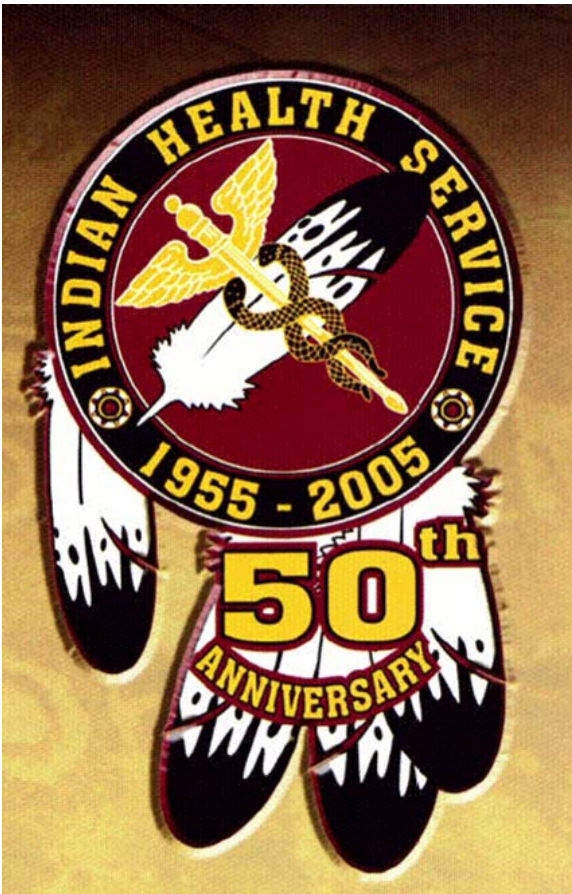

IHS National STD Program 2005 Annual Report

VISION

Healthier American Indian Alaska Native Communities

MISSION

The mission of the IHS National STD Program, in partnership with American Indian/Alaska Native people, is to raise their physical, mental, social, and spiritual health to the highest level possible through prevention and reduction of sexually transmitted diseases.

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The staff of the IHS National STD Program would like thank Dr. Lily Blasini-Alcivar, Program Consultant with the Division of STD Prevention, CDC and Dr. James Cheek, Director of the Division of Epidemiology and Disease Prevention, IHS and for their guidance, support, and encouragement.

Background

Sexually transmitted diseases (STDs) are a significant public health problem in the United States and remain largely unrecognized as a serious public health threat. Each year there are an estimated 19 million new STD infections. In 2003, 85% of diseases reported to the Centers for Disease Control and Prevention (CDC) were sexually transmittable (specifically, chlamydia, gonorrhea, AIDS, and syphilis). STDs cause harmful and often irreversible complications, including chronic pelvic pain, infertility, cancer, poor pregnancy and fetal outcomes, and even death. They are also expensive to society as a whole, with direct medical costs as high as $15.5 billion in a single year.

Although widespread across the U.S. in all populations, the STD epidemic disproportionately affects certain racial and ethnic groups. Such disparities in STD rates are complex to understand, but may be rooted in a number of social factors such as poverty, inadequate access to health care, lack of education, social inequality, and cultural influences. One group adversely affected by STDs is the American Indian and Alaskan Native (AI/AN) population.

Since 1994, CDC has collaborated with the IHS Division of Epidemiology and Disease Prevention by providing staff, funds, and technical assistance to address the STD prevention needs of AI/AN. This relationship has been and continues to be critical for the development of STD prevention capacity in Indian Country. In recent years, the staff and budget of the IHS National STD Program have grown dramatically. Today, the program is staffed by three CDC assignees, one IHS administrative staff, and two contractors. The operational budget in 2005 was approximately $500,000. As this annual report illustrates, Indian Country has benefited significantly from the efforts of this small, but industrious, team.

Laura Shelby, BA

Laura Shelby served as the Program Manager for the IHS National STD Program since 1996. Laura began her career at CDC in 1990 as a disease intervention specialist with the City of Chicago STD Program. In addition, she was assigned to the Philadelphia STD program and participated in several international temporary duty assignments (in Nigeria with the Global 2000 Guinea Worm Eradication Program and in Uganda with the Global AIDS Program).

Laura has a bachelors degree in Spanish from the University of Northern Iowa (1984) and a Certificate of Public Health from Johns Hopkins University (1998). Laura began graduate degree work in the Masters of Public Health Program at the London School of Hygiene and Tropical Medicine in September 2005. Laura has earned the respect, trust, and admiration of her co-workers and I/T/U staff across Indian Country and will be greatly missed by all. Good luck, Laura!

Lori de Ravello, MPH

Lori de Ravello is a Public Health Advisor with CDC assigned to the IHS National STD Program. Since December 2002, Ms. de Ravello has been jointly-funded by CDC's Divisions of STD Prevention and Reproductive Health to support the integration of STD, HIV, and reproductive health services. Lori has worked for CDC since 1993, both domestically and internationally, on a wide range of projects addressing women's health issues.

Lori has a bachelors degree in international relations from the University of New Mexico (1989) and a masters degree in international public health from the University of Alabama at Birmingham (1993). She served as a Peace Corps Volunteer in Honduras (1990-1991).

David Wong, MD

David Wong is a board-certified pediatrician and medical epidemiologist who has been with the CDC Division of STD Prevention since 2002. He has been an assignee to the IHS National STD Program since August 2004. As an Epidemic Intelligence Service Officer (2002-2004), David had the opportunity to lead studies at five county health departments and to participate in two international investigations, including the initial response to the Severe Acute Respiratory Syndrome (SARS) outbreak in Taiwan. His public health interests include outbreak investigations, access to care, health disparities, and disease surveillance.

David received his bachelor's degree (biology, 1994) and medical degree (1998) from Duke University. He completed an internship and residency in pediatrics at the Children's Hospital of Philadelphia (2001).

Cleora Chicharello

Cleora Chicharello has been a contract data analyst with the IHS National STD Program since September 2004. She is originally from Gallup, New Mexico and is a member of the Navajo Nation. She has previously taken university-level courses at the University of Utah and is currently taking courses through TVI in pursuit of her bachelors degree. Her organizational skills, and cheery disposition are a great asset to the team.

2005 Program Highlights

For the IHS National STD Program, 2005 was a year of establishing and nurturing new partnerships. Below, we highlight a few of these efforts.

Regional STD Summits

We received FY 2004 end of year funding to hold three regional STD summits in FY2005. The idea for the summits arose following a roundtable session on AI/AN the IHS National STD Program sponsored at the 2004 National STD Conference. The goal of the roundtable sessions and the regional summits was to bring together IHS, tribal health, state, and county programs together to develop a strategy to collaborate more closely together to improve STD prevention and control activities in Indian Country. Summits were held in Alaska and the Four Corners Area in 2005; a third summit will take place in Phoenix in January 2006.

Alaska

The Alaska Native Epidemiology Center (ANEC) hosted the first STD summit in Anchorage, Alaska in January 2005. ANEC devoted one day of its quarterly Advisory Council meeting to a discussion of STDs among Alaska Natives. There were 41 ANEC Advisory Council members present for the STD summit, representing both public and private organizations from across the state. Topics discussed at the summit included:

- STD epidemiological data for Alaska Natives
- an overview of the Alaska Native Health System
- an overview of the Alaska Native Medical Center's STD Program
- tribal perspectives on STDs
- reporting issues
- partner notification issues
- new testing options
- the role of not-for-profits and non-governmental organizations in STD prevention and control
- training opportunities

As one might imagine, the Alaska health care delivery system for Native Americans has many unique features compared to that in the "Lower 48". One primary issue is that 58% of Alaska Natives live in villages with fewer than 300 residents. To provide health care services for its 178 Native villages, Alaska developed a unique health care delivery system in the 1960s that relies on Community Health Aides and Practitioners (CHAPs). Today, there are 500 CHAPs who provide 300,000 patient encounters a year.

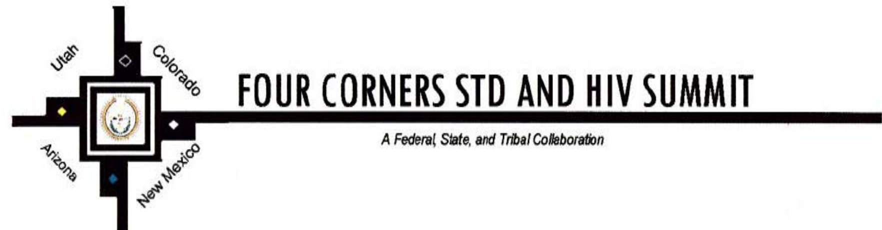
CHAPS undergo standardized training from one of four training centers in Alaska and there are well-developed program standards, quality assurance measures, and referral guidelines in place. CHAPs involvement in STD services appears to vary somewhat from provider-to-provider and depending on what other nearby referral services are available. In some instances, the CHAP will do the initial STD exam and will call in the results to a physician for a treatment decision.

Chlamydia in Alaska

According to the state, Alaska's 2003 chlamydia rate (600 cases per 100,000 population) was the nation's highest for the third year in a row. Among AI/AN in Alaska, the chlamydia rate was 1,578/100,000, followed by 1,196/100,000 for Blacks. Of the 3,900 chlamydia cases reported in 2003, 46% were among Alaska Natives (who represented only 18% of the Alaskan population that year).

The Four Corners STD/HIV Summit

The Four Corners STD and HIV Summit took place June 22-24, 2005 in Farmington, New Mexico. The Summit was attended by 140 people from the four state region (Arizona, Colorado, New Mexico, and Utah), federal partners from Atlanta and Washington, D.C., and other public and private organizations from the area and nationwide.



The specific goals of the Four Corners STD/HIV Summit were to:

- Improve STD/HIV disease control, partner services, and prevention activities.
- Increase awareness and knowledge of STDs and motivate behavior change in at-risk populations.
- Share STD/HIV data and disease trends.
- Enhance state and tribal relationships.
- Share successful STD/HIV interventions in AI/AN populations.
- Enhance skills of Navajo Nation Division of Health and Navajo Area IHS staff concerning sexual health issues.

4 Corners Summit Sessions

Reaching the Unreachable: How to Engage Your Target Population, Mattie Jim, Navajo AIDS Network♦ **Data 101: Why Numbers Count**, Michael Samuel, California CHS STD Control Branch ♦ **Rapid HIV Testing,** Ann Gardner, Arizona Department of Health Services ♦ **Understanding 638 Programs**, Taylor McKenzie, Sage Memorial Hospital (Ganado, AZ) ♦ **HIV Stigma: Living in the Red**, Darrell Joe, Navajo Division of Health ♦ **Understanding Navajo Culture in Public Health Practice**, Larry Foster, NDOH & Martha Garrison, Dine College ♦ **Innovative Partner Management Techniques**, Wanda Jackson, California STD/HIV Prevention Training Center ♦ **State and Tribal Relationships: The Role of a Tribal Liaison**, Michael Allison, Arizona Department of Health Services & Wanda Yazzie, New Mexico Department of Health ♦ **Navajo Nation Tribal Epidemiology Center**, Cheryl Mason, Navajo Nation Tribal Epidemology Center ♦ **The Ins and Outs of Social Marketing**, Kathleen Russell & Charlie Altekruse, Kathleen Russell Consulting ♦ **Model Interventions**, Nina Tsethlikia, NDOH; Bruce Trigg, New Mexico Department of Health; Stephanie Mahooty, Zuni PHS Indian Hospital ♦ **Tribal Legislation and Public Health**, Frank Dayish, Navajo Nation Vice President

Phoenix Area STD Summit

The third summit in this series will occur in Phoenix, Arizona in January 2006 and is a collaborative effort between our office and the Tribal Epidemiology Center of the Inter Tribal Council of Arizona.

Partnership with NCSD

To improve collaboration and coordination of STD prevention and control efforts in AI/AN communities, the IHS National STD Program developed a position paper, "Preventing STDS in Indian Country: A Call for Collaboration", recommending that the National Coalition of STD Directors (NCSD) form a subcommittee of state STD Directors from states with large AI/AN populations. NCSD strengthens state STD programs by advocating for effective policies, strategies, and sufficient resources and by increasing awareness of the medical and social impact of STDs. Through this subcommittee, NCSD can provide necessary leadership and guidance to unite states, tribes, IHS, and CDC to collaboratively confront the challenge of reducing STDs in AI/AN communities.

The objective of this project is to develop a subcommittee of state STD Directors and other public health partners through NCSD. The anticipated benefits of this subcommittee by agency are:

- State STD Programs
    - Increase access to AI/AN constituents.
    - Increase knowledge about AI/AN and better address their prevention and health needs.
    - Improve partnerships with IHS and tribal health programs.
    - Decrease STD morbidity.
- IHS and Tribal Health Programs
    - Increase opportunities for capacity building in STD prevention and control.
    - Improve health status of tribal community members.
    - Improve STD clinical and partner management.

- CDC
    - Decrease health disparities in STDs.
    - Increase knowledge about AI/AN better address their prevention and health needs.
    - Foster the creation of public health and tribal networks that can serve not only the STD issue well, but also other public health issues and emergencies.
- NCSD
    - Educate federal, state, and local policymakers about issues relevant to the prevention.

NCSD approved the recommendation in October 2004 and established a subcommittee consisting of 10 state STD programs: New Mexico, South Dakota, Minnesota, Florida, North Dakota, Montana, Georgia, Washington, North Carolina, and Utah. Tim Lane, Utah STD Program Manager, and Julia Ashley, Minnesota STD Program Manager, co-chair this subcommittee.

In addition, the IHS National STD Program and NCSD have entered into a Memorandum of Agreement to hire a contractor to support the activities of the AI/AN subcommittee. The contractor will:

- Define areas for NCSD advocacy as it relates to STDs in AI/AN.
- Increase awareness of AI/AN in each individual project area.
- Identify resources, national and local, available to address the need of AI/AN related to STDs and make available all resources relating to STD prevention.

NCSD posted the RFP for this contract in September; the contract should be in place by the end of 2005.

STD Research Work Group

Improvements in STD control and prevention in Indian Country are clearly needed; yet, little is known about which components of STD programs, prevention activities, or protocols of care are most effective for controlling the spread of STDs in this population. To develop strategies to increase STD research in AI/AN populations, we convened a workgroup of prominent STD researchers and key tribal/IHS public health personnel.

IHS National STD Program facilitates the work group. In addition to Dr. David Wong, the members include:

- Linda Dicker, CDC, Division of STD Prevention
- Tinka Duran, Northern Plains Tribal Epidemiology Center
- Carol Kaufman, American Indian Alaska Native Programs, University of Colorado Health Sciences Center
- Jeanne Marrazzo University of Washington, Department of Medicine
- Sarah Patrick, University of South Dakota School of Medicine and Health Sciences
- Matthew Town, Northern Plains Tribal Epidemiology Center

The work group's first effort was to write an article (*Within the Hidden Epidemic: Sexually transmitted diseases and HIV/AIDS among American Indians and Alaska Natives)* that outlined gaps in STD research in AI/AN populations. We plan to submit this article to JAMA for consideration.

In addition, we drafted a resolution for submission to American Public Health Association at their next annual meeting.

STD Surveillance Report

IHS health data primarily focus on population statistics, natality/mortality data, and patient care utilization. Data on STDs and other nationally notifiable diseases are lacking. Yet, these diseases represent a significant burden on the IHS healthcare system.

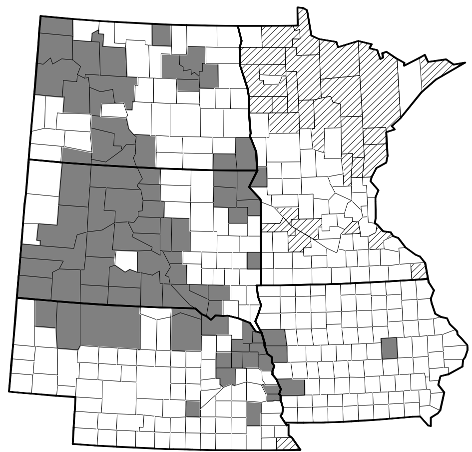
In order to bridge this data gap, our office is collaborating with statisticians from CDC and IHS to create an AI/AN STD Surveillance Report. STD surveillance data reported to CDC is typically available only at the county, state, or national levels. IHS administrative areas, however, are made up of select counties from select states. Because of this disconnect in how CDC and IHS define populations, current CDC data are not ideal.

With this collaboration, we have created a new AI/AN STD surveillance methodology, whereby CDC STD data are coded and presented using IHS service population definitions. Our report focuses on the three "classic" STDs (chlamydia, gonorrhea, and syphilis), and includes both national and regional data. The map and charts of the Aberdeen Area IHS on the following page illustrate one example of how data were coded regionally.

Currently, we are finalizing the report and will then submit it for clearance to IHS and CDC. The report will be made available in both electronic and paper format and will be distributed to tribal health organizations, Urban Indian health programs, IHS, CDC, state departments of health, and other interested parties. We hope to share this innovative surveillance methodology with other CDC disease divisions (e.g. hepatitis, tuberculosis).

1998-2003 STD Rates for Aberdeen IHS Area, All IHS Areas, and All U.S.

Aberdeen IHS Area



Geography:

States: 5 (IA, MN, ND, NE, SD)

Counties: IA (4/99) MN (1/87) NE (19/93) ND (20/53) SD (36/66)

Tribes: nn

AI/AN population served by IHS

2003 (est.): 107,494

Rank: 7 of 12 areas

About these graphs

Rates are cases per 100,000 population

Cases with unknown race are redistributed

Exclusions: none

Figure A. Total Chlamydia Rates

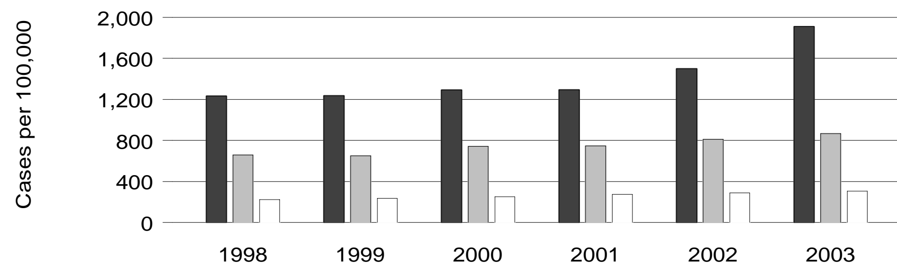


Figure B. Total Gonorrhea Rates

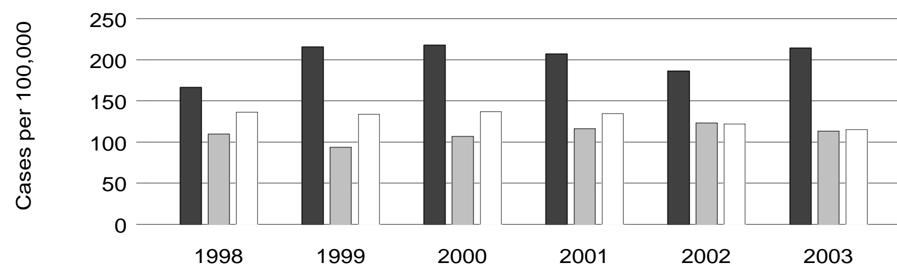
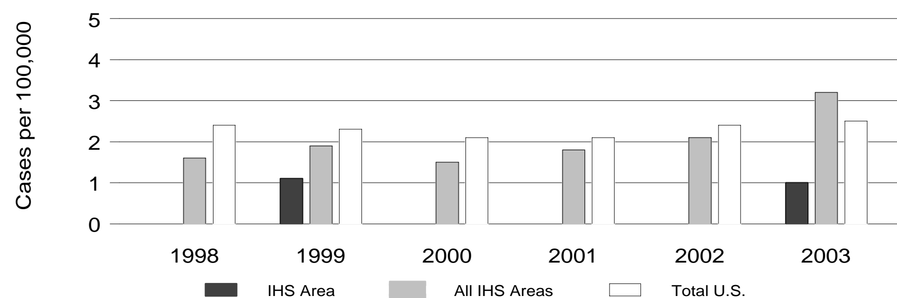


Figure C. Total P/S Syphilis Rates



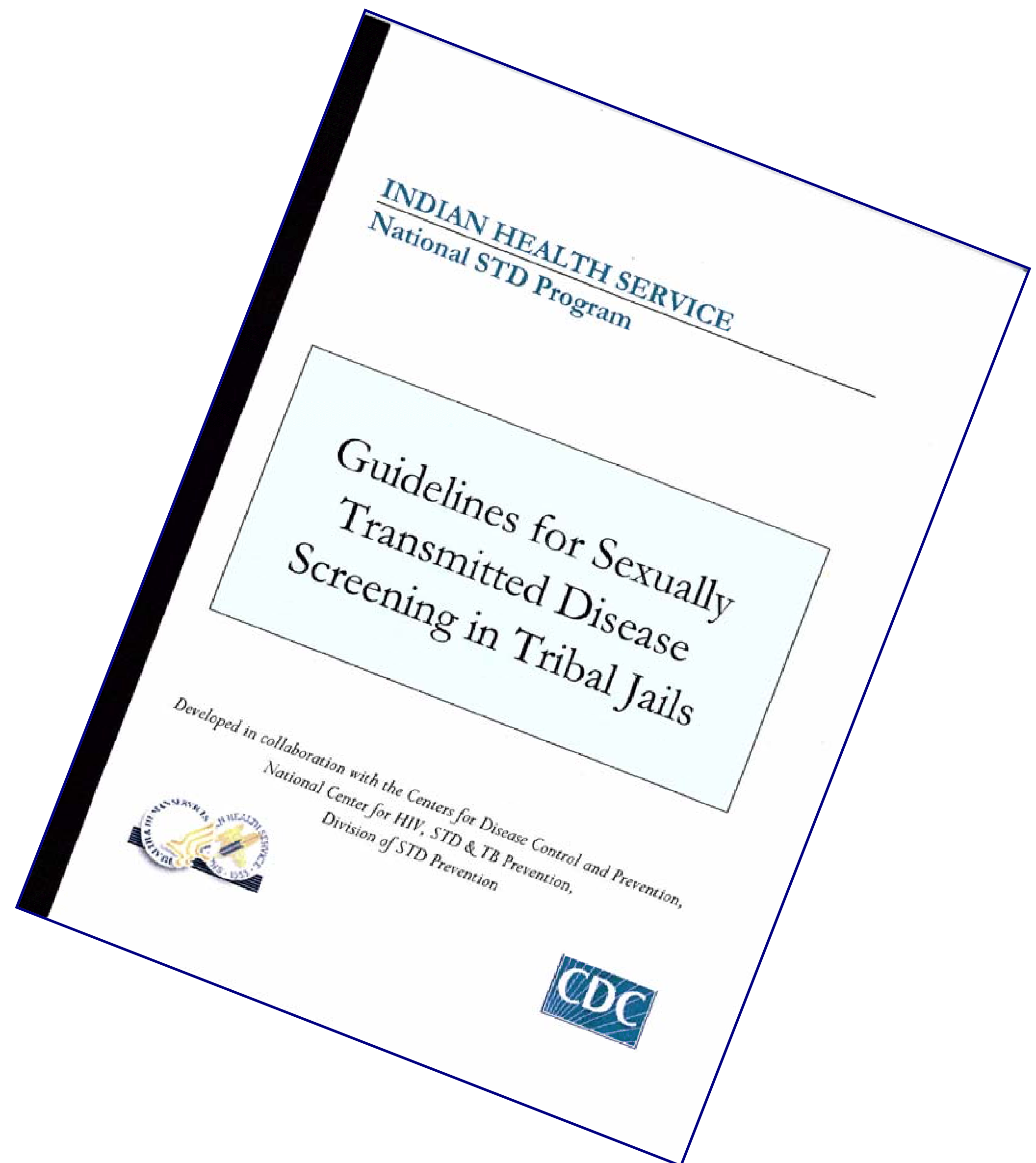
Note: These data are provisional and not for distribution.

Guidelines for STD Screening in Tribal Jails

In 2004, the IHS National STD Program facilitated the development of a correctional health work group on the Navajo Nation, with members from the Navajo Nation Division of Health and Department of Corrections, and the Navajo Area IHS. The work group developed and implemented a syphilis screening pilot project in the Window Rock Detention Facility.

Based on lessons learned from the pilot project, the IHS National STD Program developed STD screening guidelines for tribal jails. We distributed the guidelines to administrators of BIA and tribal detention facilities and to key IHS and tribal staff. Since then, we have received numerous requests from jail and health care staff throughout Indian Country who are interested in implementing the guidelines in the detention facilities in their communities.

We are currently providing technical assistance to several groups implementing jail-based STD screening.



2005 Project List

The following are other IHS National STD Program projects not otherwise highlighted in this report (in alphabetical order by project name):

ALASKA CHLAMYDIA/GONORRHEA PREVENTION PROJECT

Background

In 2003, the state of Alaska had the highest chlamydia rate in the US (605.8 per 100,000). Nearly half of all reported chlamydia cases in this state are in the Alaska Native population.

Objective

To reduce the incidence of chlamydia in two Alaska Regional Native Health Corporations (ARNHC). Findings and recommendations will be shared with other service units in Alaska for potential adaptation and implementation.

Status

- Project was funded in August 2005.
- First steps are to:
  - review current protocols for chlamydia and gonorrhea.
  - use existing data collection systems to determine current testing and treatment statistics (including total number of tests performed by test, provider, and facility type and numbers of positive.
  - work with each ARNHC to develop an intervention to improve outreach for testing and treatment of index cases and for outreach and treatment of identified partners.
- Later steps include identifying financial support for one or more discrete prevention activities in each region, evaluating results, and disseminating findings.

CHLAMYDIA SCREENING EVALUATION

Background

Chlamydia infection rates on Indian reservations in South Dakota are up to six times higher than the state and national rates. Improving chlamydia screening coverage, particularly among sexually active young women, can lead to earlier detection of disease, decreased incidence of complications, and decreased transmission to sexual partners.

Objectives

1. Describe chlamydia screening policies and practices at individual healthcare facilities.
2. Estimate facility-level and community-level chlamydia screening coverage for women 15-44 years.
3. Compare costs using different chlamydia screening policies.

Status

We are planning an evaluation to describe chlamydia screening policies and practices at healthcare facilities serving the Cheyenne River Sioux tribe in South Dakota. The findings of the evaluation will assist in improving and developing more effective chlamydia screening policies.

We hope to complete these activities in FY 2006:

- Submit protocol to Aberdeen Area and CDC IRBs.
- Establish MOUs with local healthcare facilities (to allow for data collection and analysis).
- Conduct multiple site visits to Cheyenne River for data collection.
- Present and disseminate data and recommendations to tribe and other stakeholders.

COMMUNITY-WIDE STD ASSESSMENT PROJECT

Background

Of the 12 IHS administrative areas, AI/AN in the Aberdeen Area (North Dakota, South Dakota, Nebraska, and Iowa) have the largest disparities in rates of reportable STDs compared with the non-AI/AN population. In 2002, the chlamydia rate among AI/AN was 6.8 times higher than among non-AI/AN people in Nebraska, 5.7 times higher in South Dakota, 4.3 times higher in North Dakota, and 1.7 times higher in Iowa. Similarly, the gonorrhea rate among AI/AN people 10.7, 6.1, 2.3, and 1.5 times higher, respectively, than the rates among the non-AI/AN populations. Although the rates of HIV infection do not show similar disparities, these high rates of STDs indicate that AI/AN in the Aberdeen Area are also vulnerable to the spread of HIV infection.

Objective

To assess community health personnel and clinical providers in the Aberdeen Area IHS for STD service and program needs, referral processes, education and training regarding STD, and follow-up to prevent and control STDs.

Status

Both the community health personnel and clinical provider survey instruments have been developed. The Northern Plains Tribal Epidemiology Center is currently seeking approval of all 18 tribes in the Aberdeen Area IHS.

HEALING LODGE EVALUATION

Background

The Lumbee Nation in North Carolina is the largest state-recognized tribe in the U.S. and has high rates of syphilis and HIV. In 2002, the tribe was awarded a Health Resource Services Administration (HRSA) grant to fund the Healing Lodge, a multi-disciplinary, faith-based organization whose activities include the training of pastors and lay persons about HIV, STDs, and other health issues.

Objective
To describe and estimate the impact of the Healing Lodge on local STD and HIV control.

Status
We are working on a proposed evaluation to describe the Healing Lodge activities and to measure the impact that such trainings have had for pastors and other individuals. We plan to share the findings with other tribes, so similar faith-based or community-based interventions can be developed.

Activities planned in 2006 include:

- Obtain approval from the Healing Lodge Board to assist in this evaluation.
- Write protocol and submit to the appropriate IRBs for approval.
- Assist and/or coordinate data collection with Healing Lodge staff and/or other partnering agencies.
- Assist in the analysis and dissemination of findings.

IHS/PTC TRAINING WORKGROUP

Background
The IHS National STD Program and the National Network of Prevention Training Centers collaborate through regular conference calls to ensure STD/HIV training needs are being met in Indian Country. This collaboration has resulted in training events in several IHS Areas, jointly-written articles in the IHS Primary Care Provider journal, and delivery of site-specific technical assistance.

Objective
To improve the knowledge, skills, and abilities of health care providers serving AI/AN to prevent and control STD/HIV.

Status

We participate in quarterly conference calls and other informal phone and e-mail communications to discuss and address STD/HIV/RH training needs in Indian Country. Through these calls, we are able to define emerging training needs and identify appropriate training or technical assistance response.

INFERTILITY PREVENTION PROJECT

Background

The Infertility Prevention Project (IPP) is a congressionally-mandated national demonstration project funded by CDC to decrease the prevalence of chlamydial infection and its sequelae. IPP funds are used to screen and treat women and their partners for chlamydia, to counsel women and their partners on safer sex practices, and to collect and report prevalence data. The project goals of the national legislation require a commitment to partnerships between STD bureaus, family planning agencies, and public health laboratories at the state/territorial and regional levels. Throughout the country, CDC funds regional infertility prevention advisory committees which set regional priorities, establish regional screening and treatment guidelines, and link surveillance and epidemiologic activities.

Objectives

To maintain a partnership with IPP to ensure AI/AN issues are represented and to identify opportunities to expand the inclusion of AI/AN in IPP efforts.

Status

The IHS National STD Program participates in IPP Coordinator meetings and in Regional IPP meetings in DHHS regions VI, VIII, and X.

In November 2004, the Region VIII IPP project held an AI/AN-focused meeting in Denver, Colorado. This meeting brought together IPP members from state family planning and STD programs, public health laboratorians, with IHS and tribal health staff to discuss challenges solutions they face in

addressing STD prevention and control among AI/AN. For participants from several states, this was the first time they had ever met with their respective state or IHS colleagues. From this meeting, several collaborations and projects emerged throughout the region.

METHAMPHETAMINE TRAINING

Background

Methamphetamine addiction is a major and growing problem in rural America, including in Indian Country. IHS and tribal health care providers do not know how to respond to the increased meth use they are seeing in their communities. Because meth use fuels high-risk sexual behavior and the spread of STDs and HIV, the IHS National STD Program has taken a special interest in helping health care providers respond to this concern. Over the course of several site visits to Montana, we initiated discussions about training and technical assistance needs with the Billings Area IHS and several service units.

Objective

To increase the ability of IHS and tribal providers to better care for patients using meth and to make providers aware of potential occupational risks to providing services to meth users.

Status

We developed and supported the delivery of two meth-related training events for the providers on the Northern Cheyenne Indian Reservation in Lame Deer, MT. The first was on July 7, 2005, and addressed occupational health issues mainly for ER staff and public health nurses who conduct home visits. The second was on August 4, 2005 and addressed clinical issues. Both trainings were well-received.

NAVAJO NATION SOCIAL MARKETING CAMPAIGN

Background

In 2003, dramatic increases in syphilis cases were reported by the Navajo Nation, the largest American Indian reservation. Increases in syphilis raise concern for current, high-risk sexual behavior and suggest that transmission of HIV, syphilis, and other STDs may continue. Despite a sizeable public health response, including press releases, additional training of health department investigators, and community-based outreach efforts, case reports have continued to increase. From 2002 to 2003, the number of syphilis cases almost tripled from 34 to 93. For both years, almost 50% of cases were reported from the health service unit in Gallup, New Mexico. Current outreach efforts have been inadequate to substantially reduce the number of syphilis cases occurring in the Navajo Nation. Having a better understanding of the specific risk and health-seeking behaviors of these populations will lead to more effective public health interventions and disease control strategies.

Objective

To better target interventions for populations at-risk for syphilis in the Navajo Nation.

Status

The IHS National STD Program, with funding from CDC, contracted with Kathleen Russell, Inc., a social marketing agency with expansive experience working with AI/AN populations. A social marketing plan is being developed to better target interventions for populations at-risk for syphilis in the Navajo Nation.

SCHOOL-BASED STD SCREENING IN THE NORTHERN PLAINS

Background

Quentin N. Burdick Memorial Healthcare Facility is located in Belcourt, North Dakota on the Turtle Mountain Chippewa Reservation. This facility provides services to several high schools both on and off the reservation.

Objective

To reduce the STD burden in the Turtle Mountain Chippewa community by incorporating health promotion and disease prevention activities into routine education at two local high schools.

Status

This project targeted high school students during normal school hours. A team of IHS staff worked with school staff to provide a STD prevention education session. Youth that consented to screening provided a voluntary and confidential urine sample for chlamydia and gonorrhea testing. To maintain confidentiality, each student was given a number coded brown paper bag which contained a specimen collection kit before they entered the bathroom. Once in the bathroom stall, each student decided for him or herself whether or not they wanted to provide a urine sample. As the students exited the bathroom stall, they placed the brown paper bag into the specimen collection area (whether or not they submitted a sample). The bags were sorted through and urine samples were sent to the North Dakota State Lab for processing. All students were seen back for a one-on-one counseling session, regardless of whether or not they submitted a sample. At this counseling session, students with positive tests were treated and counseled and students with negative tests and those that did not submit a sample were counseled. The field epidemiologists conducted partner management in the usual manner with positive cases.

STD/HIV/HEPATITIS PROGRAM ASSESSMENT: DEVELOPING PREVENTION PROTOCOLS FOR THE I/T/U HEALTH CARE DELIVERY SYSTEM

Background

Currently, there are no existing recommendations on STD, HIV, and hepatitis prevention services in the I/T/U health delivery system.

Objective

To develop recommendations on STD, HIV, and viral hepatitis prevention services in the I/T/U health care delivery system. IHS National STD Program will develop these recommendations through a comprehensive assessment at an IHS facility in the Northern Plains.

Status

This assessment will begin in November 2005. The proposed steps are to:

1. Refine an existing STD program assessment tool for an IHS primary care setting.
2. Assess "readiness" of the health system to change.
3. Assess current STD, HIV, Hepatitis services.
4. Develop recommendations to improve services and integrate prevention practices.
5. Develop a prevention practice protocol to respond to recommendations.
6. Establish a process to integrate improvements and prevention services
7. Develop an evaluation tool to assess progress.

STD PROGRAM WEBSITE

Background

The IHS National STD Program will develop, implement, and maintain a website devoted entirely to AI/AN STD issues, as well as, publish appropriate resources, trainings, and publications for I/T/U partners.

Objective

To increase the ability of the National STD Program to disseminate timely STD/HIV prevention information.

Status

We are working with a contractor to finalize the National STD Program website. It should be live by the end of November 2005.

STD SERVICES FOR THE CHEROKEE NATION

Background

A cornerstone of STD prevention and control is the efficient treatment and management of case-patients and their sexual partners. In many U.S. jurisdictions, these activities are conducted primarily

by state and county health departments. On the Cherokee Nation, however, public health services are also provided by tribal and federal entities. The specific duties, responsibilities, and interactions of these various agencies, as applicable to STD control, are not well described.

Objective:

To describe STD services provided by the Cherokee Nation, county and state health departments, and IHS.

Status

During a weeklong site visit, we conducted key informant interviews with individuals involved with STD programs and services at the county, state, federal, and tribal levels. Where available, written protocols and guidelines were collected and reviewed.

We looked at screening policies and protocols, STD tests and laboratory services, case reporting, case management, and partner management. We found that, despite notable differences at each facility, protocols for STD management and reporting appeared to work well. From our findings, we recommended that each facility perform chart reviews and audits on a regular basis, standardize and clarify existing STD protocols, and create an inter-agency STD working group to facilitate communication and to serve as a forum for sharing common experiences.

STOP CHLAMYDIA USE AZITHROMYCIN PROGRAM

Background

Because azithromycin is a costly drug, few IHS Service Units routinely make it the drug of choice for treating chlamydia. When azithromycin is delivered as a one-dose directly observed therapy, it can have a major impact for populations where compliance is unreliable.

Participating clinics in this program receive free azithromycin in exchange for data on all laboratory-confirmed chlamydia cases. The data are entered into a database, analyzed, and returned to the participating clinics as summary reports every quarter.

Objective

The original objective of the program was to increase treatment for patients testing positive for chlamydia.

Status

We are in the process of revamping the Stop Chlamydia program to increase the quality and utility of the data reported.

Future Directions

The future is bright for the IHS National STD Program: our staff is growing, our partnerships are flourishing, and our ability to respond to the training and technical assistance needs of Indian Country is improving.

Projects and activities we have planned for 2006 and beyond include:

- Launching the IHS National STD website.
- Developing, producing, and distributing AI/AN-specific STD educational materials.
- Developing a mechanism to recognize and reward innovative STD interventions.
- Supporting the National Coalition of STD Director's AI/AN work group
- Providing STD training support for I/T/U staff.
- Increasing the availability of STD positivity data for AI/AN.
- Increasing access to AI/AN STD surveillance data
- Partnering with the STD Research Group to increase STD research among AI/AN.
- Developing an integration plan for STD, HIV, and hepatitis prevention and control activities for the IHS Division of Epidemiology and Disease Prevention.
- Assessing chlamydia screening coverage.
- Developing a tool and technical assistance package to assess STD, HIV, and hepatitis services at the service unit level.
- Convening a work group to develop guidelines for school-based STD screening in Indian Country.

Appendix A: 2005 Goals & Objectives

Goal 1: Raise awareness of STDs among AI/AN as a high priority health issue.

Objective A Increase internal collaboration and communication, with CDC, Division of STD Prevention (CDC, DSTDP) and Indian Health Service, Office of Public Health Support (IHS, OPHS).

Objective B Organize and facilitate 3 regional STD meetings among State, I/T/U, and community-based organization partners.

Objective C Disseminate STD prevention and control information in a timely manner to I/T/U partners.

Goal 2: Expand partnerships with state STD programs, I/T/U health programs and other public health agencies to improve collaboration and coordination of efforts to prevent and control STDs in AI/AN communities.

Objective A Develop a partnership with CDC's Infertility Prevention Project (IPP) to build a network of I/T/Us, state, laboratory, and other public health professionals dedicated to the reduction of chlamydia in AI/AN populations.

Objective B Develop a partnership with the National Coalition of STD Directors (NCSD).

Objective C Develop a partnership with National Indian Health Board (NIHB).

Goal 3: Develop, implement, and evaluate public health interventions and programs.

Objective A Develop and implement demonstration projects with I/T/Us and state STD programs to assess effectiveness of STD programs and interventions.
Objective B Conduct an assessment of STD prevention activities undertaken by tribal health programs.

Objective C Collaborate with tribal health programs, tribal correctional systems, and IHS to implement STD screening programs in tribal jails.

Objective D Support implementation of CDC's STD screening, treatment, and partner management policies and procedures.

Objective E Provide single dose therapy for chlamydia to I/T/U facilities through the Stop Chlamydia! Use Azithromycin Program.

Objective F Support improved staff performance in partner management services.

Goal 4: Provide up-to-date STD training for clinicians and other health professionals caring for AI/AN.

Objective A Collaborate with CDC's STD/HIV Prevention Training Centers (PTCs) to increase I/T/U providers' access to STD training.

Objective B Collaborate with HRSA's AIDS Education and Training Centers to increase I/T/U providers' access to HIV/AIDS training.

Objective C Collaborate with the Regional Training Centers for Family Planning to increase providers' access to reproductive health and sexual health training.

Objective D Collaborate with the Addiction Technology Transfer Centers to increase providers' access to substance abuse prevention and treatment training.

Objective E Keep abreast of relevant training and technical assistance issues at the federal level.

Goal 5: Support and strengthen surveillance systems to monitor STD trends.

Objective A Publish an AI/AN-specific STD surveillance report and include STD surveillance data in *Regional Differences in Indian Health* and *Trends in Indian Health*.

Objective B Collaborate with IPP, state laboratories, and private laboratories to collect accurate and timely chlamydia data from I/T/U facilities.

Goal 6: Promote STD research to help identify effective interventions for reducing STD morbidity in AI/AN communities.

Objective A Conduct appropriate and relevant research in STD prevention and control.

Objective B Collaborate with the Tribal Epidemiology Centers to conduct research in STD prevention and control.

Objective C Serve as a liaison to CDC and other Federal agencies, universities, foundations, and interested groups and advocate for the need to do research beneficial to AI/AN communities.

Goal 7: Support syphilis elimination efforts in affected AI/AN communities.

Objective A Ensure a timely response to emerging outbreaks.

Objective B Assist I/T/Us develop outbreak response plans.

Objective C Assist the Navajo Nation Division of Health (NDOH) in on-going syphilis outbreak response activities.

Goal 8: Operate strategically.

Objective A Update the strategic plan annually.

Objective B Implement the strategic plan.

Goal 9: Promote and for support professional development of its staff.

Objective A IHS National STD Program staff and contractors will be trained in relevant areas of public health.

Appendix B: 2005 Budget

2005 Funding

Core	$491,677.00
Supplemental	$40,802.00
Total	$532,479.00

FINAL STD BUDGET FY 2005	Obligated	Actual
STAFF		
Administrative Support	$32,000.00	$32,000.00
NCSD Consultant	$45,000.00	$45,000.00
Public Health Prevention Coordinator	$42,240.00	$42,240.00
STD/MIS Coordinator for Navajo	$30,000.00	$30,000.00
STD Analyst	$42,000.00	$42,000.00
PROGRAMS		
Alaska STD Intervention Project	$25,000.00	$25,000.00
NCSD AI/AN Meeting	$15,000.00	$15,000.00
Navajo Social Marketing Campaign	$5,000.00	$5,000.00
Regional STD Summit		
Alaska Summit	$5,800.00	$5,800.00
Phoenix Summit	$5,800.00	$5,800.00
School-based screening program	$6,000.00	$6,000.00
Stop Chlamydia! Use Azithromycin	$0.00	$18,301.00
Tribal STD Program Assessment	$35,000.00	$47,345.00
ADMINSTRATIVE COSTS (rent, utilities, building security, telephone)	$44,980.00	$44,980.00
TRAVEL		
Estimated Travel for the Navajo PHA	$5,000.00	$4,335.00
Estimated Travel for IHS Staff , Students	$91,600.00	$71,740.00
Meth Trainings, and Region VIII Meeting	7,827.00	7,827.00
Estimated Travel for STD Provider Training	$12,800.00	$2,679.00
SUBTOTAL	**$451,047.00**	**$451,047.00**
FY2005 SUPPLEMENTAL FUNDS		
Navajo Public Health Advisor	$40,802.00	$40,802.00
TOTAL	**$491,849.00**	**$491,849.00**

2004 End-of-Year Award	Obligated	Other	Travel	Final
Navajo Summit	$16,778.65	1,812.07	6224.33	$8,036.40
Phoenix Summit	$22,000.00	22,000.00		$22,000.00
Alaska Summit	$21,961.35	21961.35		$21,961.35
Social Marketing Campaign	$30,000.00			$30,000.00
Public Health Prevention Coordinator	$34,260.00			$43,002.25
Sub-Total	$125,000.00			$125,000.00
Indirect	$12,500.00			$12,500.00
Total	**$112,500.00**			**$112,500.00**