chlamydia:** According to Florida's AI profile, there were 213 CT cases reported in CY 2005; 135 CT cases in CY 2006; 47 CT cases in 2007; 54 CT cases in 2008; 66 CT cases in 2009 and 90 cases in CY 2010. The low number of reported cases makes it difficult to examine and interpret trends associated with the burden of infection in the community.

**Gonorrhea:** The number of GC cases reported is lower than CT cases reported; however, interpretation of trends is difficult due to the low number of reported cases. Per Florida's AI profile, there were 55 GC cases reported in CY 2005; 49 GC cases reported in CY 2006; 17 GC cases reported in CY 2007; 23 GC cases reported in 2008; 19 GC cases reported in 2009 and 17 GC cases reported in CY 2010. As stated above, it is difficult to interpret any trends due to the low number of GC cases reported.

**Chlamydia and Gonorrhea Positivity Data for AI/AN:**

**Chlamydia Positivity:** Based on Florida's AI profile, among the female AI population there was a CT positivity of 7.9% (242 CT tests; 19 CT positive tests) in CY 2010. Among the male AI population, there was a CT positivity of 17.9% (56 CT tests; 10 CT positive tests) in CY 2010.

**Gonorrhea Positivity:** Florida's AI profile demonstrates that, among the female AI population, there was a GC positivity of 2.5% (236 GC tests; 6 GC positive tests) in CY 2010. In AI males, there was no GC positivity reported in CY 2010 (164 tests performed).

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**Tribal Health Care Delivery System:** Florida did not provide any information on AI/AN reservations, CT/GC screening criteria, laboratory used for testing or type of laboratory tests used.

**MISSISSIPPI**

**Estimated Population of AI/AN:** Project area did not provide state AI/AN population data.

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

**Chlamydia:** According to Mississippi's AI profile, there were 152 CT cases reported in CY 2005; 117 CT cases in CY 2006; 142 CT cases in 2007; 126 CT cases in 2008; 129 CT cases in 2009 and 151 cases in CY 2010. The low number of reported cases makes it difficult to examine and interpret trends associated with the burden of infection in the community.

**Gonorrhea:** The number of GC cases reported is lower than CT cases reported; however, interpretation of trends is difficult due to the low number of reported cases. Per Mississippi's AI profile, there were 36 GC cases reported in CY 2005; 35 GC cases reported in CY 2006; 30 GC cases reported in CY 2007; 38 GC cases reported in 2008; 33 GC cases reported in 2009 and 27 GC cases reported in CY 2010. As stated above, it is difficult to interpret any trends due to the low number of GC cases reported.

**Chlamydia and Gonorrhea Positivity Data for AI/AN:**

**Chlamydia Positivity:** Based on Mississippi's AI profile, among the female AI population there was a CT positivity of 7.6% (66 CT tests; 5 CT positive tests) in CY 2010. Among the male AI population, there was a CT positivity of 7.7% (39 CT tests; 3 CT positive tests) in CY 2010.

**Gonorrhea Positivity:** Mississippi's AI profile demonstrates that, among the female AI population, there was a GC positivity of 4.5% (66 GC tests; 3 GC positive tests) in CY 2010. In AI males, there was a 7.7% GC positivity reported in CY 2010 (39 tests performed; 3 positive).

**Tribal Health Care Delivery System:** Mississippi's Choctaw population has a Choctaw Health Center which provides CT and GC screening services on the reservation located in Choctaw, Mississippi (Neshoba County). This health center uses LabCorps for processing tests, although CT/GC screening criteria and test technology used are unknown.

**NORTH CAROLINA**

**Estimated Population of AI/AN:** Estimated state population of AI/AN (all ages) was 1.3% (122,425) of its total population of approximately 9.3 million in CY 20010 (see **Appendix 1** for the North Carolina AI/AN profile).

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

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Chlamydia: According to North Carolina's AI profile, there were 465 CT cases reported in CY 2005; 367 CT cases in CY 2006; 370 CT cases in 2007; 502 CT cases in 2008; 572 CT cases in 2009 and 527 cases in CY 2010. The number of CT reported cases is higher than other project areas in Region IV, likely due to the Chlamydia Awareness Campaign screening initiative impacting the state's Lumbee AI population.

Gonorrhea: The number of GC cases reported is lower than CT cases reported. The North Carolina AI profile shows 198 GC cases reported in CY 2005; 157 GC cases reported in CY 2006; 194 GC cases reported in CY 2007; 272 GC cases reported in 2008; 199 GC cases reported in 2009 and 168 GC cases reported in CY 2010.

**Chlamydia and Gonorrhea Positivity Data for AI/AN:**

Chlamydia Positivity: North Carolina's AI profile demonstrates that among the female AI population, there was a CT positivity of 9.8% (960 CT tests; 94 CT positive tests) in CY 2010. A higher positivity of 16.5% was seen in females among the 15-19 age group in CY 2010. In the male AI population, there was a CT positivity of 9.1% (22 CT tests; 2 CT positive tests) in CY 2010.

Gonorrhea Positivity: Per North Carolina's AI profile, among the female AI population there was a GC positivity of 2.6% (960 GC tests; 25 GC positive tests) in CY 2010. No GC positivity was reported among the male AI population in CY 2010.

**Tribal Health Care Delivery System:**

Special Screening Initiatives: Chlamydia Awareness Campaign (CAC). North Carolina DHHS includes the University of North Carolina-Pembroke in their annual CAC as it is located in Robeson County, which is home to a large AI (Lumbee) population. The Robeson County Health Department has partnered with local agencies to conduct screening during this event during the past two years.

Federally Recognized Tribes: The state of North Carolina has eight American Indian tribes that are formally recognized by the state government (see North Carolina AI profile). Only one of these tribes - the Eastern Band of the Cherokee Indians (EBCI) - is recognized by the federal government and is therefore eligible for services such as those offered by the Indian Health Service (IHS). The state's largest tribe of Lumbee Indians has been lobbying for federal recognition for many years.

Screening Programs: The NC Communicable Disease Branch does not have specific screening programs associated with each of the tribes. Since the vast majority are not eligible for IHS services, it is presumed that those populations who need public access to health care use the county health departments in their areas. Robeson County in particular has a large and active health department that participates in a number of screening projects for HIV and syphilis in addition to chlamydia and gonorrhea.

**Special Report**SOUTH CAROLINA

Estimated Population of AI/AN: Estimated state population of AI/AN (all ages) was 0.4% (19,524) of its total population of approximately 4.6 million in CY 2010 (see **Appendix 1** for South Carolina AI/AN profile).

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

Chlamydia: Per South Carolina's AI profile, there were 19 CT cases reported in CY 2005; 17 CT cases in CY 2006; 19 CT cases in 2007; 15 CT cases in 2008; 18 CT cases in 2009 and 21 cases in CY 2010. The number of reported cases is low making it difficult to examine and interpret trends associated with the burden of infection in the community.

Gonorrhea: The number of GC cases reported is lower than CT cases reported. Based on South Carolina's AI profile, there were 8 GC cases reported in CY 2005; 3 GC cases reported in CY 2006; 7 GC cases reported in CY 2007; 1 GC case reported in 2008; 7 GC cases reported in 2009 and 10 GC cases reported in CY 2010. As stated above, it is difficult to interpret any trends due to the low number of GC cases reported.

**Chlamydia and Gonorrhea Positivity Data for AI/AN:**

Chlamydia Positivity: According to South Carolina's AI profile, among the female AI population, there was a CT positivity of 9% (55 CT tests; 5 CT positive tests) in CY 2010. Among the male AI population, there was CT positivity of 12.5% (8 CT tests; 1 CT positive test) in CY 2010.

Gonorrhea Positivity: Per South Carolina's AI profile, among the female AI population, there was a GC positivity of 1.75% (57 GC tests; 1 GC positive test) in CY 2010. In the male AI population, there was no GC positivity reported during CY 2010.

**Tribal Health Care Delivery System:** South Carolina did not provide any information on AI/AN reservations, CT/GC screening criteria, laboratory used for testing or type of laboratory tests used.

**F. CONCLUSION**

Among states in Region IV, AI populations make up about 1% or less of total state populations. This coupled with limited resources makes it difficult for states to highlight AI populations as a priority. Still, chlamydia and gonorrhea impose a great burden on AI populations in the Southeast as seen by the high positivity reported through IPP prevalence monitoring data. Furthermore, 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.

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Given the gaps in chlamydia and gonorrhea prevention and control among AI populations in Region IV, there is need for implementation of effective programs to address AI health inequities and expand STD prevention services. Such collaborations would allow STD, Family Planning and Public Health Laboratory programs to better understand and meet the needs of AI communities in their states, and would enhance the quality and quantity of STD-related data for AI populations. The Infrastructure continues to pursue AI activities in Region IV 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. Additionally the Infrastructure is working closely with Mr. Tulloch and Ms. de Ravello to explore the potential use of screening performance indicators collected by IHS HIV/AIDS program partners to better assess screening coverage among AI populations living off of reservations in Region IV.