

THE CENTERS FOR DISEASE CONTROL AND PREVENTION'S ANNUAL TRIBAL BUDGET AND CONSULTATION REPORT FISCAL YEAR 2006

Section 1. Tribal Priorities

Tribal Priority 1, Funding and Related Issues

Objectives: Manage the Centers for Disease Control and Prevention's (CDC) fiscal and personnel resources in a manner that maximizes impact on the health and safety of American Indian/Alaska Native (AI/AN) people, accurately monitor CDC resources allocated to benefit AI/AN communities, and make this information readily available to tribal leaders.

Background: In addition to a new strategic focus on health impact, another of CDC's six new strategies is accountability. This means that CDC will work to sustain people's trust and confidence by making the most efficient and effective use of the public's investment in CDC. Improved accountability and better management of resources devoted to AI/AN populations will strengthen CDC efforts to improve public health in Indian country.

Activities: (1) CDC is using a portfolio management approach to its resources devoted to AI/AN health issues. This approach will improve how CDC tracks and displays its AI/AN resource commitments (see below). Also as part of this approach, CDC will more closely monitor funds distributed to state health departments via CDC grants and cooperative agreements to help ensure that AI/AN communities receive appropriate benefit from CDC funds. (2) CDC will continue to submit to the Department of Health and Human Services (HHS) and tribal leaders an annual tribal budget and consultation report that includes a summary of CDC resources committed to programs that benefit AI/AN communities. This information will portray fiscal information as committed by CDC's various organizational components and by defined categories. The latter will include a summary of grants and cooperative agreements awarded directly to tribes and tribal organizations.

Expected Outcomes: Better management and improved flow of resources will help to maximize the health impact of CDC programs/projects that focus on AI/AN populations. Increasing transparency in CDC's AI/AN resource allocation process and outcomes will facilitate tribal awareness of, and participation in, CDC efforts to address tribal public health issues.

Tribal Priority 2, Increased Access to CDC Programs

Objectives: Eliminate barriers and improve tribal access to CDC's extramural funding opportunities.

Background: In order to take full advantage of the many opportunities that CDC offers for public health support, tribal leaders need to know what those opportunities are and how best to access them. Extramural funding through grants and cooperative agreements is a key mechanism for tribal access to CDC resources.

Activities: All CDC program announcements are now available for viewing and application submission through www.grants.gov. In addition, CDC is working with tribal

organizations such as the National Indian Health Board (NIHB), and networks such as the Tribal Epidemiology Centers, to help ensure that news of program announcements is reaching more potential applicants from Indian country. CDC program announcements now contain standardized language specifying tribal eligibility for most program announcements.

Expected Outcomes: These activities will produce (1) an increased number of tribal applications/proposals from Indian country in response to CDC program announcements, (2) a broader spectrum of tribal awardees (tribal governments, tribal organizations) and (3) a more accurate measure of CDC's extramural funds that support programs in Indian country.

Tribal Priority 3, Health Promotion and Disease Prevention

- Cancer Prevention

- Comprehensive Cancer Control for AIs/ANs

- Objective: To promote cancer prevention, improve cancer detection, increase access to health and social services, and reduce the burden of cancer.

- Background: The significant growth of cancer prevention and control programs within health agencies has resulted in recognizing that improved coordination of cancer control activities is essential to maximize resources and achieve desired cancer control outcomes. Comprehensive cancer control results in many benefits, including increased efficiency for delivering both public health-related messages and services to the public.

- Activities: The National Comprehensive Cancer Control Program (NCCCP) is a collaborative process through which a community and its partners pool resources to promote cancer prevention, improve cancer detection, increase access to health and social services, and reduce the burden of cancer. Special activities include CCC Leadership Institutes (CCCLI) focusing specifically on the needs of AI/AN populations. During the interactive institute, six leadership modules were presented that focused on issues and strategies addressing planning and implementation of tribal cancer control plans. The featured speakers and program presenters were American Indians or Alaska Natives. Prior to the Institute, a planning committee of National Partners and AI/AN members ensured that all content was culturally relevant and applicable for Indian country. The first three-day CCCLI was for individuals engaged in cancer control coalition efforts in tribes currently funded by CDC to develop, prepare to implement, or implement comprehensive cancer control initiatives. Another CCCLI was held in October 2006.

- Expected Outcomes: These efforts will contribute to reducing cancer risk, detecting cancers earlier, improving treatments, and enhancing survivorship and quality of life for cancer patients. One outcome of the first CCCLI was the formation of the "Comprehensive Cancer Control American Indian/Alaska Native Workgroup." The Workgroup will develop a toolkit providing information on how states can work effectively with tribes and tribal organizations and how tribes and tribal organizations can work effectively with states. The Workgroup will develop educational forums on "Working Effectively with AI/AN Tribes and Communities," which will include developing sessions for June and February CCCLIs.

Breast and Cervical Cancer Early Detection for AI/AN Women

Objective: Assist AI/AN women to gain access to lifesaving screening programs for early detection of breast and cervical cancers.

Background: To help improve access to screening for breast and cervical cancers among underserved women, Congress passed the Breast and Cervical Cancer Mortality Prevention Act of 1990, which created CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP). The Act was amended the following year to include AI/AN women. This program provides both screening and diagnostic services, including clinical breast examinations, mammograms, Pap tests, surgical consultation, and diagnostic testing for women whose screening outcome is abnormal. Referral for cancer treatment is also provided to women diagnosed in the Program.

Activities: NBCCEDP targets low-income women with little or no health insurance and has helped reduce disparities in screening for women from racial and ethnic minorities. Approximately 57 percent of women screened through the program were of racial or ethnic minority groups, and 4.2% were AI/AN women. NBCCEDP currently funds 13 Native American/Alaska Native organizations. From 2001-2005, these 13 organizations provided 91,023 Pap tests and 46,607 mammograms to 52,230 unduplicated women and detected 218 breast cancers, 7 invasive cervical cancers, and 417 pre-cancerous cervical lesions.

Expected Outcomes: Many deaths from breast and cervical cancers will be avoided by increasing cancer screening rates among women at risk. Timely mammography screening among women aged 40 years or older will reduce breast cancer mortality by approximately 20-25% over ten years compared with women who are not screened. Pap tests can find cervical cancer at an early stage when it is most curable or even prevent the disease if precancerous lesions found during the test are treated.

▪ Diabetes Programs

Technical Assistance for Tribal Diabetes Prevention Programs

Objective: Tribes, tribal organizations, and tribal colleges and universities (TCUs) can easily obtain technical assistance in developing diabetes prevention initiatives.

Background: Discussion groups in 2001 conducted by CDC and the Indian Health Service (IHS) identified a critical, universal need for technical assistance in developing diabetes prevention programs from conceptualization to implementation. The Tribal Leaders Diabetes Committee (TLDC) echoed this need.

Activities: Through contracted services, the CDC Native Diabetes Wellness Program is working to provide culturally appropriate technical expertise in public health program planning and implementation. In addition to an open invitation to tribes, tribal organizations and TCUs to access this expertise, formal consultation is being provided to the eight grantees of the Health Promotion and Diabetes Prevention Projects for AI/AN Communities: Adaptations of Practical Community Environmental Indicators project. The initial meeting among the CDC Wellness Program, McKing Consultants, and the grantees was held in Albuquerque, New Mexico, during November 15–16, 2005. Software support tools developed by the Wellness Program include “CDCynergy: AI/AN Diabetes Edition” and the “Diabetes Atlas: Mapping the Vision of Hope,” a Geographic Information Systems tool for communities maintained by the University of New Mexico Earth Data Analysis Center.

Expected outcomes: Increased utilization of technical assistance resources will build program and infrastructure capacity and sustainability.

The Talking Circles Project

Objective: Training for a program that provides emotional support to community members with and at risk for diabetes is provided across the country, using a tested “Talking Circles” curriculum.

Background: A culturally-rooted, participatory study, “Diabetes Wellness: American Indian Talking Circles” (Talking Circles), which took place on four reservations in South and North Dakota in recent years, represents an ancient way of gathering tribal members in a group such as “talking circles,” “council fires,” and “talkstories.” Directed by Dr. Felicia Hodge and implemented by Ms. Lorelei DeCora, the project engages families and community members in a process of listening, dialogue, and action to impart wisdom and support for members.

Activities: Community health workers—community health representatives (CHRs), diabetes outreach workers—in the Aberdeen, Billings, and Bemidji areas have been trained to serve as “Talking Circle” facilitators in their communities and all interested tribes in the Northern Plains, and Woodlands in Minnesota, Michigan, and Wisconsin have been trained. In addition to Talking Circles training, CHRs and diabetes outreach workers have been provided additional tools including, the "Eagle books" for children, "CDCynergy: Diabetes version for American Indian/Alaska Native Communities" (a software package for health communication program development and planning), "Diabetes Atlas" (a geographic information systems tool to assist communities with surveillance and planning), and the DVD curriculum, “The In-Between People: Including Community Health Workers in the Circle of Care.”

Expected Outcomes: Community health workers and other health leaders in Plains and some woodland communities (Aberdeen, Billings, and Bemidji IHS areas) will use the tools and their training to bring awareness to their communities through the use of “Talking Circles” diabetes curriculum for interested groups in their communities.

▪ Environmental Health

Objective: Provide environmental health technical and administrative support to state, county, city, and tribal health agencies in an eight-state region in the western United States and Pacific Rim.

Background: CDC’s National Center for Environmental Health (NCEH) funds cooperative agreements to academic centers, such as Loma Linda, to assist state, local, and tribal health agencies to develop effective, state-of-the-art environmental public health programs. The cooperative agreement with Loma Linda focuses on assisting tribes in this regard.

Activity 1: Navajo Nation Environmental Health Surveillance Capacity Building - Loma Linda hosted a Navajo Professor from Dine’ College for approximately 1 month. The professor received intensive training in the environmental health applications of geographic information systems (GIS). Dine’ College then hosted a Loma Linda graduate student, who trained the college’s trainers on the use and applications of GIS.

Beneficiary: Navajo Nation.

Activity 2: California’s County and City Environmental Health Services Delivery System

- This 165-page report provides a comprehensive description of environmental health service delivery in California. Policy and decision makers at the state and local levels are using the report to support a more strategic approach to environmental health management systems. The beneficiaries are the state of California and tribal programs in California.

Expected Outcomes: Environmental public health capacity will be improved in the areas served.

▪ Epidemiology and Public Health Practice

Objective: Continue to place qualified professionals in direct assistance/trainee positions with IHS and tribal organizations.

Background: CDC offers several training programs whose assignees/trainees contribute to health promotion and disease prevention in Indian country. Examples include the Epidemic Intelligence Service, the Preventive Medicine Residency Program, and the Public Health Prevention Specialist Program. For several years, CDC has assigned professional trainees to work with the IHS Division of Epidemiology and Disease Prevention in Albuquerque, New Mexico, and recently has expanded these assignments to include tribal organizations.

Activities: Existing and future trainees working in Indian country will provide increased technical assistance to IHS and tribes in epidemiology, training, and building epidemiologic capacity. In particular, working relationships with the Tribal Epidemiology Centers will be strengthened as a pathway for bringing CDC technical expertise to tribal communities.

Expected Outcomes: Strengthened public health infrastructure and epidemiologic capacity in national and regional organizations will positively impact public health services provided to AI/AN communities.

▪ Fetal Alcohol Syndrome (FAS)

Objective: Reduce the incidence of FAS in Northern Plains AI/AN children.

Background: Alcohol use during pregnancy continues to be a problem for some AI/AN communities. Programs are needed to educate communities about the effects and prevention of FAS, as well as its identification and management.

Activities: In collaboration with Black Hills State University, Little Wound School on the Pine Ridge Reservation agreed to participate in the pilot testing of a school-based curriculum for students in grades 5-8, based on "Making the Right Choices: A Grade 5-8 Fetal Alcohol Syndrome Prevention Curriculum," developed and used in the Frontier School Division of Canada. In addition, a curriculum was developed and used to conduct a two-day workshop for teachers, juvenile justice workers, and others who might have responsibilities for working with young people with FAS. In collaboration with the University of South Dakota, AI communities in Rosebud, Standing Rock, and Turtle Mountain Chippewa participated in the development of a media campaign to promote a toll-free helpline for women of childbearing age to either reduce their drinking or to increase family planning. In fiscal year (FY) 2006, implementation of the surveillance component of the project occurred as well as the tracking system for linking affected individuals with appropriate community services.

Expected Outcomes: Trainings/workshops for educators, juvenile justice workers, social service workers, foster care and adoption workers, justice system workers, and others who work with children and youth with FAS and their families, will continue in an effort to improve care for those affected by FAS. A media campaign designed to engage AI/AN women in the project will provide a toll-free number for women to call for support in decreasing alcohol consumption and/or increasing effective contraception use.

▪ HIV Prevention: Native Peoples

Objective: To promote HIV prevention in AI/AN communities.

Background: In FY 2006, the National Center for HIV, Hepatitis, STD, and TB Prevention's (NCHHSTP) Division of HIV/AIDS Prevention (DHAP) continued to work with AI/AN leaders from the Native People's Alliance in conjunction with DHAP's National HIV/AIDS Partnership (NHAP) activity. The Native Peoples Alliance is one of several alliances within NHAP.

Activities: NHAP continues to recruit and collaborate with AI/AN leaders. To date, AI/AN leaders representing business, faith, tribal, civic and social organizations are actively involved in partnership activities. AI/AN partners recruited in 2006 include Rev. Alvin Deere, executive director of the Native American International Caucus, and Wallace Coffey, the chairman of the Comanche Nation of Oklahoma. In addition, Rev. Marlene Whiterabbit Helgemo, Minister of All Nations Indian Church, attended the CDC Consultation on Faith and HIV Prevention in February of 2006. AI/AN leaders like Karen Hatcher, president of Pequot Health Care, continue to play an integral role in reaching out to other AI/AN leaders in order to engage them in HIV/AIDS prevention awareness activities. Finally, the 2006 Red Ribbon Leadership Awards was held on World AIDS Day, December 1st, at the National Museum of the American Indian. The awards serve to increase awareness of the importance of leadership in HIV/AIDS prevention. The venue also serves as an opportunity to call attention to the impact of HIV on AI/AN and other communities of color.

Expected Outcomes: CDC will continue to disseminate public service announcements, posters, and related print media to promote HIV prevention within AI/AN communities. NHAP will continue to expand its collaboration with AI/AN leaders and communities in an effort to increase HIV/AIDS awareness where AI/AN and other communities live, work, play, and worship. Recruiting AI/AN leaders from diverse sectors to disseminate HIV awareness and prevention messages will remain a top priority in fiscal year 2007.

▪ Immunizations

Objective: To help ensure that AI/AN children benefit fully from Vaccine for Children (VFC) services and to accurately monitor immunization coverage/utilization.

Background: In FY 2006, the VFC program purchased more than \$2 billion in vaccines for children birth through 18 years of age who are eligible for the VFC entitlement, which includes all AI/AN children. Based on state population estimate surveys, CDC estimates that AI/AN children make up 2.45% of the VFC eligible population 0 – 18 years of age. AI/AN children receive VFC services through both IHS and non-IHS providers and facilities.

Activities: Coverage and utilization data for AI/AN populations are monitored through the IHS immunization registry, the National Immunization Survey, and state

immunization registries. CDC is working with IHS staff and state immunization registries to develop software to allow the electronic exchange of immunization data between IHS, Tribal, and Urban Indian Health (I/T/U) facilities and state immunization registries. The software is currently operational in five states, with further expansion expected.

Expected Outcomes: The inclusion of immunization data from I/T/U facilities into state immunization registries will improve patient care for this population, allow for more complete information on immunization coverage at the state level to monitor potential disparities, and conserve resources.

- Infectious Diseases in Alaska Natives

Objective: Prevention and control of infectious diseases in Alaska Natives.

Background: The Arctic Investigations Program (AIP) located in Anchorage, Alaska, is one of three U.S. field stations operated by CDC's Coordinating Center for Infectious Diseases. Core program activities include surveillance of infectious diseases, public health research, health communication and education, public health emergency preparedness and response, and bioterrorism preparedness and response.

Activities: AIP maintains a statewide surveillance system for invasive diseases caused by certain bacteria: *Streptococcus pneumoniae*, *Haemophilus influenzae*, *Neisseria meningitidis*, and Groups A and B Streptococcus. In Alaska, the infant pneumococcal vaccine (PCV7) was introduced in 2001 and disease rates due to vaccine types declined by 85 percent among children under 2 years of age. However, the adult pneumococcal vaccine remains underutilized. For example, surveillance identified an outbreak among unvaccinated adults for whom vaccine was indicated but not received by 50% of outbreak cases. Clusters of invasive *H. influenzae* type A infections have been identified through surveillance among Alaska Natives, and rapid case investigations/interventions are linked to an intact surveillance system. *N. meningitidis* remains an important cause of bacterial meningitis for which a new vaccine has recently been introduced. Surveillance data indicate that 57% of early-onset group B streptococcus (GBS) cases in Alaska were preventable through use of national guidelines for prenatal screening and treatment. These findings promoted an educational effort by AIP and the Alaska Department of Health and Social Services to increase awareness among Alaska healthcare providers regarding appropriate diagnosis and treatment of perinatal GBS disease. Surveillance is needed to determine whether this education can reduce rates of GBS disease.

Expected Outcomes: Vaccine policies and programs need ongoing high quality data collection to be responsive to changes in disease trends. With continued surveillance for these diseases, AIP will assess vaccine program effectiveness, monitor for the emergence of bacterial types not covered by current vaccines, and test for the development of drug resistant strains. The impact of the newly introduced vaccine against *N. meningitidis* will be determined through disease surveillance.

- Injury Prevention

- Prevention of Motor Vehicle Injuries

Objective: The purpose of the program is to design/tailor, implement, and evaluate AI/AN community-based interventions with demonstrated effectiveness for preventing motor vehicle injuries.

Background: Unintentional injuries are the third leading cause of death among AI/AN populations of all ages combined, with motor vehicle crashes accounting for about half of those deaths.

Strategies to prevent motor vehicle injuries include (1) reducing alcohol-impaired driving among high risk groups; (2) increasing safety belt use among low-use groups; and (3) increasing the use of child safety seats and booster seats among low use groups.

Activities: Beginning in FY 2004, CDC's National Center for Injury Prevention and Control (NCIPC) has funded four tribes (Ho-Chunk Nation, White Mountain Apache Tribe, Tohono O'odham Nation and San Carlos Apache Tribe) to develop, implement, and evaluate tailored, community-based interventions with demonstrated effectiveness to reduce motor vehicle-related injuries among AI/AN populations. This project has a four-year project period.

Expected Outcomes: Each participating tribe will reduce injury and deaths due to motor vehicles and increase seat belt and booster seat use.

Reduction of AI/AN Injury Disparities

Objective: Reduce injury disparities among AI/AN populations by providing technical assistance to IHS and tribes in injury epidemiology, training, and building capacity in injury prevention.

Background: Since 1985, CDC and IHS have had an interagency agreement to help reduce the injury disparities among AI/AN populations. IHS details one Injury Prevention Specialist to CDC's NCIPC to work on injury epidemiology, to conduct special studies with IHS and tribes, and to provide training and technical assistance.

Activities: Through the intra-agency agreement, NCIPC has published several documents that assist IHS and tribal staff with injury program management.

Expected Outcomes: The agreement will continue to help reduce injury disparities among AI/AN population.

Suicide Prevention Program Evaluation

Objective: Reduce injuries and deaths among AI/AN populations by providing enhanced evaluation on suicide prevention programs.

Background: In 2006, CDC and the Substance Abuse and Mental Health Services Administration (SAMSHA), using funding from the Garrett L. Smith Memorial Act, established a collaboration for the support of several sites to perform enhanced evaluation of suicide prevention programs.

Activities: NCIPC is funding The Native American Rehabilitation Association (NARA) in Portland, Oregon for a period of three years. NARA will be collaborating with nine federally recognized AI communities in Oregon to assess whether the range of suicide prevention activities implemented in these communities will enhance protective factors and/or reduce risk factors for suicidal behavior among AI youth.

Expected Outcomes: Continued agreement and activities for a period of three years will reduce suicidal behavior among youth.

- Occupational Safety and Health

Objective: Enhance the capacity of Navajo model farmer “opinion leaders” to provide consulting expertise to intervention group farmers through training, equipment, and supplies.

Background: Model Farmer Dissemination Project: Until the late 1990s, pesticide and herbicide use was minimal on the Navajo Nation. With the spread of invasive weeds threatening the long-term environmental stability and health in the Four Corners region, devastating infestations of grasshoppers and cutworms in recent years have brought about enhanced use and interest in pesticides. Prior work with this population reinforces the importance of using traditional methods to increase the capacity of farmers to use pesticides and herbicides safely and properly. Experience on the Navajo Nation over the last four years has provided the preliminary data needed to build a theoretically derived intervention, based on traditional methods of adult learning. CDC’s National Institute for Occupational Safety and Health (NIOSH) is working with a cohort of farmers and ranchers who have asked NIOSH to continue working with them to improve health and safety on their farms.

Activities: 1) Undertake a case/control intervention with Navajo farmers to assess the effectiveness of best management practices and pesticide safety application procedures on farm yield, safety behaviors, and environmental effects; 2) Develop recommendations about “model farms” and “model farmers” that can be used to disseminate best practices to neighboring farmers on the Navajo Nation and to other culturally differentiated groups where health disparities may be common.

Expected Outcomes: Results of the study will be used to develop recommendations about "model farms" and "model farmers" that can be used to disseminate best practices to neighboring farmers on the Navajo Nation and to other culturally differentiated groups where health disparities may be common.

- Racial and Ethnic Approaches to Community Health (REACH) Programs

Racial and Ethnic Approaches to Community Health (REACH) 2010 is one of the cornerstones of CDC’s efforts to eliminate racial and ethnic disparities in health. REACH 2010 is designed to eliminate disparities in the following six priority areas: cardiovascular disease, immunizations, breast and cervical cancer, diabetes, HIV/AIDS, and infant mortality. REACH programs for tribal communities focus on tribal community capacity building and include the following:

Breast and Cervical Cancer Prevention – Southwest United States

Objectives: 1) To improve collaboration and communication between tribal health programs and the scientific community, 2) to increase public health skills among community health providers, 3) to develop more effective cancer screening programs, and 4) to design and implement community-based preventative interventions. build tribal community and scientific capacity to address the rising incidence of breast and cervical cancer among American Indian women.

Background: This program is supported through Albuquerque Area Indian Health Board and the following communities it represents and serves: Alamo Band of Navajos, TóHajiilee Band of Navajos and Ramah Band of Navajos; Mescalero Apache Tribe; Jicarilla Apache Nation; Ute Mountain Ute Tribe, and Southern Ute Indian Tribe. In

recent years, AAIHB has expanded its service base to include the urban American Indian population of Albuquerque, New Mexico.

Activities: Program activities include public health skills building courses, breast and cervical health training, community needs/capacity assessment, public health infrastructure strategic planning, and community outreach. To date, this project has created a model for developing public health capacity within tribes and has established sustainable networks and partnerships within tribal communities and between tribes and relevant outside programs and academic institutions. Program partners have also significantly raised awareness and improved screening behavior among tribal women, and changed cultural beliefs about “the sore that does not heal.”

Expected Outcomes: Tribally-specific preventive interventions will be developed to raise cancer awareness and improve screening behavior, and increase tribal scientific capacity.

Cardiovascular Disease Prevention – Choctaw Nation

Objective: In building capacity, the project has spearheaded the formation of six coalitions in Choctaw Nation Communities within the 10 ½ county jurisdictional area of the Choctaw Nation.

Background: This program works to identify the burden of cardiovascular disease (CVD), assess the adequacy of prevention efforts, and implement improved prevention and treatment strategies for CVD within the Choctaw Nation of Oklahoma (CNO) Boundaries. More than 80,000 American Indians reside inside the CNO Boundaries, and there are more than 395,000 American Indians in the state of Oklahoma.

Activities: Partnerships have been established within the Choctaw Nation Health Services, the Diabetes Wellness Center, community health representatives, and lay health advisors. The program has successfully worked with resource partners to establish 12 community coalitions within the 11 counties of the CNO to raise awareness about CVD prevention, improve access to care, and assess the communities’ greatest health needs. It has also developed an innovative educational program that increases awareness about CVD prevention and addresses the established needs of each community surveyed. Substance abuse education was identified as one of the greatest health needs within CNO. The project has exceeded expectations by developing six sustainable coalitions.

Expected Outcomes: The formation and implementation of interventions will promote coalition building, enhance scientific capacity, strengthen use of data supported prevention efforts, and build partnerships and networks. This program will continue to raise awareness about CVD prevention by sharing the community capacity plan, both locally and nationally, with other tribes, school systems, coalitions and public events. The Choctaw Nation also plans to work with partners like Colorado State University’s Center for Applied Studies in American Ethnicity to integrate CVD prevention into college curriculums.

Cardiovascular Disease Disparities in Alaska Natives

Objective: The Chugachmiut Native Organization of Alaska works to increase the ability of Chugach region communities to reduce disparities in CVD outcomes.

Background: Chugachmiut Native Organization serves seven rural and remote Alaska Native communities in the Prince William Sound, Resurrection Bay, and Lower Cook Inlet areas of Alaska. All but two villages are accessible only by plane. They provide

health and social services, education and training, and technical assistance to the Chugach native people in a way which is acceptable to native cultural values and tradition. As of 1999, heart disease was the third leading cause of death for Alaska Native men, and the second leading cause of death for Alaska Native women. Alaska Natives are the only racial group with a rate of cardiovascular disease much higher than the U.S. rate. Alaska Natives are more likely to be smokers, to be physically inactive and obese, and less likely to be screened for high cholesterol than non-Natives.

Activities: Train a person in each REACH community to be a Community Wellness Advocate through the one-year distance training offered by University of Alaska in Sitka in conjunction with the SouthEast Alaska Regional Health Consortium. Partner with local village tribal councils, Community Health Aides, Community Health Representatives, and other itinerant providers for project support. Work to develop and implement culturally appropriate community programs and activities to increase awareness of CVD and promote healthy lifestyle changes. Conduct community health assessments, as well as provide technical assistance and training to guide local interventions in all Chugach region communities. Development of a yearly interactive “Take the Idita-Heart Challenge” Calendar. Implementation of 312 cardiovascular disease prevention community events. Management of more than 3,000 Community Wellness Advocates and cardiovascular disease education contacts. Completion of 535 cardiovascular awareness tests with post-tests demonstrating an increase in knowledge among participants.

Expected Outcomes: Chugachmiut will continue to educate Alaska Natives in the region about CVD and other chronic disease problems as well as continue to disseminate project information and lessons learned from the project to local, regional, and national audiences.

Diabetes in AI/AN Elders in New Mexico

Objective: The project, administered by the National Indian Council on Aging (NICOA), serves American Indian elders living in New Mexico. The Diabetes Education and Outreach Strategies (DEOS) project works to promote awareness of the need to adopt healthy living practices and good personal diabetes management strategies and offers technical assistance to help mobilize communities.

Background: Among AIs/ANs in all age groups, the prevalence of diabetes is 2-4 times higher than among non-Hispanic whites, and they suffer from higher rates of diabetes complications than all other ethnic groups.

The risk of developing diabetes increases with age; rates increase from 3.5% for AI/ANs aged 20-44 years to over 20% for AI/ANs aged 65 or older AI/ANs have significantly higher prevalence of health risk factors such as obesity, smoking and lack of physical exercise than other ethnic groups.

Activities: DEOS trained community members on 10 reservations to begin and maintain diabetes support groups with training materials modified to fit the needs of each community. Over 66% of participants said the support group helped them maintain their eating and physical fitness goals. The project provided technical assistance to American Indian diabetes programs by supporting capacity building for outreach, and fostering partnership development with community organizations that share common goals to help elder’s live healthier lives.

Expected Outcomes: NICOA will develop a roadmap to help tribal program participants assess their community's level of readiness to address diabetes prevention. The stage of readiness will indicate to local leaders what approach they should take before they plan for capacity building. This roadmap will accompany an instrument for community needs assessment providing clear guidelines for determining how to evaluate health care plans with measurable outcome indicators. DEOS will create targeted marketing materials that can be used by community programs for advertising prevention activities and bringing awareness to prevention activities within the community.

Diabetes and Cardiovascular Disease Prevention – Oklahoma Tribes

Objective: Oklahoma's REACH 2010 Coalition partners represent eight AI tribes/nations, one urban Indian health center, and the Oklahoma State Department of Health, Chronic Disease Service. The main goal of the Oklahoma REACH 2010 Project is to reduce disparities in cardiovascular disease and diabetes through the expansion and implementation of primary and secondary prevention interventions of physical activity, nutrition, and smoking cessation.

Background: The age adjusted diabetes mortality rate is nearly 200% higher among the AI/AN population than whites (2001 Oklahoma Vital Statistics). The prevalence rate of diabetes among Oklahoma adults is 13.1% for AI/AN, compared to 7.0% for whites, and the obesity prevalence rate is 31.6% for AI/AN, compared to 22.2% for whites (BRFSS 2001 and 2003).

Activities: Reduce racial disparities in diabetes, cardiovascular disease, and their risk factors through increased availability and promotion of physical activity on a community level. The program includes physical fitness/wellness programs in all nine communities, at least one Physical Fitness Specialist or equivalent trained in each community, establishing policy/environmental changes in all communities, collecting baseline and follow-up measurements on participants, continued formal education of staff, and education of participants about the importance of physical activity and nutrition. Over 5,000 participants are enrolled in Oklahoma's REACH 2010 Project. Collectively all nine REACH partners have 23 trained and certified staff who have successfully implemented over 75 physical activities per week. Over 75 tribal staff and community members have been trained in fitness and health promotion. All partners have employee fitness/wellness programs and have implemented secondary prevention programs related to nutrition, smoking cessation and obesity. All partners have implemented environmental changes such as tobacco policies, employee fitness policies, and healthy food policies. Community partners have received over \$2 million dollars in additional funding to expand and enhance their programs. Dissemination has included 34 national presentations, 2 international presentations, 3 peer reviewed articles, 1 book chapter, and 2 reports.

Expected Outcomes: This program will reduce racial disparities in diabetes, cardiovascular disease, and their risk factors through increased availability and promotion of physical activity on a community level. Future plans of the Oklahoma Native American REACH 2010 Project will include sustaining programs, institutionalizing activities, sharing with other Native communities, and moving into the larger community.

Healthy Lifestyles and Diabetes Prevention – Eastern Band of Cherokee Indians

Objective: Men and women of the Eastern Band of Cherokee Indians (EBCI) are twice as likely to be obese than other North Carolina men and women. EBCI men and women reported a combined type-2 diabetes prevalence rate of 23.8%, more than three times the combined rate for men and women in North Carolina.

Background: In order to mobilize the community to confront environmental and biological factors that put Cherokee people at risk for developing diabetes, a program known as “Cherokee Choices” addresses racism and mental health, creates a supportive environment, and develops health policy changes. A team of mentors works with elementary school children and staff to develop lesson plans for the classroom on self-esteem, cultural pride, conflict resolution, emotional well-being and health knowledge, and develop a weekly after-school program to enhance team-work, cultural awareness and physical health. Nutritionists, dietitians, and fitness workers help tribal workers and church members participate in activities to reduce stress, eat healthier, and increase physical activity.

Activities: Housed in the Health & Medical Division of the Eastern Band of Cherokee Indians, Cherokee Choices is a three-component program: elementary school mentoring, worksite wellness for adults, and church-based health promotion. The cornerstones of the program are listening to the community and providing social support to increase physical activity and promote well-being and healthy choices which reduce the risk of obesity and diabetes. The REACH 2010 intervention in Cherokee focuses on three main components: Worksite wellness, School wellness, and Faith-based wellness. The interventions have succeeded in changing school systems to increase physical activity among the students and staff, decrease the amount of fat in school lunch menus, increase the fresh fruit and vegetable options in the school lunch menus, and increase parental participation in student activities. Some participants have been able to decrease or eliminate medications for diabetes and or high blood pressure. Also, significant decreases have been found in the percentage of body fat in worksite wellness participants.

Expected Outcomes: Expansion of the worksite wellness program and mentoring program will incorporate more worksites, churches and schools. Anticipate the sharing of knowledge will facilitate development of similar programs with surrounding counties. Intent to seek funding to create a more walk-able community with greenways and sidewalks.

HIV/AIDS Risk Reduction

Objective: The Association of American Indian Physicians (AAIP) REACH 2010 community capacity program aims to reduce the risk of HIV/AIDS among AIs/ANs, with an emphasis on youth and prevention.

Background: The coalition, Native Nations United Against AIDS (NNUAA), implements events to increase awareness of HIV/AIDS during World AIDS Day community activities and at cultural events, including a Pow-Wow.

Activities: NNUAA is also developing a speaker’s bureau of coalition members trained to conduct basic HIV/AIDS awareness presentations to communities upon request. AAIP also created an educational video and study guide titled: The Phillip Smith Story, to serve as an educational tool for American Indian youth. Over 1,000 community members have attended recent community-based activities sponsored by each coalition. Coalitions have

gained the support of traditional tribal members within the communities. 100 American Indian parents brought their daughters to a recent community training. Coalitions have gained the support of the public school system and tribal boarding schools in their regions.

Expected Outcomes: Activities will continue to incorporate faith based and non-Native organizations in the community to raise community awareness, as well as the implementation of Community PROMISE, a community level intervention training that consists of understanding Behavioral Theory and Social Norms, community identification through rapid ethnography, and media development and dissemination.

Reducing Infant Mortality and Improving Immunization Coverage - United Southern and Eastern Tribes (USET)

Objective: To assist tribes in developing local immunization programs to utilize immunization registries, conduct surveillance for immunization coverage and vaccine-preventable disease incidence, and develop community-specific interventions. Assistance includes training and technical support, dissemination of information, and coordination of activities between tribal, local, state, and federal public health resources. Conduct data quality assessment at the tribal level to ascertain and address data weaknesses in the computerized health data management system.

Background: The AI/AN population have higher rates of morbidity and mortality than other Americans. In 2003, the infant mortality rate for American Indians was 8.7 per 1,000 while the U.S. all-race infant mortality rate was 6.8 per 1,000, and the white rate was 5.7 per 1,000 (National Center for Health Statistics data). USET tribal childhood immunization coverage is well below Healthy People 2010 goal. For example, the percentage of 19-35 month olds with age-appropriate complete immunizations for the 4:3:1:3:3:1 (DTP, IPV, MMR, HiB, Hep B, Var) series for calendar year 2005 was 74%, well below the Healthy People 2010 goal of 90%. The incidence of vaccine-preventable disease is not known due to racial misclassification of AI/ANs in state notifiable disease reporting systems and inadequacies in tribal health data systems. Risk factors such as obesity and tobacco use is disproportionately higher in our tribes than in the nation at large.

Activities: Twenty USET tribes are currently involved in the collection of prenatal data to determine what factors may influence infant death, and 23 are currently involved in the collection of mortality data for linking to birth records. USET is assisting tribes in developing local immunization programs to utilize immunization registries, conduct surveillance for immunization coverage and vaccine-preventable disease incidence, and develop community-specific interventions. Assistance includes training and technical support, dissemination of information, and coordination of activities between tribal, local, state, and federal public health resources. USET is also conducting data quality assessment at the tribal level to ascertain and address data weaknesses in the computerized health data management system. Currently, 83.0% of USET tribes are participating in the infant mortality project. The number of tribes using immunization registries has increased from 9 to 21 and the number of American Indian children tracked for immunization coverage has increased 3-fold. In addition, USET has provided several immunization registries trainings and assisted tribes in gaining access to their respective state immunization registries.

Expected Outcomes: USET will continue to produce and distribute annual tribal-specific and aggregate immunization reports to provide an overview of tribal programs and monitor progress, as well as periodic tribal-specific and aggregate mortality reports. USET will also continue to provide technical assistance and training for our tribal immunization programs and focus on improving immunization rates at the community level; conduct data quality assessment for each tribe to improve data completeness in the tribal health data system; provide mortality reports to tribal programs; work towards establishing data sharing agreements with state agencies and improve state to tribe relationships; and provide prenatal care and assessment reports and recommendations to tribal programs to improve infant outcomes.

▪ Reproductive Health (RH)/Maternal-Child Health (MCH)

Objective: To carry out activities in epidemiology, surveillance, capacity building, and enhanced data utilization and dissemination that lay the groundwork for improvements in reproductive and maternal-child health among AI/AN populations.

Background: In recent years, CDC's Division of Reproductive Health (DRH) modified its approach to AI/AN health, implementing and supporting more activities that are aimed toward expanding and improving AI/AN RH/MCH in the United States. The new approach has focused on efforts to help overcome obstacles to such activities and assist tribal organizations to make RH/MCH improvements.

Activities: DRH convened a meeting of experts in MCH among AI/AN populations in the spring of 2004 with the goal of raising awareness of the need for enhanced research into this much neglected area. This meeting has led to a number of on-going activities inside and outside DRH. One such activity is the production of a special issue of the Maternal and Child Health Journal that will help publicize AI/AN MCH disparities and develop publication capacity among AI/AN researchers. DRH researchers are studying the effects of smokeless tobacco on pregnancy outcomes in Alaska Native women. DRH staff has explored potential applications of IHS clinical MCH data and have conducted a study of maternal morbidity in IHS facilities using such data. DRH is also playing a lead role in a new international initiative regarding the measurement of health indicators in indigenous populations. In FY 2006 DRH awarded a Pregnancy Risk Assessment Monitoring System (PRAMS) grant to an American Indian group. This is the first PRAMS contract not awarded to a state. Finally, DRH is working with AI groups to improve and standardize death scene investigations for sudden infant death syndrome (SIDS) deaths and working with Tribal EpiCenters to use data to create positive change in tribal communities.

Expected Outcomes: Enhanced research and surveillance activities on MCH and reproductive health among AI/AN population, in both basic epidemiology and programmatic issues, will improve capacity of tribes and tribal organizations to carry out and publish research in RH/MCH, complete successful MCH epidemiologic studies and improve understanding of measurement issues and data collection among AI/AN populations.

▪ STD Prevention and Control

Objective: To develop a National Coalition of STD Directors (NCSD) subcommittee to better address STD prevention and control efforts among AI/AN populations.

Background: In 2004, CDC and the IHS National STD Program recommended to NCSO that it form a subcommittee of state STD Directors from states with large AI/AN populations to better address STD prevention and control efforts among AI/AN populations. NCSO accepted the recommendation and voted to form this subcommittee in early 2005.

Activities: The AI/AN subcommittee is currently co-chaired by the STD Directors of Minnesota and Utah and has approximately 15 members. CDC and IHS will support NCSO in hiring a contractor to support many of the subcommittee's efforts. In January 2006, JSI Research and Training Institute, in partnership with the Northern Plains Tribal Epidemiology Center (NPTEC) of the Aberdeen (South Dakota) Area Tribal Chairman's Health Board (AATCHB), was awarded a contract to develop AI/AN-specific materials and training. To date, NCSO/JSI have conducted two separate trainings to increase awareness about working in Indian country (one session was conducted at the National STD Conference and one session was conducted at a recent NCSO meeting). In addition, JSI is developing AI/AN fact sheets for all 65 project areas in an effort to educate state STD program managers about the native populations within their respective states.

Expected Outcomes: The NCSO AI/AN subcommittee will facilitate improved education of federal, state, and local policymakers about issues relevant to STD prevention and control measures in AI/AN populations and will foster stronger partnerships between tribal and state public health programs to address STD control in AI/AN communities. These partnerships should lead to 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.

▪ Tobacco Programs – Tribal Support Centers

Objectives: (1) Increase the capacity and infrastructure of commercial tobacco prevention and control at the tribal/community level using culturally appropriate methods and scientific, population-based strategies. (2) Evaluate promising, culturally competent commercial tobacco programs, curricula and/or strategies that were developed by AIs/ANs to serve AI/AN populations in the area of commercial tobacco control and prevention.

Background: In FY 2005/2006 a new round of candidates vied for Tribal Support Center cooperative agreements with CDC's Office for Smoking and Health (OSH). The Request for Proposals differed from the first round of Tribal Support Center funding in that AI/AN tribes and tribal organizations could compete for either capacity-building funding or implementation funding – the latter intended to assist in the sustainability of previously funded Tribal Support Centers. The implementation programs are venues through which culturally competent AI/AN-developed promising practices are implemented inter-tribally and then scientifically evaluated. Capacity Grantees are (1) Cherokee Nation, Tahlequah, Oklahoma (2) Southwest Navajo Tobacco Education and Prevention Program – Winslow, Arizona (3) California Rural Indian Health Board (CRIHB), Sacramento, California and (4) Indigenous Peoples' Task Force (IPTF) – Minneapolis, Minnesota. Implementation Grantees are (1) Muscogee (Creek) Nation – Okmulgee, Oklahoma (2) South East Alaska Regional Health Consortium (SEARHC) – Sitka, Alaska and (3) California Rural Indian Health Board (CRIHB), Sacramento, California.

Activities: Examples of Capacity Grantee activities include training tribal health educators and IHS providers in commercial tobacco prevention and control efforts, and training tribal community facilitators of *Second Wind*, a culturally competent smoking cessation program. Grantees work with community gatekeepers and tribal governments to develop binding resolutions in the area of commercial tobacco-free policies, educate tribal council members and community gatekeepers in policies that deter youth commercial tobacco use (e.g., raising taxes on cigarettes), and work with tribal police agencies to ensure that tribal smoke-shops do not sell to minors. They facilitate collaborations between tribes, state health departments, other Tribal Support Centers; and state, regional, and national organizations; work with IHS to ensure that protocols regarding commercial tobacco use are put into place and used by providers (e.g., referring AI/AN smokers to cessation classes provided by Tribal Support Centers), and provide resources and technical assistance to tribe and community educators. Programs are also working to integrate commercial tobacco education into other areas of health education, i.e., diabetes, cardiovascular health, physical activity and nutrition, pre-natal care, and are encouraging tribal casinos to produce needs assessments that include areas of interest to casinos (e.g., marketing efforts) but also include commercial tobacco free policy data. Capacity grantees provide mini-grants to community centers, other tribes, youth camps, and the like for their efforts in commercial tobacco prevention and control. Some grantees have developed AI/AN culturally relevant and appropriate materials, tool kits, curricula, media campaigns in the area of commercial tobacco control and prevention. They have worked with state health departments to develop and implement targeted, tailored campaigns using native faces and native languages to urge AI/AN commercial tobacco users to call the quit lines, disseminated information at culturally appropriate venues, e.g., health fairs, pow-wows, community center pot lucks, and integrated popular forms of traditional sports for AI/AN youth with commercial tobacco education. Examples of Implementation Grantee activities include developing scientifically rigorous, yet culturally competent, evaluation plans; identifying potential evaluation partners and sites; and generating buy-in from potential evaluation partners (e.g., Tribal Councils, State Health Departments, State Quit Line managers, Quit Line Contractors such as Free and Clear). They also have trained cessation facilitators and quit line counselors, implemented evaluations of activities, and monitored these evaluation findings to inform and improve the evaluation plans.

Expected Outcomes: Capacity Grantees activities will increase referrals to cessation classes by IHS and tribal clinic providers, decrease AI/AN youth commercial tobacco initiation, enhance knowledge by tribal members of the adverse health affects of commercial tobacco use, and initiate dialogues regarding commercial tobacco-free policies (this is typically a very sensitive area due to the issue of sovereignty – respect for the sovereign status of the tribes is overarching in this process). These grantees will also implement commercial tobacco-free policies on tribal health campuses, increase the number of cessation facilitators in tribal communities, and increase the number of cessation classes held in tribal communities, rather than just the clinics, which will also increase accessibility for AI/AN smokers. These tribal grantees will also develop culturally appropriate materials, tool kits, curricula, media campaigns and increase use of quit lines by AI/AN tribal members served by the Tribal Support Centers. Most importantly, they will initiate dialogue between the Tribal Support Centers and tribal

councils on the issue of raising taxes in tribally owned smoke-shops. (Note that many smoke-shops on tribal lands are owned by individuals rather than tribes.) The implementation grantees are expected to develop promising approaches that will emerge as evidence-based practices.

- Violence Intervention

Objective: To create partnerships with communities to support the delivery of intimate partner violence interventions to prevent intimate partner and sexual violence and services for AI/AN communities.

Background: This is a new program with a project period of three years and is intended to assist racial/ethnic minority communities to assess and prevent sexual and intimate partner violence.

Activities: CDC's NCIPC funds the National Indian Justice Center to build capacity for AI/AN communities to prevent intimate partner and sexual violence. There will be an emphasis to work with men and boys in a culturally appropriate manner to prevent these forms of violence before they occur.

Expected Outcomes: Culturally competent demonstration projects for early intervention of both sexual and intimate partner violence will be developed, implemented, and evaluated.

- Viral Hepatitis Prevention and Control

Objective: To reduce the morbidity and mortality of disease caused by hepatitis A, B, and C viruses.

Background: *Hepatitis A virus:* Until the hepatitis A vaccine became available in the United States in 1995, the highest hepatitis A rates in the country occurred among AI/ANs (as high as 10 times the national average in some years). In the 1980s and early 1990s, the lifetime risk of hepatitis A virus infection among Alaska Natives living in villages approached 90 percent, and during outbreaks the peak reported incidence exceeded 2,000 cases per 100,000 population. In 1996, the Advisory Committee on Immunization Practices (ACIP) recommended routine hepatitis A vaccination of American Indian and Alaska Native children. CDC and IHS worked first to implement pilot programs and then to achieve high coverage among AI/AN children. Since then, hepatitis A rates among AI/ANs have declined by 99%. In 2004, less than 20 hepatitis A cases were reported among AI/ANs in the entire country. Hepatitis A rates among Alaskans are now similar to rates in other parts of the United States. *Hepatitis B virus:* Before the availability of a hepatitis B vaccine in the mid-1980s, hepatitis B virus infections were very common in Alaska Natives. Many of these infections occurred in young children and caused chronic infection leading to greatly increased risk of liver cancer and cirrhosis. Routine childhood hepatitis B vaccination implemented during the past 20 years with support from CDC and IHS has increased hepatitis B vaccine coverage to high levels and virtually eliminated new cases of chronic hepatitis B virus infection in Alaska Native children. *Chronic Liver Disease:* No vaccine yet exists for hepatitis C, a major cause of chronic liver disease (CLD) and liver cancer among Alaska Natives and American Indians. Other common chronic conditions that can contribute to the development of CLD include hepatitis B, alcoholism and obesity. For AI/ANs, the risk of death from CLD is approximately 2.5 times the national rate, with hepatitis B, hepatitis

C, alcoholism, obesity, and other diseases all contributing to this burden. CDC is supporting efforts to determine the causes of CLD, and the factors that contribute to more severe CLD among AI/ANs.

Activities: Evaluate the long term efficacy of hepatitis A and B vaccine administered in early infancy. Assess the prevalence of, and risk factors for, hepatitis C virus infection. Determine the burden and etiology of chronic liver disease. Identify and implement interventions to reduce the burden of disease.

Expected Outcomes: Activities will support and inform the development of vaccine policy (e.g., is a booster dose needed?) to reduce disease incidence and determine methods for identifying chronically infected individuals and link them to care.

Tribal Priority 4, Recruitment and Retention of Healthcare Providers

- Professional Clinical Skills Development

Objective: To train mid-level providers to perform flexible sigmoidoscopy in IHS and tribal health facilities.

Background: This is the second of a two-year CDC–IHS Intra-Agency Agreement. Alaska Natives have the highest incidence and mortality rate from colorectal cancer in the United States, yet currently there is little screening capacity in rural facilities. This project aims to increase capacity by training primary care providers from rural facilities to address this gap.

Activities: Activities that have occurred thus far include curriculum development for trainees, purchase of screening equipment, training of mid-level practitioners from Kotzebue, Klawock, Juneau, Kenai, and Bethel at the Alaska Native Medical Center; development of a training program brochure; abstracts about the program have been submitted/accepted for the American Public Health Association, Inuit Rural Health Conference, and the Alaska Public Health Summit; baseline rates have been established in all areas for trainee regions; and there is participation in the development of RPMS-based tracking systems.

Expected Outcomes: It is anticipated that screening rates for colorectal cancer will increase for the Alaska Native population based on increased access to these services.

Tribal Priority 5, Emergency Preparedness

- Communicable Disease Control

Objective: To revise federal communicable disease (quarantine) regulations.

Background: The federal regulations that implement CDC’s statutory authorities for communicable disease control are in the Code of Federal Regulations (42 CFR, Parts 70, 71). These regulations, which have not been updated in many years, contain no specific provisions regarding Indian country.

Activities: During FY 2005, CDC initiated a tribal consultation process regarding the proposed revisions that included presentations at HHS Regional Tribal Consultation Sessions and the distribution of a Dear Tribal Leader letter from Directors of CDC and IHS. These activities served to advise tribal leaders about the formal release of revised

draft regulations in the form of a Notice of Proposed Rule Making (NPRM). The NPRM containing the proposed revisions was released for tribal and public comment early in FY 2006. Tribal leaders' comments were collected and specifically addressed as part of CDC's newly established tribal consultation procedures.

Expected Outcomes: New regulations formed with tribal input will specifically and effectively address the application of these regulations in Indian country. The proposed regulations will continue to undergo internal HHS review. CDC will carefully review more than 500 pages of public comments received and will consider policy options and responses to the hundreds of insightful comments and recommendations received. The time necessary in this process will be taken to fully consider all options before promulgating a final rule.

- Cross-Border Preparedness

Objective: To establish cross-border emergency preparedness partnerships with Canada and Mexico.

Background: Communities located on or near international frontiers face unique jurisdictional and organizational challenges when planning for, or responding to, health crises such as pandemic influenza, outbreaks of other infectious diseases, or biologic, radiologic, chemical or bioterrorism events.

Activities: The Early Warning Infectious Disease Surveillance (EWIDS) project is working to enhance surveillance and epidemiological capabilities at the U.S. northern and southern borders, with emphasis on creating interoperable systems with Canada and Mexico. States along the Canadian border participating in EWIDS have had discussions with First Nations (FN) representatives, Health Canada, and provincial partners to support cross border surveillance and epidemiological capabilities with tribal communities on the border, and to ensure their participation in federal-state-provincial planning activities.

Expected Outcomes: Continued focus on EWIDS activities will help to create a greater awareness of the on-going challenges to effective emergency preparedness and response faced by FN communities located on or near the U.S.–Canadian international frontier.

- EMS Services

Objective: The purpose of this program is to support collaboration between national organizations of professionals in acute medical care, trauma, emergency medical services (EMS) with state and local public health programs and CDC in efficiently and effectively responding to mass trauma events resulting from terrorism.

Background: Despite our best efforts to protect the public, large numbers of Americans may be seriously injured in future mass trauma events, such as a large-scale natural disaster, bomb explosion, or disease outbreak. The ability to effectively minimize the impact of such injuries will critically depend upon the appropriate responses of all levels of the emergency medical response system. State and local health systems must also be fully prepared and capable of responding to the public in the event of a potential mass casualty event.

Activities: Since 2004, CDC's NCIPC has funded the National Native Americans EMS Association for Linkages of Acute Care and EMS to State and Local Injury Prevention Programs. This program supports collaboration between national organizations of

professionals in emergency care and state and local health departments. These relationships are critical to response to mass trauma events.

Expected Outcomes: Facilitated development of critical relationships related to acute care, trauma, EMS services, and public health will assist CDC to respond effectively to mass trauma events resulting from terrorism.

- Tribal-Federal AI/AN Task Force

Objective: To establish an AI/AN Task Force on Bioterrorism and Emergency Preparedness.

Background: Improved coordination across the many federal organizations that play a role in addressing emergency preparedness and response in Indian country would help AI/AN communities and governments to be better prepared. Preliminary discussions among federal and Tribal officials have addressed the possibility of establishing a Tribal-federal task force that would address the issue of collaboration between federal agencies (e.g., CDC, Environmental Protection Agency, Indian Health Service, Federal Emergency Management Agency, Division of Health Studies, Bureau of Indian Affairs, Department of the Interior, Health Resources and Services Administration, Office of the Assistant Secretary for Public Health Emergency Preparedness, Agency for Toxic Substances and Disease Registry) and Tribal governments, Tribal-serving organizations (e.g., National Congress of American Indians, National Indian Health Board, NNAEMS, regional health boards, etc.), and other Tribal entities involved in addressing bioterrorism and emergency preparedness issues.

Activities: During FY 2006, CDC had several discussions/meetings with Tribal and federal partners to discuss goals for the proposed task force. Although a formal taskforce was not organized, ongoing formal collaboration and consultation between each of the OPDIVS and tribal serving entities are occurring -- in particular with the newly created IHS Office of Emergency Services Program.

Expected Outcomes: Continued discussion of finalizing the proposed task force will allow for more consistent communication between federal agencies and Tribal entities, and will facilitate effective, coordinated planning for emergency preparedness and response and pandemic influenza initiatives in Indian country.

Tribal Priority 6, Data and Research

- CDC Prevention Research Centers (PRCs) are a network of academic researchers, public health agencies, and community members that conducts applied research in disease prevention and control. Several PRCs have tribally-focused projects:

University of Oklahoma PRC: TRAILS (The Regular Activity in Life Study) - Obesity

Objective: About 45 Anadarko high school students, 34 of whom are enrolled in the study, are participating in a 16-week elective physical education class which includes a 35–40 minute daily walking or running session. The superintendent and principals support this effort to increase physical activity during school hours.

Background: In Anadarko, Oklahoma, community members and school administrators asked researchers to develop an affordable and effective intervention to prevent and

reduce the high rates of obesity among the community's adolescents. Almost half the students in Anadarko's public schools are overweight or at risk of becoming overweight. In the high school, about 60% of the students are American Indian and at especially high risk for developing diabetes.

Activities: Before the intervention, students complete a 1-mile walking test to determine their physical fitness level. They also have their blood pressure taken; random cholesterol, triglycerides, and glucose measured; height and weight measured; and body mass index (BMI) and body composition determined. Project staff will ask students about their program likes, dislikes, and ideas for improvement. Project staff are also working with the high school administrators and food service personnel to provide students with healthier vending machine and cafeteria food choices.

Expected Outcomes: The overall goal of TRAILS is to serve as a model for school administrators and state and local policymakers that will encourage affordable and manageable programs for in-school physical education classes.

University of Oklahoma PRC: Healthy Kids Screening Project - Obesity

Objective: Track trends over time to determine if any changes have occurred and how many children and adolescents remain at risk for obesity-related diseases.

Background: The school population is more than 60% Native American and about 6% Hispanic. In a project ongoing for several years, the center's faculty, staff, and students have screened about 2,000 students in the Anadarko public schools (elementary grades through high school) for height and weight, and calculated their BMI. Close to 80% of the students are eligible for low or reduced price lunches. In the 2002–2003 school year, half the students were overweight or at risk for overweight.

Activities: Blood pressure measurements have been done twice. Screening is being repeated in the 2005–2006 school year, and researchers will track trends over time to determine if any changes have occurred and how many children and adolescents remain at risk for obesity-related diseases.

Expected Outcomes: Information will be shared with parents and school officials. The findings will serve as the basis for developing new physical activity interventions and promoting changes in nutrition.

University of New Mexico PRC: Teen Health Resiliency Intervention for Violence Exposure (THRIVE)

Objective: The community intervention aims to improve youths' quality of life and reduce the traumatic effects of their exposure to violence. The intervention's focus is on addressing the negative effects of historical trauma experienced by American Indians. Parents, teachers, and community members are being trained to recognize the signs of trauma among youth and get them help.

Background: Project collaborators developed THRIVE to test the effectiveness of school- and community-based interventions for identifying and reducing psychological distress among American Indian youth who witness or experience violence (such as child abuse or domestic violence). Psychological distress has been associated with heart disease (the leading cause of death among American Indian adults) and suicide – AI/AN youth (aged 15-24 years) have the highest rate of suicide in the United States.

Activities: The in-school intervention includes an intensive mental health program for 6th to 12th grade students based on the 10-week CBITS program (Cognitive Behavioral Intervention for Trauma in Schools) initially created in California for urban youth in Los Angeles. Center researchers, the community advisory committee, and other project collaborators adapted the CBITS program for American Indian youth. During the intervention, about 30 students who reported symptoms of violence-related trauma on the center's mental health screening questionnaire were referred to an early- or delayed-CBITS group; students reporting other mental health issues were referred to individual counselors at their schools' teen health centers. Students participating in the CBITS intervention meet in small groups to share experiences, express feelings, receive group support, and build coping skills. Their parents and teachers are trained to support them at home and in the classroom. Students also meet individually with a mental health counselor as needed. Evaluators will determine whether the program increases students' coping skills; reduces their symptoms of violence-related trauma such as depression and anxiety; and whether positive effects persist 6 months later.

Expected Outcomes: About 20 parents and their children will participate in a 6-month intervention designed to heal historical trauma, improve family relationships, teach positive parenting skills, and reconnect parents and youth with traditional culture—all of which help to increase youth resilience to stress, and may reduce alcoholism, child abuse, and domestic violence. Tribal elders will teach participants about their cultural heritage and history, and reconnecting youth to their traditions through group discussions and communal healing practices. If effective, researchers will develop a program manual and tool kit to disseminate throughout the United States and conduct large-scale effectiveness studies.

University of Oregon PRC: Tribal Vision Impairment Prevention Project (VIP Project)

Objective: This project aims to increase residents' access to eye exams, improve the quality of life for residents who need prescription eye glasses, reduce the risk of blindness for residents who have diabetes, and determine the extent and possible causes of the community's visual impairments.

Background: Visual impairment is the second-leading cause of disability among American Indians living in the Pacific Northwest, and contributes to this population's diminished quality of life by limiting their ability to pursue educational and employment opportunities, social interactions, interests, and hobbies. Only 2 of the 43 American Indian tribes in the Pacific Northwest have an eye care provider, and most tribal members must travel 60 miles or more to have an eye exam.

Activities: To address these issues, the center collaborated with the Tribal Community Advisory Council, the Northwest Portland Area Indian Health Board, and the Devers Eye Institute to design, implement, and evaluate this project. About 450 residents from 3 tribes are participating: Umatilla in Oregon, Shoshone-Bannock in Idaho, and Lummi in Washington. Basic eye exams are performed onsite by a vision technician, and participants who need them, are given free prescription eye glasses and participate in a survey to compare their before and after quality of life scores. Participants with abnormal results are referred to an ophthalmologist at the Devers Eye Institute who conducts a full eye examination and determines the accuracy of the initial results (participants without transportation are taken to the eye clinic or visited at home by an eye doctor). Participants

with diabetes receive an in-depth eye exam using a telemedicine technique of taking photographs of the eyes and using a computer to send digital images of the pictures to an ophthalmologist at another location. The ophthalmologist reviews the images, makes a diagnosis, and recommends treatment.

Expected Outcomes: During the evaluation, researchers will find out if brief initial eye exams are accurate and improve the population's accessibility to eye care. They will also determine whether telemedicine is an accurate and feasible method for detecting cataract, glaucoma, diabetic retinopathy, and macular degeneration. Participants will be asked for project recommendations and suggestions for expanding it to other Native communities.

- Cancer

- Alaska Breast Cancer Study

- Objective: Compare levels of organochlorine compounds in Alaska Native women who have breast cancer and those who do not have breast cancer.

- Background: Dietary practices may place Alaska Natives at increased risk of exposure to organochlorine compounds. These compounds are being evaluated for a possible role in the development of breast cancer.

- Activities: Methodology for analyzing organohalogen compounds in breast adipose tissue will be evaluated and certified. Then the 229 adipose tissue sampled will be analyzed for brominated flame retardants, polychlorinated biphenyls, and persistent pesticides. This project is planned to be completed during the spring of 2006.

- Expected Outcome: The project will enhance primary prevention of breast cancer by evaluating the environmental risk factors for this disease.

- Breast Cancer and Exposures to Persistent Organic Pollutants (POPs) Among Alaska Native Women

- Objective: Compare levels of organochlorine compounds in Alaska Native women who have breast cancer and those who do not have breast cancer.

- Background: Alaska Natives may be at an increased risk of exposure to organochlorine compounds because of their diets.

- Activities: Samples of blood, urine, and/or breast tissue were used in the study. Participants were interviewed about many topics, including pregnancy history, diet history, and other aspects of life. There were 203 women enrolled in the study, ranging in age from 30 to 88 years old, with the average age of 51. According to the information we collected during the interview, all major Alaska Native ethnic groups and geographic regions were included in the study. More than half (52%) of participating women listed Anchorage as the primary location for receiving health care. Of the 203 women, 190 (94%) reported being pregnant at least once, with an average age of 21 years old at the time of first birth. Of these 190 women, 183 (96%) had an average of four children each. Seventy-one percent (71%) of these 183 women reported breast feeding each child for at least 1 month and breast fed each child an average of 25 months. During interviews, participants were asked about a list of ten Native foods known to be consumed by Alaska Natives throughout the state. Participants were asked to report what foods were consumed at three points in their lives - at ages 10, 20, and 40. In general, study participants reported eating the same amount or somewhat less of the selected Native foods as they got older. There was no difference in levels of PCBs, DDT, and DDE

among women with breast cancer compared to women without the disease. The Native diet is nutritious, especially eating younger fish and mammals, since they have lower levels of PCBs, DDT, and DDE.

Expected Outcome: The project will enhance primary prevention of breast cancer by evaluating the environmental risk factors for this disease. Findings from this study will be published in peer reviewed scientific journals.

Cancer Incidence and Mortality/Cancer Burden

Objective: To provide national data on the burden of cancer among AI/AN populations.

Background: Because of misclassification of AI/AN cancer patients as non-Natives in medical records, the cancer incidence data for AI/ANs have not been reliable.

Activities: Cancer cases diagnosed from 1995 through 2004 for the NPCR and SEER cancer registries were linked with administration records from the IHS. This linkage helps to avert racial misclassification.

Expected Outcomes: All NPCR registries have linked their data with IHS patient registration files to decrease race misclassification for AI/AN cases. The linked data will be used for a monograph focusing on AI/ANs as well as the 2007 Annual Report to the Nation on the Status of Cancer. These publications will provide the most comprehensive and reliable assessment of the burden of cancer among the AI/AN population, and would be useful for guiding cancer control activities in this population.

▪ Environmental Health

Alaska Native Maternal Organics Monitoring Study (MOMS)

Objective: Arctic research program focused on improving public health in Arctic communities by studying human exposure to environmental pollutants.

Background: Persistent organic pollutants (POPs), such as organochlorine pesticides and polychlorinated biphenyls, and heavy metals produced in the lower 48 states and other sub Arctic regions have been transported to Arctic regions, contaminating the Arctic food supply. Alaska Natives who rely on traditional diets of fish and marine mammals are exposed to higher levels of pollutants than are people living in the southern latitudes. Although health effects from occupational exposures to high doses of POPs have been documented, the developmental and health effects from long-term exposure to low levels of POPs, such as those found in wild animals eaten for food, require further study. Growing fetuses and infants may be particularly sensitive to POPs and other toxic contaminants in the food supply. A fetus or child may be exposed to several of these contaminants in utero or through breast milk; thus, the child's exposure depends largely on the levels present in the mother.

Activities: Study involves collecting serum and urine samples from mothers during one prenatal visit, and umbilical cord blood samples at delivery from Alaska Natives. Samples are analyzed for persistent organic pollutants, non-persistent pesticides, and trace metals, as well as for various nutritional markers. Pregnant women are enrolled at the Yukon-Kuskokwim Delta Regional Hospital in Bethel in collaboration with the Yukon-Kuskokwim Health Corporation Delta and in communities in the Aleutian and Pribiloff Islands in collaboration with the Aleutian-Pribiloff Island Association. Preliminary results from MOMS suggests that lead concentrations in Bethel are two times higher than in Northern Alaska (e.g., Barrow, AK), an area where steel shot is the

predominant form of ammunition used for hunting animals, waterfowl in particular, which make up part of the Native subsistence diet. A study was conducted to identify whether lead-shot used for hunting is a source of lead exposure in Alaska Natives. A cross-sectional exposure assessment study utilized isotope ratio (IR) methodology to compare the isotopic profiles of: 1) blood lead in Alaska Native women of Bethel and Barrow; 2) lead-shot samples from Bethel and Barrow; and 3) lead mineral and ore from a large smelter in Torreon, Mexico, implicated as the source of the lead in the shot. The lead IRs for blood samples from Torreon, Mexico, are significantly different from blood samples of residents in Bethel ($p = 0.023$) and Barrow ($p < 0.001$), implicating different sources of lead exposure in the two samples.

Expected outcome: Enrollment into the study will be completed in early 2007. An additional 200 women will be enrolled, and their samples sent to the NCEH Division of Laboratory Sciences for analysis.

- Heart Disease and Stroke Prevention

Objective: Reduce the time to treatment for myocardial infarction (MI) for rural AI/AN communities.

Background: Data from the National MI Registry show that the greatest disparity for time to treatment exists among racial ethnic groups and the AI/AN group has the longest delay times. The NATIVE study shows that rural American Indians presenting with acute MI have marked delays in time to treatment (12% of patients waited between 12–24 hours and 23% waited more than 24 hours to present) thus, limiting treatment options; the primary cause of the delay was due to patient misunderstandings about the symptoms of MI.

Activities: Monthly meetings are held with an advisory workgroup consisting of tribal persons, one WISEWOMAN project coordinator (Alaska), two Heart Disease and Stroke Program Coordinators (Montana, Alaska), and CVD HP2010 Partners, including American Heart Association, Indian Health Service, and National Heart Lung and Blood Institute. The advisory group is currently working to formulate questions interview and focus group questions.

Expected Outcomes: To gain an understanding of the barriers that impact AI/AN populations understanding of MI signs and the delays in treatment following an MI; to develop culturally tailored messages that customize the “Act in Time” national campaign; identify methods and style of delivery for the messages; identify innovate intervention strategies; pilot the messages with MI patients and their families in the Native American Cardiology Program.

- Infectious Diseases in Alaska Natives

- Monitoring Infectious Disease Trends

Objective: To describe the burden and trends of overall and specific infectious disease morbidity (hospitalizations and/or outpatient visits) among AI/AN populations using data from the IHS/tribal health care system, and to examine overall and specific infectious disease morbidity and health disparities among AI/AN populations as compared to the general U.S. population. Specific diseases are examined by appropriate age groups to describe the occurrence with those ages.

Background: Significant health disparities have been identified among the AI/AN population as compared to the general U.S. population. Further information is needed to assist in determining areas where prevention efforts would be most beneficial. Infectious disease has incurred excessive mortality and morbidity among AI/AN populations compared to the general U.S. population. For many specific infectious diseases, the occurrence and rate are not known or have not been recently studied within the AI/AN populations.

Activities: The projects are ongoing collaborative efforts between the Indian Health Service, Alaska Native Consortium, the CDC Arctic Investigation Program, and other agencies or CDC divisions to address the objectives of the studies. Hospital discharge and/or outpatient visit data and population data for AI/ANs were obtained from the Indian Health Service National Reporting System. Data are analyzed to describe the occurrence and rate of infectious disease hospitalizations and/or outpatient visits overall and for specific infectious diseases. Studies focus on overall and specific infectious diseases, for example, Rocky Mountain spotted fever, respiratory diseases, and diarrheal diseases.

Expected Outcomes: Gain a better understanding of the occurrence and rate of overall and specific infectious diseases among AI/AN populations, and identify geographic areas and demographic groups at high risk. The study findings will provide health information to assist in developing prevention strategies and reducing health disparities among AI/AN populations in the areas of infectious diseases. Disseminate study results through publications in peer reviewed journals, presentations at professional conferences, Indian Health Service Reports, Indian Health Service Provider newsletters, as appropriate.

Viral etiologies of respiratory hospitalizations in Alaska Native children

Objective: The projects are a collaborative effort between the Alaska Native Consortium, Arctic Investigation Program, Indian Health Service, and CDC/NCZVED/DVRD to address the analytic objectives of the study. The study objectives consist of: 1) To conduct active surveillance for viral etiologies of LRTI in the Yukon Kuskokwim (YK) Delta of Alaska among children less than three years of age; 2) to determine the relative burden and seasonality of RSV infections using sensitive and specific RNA detection methods; 3) to determine the sensitivity and specificity of current antigen-based RSV tests as compared with RNA detection methods; and 4) to determine whether children with more than one RSV hospitalization in the same season have the same or different RSV strain.

Background: Lower respiratory tract infections (LRTIs) account for approximately 50% and 75% of hospitalizations among U.S. infants and AI/AN infants (<1 year of age), respectively. Respiratory syncytial virus (RSV) is the major cause of LRTI in infants and the highest published RSV hospitalization rate was reported in Alaska Native infants from Alaska's Yukon Kuskokwim (YK) Delta (rate of 156:1,000 infants; 1993–1996 data from active lab surveillance). Passive surveillance conducted in the Yukon Kuskokwim Delta since 1996 has shown a decrease in RSV from 178 per 1,000 infants/year to 104 per 1,000 but the overall hospitalization rate for LRTI remained stable at 284 per 1,000 infants from 1994–2004.

Activities: The study is conducted by the CDC Arctic Investigations Program (AIP) and the Alaska Native Tribal Health Consortium (ANTHC) with collaboration from CDC's

Division of Viral and Rickettsial Diseases (DVRD). The study activities consist of obtaining nasopharyngeal swabs for PCR evaluation for all children <3 years of age hospitalized at the YK Delta Regional Hospital for LRTI (informed consent is obtained prior to testing). Patient charts and radiographs will also be reviewed. Swabs will be sent to CDC-AIP laboratories for RT-PCR test for RSV, influenza A and B viruses, parainfluenza viruses I and III, corona virus, rhino virus and metapneumovirus. Sequencing of the RSV G gene will be performed by one of the collaborating laboratories for repeat RSV hospitalizations during the same season. Nasopharyngeal specimens for viral diagnostic testing will be collected on a comparison group of healthy children of similar age.

Expected Outcomes: Rates of LRTI and RSV hospitalizations will be calculated and analysis of demographic variables, receipt of RSV prophylaxis, and severity of disease will be conducted. The impact of viral load of each virus will be studied with respect to several variables. Quantitative RSV data will be used to assess the validity of rapid diagnostic tests. A case-control study will be conducted to evaluate factors associated with hospitalization. Information on viral etiologies of LRTIs will help determine the potential benefit of current and future interventions to prevent hospitalizations due to these infections.

▪ Rabies Control, Navajo Nation

Objectives: To examine the ability to reach feral dogs for rabies vaccination within the Navajo Nation; to test the differences in oral baits used to administer the rabies vaccination; and to successfully reach most feral dogs with the oral bait vaccination technique.

Background: The majority of yearly reported rabies cases in this area are due to canines, and roaming packs of feral dogs exist on land belonging to the Navajo Nation. Oral baits have previously been used to vaccinate feral dogs with success.

Activities: Offer free rabies canine vaccinations and limited serology testing through a clinic in the Navajo Nation during the month of April (continuation of annual project that began in 2003).

Expected Outcomes: Through the evaluation of different oral baits for the vaccination of canines, calculate the approximate total number of dogs that were successfully vaccinated and determine the most appropriate means for vaccinating feral dogs in this setting.

▪ REACH 2010 Risk Factor Survey

Objective: Continued collection and use of the REACH 2010 Risk Factor Survey

Background: CDC has conducted the annual REACH 2010 Risk Factor Survey in 27 minority communities since 2001.

Activities: The questionnaire included questions related to health status, health-care access, self-reported height and weight, cigarette smoking, awareness of hypertension, cholesterol, and cardiovascular disease, diabetes and diabetes care, and receipt of preventive services, such as mammography, Papanicolaou (Pap) smear, and influenza and pneumococcal vaccination. American Indian communities that were included in this survey were: Oklahoma (via telephone interview) and Eastern Band of Cherokee in North Carolina (via person-to-person interview).

Expected Outcomes: Data will be available on the above activities and used with and for the REACH projects.

▪ Rocky Mountain Spotted Fever (Evaluation), Arizona

Objectives: Determine the prevalence of *R. rickettsii* and identify the quantity, species, and stage of ticks present on the dogs at the time of blood sampling; determine if other sites near that of the study were at risk for cases of RMSF Arizona counties: Apache, Coconino, Gila, Graham, Greenlee, Navajo, and Pinal.

Background: The primary vector of Rocky Mountain spotted fever (RMSF) in the western United States is *Dermacentor andersoni*, whose range extends into northern and eastern Arizona. From 1981–2000, only 3 cases of RMSF were reported from the entire state. In 2004, during an investigation of an outbreak of Rocky Mountain spotted fever in communities within a region of east-central Arizona, *D. andersoni* ticks were not detected. Instead, the investigation identified *Rhipicephalus sanguineus* as the vector responsible for transmission of *Rickettsia rickettsii* (1). This tick has not been previously associated with transmission of RMSF to humans in the United States. Although *R. sanguineus* preferentially feeds on dogs, very large numbers of *R. sanguineus* found on dogs and in the peridomestic environments of this community appear to have facilitated the transmission of *R. rickettsii* to humans. A seroprevalence survey in dogs from the communities was undertaken in 2004, and 70% of dogs sampled were positive by IFA for antibodies to *R. rickettsii*. Interestingly, sera collected in 1996 from dogs in this same area had yielded a prevalence of 5%, indicating that the rate of *R. rickettsii* infections had increased in the tick population of this area.

Activities: Ten sites in seven counties participated by randomly enrolling dogs that were housed in animal shelters, and serum samples were obtained and ticks were collected from 265 dogs. Serum was tested for IgG antibodies to *R. rickettsii* and dogs were examined for the presence of *R. sanguineus* ticks as well as *Dermacentor andersoni*

Expected Outcomes: Using a minimal threshold of 1/32, seroprevalence by county will be calculated and the level of tick infestation on sampled dogs will be determined.

▪ Rocky Mountain Spotted Fever (Proposal for Control), Arizona

Objectives: To assess and reduce the risk of RMSF among inhabitants of reservations in Arizona, we are proposing the development and implementation of a comprehensive program for education, reservoir and vector control, and surveillance. These activities should have considerable impact in increasing awareness of the risk and dramatically reducing peridomestic populations of *R. sanguineus* ticks. The program will be piloted within five reservations. An integrated effort will include surveillance at local clinics and hospitals; physician and medical staff awareness for early diagnosis and initiation of treatment; community-based education to increase awareness of RMSF risk; coordinated peridomestic clean-up campaign to decrease suitable tick habitat; treatment of infested home environments with effective acaricides; treatment of dogs with effective acaricides; and development of an animal control program to address stray dog issues.

Background: RMSF, caused by *Rickettsia rickettsii*, is a severe and sometimes fatal disease transmitted to humans via ticks. Starting in 2003, an unusually high rate of RMSF cases was reported in a region of eastern Arizona encompassing 2 American Indian reservations. Since 2002, there have been 24 cases of RMSF, primarily among children

less than 12 years of age. The average annual incidence of pediatric RMSF in this region ranges from 8.9 to 12.7 cases per 100,000 persons, which is over 500 times higher than the average annual incidence of this disease in children in the United States. The economic and emotional burden of these cases is high, with 13 cases having an illness severe enough to require hospitalization, 6 cases developing life-threatening illness severe enough to require intensive care or medical evacuation, and 2 cases having fatal outcome (both young children). Populations of *R. sanguineus* ticks, a vector for *Rickettsia rickettsii*, may be extremely numerous on other reservations. RMSF cases may also be occurring, but not recognized due to lack of awareness by physicians and the local population. Risk assessments on other reservations in Arizona need to be conducted to identify potential risk for RMSF in order to apply appropriate prevention and control.

Activities: Planned activities include surveillance; physician and medical staff awareness; community education; community clean-up campaigns; treatment of infested home environments; treatment of dogs; development of an Animal Control Program:

Expected Outcomes: Active surveillance will be instituted at the local clinics and hospitals serving the reservations to identify cases of RMSF with a broad case definition of febrile illness of unknown origin. Patient records will be reviewed for the past two years using the case definition of fever and rash to identify possible cases of RMSF. Educational materials will be developed to include general information on RMSF and specific information regarding clinical signs and symptoms, diagnostic testing, and appropriate treatment regimens for adults and children. A program will be established to provide seminars for medical staffs either at individual health facilities or as part of a continuing education program. Collaborating partners will coordinate community clean-up campaigns specific for each reservation- targeting the removal of items ticks could inhabit. Efficacy of dry ice traps will be determined during dwelling clean up measures. Efficacy of the tick control on dogs and in the community will be assessed. An animal control program will developed early in the intervention process to ensure a timely reduction in stray dog numbers prior to treatment of infested homes.

- SIDS and Fatty Acid Ethyl Esters

Objective: To analyze the meconium samples collected for Fatty Acid Ethyl Esters (FAEE) in order to link alcohol usage during pregnancy in mothers who have lost children due to SIDS and stillbirth.

Background: Compelling epidemiologic, physiologic, and pathologic data now suggest that maternal drinking during pregnancy, SIDS, and stillbirth may be inter-related in important ways. The Prenatal Alcohol, SIDS, and Stillbirth (PASS) Research Network proposes here a community-linked prospective study to investigate the role of prenatal alcohol exposure in the risk for SIDS and stillbirth, as well as other adverse pregnancy outcomes, including fetal alcohol syndrome. This study will involve women from two areas plagued by high rates of perinatal mortality and prenatal alcohol exposure: American Indians in Northern Plains and Cape Coloured (mixed race ethnicity) in South Africa. Data about the mother and infant will be collected during the prenatal period and through the infant's first year of life. Information on exposures during the prenatal period, fetal and physiological development, infant neurobehavioral measures, maternal and infant genetic factors, and placental tissue pathology will be collected.

Activities: CDC is awaiting the arrival of samples for analysis.

Expected outcome: Examine the inter-relationships between alcohol, SIDS, and stillbirth, and the influence of genetic and environmental interactions in the pathogenesis of a spectrum of adverse pregnancy outcomes related to maternal drinking.

▪ Tobacco-Related Research

American Indian and Alaska Native Adult Tobacco Surveys

Objective: The purpose of the American Indian Adult Tobacco Survey (AI ATS) is to collect tribal-specific data that will help determine tobacco use in specific tribes and guide the development of tribal-specific interventions. The AI ATS will facilitate the collection of tribal-specific tobacco-related data by providing a culturally competent tool that respects the culture and sovereignty of tribes and their villages.

Background: National surveys have shown the prevalence of smoking among the American Indians (AI) to be higher than 30%. Acknowledging the high prevalence of commercial tobacco use in specific AI tribes and the lack of tribal-specific data, CDC's Office on Smoking and Health (OSH) convened representatives from Tribal Support Centers, tribes, and the AI community to participate and advise OSH on survey development. The AI ATS was designed as both surveillance and evaluation tools to provide tribal-specific information regarding trends in tobacco use, cessation efforts, exposure to secondhand smoke, and tobacco-related knowledge and practices among adults 18 years of age and older who reside within their respective tribal community.

Activities: The AI ATS was first conducted in 2005 among 11 tribes by trained local tribal interviewers. The data collected are owned exclusively by the tribes or villages that participate in the surveys, not by states or the federal government. The 11 tribes that conducted the AI ATS, found that the face-to-face method was the most appropriate way to administer the survey within their communities, but that telephone interviews may also be conducted. Previous cognitive interviewing findings indicated that Alaska Natives were so culturally distinct from American Indians that a separate survey was needed for them. Further cognitive interviewing findings indicate that two distinct surveys were needed – one for rural Alaska Natives and one for urban Alaska Natives. Issues that informed this decision include differences in types of tobacco use; differences in average educational attainment; differences in world-views; differences in traditionalism and the like. As a result, OSH is currently developing both a Rural Alaska Native Adult Tobacco Survey and an Urban Alaska Native Adult Tobacco Survey. The Alaska Native Tribal Health Consortium is expected to field these surveys and it is anticipated that community-specific prevalence and use information will be generated. The findings will inform and improve community-specific programs and interventions.

Expected outcomes: AI ATS will provide tribal-specific data that can be used to guide tribal tobacco control efforts. Data from the survey can be used to help direct culturally appropriate program planning, evaluate programs and develop policy; tailor interventions, allocate resources, obtain funding, and monitor industry marketing tactics for specific U.S. tribes.

Nicotine Exposure and Metabolism in Alaska Native Adults

Objective: Describe exposure to nicotine and carcinogens (tobacco-specific nitrosamines [TSNAs] and polycyclic aromatic hydrocarbons) in Alaska Native adults who smoke cigarettes, use commercial chew tobacco, or use a homemade mixture of chew tobacco

and ash (Iqmik); characterize nicotine metabolism in Alaska Native adult tobacco users by measuring plasma 3'-hydroxycotinine:cotinine ratio and by sequencing genes related to nicotine metabolism; and quantify the pH, free nicotine content, and carcinogen (TSNA) content in commercial chew and Iqmik.

Background: The prevalence of cigarette smoking in AI/AN is 40.4 percent; the highest of any group in the United States. The prevalence of cigarette smoking in AN 43%, compared with 23% in the general U.S. population. The prevalence of smokeless tobacco use is 14% among AN adults versus 4% in the total U.S. population.

Activities: CDC will provide urinary nicotine metabolite profiles (including cotinine) on all tobacco users in the study; other collaborators at UCSF are conducting the other biomarker analyses in the study.

Expected Outcomes: CDC's laboratory results will be part of the overall analysis of this study to fully understand nicotine and carcinogen exposure among Alaska Native individuals who use various tobacco products. Comparisons will be able to be made between product types which ultimately can guide cessation efforts.

Smoking Cessation in Alaska Native Women Study

Objective: Increase smoking cessation among Alaska Native women.

Background: Alaska Natives have the highest smoking rate during pregnancy of any ethnic group. Alaska Native leaders are aware of this problem and they are committed to changing it. This study is a planned intensive smoking cessation effort to be undertaken as part of the Smoke-Free Families initiative to stop smoking during and beyond pregnancy. This study will involve approximately 500 women who will be evaluated and counseled at their first prenatal visit, and again at the 6th and 8th month of pregnancy. Previous studies of smoking cessation during pregnancy have confirmed that biomarkers, such as cotinine measurements, are essential for accurate assessment of the results.

Activities: CDC will provide analyses of biomarkers to ensure accurate assessment of study results. These data will also provide needed new information on the extent of exposure, based on biomarker analysis, in this population. During FY 2005, we completed an initial pilot study of this project. During FY 2007, we will provide analyses for the fuller study. This will include measuring salivary cotinine in women and children; women will have three measurements taken during pregnancy, and both the mother and infant will have 5 measurements taken during the first year of the infant's life.

Expected Outcome: Identification of facilitators and barriers to smoking cessation among Alaska Native women.

Smokeless Tobacco Use by Alaska Natives

Objective: To study the health effects of iq'mik, a form of smokeless tobacco used by Alaska Natives.

Background: Alaska natives in specific remote locations use a form of smokeless tobacco called iq'mik. This is a combination of tobacco and punk tree ash. The punk tree ash is likely used to increase nicotine bioavailability by altering the pH of the material. Iq'mik is widely provided to infants to lessen the pain from teething and used by pregnant women as an alternative to smoking. Both of these uses pose an increased risk of disease in a population that may not have been well educated concerning the risks.

Activities: CDC is working with Alaska Native groups to develop information on the product and its effects in people that can then be used in educating AN communities about the threats of adverse effects from the use of iq'mik. During FY 2006, CDC completed plans and implemented protocols for this study; CDC also obtained iq'mik samples and has begun to assess levels of toxic and addictive compounds in these samples. The study will continue through FY 2007.

Expected Outcome: Increased scientific understanding of the harms of iq'mik use and enhanced awareness of risk among Alaska Native people.

▪ STD Prevention and Control

Objective: To improve the relevance of national STD surveillance data for Indian country.

Background: The IHS system of records provides a rich source of health data for approximately 56% of the total U.S. AI/AN population. IHS health data primarily focus on population statistics, birth/death data, and patient care utilization. Data on STDs and other nationally notifiable diseases are lacking, yet these diseases represent a significant burden on healthcare systems in Indian country. STD surveillance data reported to CDC are typically available only at the county, state, or national levels. IHS and tribal administrative areas, however, are made up of groupings of select counties from select states. New approaches and methodologies are needed to better manage and analyze federal data sources that support public health programs in Indian country.

Activities: CDC and IHS National STD Program staff collaborated with statisticians from both agencies to improve AI/AN STD surveillance methodology, whereby CDC's nationally compiled STD data are coded and presented using population parameters based on IHS and tribal administrative regions (Areas and Service Units). A final report focusing on chlamydia, gonorrhea, and syphilis was published in early FY 2007 and will be distributed broadly to public health programs in Indian country.

Expected Outcomes: This approach to analysis of surveillance data will improve the accuracy of STD epidemiologic data for AI/ANs, and may serve as a model for addressing similar issues for other reportable diseases, such as hepatitis and tuberculosis.

West Nile Virus (WNV)

Objective: As part of overall efforts to monitor WNV and other insect transmitted diseases (arboviruses), monitor trends in WNV among AI/AN populations.

Background: In 2006, there were 50 reported cases of WNV infection and 1 reported case of LaCrosse encephalitis for whom the race of the case was reported to be American Indian/Alaskan Native. Fourteen of these WNV cases were reported to be neuroinvasive (meningitis or encephalitis), 31 were uncomplicated fever, and 5 were unknown/other clinical presentation. These WNV cases represent 1.3% of total reported WNV cases in 2006 (as of 10/31) and 1.1% of the WNV neuroinvasive cases in 2006. West Nile Virus cases among Native Americans came from 11 states, Arizona, California, Colorado, Montana, North Dakota, New Mexico, Nevada, South Dakota, Utah, Wyoming, and the LAC case was from North Carolina. Of note, only about 70% of the arboviral infections reported to CDC include information on the case's race.

Activities: CDC developed an electronic-based surveillance and reporting system (ArboNet) to track WNV activity in humans, horses, other mammals, birds and

mosquitoes. ArboNet surveillance system has been used to streamline reporting to CDC of WNV activity by the state public health departments.

Expected Outcomes: Provide ongoing information about trends in WNV and other arboviral diseases among AI/AN populations.

Section 2. Tribal Consultation Activities

Name of Division: Centers for Disease Control and Prevention

Date	Event	In Attendance	Summary
Regional Consultation Sessions			
March 10, March 30, April 5 - 6, April 11-12, April 18-19, April 24-26, May 16-17, 2006	Regions I, II, III, and IV, Region V, Region VI, Region VII, Region VIII, Region IX, Region X, and the 2 Annual HHS National Session	CDC Staff, IGA and HHS national and regional Staff, Tribal leaders, Regional and National Tribal Organizations.	CDC participated in all HHS consultation sessions and provided an update of CDC's implementation of the Tribal Consultation Policy, an accounting of FY 2005 tribal access to CDC resources, pandemic flu activities, and an overview of the guidance for the supplemental funding for pandemic flu as it applies to tribes.
Workgroup and Task Forces			
December 2005 through present	CDC and National Cancer Partners AI/AN Advisory Workgroup	Newly established workgroup was formed based on tribal recommendations provided at the <i>Advancing Parity in Comprehensive Cancer Control With AI/AN Populations: Comprehensive Cancer Control Leadership Institute</i> . CDC and all national cancer partners, AI/AN professionals and tribal leaders involved in cancer prevention across Indian country.	Workgroup meets at least on a quarterly basis or as frequently as need dictates to advise national partners about Comprehensive Cancer Control (CCC) needs of AI/ANs. Workgroup has played an integral role in planning the Annual Tribal and CCC Leadership Institutes and assisting and assuring tribes have greater access to these resources and programs. They also have been working with DCPC to communicate to states the role they play in assuring CDC resources get to AI/ANs.
May of 2006 through present	CDC Tribal Pandemic Influenza Preparedness Work Group	An ad hoc, internal CDC work group established by OMHD/OSI/OD to facilitate internal communications and information sharing about pandemic influenza preparedness in AI/AN communities. Meet by conference call monthly to ensure improved collaboration and coordination of activities.	Specific activities have included the following: providing subject matter expertise to the CDC Pandemic Influenza Coordinating Group and its functional area teams, developing an inventory of communication channels with tribes, tribal organizations, and tribal stakeholders to assist National Center for Health Marketing and the Office of Enterprise in making pandemic flu preparedness information available to AI/AN communities, helping ensure that information and guidance specific to avian influenza is available to AI/AN communities - particularly where subsistence hunting of water fowl

Name of Division: Centers for Disease Control and Prevention

Date	Event	In Attendance	Summary
January of 2006 through present	CDC Public Health Law Workgroup	<p>CDC staff and Valerie Davidson (JD, & Intergovernmental Affairs/ ANTHC), Joe Finkbonner, (MPH/Executive Director, of the NW Portland Area Indian Health Board), Hilary Frierson, JD (Attorney with OGC/HHS, IHS Branch), Tim Gilbert, MPH (Senior Director, Division of Comm. Health, ANTHC), Mechelle Johnson, JD (Attorney with OGC/HHS, IHS Branch), Myra Munson JD, MSW (former state of AK Health Commissioner, Turning Point Project consultant; currently in private legal practice in Juneau), JT Petherick JD, MPH (former Exec Dir National Indian Health Board, currently Health Legislative Officer, Cherokee Nation, OK), Teresa Wall, BSN, MPH (former Exec Director, Dept of Public Health, Gila River Indian Community; Turning Point project consultant.</p>	<p>is common practice, assisting in coordinating tribal pandemic flu preparedness activities with the IHS, interfacing with tribally-focused HHS committees (e.g., Secretary's Intradepartmental Council on Native American Affairs- ICNAA; HHS Tribal Health Research Advisory Council), and monitoring pandemic influenza preparedness activities at CDC to ensure compliance with CDC and HHS Tribal Consultation Policies. Workgroup is in the process of planning a Tribal Forum on Legal Foundations for Public Health Practice in Indian country for May 17 - 18, 2007 in Anchorage, Alaska. Forum will be sponsored by the Alaska Native Tribal Health Consortium, South Central Foundation, and CDC.</p> <p>It is intended that the Forum will be a working meeting of tribal, state, and federal public health professionals and consultant legal experts to discuss the current status of public health legal preparedness in Indian country, to identify gaps in public health legal foundations, and to develop an initial plan of action to address these gaps.</p>

Name of Division: Centers for Disease Control and Prevention

Date	Event	In Attendance	Summary
August 2006 through present	The CDC Division of Heart Disease and Stroke Prevention recently formed an advisory workgroup to gain an understanding of the barriers that impact AI/AN populations understanding of MI signs and the delays in treatment following an MI.	Workgroup meets monthly and consists of tribal persons, one WISEWOMAN project coordinator (Alaska), two Heart Disease and Stroke Program Coordinators (Montana, Alaska), and CVD HP2010 Partners, including American Heart Association, IHS, and National Heart Lung and Blood Institute.	Workgroup is currently working on formulating questions to be used in interviews and focus groups to develop culturally tailored messages that customize the "Act in Time" national campaign; identify methods and style of delivery for the messages; identify innovate intervention strategies; and pilot the messages with MI patients and their families in the Native American Cardiology Program.
Agency Consultation Sessions			
October 20, 2005	NIHB's Annual Public Health Day – Division of Reproductive Health (DRH) consultation session relative to the Sudden Unexplained Infant Death Initiative.	DRH staff, NIHB staff and board members, and 95 AI/AN tribal providers and leaders.	DRH in collaboration with partners, launched the Sudden Unexplained Infant Death Initiative (SUIDI) in 2004 to improve and standardize infant death scene investigations and cause-of-death reporting. Its objectives were to revise the SUIDI Reporting Form and to develop a standard training curriculum and materials for those who investigate and determine causes of death. CDC obtained input from attendees as how to proceed with this work in tribal communities and how to engage tribes in developing training materials. Tribal leaders suggested that there be a component relative to the tribes in all regional trainings as well as one training specific to AI/ANs.
November 15-16, 2005	Division of Diabetes Translation (DDT) consultation session.	DDT and the National Diabetes Wellness Program (NDWP) staff, eight tribal grantees of the Health Promotion and Diabetes Prevention Projects for AI/AN communities: Adaptations of Practical Community Environmental Indicators project.	Grantees and the national Tribal Leaders Diabetes Committee identified a critical need for tribes and tribal organizations to be able to easily obtain technical assistance (TA) from CDC in developing diabetes prevention programs. CDC Wellness Program hired a contractor to provide culturally appropriate TA and utilized this initial meeting to engage funded tribal partners in this activity as well as publicly invite all tribes the opportunity to access this expertise.

Name of Division: Centers for Disease Control and Prevention

Date	Event	In Attendance	Summary
2001-2006	CDC National Diabetes Wellness Program (NDWP) seeks ongoing Tribal guidance and formal and informal tribal consultation to guide program efforts and implementation of diabetes work plan.	NDWP staff, the Tribal Leaders Diabetes Committee (TLDC), IHS Division of Diabetes Treatment and Prevention, National Institute of Diabetes, and NIH	TLDC continues to work closely with DDT and NDWP to decrease the diabetes epidemic in tribal nations. The purpose of the Program is to work with tribal nations, tribal organizations, other federal agencies and state governments to eliminate health disparities and increase the quality of life for AI/ANs with or at-risk of developing diabetes.
Agency Consultation Sessions (continued)			
June 28, August 29 and 30, 2006	Division of Cancer Prevention and Control (DCPC) consulted with all currently funded tribal cancer programs about development of new RFA for 2007. DCPC also did a DTLL inviting all tribal leaders to participate in a series of conference calls hosted by NIHB on August 29 and 30 th . NIHB disseminated information through their email alert and Area Health Boards requesting tribal consultation regarding this new program announcement.	13 of the 18 funded tribal programs participated in the initial call. 12 additional tribes/organizations participated on the August calls. Notice of calls and intent was disseminated by NIHB as well as posted on their web page. All interested participants were thanked for their input and told that their input would be considered as DCPC developed the new program announcement scheduled for release early in 2007.	DCPC complied with CDC's Tribal Consultation Policy by consulting with tribes and tribal organizations in the development of a program that has partnered with AI/AN tribes for 12 years. This program has and will continue to impact cancer prevention activities in Indian country and input was greatly desired by DCPC. This process of engaging tribal leaders provided some valuable input into a RFA development. It was felt that this process of engaging tribal leaders can be strengthened and used again as other CDC programs are developing program announcements.
Oct. 13, 2006	CDC AI/AN Public Engagement Meeting	CDC began day long meeting with a panel of senior staff - Debra Lappin, Chair of the CDC Partnership for Prevention Task Force, Rosie Henson, Deputy Director of the National Center for Chronic Disease Prevention and Health Promotion; and Don Shriber, Director of the CDC Washington Office. Many tribal leaders beginning dialogue with some 150 AI/ANs in attendance. Several other CDC directors and Goal Team	CDC recorded in full all comments and recommendations made and incorporated them with additional recommendations received at other Partner and Public Engagement Meetings. These recommendations from the AI/AN people and leader provided needed insights into how the draft goals and objectives could be strengthened to assist CDC in achieving true improvements in people's health and eliminating health disparities throughout the Nation.

Name of Division: Centers for Disease Control and Prevention

Date	Event	In Attendance	Summary
		Leaders helped to facilitated small group consultation sessions which the body divided into for increased opportunity to hear from AI/AN people and tribal leaders.	
Tribal Conferences and Summit			
May 18, 2006	HHS Tribal Pandemic Flu Summit	CDC Staff, IGA and HHS national and regional Staff, Tribal leaders, Regional and National Tribal Organizations.	Focused on identifying, framing and examining issues surrounding a coordinated response and plan for Pandemic flu in tribal nations.
Other Consultation Efforts			
5/9/2006	DTLL	N/A	The CDC Director sent a DTLL to every Tribal Government, national Tribal Organizations, and Regional Tribal Health Board requesting help in identifying elected tribal leaders to serve on CDC's Tribal Consultation Advisory Committee to be formally established in late 2006 to increase opportunities for tribal input into CDC's decision making processes.
8/24/2006	DTLL	N/A	The Director of the CDC's Division of Cancer Prevention and Control with the assistance of NIHB sent a letter to all tribal leaders requesting their input and consultation regarding the formulation of the new RFA for cancer prevention programs.

Name of Division: Centers for Disease Control and Prevention

Date	Event	In Attendance	Summary
Sept.29, 2006	DTLL	NA	The CDC Director sent a letter to all tribal leaders, tribal health boards, and tribal organizations to inform, engage, and consult with them about CDC Goals Management Process. CDC in collaboration with the Partners for Prevention was hosting a series of partner and public engagement meeting to gain input on what people and communities across the country view as most urgent and important along to achieve health impact. This letter also served as an invitation to the AI/AN Public Engagement Meeting scheduled as part of the NIHB Consumer's Conference on October 13 th . CDC staff listened and recorded tribal leaders ideas and input to assist CDC in formulation of final goals.

Section 3. Outcomes and Evaluation

Major Outcomes and Accomplishments

- **Tribal Priorities #1 and #2, Funding and Related Issues, and Increased Access to CDC Programs**

CDC/ATSDR Tribal Consultation Policy

This policy, officially released early in FY 2006 (October 18, 2005), describes steps that CDC programs should take toward working effectively with AI/AN communities and organizations. The policy identifies when CDC programs should involve tribal leaders and outlines specific responsibilities regarding program activities, including mutual participation in setting program and budget priorities. The policy also provides guidance on enhancing AI/AN access to CDC programs and resources, including those awarded to State health departments. As a result of the policy, CDC is consulting more effectively with tribes and is receiving helpful tribal input on a broad range of issues that include the development of new program announcements, implementation of new or ongoing public health programs, and the fostering of stronger partnerships between tribes and other CDC partners such as state health departments and academic institutions. Implementation of this policy across CDC and ATSDR is ongoing and the implementation process has been enhanced by the establishment of the CDC/ATSDR Tribal Consultation Advisory Committee (TCAC).

The TCAC was established as an advisory committee to the CDC Director and ATSDR Administrator in order to provide a complementary venue wherein tribal representatives and CDC staff would exchange information about urgent public health issues in Indian country and collaborate on approaches to address these issues and needs. The TCAC assists in strengthening CDC partnerships with tribes and tribal organizations, and in planning and coordinating upcoming tribal consultation sessions. The TCAC also provides enhanced connectivity between CDC and tribal leaders through their regional health boards and the National Indian Health Board. This connectivity will help to ensure that CDC activities or policies that impact Indian country are brought to the attention of tribal leaders as well as CDC senior leadership. The TCAC Charter is attached as Appendix One. The CDC/ATSDR Tribal Consultation Policy and related documents are available at:

<http://www.cdc.gov/omh/TCP/TribalConsultation.htm> and
<http://www.cdc.gov/omh/TCAC/TCAC.html>.

Tribal Access to CDC Programs and CDC AI/AN Resource Allocations

CDC's Tribal Consultation Policy also helps to assure tribal eligibility for CDC program announcements. In FY 2006, CDC funded 69 cooperative agreements to 50 tribal partners (tribal governments, tribal health boards, tribal organizations, Alaska Native health corporations, urban Indian health centers, and tribal colleges) across 19 states (see Appendix Two). Total funds allocated through competitively awarded grants and cooperative agreements exceeded \$22.0 million. Compared to FY 2005, although total funding in this category decreased by about \$500 thousand, the number of awardees remained the same and the total number of awards increased from 58 to 69 (19 percent increase).

In addition to grants and cooperative agreements awarded to tribal partners, CDC also allocated more than \$8.5 million through grants/cooperative agreements awarded to state health departments and academic institutions for programs focusing on AI/AN public health issues. The remainder of CDC's AI/AN portfolio falls into three categories: (1) intramural resources (about \$8.5M), (2) federal intra-agency agreements (about \$2.8M), and (3) indirect allocations (\$51.8M). The indirect category primarily represents resources devoted to immunizing AI/AN children through the Vaccines for Children (VFC) program.

If indirect funds are included (see Figure 1 below), CDC estimates its total FY 2006 resource allocation for AI/AN programs to be approximately \$93.9 million, 23 percent of which goes directly to tribal partners and 88 percent overall is expended outside of HHS. The total figure (\$93.9M) represents a 36 percent increase over AI/AN allocations in FY 2005.

If indirect funds are not included (see Figure 2 below), CDC estimates its total FY 2006 allocation for AI/AN programs to be approximately \$42 million, 53 percent of which goes directly to tribal partners and 73 percent overall is expended outside of HHS. The total figure (\$42M) represents a 3.2 percent increase over AI/AN allocations in FY 2005 (See Figure 3 below).

The resource allocation categories are defined as follows:

1. **AI/AN Awardee:** Competitively awarded programs (i.e., grants, cooperative agreements) where the awardee is a tribe, tribal health board or coalition, tribal organization, Alaska Native organization, urban Indian Health program, or tribal college/university.

2. **Extramural AI/AN benefit:** Competitively awarded programs where the purpose of the award is to primarily or substantially benefit AI/ANs; however, the awardee is not a tribal organization as defined in #1 above (e.g., state health departments, academic institutions). (*“primarily or substantially” is defined as 50 percent or greater devotion of funds/efforts.*)
3. **Federal AI/AN benefit:** Federal Intra-Agency Agreements where the purpose of the agreement is to primarily or substantially benefit AI/ANs (e.g. with IHS).
4. **Intramural AI/AN:** Intramural programs whose purpose is to primarily or substantially benefit AI/ANs; this category includes costs (e.g., salary, fringe, travel, etc.) associated with CDC staff or contractors whose time/effort primarily or substantially benefit AI/ANs.
5. **Indirect AI/AN:** Service programs where funding for AI/ANs can reasonably be estimated from available data on the number of AI/ANs served. This category primarily reflects the Vaccines for Children program, where the amount of funding benefiting the AI/AN population is reasonably estimated by taking the proportion of clients served who identify themselves as AI/AN via patient encounters, and applying that proportion to the total funding for the program.

Figure 1. FY 2006 Al/AN Allocations, Including Indirect Estimates

FY 2006 AI/AN Funding Category Comparison	
Category	Total
AI/AN Awardee	\$22,029,344
Extramural AI/AN	\$8,578,742
Federal AI/AN	\$2,841,773
Intramural	\$8,575,345
Indirect	\$51,880,072
Total AI/AN Funding:	\$93,905,275

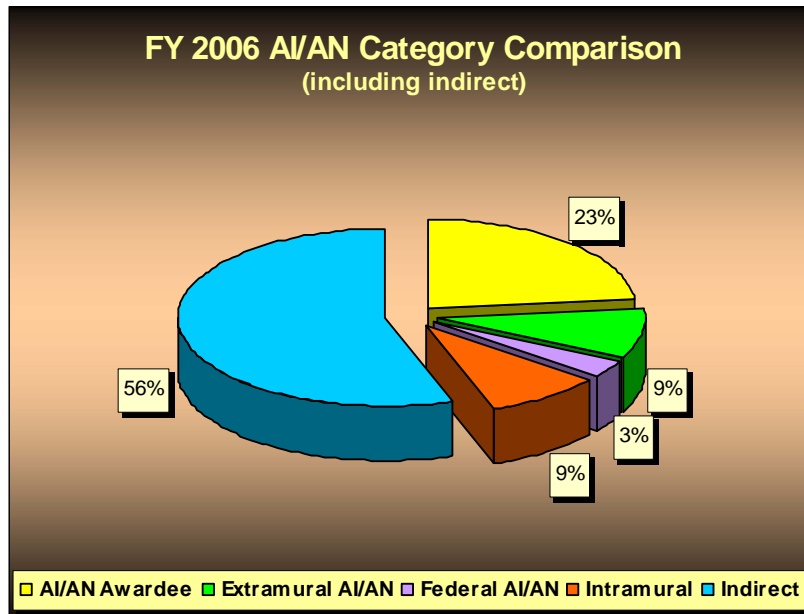


Figure 2. FY 2006 Al/AN Allocations, Excluding Indirect Estimates

FY 2006 Al/AN Funding Category Comparison	
Category	Total
Al/AN Awardee	\$22,029,344
Extramural Al/AN	\$8,578,742
Federal Al/AN	\$2,841,773
Intramural	\$8,575,345
Total Al/AN Funding:	\$42,025,204

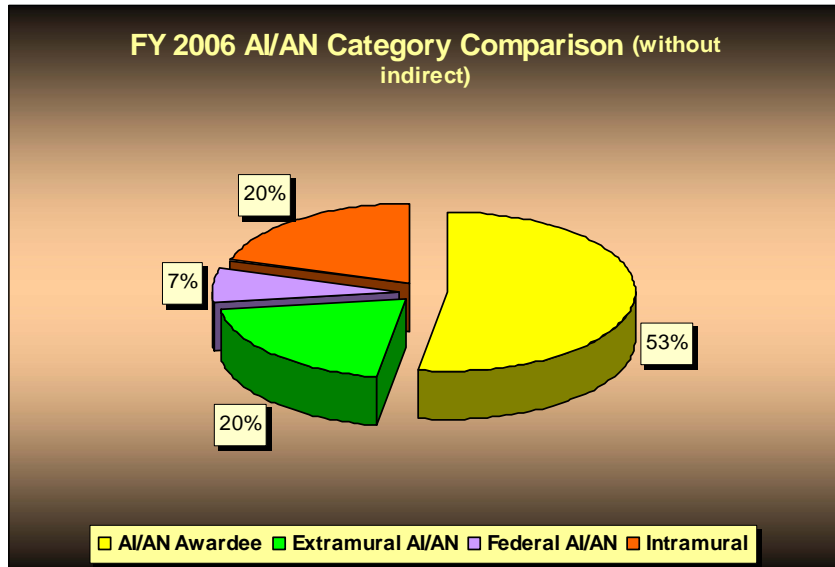
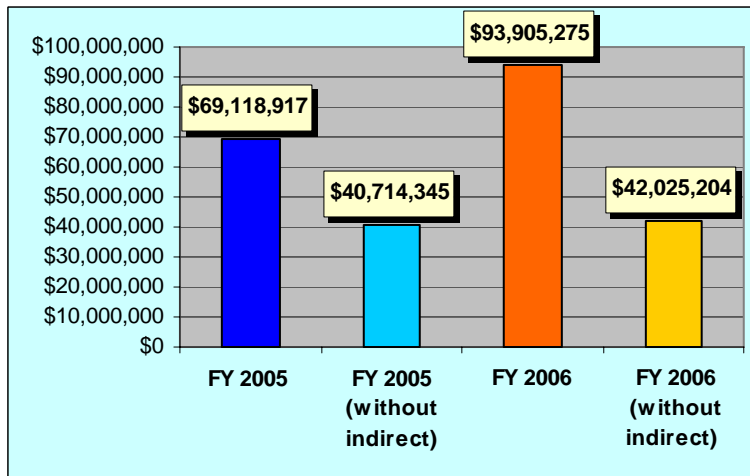


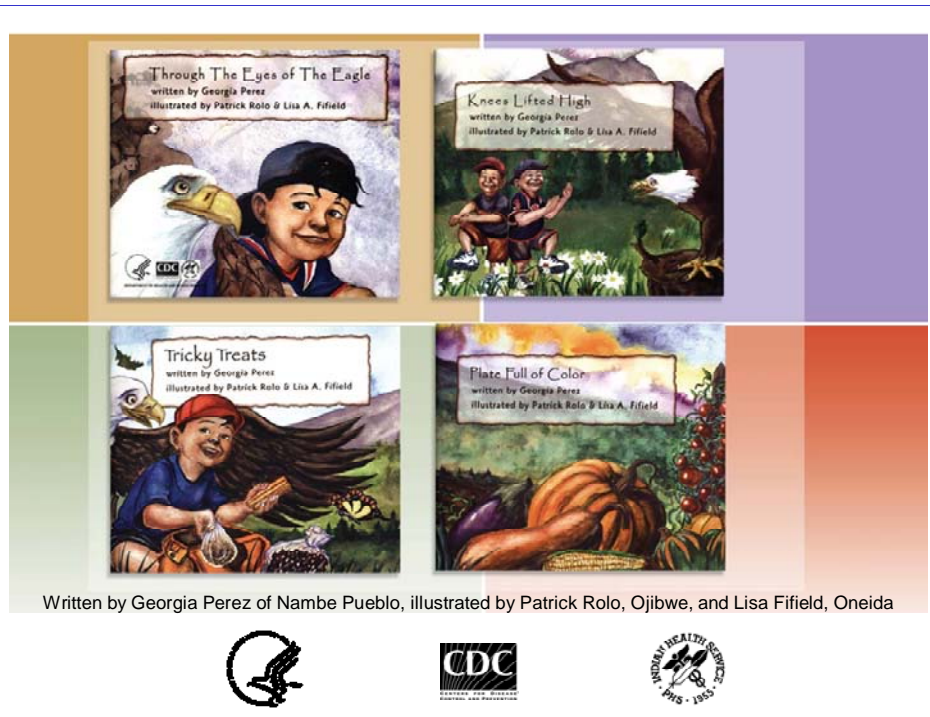
Figure 3. FY 2005 and FY 2006 Comparison Chart



▪ **Tribal Priority #3, Health Promotion and Disease Prevention**

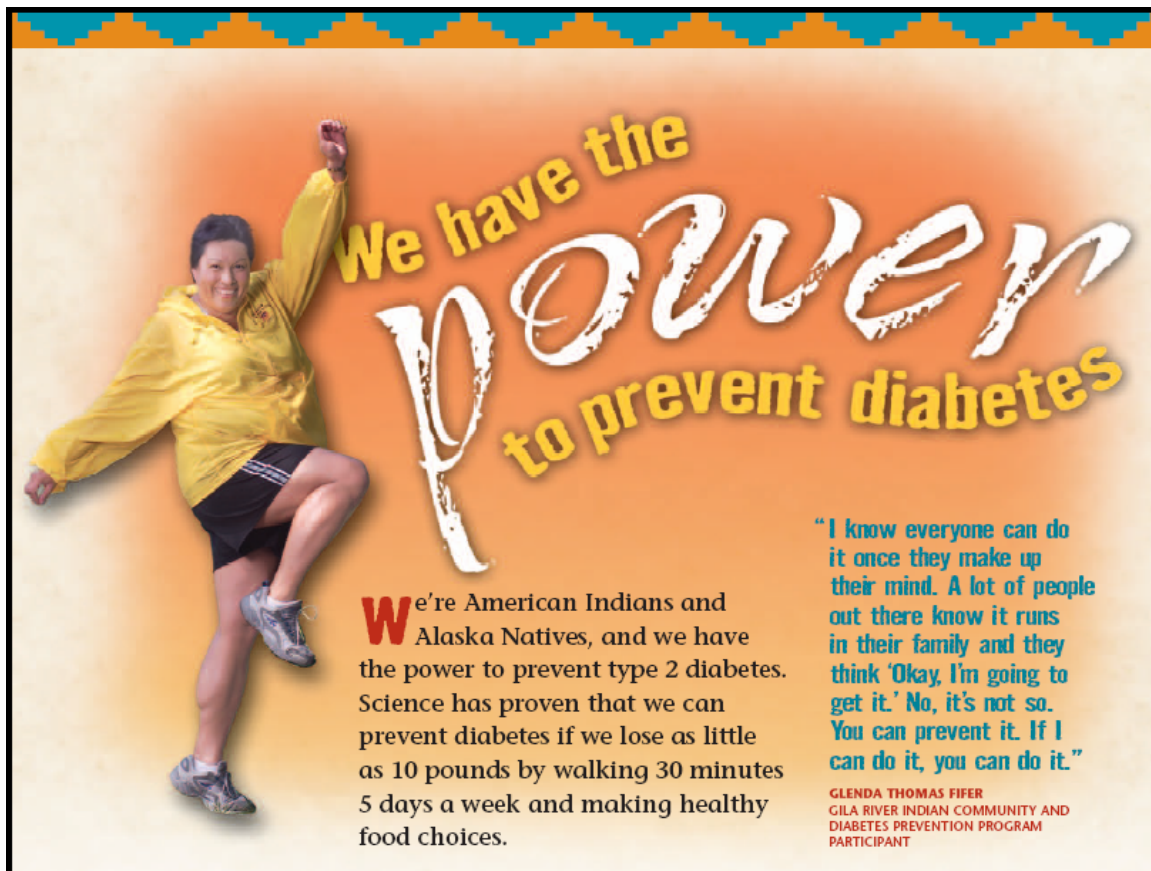
Diabetes: “Eagle Books”

The Eagle Books are a series of four books brought to life by wise animal characters—Mr. Eagle and Miss Rabbit—and a clever trickster, Coyote, who engage Rain That Dances and his young friends in the joy of physical activity, eating healthy foods, and learning from their elders about health and diabetes prevention. The Eagle Books were authored by Georgia Perez of Nambe Pueblo; illustrated by Patrick Rolo, Bad River Band of Ojibwe, and Lisa A. Fifield, Oneida Tribe of Wisconsin, Black Bear Clan. Reaching young people, particularly in the school setting where they are spending 6-9 hours a day, presents an opportunity to help improve the health outcomes of the nation's youth, which, in turn, can have positive effects on intermediate and long-term social, educational, and economic outcomes. The Eagle books and the efforts of CDC’s Native Diabetes Wellness Program, in partnership with the Indian Health Service (IHS) and the Tribal Leaders Diabetes Committee (TLDC), are putting those ideas into action by bringing to teachers, parents, and students important health promotion messages to help children grow safe and strong -- messages like good nutrition and regular physical activity. In 2006, the CDC Native Wellness Program distributed almost 1 million Eagle Books to American Indian and Alaska Native health and school organizations through partners including First Book and the Indian Health Service Division of Diabetes Treatment and Prevention. The books draw interest outside of Indian country. One teacher called them “an ambassador of hope” to Native communities and other communities who want to learn more about Native peoples, health wisdom, diabetes, and who appreciate the tradition of storytelling. For more information on the Eagle Books series see: [First Book National Book Bank](#) or call 1-866-393-1222. Free single copies may be obtained from CDC by calling: 1-800-CDC-INFO.



Diabetes: National Diabetes Education Program

The National Diabetes Education Program (NDEP), a joint initiative between CDC and NIH, has created an extensive partnership network to mobilize public and private sector organizations to work with the NDEP to improve the way diabetes is treated. An AI/AN Workgroup was formed to assist with the development of culturally appropriate TV, radio, and print ads for American Indian communities. With input from tribal leaders and community members, the campaign message became, “Control your Diabetes for Future Generations.” In addition, the Association of American Indian Physicians (AAIP) was selected by CDC to help disseminate campaign materials. The American Indian/ Alaska Native Workgroup developed a campaign focused on youth called “Move it!” The AIAN workgroup developed another campaign for adults at risk for diabetes, “We have the power to prevent diabetes.”



We have the
power
to prevent diabetes

We're American Indians and Alaska Natives, and we have the power to prevent type 2 diabetes. Science has proven that we can prevent diabetes if we lose as little as 10 pounds by walking 30 minutes 5 days a week and making healthy food choices.

"I know everyone can do it once they make up their mind. A lot of people out there know it runs in their family and they think 'Okay, I'm going to get it.' No, it's not so. You can prevent it. If I can do it, you can do it."

GLENDIA THOMAS FIFER
GILA RIVER INDIAN COMMUNITY AND
DIABETES PREVENTION PROGRAM
PARTICIPANT

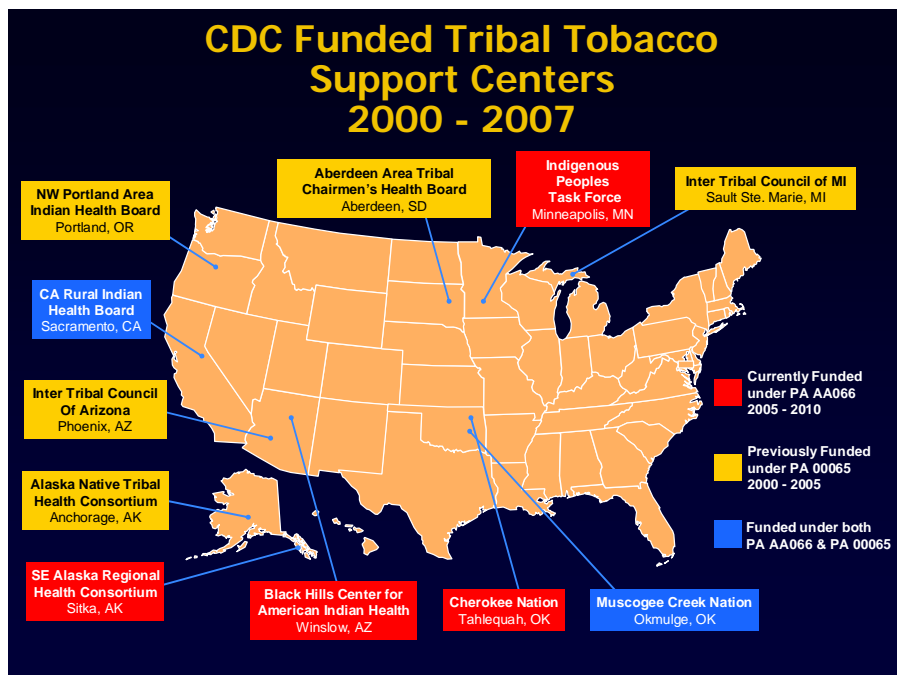
Cancer

In FY 2006, the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) funded 13 AI/AN tribes and tribal organizations among its 68 grantees. NBCCEDP targets low-income women with little or no health insurance and has helped reduce disparities in screening for women from racial and ethnic minorities. About 57 percent of screenings provided by the National Program were to women from racial or ethnic minority groups. Approximately 4.2 percent are AI/AN women.

The National Comprehensive Cancer Control Program (NCCCP) is a collaborative process through which a community and its partners pool resources to promote cancer prevention, improve cancer detection, increase access to health and social services, and reduce the burden of cancer. These efforts will contribute to reducing cancer risk, detecting cancers earlier, improving treatments, and enhancing survivorship and quality of life for cancer patients. With approximately \$15 million in appropriations in fiscal year 2006, CDC provided support for building coordinated and priority-driven cancer control programs in all states, the District of Columbia, six tribes and tribal organizations, and six U.S. Associated Pacific Islands/territories. With this support, health agencies continued to establish broad-based CCC coalitions, assessed the burden of cancer, determined priorities for cancer prevention and control, and established the infrastructure necessary to develop and implement CCC plans.

Tobacco

For the past 5 years OSH has funded 7 Tribal Support Centers to build capacity and infrastructure in "Indian country" to prevent and control the non-traditional uses of tobacco among American Indians and Alaskan Natives. The Support Centers provide technical assistance and consultation directly to tribes and organizations that work with tribes about culturally competent approaches to working with AI/ANs as they develop educational messages and policies to reduce tobacco use among native people.



▪ **Tribal Priority #5, Emergency Preparedness**

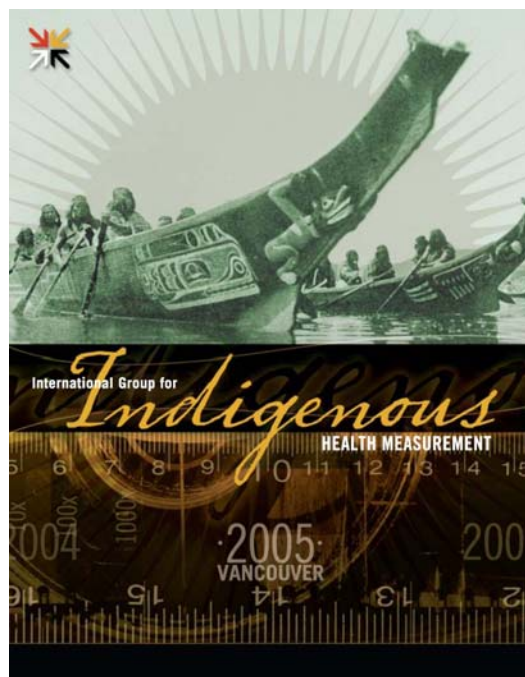
In FY 2006, \$4,116,244 of states' cooperative agreement funds were disseminated to tribal nations, IHS, and tribal organizations in the form of grants, contracts, and dedicated staff. An additional \$58,469,939 dollars was distributed to local health departments and other contractors for local-level activities and training that could reasonably be expected, in part, to contribute to the preparedness of Indian country by engaging American Indians and Alaska Natives in planning and exercises. These funds, however, are not identified specifically in the state budgets as serving Indian country.

▪ **Tribal Priority #6, Data and Research**

International Indigenous Health Measurement

CDC's National Center for Health Statistics, with assistance from the CDC National Center for Chronic Disease Prevention and Health Promotion and Office of Minority Health and Health Disparities, organized an international collaboration to focus on improving the measurement of health status in indigenous populations in the U.S., Canada, Australia, and New Zealand. This group, known as the International Group for Indigenous Health Measurement, held its first meeting in Vancouver, Canada from October 1 – 5, 2005 and its second meeting in Canberra, Australia, from November 28 – 30, 2006. In addition to CDC staff, the U.S. delegation included representatives from Tribal and Urban Indian Epidemiology Centers, a tribal health director, a University-based AI/AN researcher, and IHS. The group includes government representatives, researchers and representatives of Indigenous organizations from the four countries. Proceedings from the first meeting have been published, and proceedings from the second meeting are in preparation. In addition, representatives are preparing summaries of indigenous health statistics for each country that will be made broadly available. Details of the Canberra meeting are available at:

<http://www.aihw.gov.au/eventsdiary/igihm06/index.cfm>



In-home Water Availability and Infectious Diseases Among Alaska Natives

Challenges to bringing modern sanitation services (i.e., potable drinking water and safe wastewater disposal) to homes to remote Alaskan villages include harsh climate, small and sparse populations, geographic isolation and limited resources. Approximately 60% of Alaska Natives live in about 220 rural villages, the majority of which have populations of less than 300 people. In 2000, only 77% of Alaskan homes had sanitation services. To better understand the relationship between in-home water and wastewater service and the risk of infectious disease in rural Alaska, a number of projects were implemented. The projects are a collaborative effort between the Artic Investigation Program, Alaska Native Health Consortium, Indian Health Service, and CDC/DVRD. Data collected for these projects included: data on the level of water and wastewater service to homes in rural Alaska (source: Rural Alaska Housing Sanitation Inventory conducted from July 2001 through April 2004); hospital discharge data for 2000-2004 and population data for AI/ANs (sources: IHS Direct and Contract Health Service inpatient dataset); infectious disease hospitalizations in Alaska (diarrhea, pneumonia/influenza, skin/soft tissue infection and methicillin-resistant *Staphylococcus aureus* (MRSA) (sources: IHS Direct and Contract Health Service inpatient dataset). Using these data, average annual hospitalization rates were calculated by region of residence. Age-specific rates were also calculated, and risk ratios were calculated for comparison of the hospitalization rates by water service level. Findings included the following:

- Twenty-four percent of infants in Alaska villages with minimal or no water service are hospitalized for pneumonia.
- Low water service areas had three times the incidence of pneumonia and influenza and twice the rate of skin infections compared to high water service areas.
- These data directly influenced the decision to continue federal funding for the Village Safe Water program that aims at bringing running water and sanitation services to rural villages in Alaska – a program that had been targeted for a 75% decrease in funding.

Pneumococcal Disease in Alaska Native Infants and Children

CDC's AIP continues to conduct research and public health activities that focus on preventing pneumococcal disease in AN infants and children. AIP has helped to document a 90 percent decrease in invasive pneumococcal disease among AN infants and children after introduction of pneumococcal conjugate vaccine. This has eliminated the longstanding health disparity for vaccine-type disease among Alaska Native children. Ongoing surveillance has established that use of this vaccine has resulted in a decrease in antimicrobial resistant pneumococcal infections and an indirect effect of decreased pneumococcal disease in adults resulting from decreased transmission of pneumococci.

Vital and Health Statistics

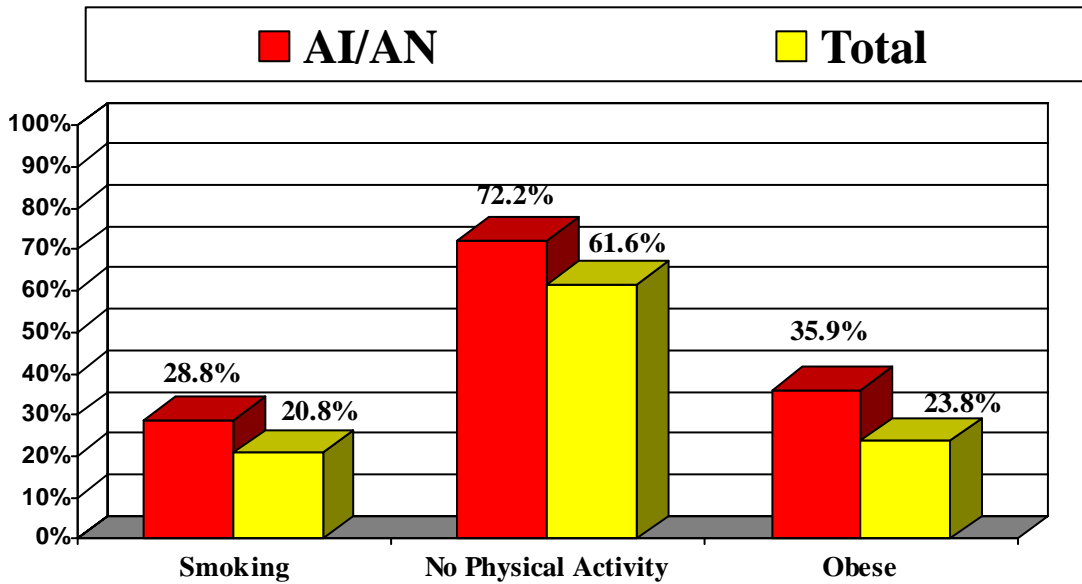
Series 10, Number 228

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
National Center for Health Statistics

Summary Health Statistics
for U.S. Adults: National Health
Interview Survey, 2004

Hyattsville, Maryland
May 2006
DHHS Publication No. (PHS) 2006-1556

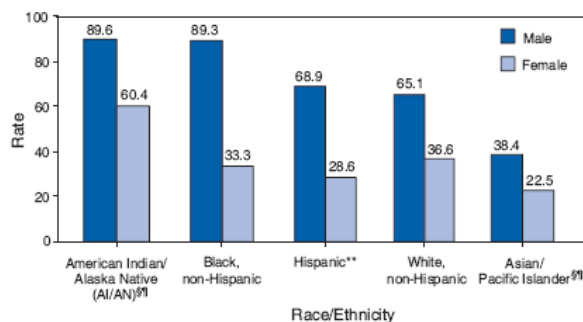
**AGE-ADJUSTED PERCENT DISTRIBUTIONS OF HEALTH BEHAVIORS
AMONG PERSONS 18 YEARS AND OLDER
AMERICAN INDIAN/ALASKA NATIVE POPULATIONS: U.S., 2004**



QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Adolescent* Death Rates,† by Race/Ethnicity and Sex — United States, 2001–2003



* Aged 15–17 years.
 † Average annual rate per 100,000 population.
 ‡ Includes persons of Hispanic origin.
 § Death rates are known to be underestimated.
 ** Might be of any race.

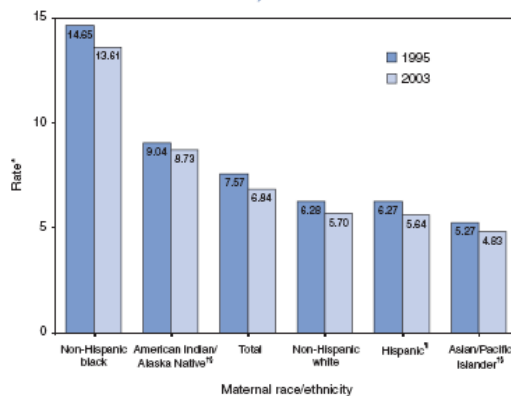
During 2001–2003, AI/AN and non-Hispanic black male adolescents had higher average annual death rates than males in other racial/ethnic populations. Among female adolescents, AI/ANs had a higher death rate than any other population. In each racial/ethnic population, males had higher adolescent death rates than females.

SOURCES: National Vital Statistics System, 2001–2003 mortality files; Health Data for All Ages, available at http://www.cdc.gov/nchs/health_data_for_all_ages.htm.

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Infant Mortality Rates, by Maternal Race/Ethnicity — United States, 1995 and 2003



* Deaths of infants aged <1 year per 1,000 live births.
 † Includes persons of Hispanic and non-Hispanic origin.
 ‡ Difference not significant at $p < 0.05$ (z test).
 § Persons of Hispanic origin might be of any race.

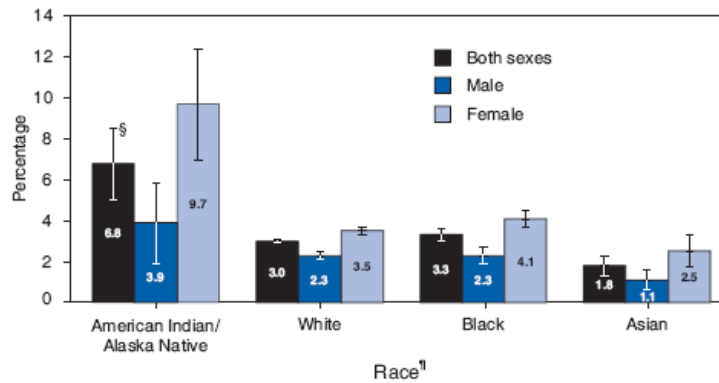
Infant mortality rates decreased significantly ($p < 0.05$, z test) in the United States from 1995 to 2003. The rate for non-Hispanic black mothers was significantly higher than for all other groups for both years; the rate for American Indian/Alaska Native mothers was significantly higher than for non-Hispanic whites, Hispanics, and Asians/Pacific Islanders for both years.

SOURCE: Mathews TJ, MacDorman MF. Infant mortality statistics from the 2003 period linked birth/infant death data set. Natl Vital Stat Rep 2006;54(15).

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Percentage of Adults with Self-Assessed Symptoms of Serious Psychological Distress,* by Sex and Race — United States, 2000–2004†



* Six psychological distress questions were included in the adult component of the National Health Interview Survey. These questions asked: "During the past 30 days, how often did you feel 1) so sad that nothing could cheer you up, 2) nervous, 3) restless or fidgety, 4) hopeless, 5) that everything was an effort, or 6) worthless?" Response codes (0–4) for the six items for each person were summed to yield a point value on a 0–24 point scale. A value of 13 or more was used to define serious psychological distress.

† Estimates are age adjusted to the 2000 projected U.S. standard population aged ≥18 years using four age groups: 18–24 years, 25–44 years, 45–64 years, and ≥65 years. Estimates are based on household interviews of a sample of the civilian, noninstitutionalized U.S. population.

§ 95% confidence interval.

‡ Persons who indicated a single racial group.

During 2000–2004, American Indian/Alaska Native (AI/AN) adults were most likely to have self-assessed symptoms of serious psychological distress, and Asian adults were least likely. Overall, the percentage was highest for AI/AN women, who were at least twice as likely as white women and black women and nearly four times as likely as Asian women to have self-assessed symptoms of serious psychological distress. AI/AN men were more than three times as likely as Asian men to have symptoms.

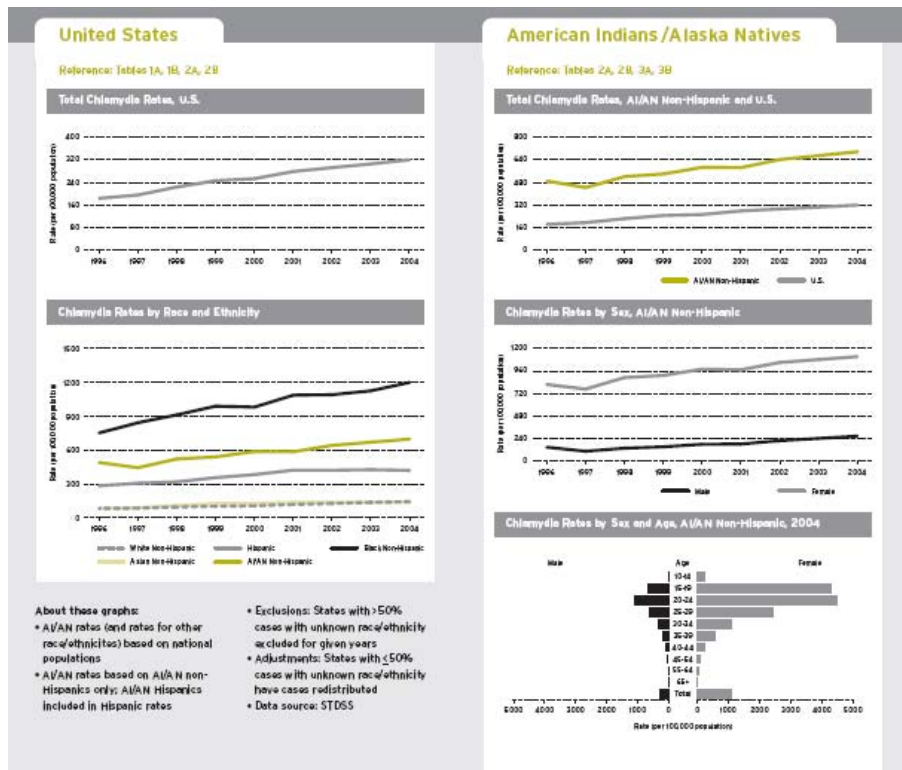
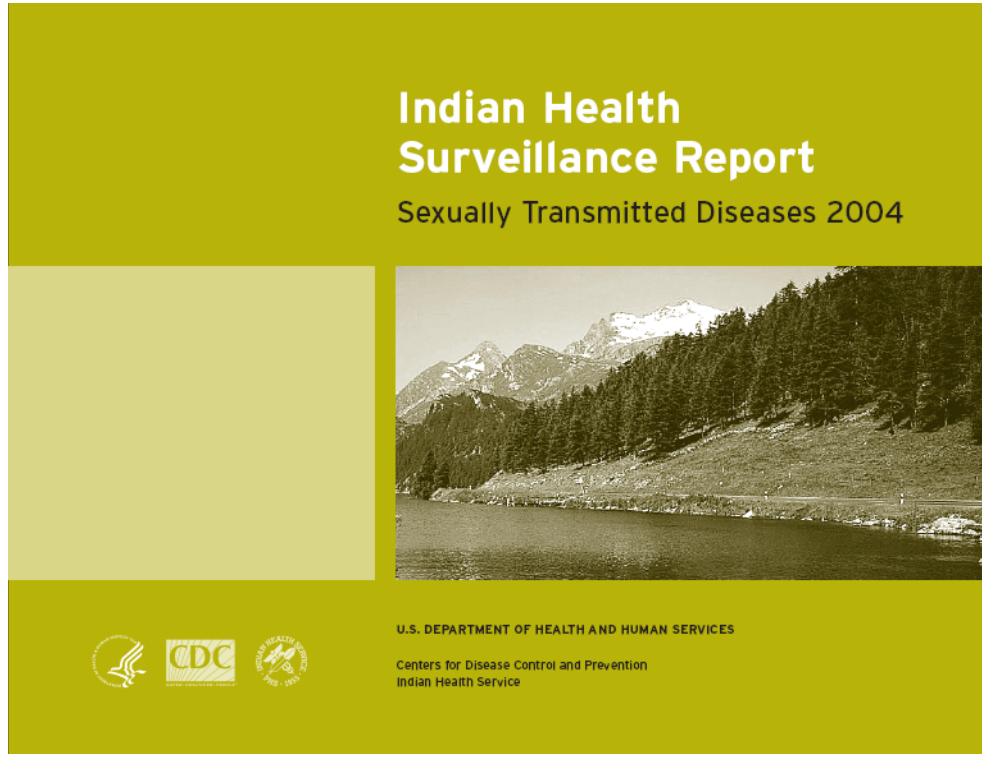
SOURCES: National Health Interview Surveys, 2000–2004. Available at <http://www.cdc.gov/nchs/nhis.htm>.

Barnes PM, Adams PF, Powell-Griner E. Health characteristics of the American Indian and Alaska Native adult population: United States 1999–2003. Advance data from vital and health statistics; no. 356. Hyattsville, MD: US Department of Health and Human Services, CDC; 2005. Available at <http://www.cdc.gov/nchs/data/ad/ad356.pdf>.

Kessler RC, Barker PR, Colpe LJ, et al. Screening for serious mental illness in the general population. Arch Gen Psychiatry 2003;60:184–9.

STD Surveillance

(See Section 1, Tribal Priority #6, for a full description of this project).



Selected CDC Publications on AI/AN Health Issues, 2006

Amon JJ, Darling N, Fiore AE, Bell BP and Barker LE. Factors associated with hepatitis A vaccination among children 24 to 35 months of age: United States, 2003. *Pediatrics* 2006;117:30-33.

Demma LF, Holman RC, Mikosz CA, et al. Rocky mountain spotted fever hospitalizations among American Indians. *Am J Trop Med Hyg.* 2006;75(3):537-41.

Doshi SR, Jiles R. Health behaviors among American Indian/Alaska Native women, 1998-2000 BRFSS. *Journal of Women's Health.* 2006;15(8):919-27.

Groom AV, Cheek JE, and Bryan RT. Effect of a national vaccine shortage on vaccine coverage for American Indian and Alaska Native children. *Am J Public Health.* 2006;96:697-701.

Singleton RJ, Holman RC, Cobb N, Curns AT, Paisano, EL. Asthma hospitalizations among American Indian and Alaska Native people and for the general U.S. population. *Chest.* 2006;130:1554-1562.

Singleton RJ, Hammitt L, Hennessy T, et al. The Alaska *Haemophilus influenzae* Type b experience: lessons in controlling a vaccine-preventable disease. *Pediatrics.* 2006;118:421-429

APPENDIX ONE

CDC/ATSDR Tribal Consultation Advisory Committee (TCAC)

Charter

PURPOSE

The Federal delivery of health services and funding of programs to maintain and improve the health of AI/AN are consonant with and required by the Federal Government's historical and unique legal relationship with Indian Tribes, as reflected in the Constitution of the United States. In recognition of this and pursuant to Presidential Executive Order No. 13175, November 6, 2000, and the Presidential Memorandum of September 23, 2004, the Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR) have established a Tribal Consultation Policy for working with Federally-recognized Tribes on a government-to-government basis. The CDC Tribal Consultation Policy establishes the formation of a Tribal Consultation Advisory Committee (TCAC) to serve as an advisory body to CDC.

The purpose of the CDC TCAC is to provide a complementary venue wherein tribal representatives and CDC staff will exchange information about public health issues in Indian country, identify urgent public health needs in AI/AN communities, and discuss collaborative approaches to addressing these issues and needs. The CDC TCAC will support, and not supplant any other government-to-government consultation activities that CDC undertakes. In addition to assisting CDC in the planning and coordination of biannual tribal consultation sessions, the TCAC will provide an established, recurring venue wherein tribal leaders will advise CDC regarding the government-to-government consultation process and will help to ensure that CDC activities or policies that impact Indian country are brought to the attention of all tribal leaders. The TCAC will assist CDC in the planning and coordination of Tribal consultation sessions and help to ensure that CDC activities or policies that impact Indian country are brought to the attention of Tribal leaders.

AUTHORITY

The U.S. Department of Health and Human Services (HHS) has adopted a Tribal Consultation Policy that applies to all HHS Divisions and includes CDC. The HHS Tribal Consultation Policy directs Divisions to establish a process to ensure accountable, meaningful, and timely input by Tribal officials in the development of policies that have Tribal implications. The President also signed an Executive Memorandum entitled "Government-to-Government Relationship with Tribal Governments", reaffirming this government-to-government relationship with Indian Tribes on September 23, 2004. In response to these directives, CDC developed a Tribal Consultation Policy that establishes the TCAC.

The TCAC charter complies with the statutory provisions set forth at 2 U.S.C. § 1534(b)1(1) & (2), and therefore will not implicate the Federal Advisory Committee Act

¹ 2 U.S.C. § 1534 (b) provides: *The Federal Advisory Committee Act (5 U.S.C. app.) shall not apply to actions in support of intergovernmental communications where – (1) meetings are held exclusively*

(FACA). The method for selecting Tribal members of the TCAC is designed to acknowledge the role of Tribal governments and their elected or appointed officials with regard to consultation on policy issues.

FUNCTION

The TCAC will provide a forum for meetings between Federal officials and elected or appointed Tribal leaders (or their designated employees with authority to act on their behalf); as well as representatives of national Tribal organizations designated by Tribal leaders to act on their behalf, in compliance with the exemptions with FACA. These programs may be funded in whole or in part by CDC. The meetings will facilitate the exchange of views, information, or advice concerning the intergovernmental responsibilities in the implementation and/or administration of CDC programs, including those that arise explicitly or implicitly under statute, regulation or Executive Order. Such meetings include, but are not limited to, seeking consensus, exchanging views, information, advice, and/or recommendations, or facilitating any other interaction relating to intergovernmental responsibilities or administration. Meetings may be face-to-face or via conference call. TCAC meetings will complement and not supplant the Tribal consultation process between CDC and the Tribes.

STRUCTURE

The TCAC will be composed of 16 members (and designated alternates) who are either elected or appointed officials of Tribal Governments (or tribal employees who are designated to act on their behalf), or representatives from national tribal organizations designated by Tribal leaders to act on their behalf.

TCAC membership will include representation from each of 12 geographic areas served by the Indian Health Service (IHS). These Areas include the following: Alaska Area, Albuquerque Area, Aberdeen Area, Billings Area, Bemidji Area, California Area, Nashville Area, Navajo Area, Oklahoma Area, Phoenix Area, Portland Area, and Tucson Area.

In addition, the TCAC will include one representative (and designate alternates) from 4 national tribal organizations: the National Indian Health Board (NIHB), National Congress of American Indians (NCAI), Tribal Self-Governance Advisory Committee (TSGAC), and Direct Service Tribes Advisory Committee (DSTAC).

The designated alternate may participate in the TCAC meetings on behalf of the principle member when that member cannot attend. If that designated alternative is not available, the principle member shall designate a second alternate in writing prior to the TCAC meeting.

between Federal official and elected officers of State, local and Tribal governments (or their designated employees with authority to act on their behalf) acting in their official capacities; and (2) such meetings are solely for the purposes of exchanging views, information, or advice relating to the management or implementation of Federal programs established pursuant to public law that explicitly or inherently share intergovernmental responsibilities or administration.

CDC SUPPORT

The Office of the Director, CDC, through the Office of Minority Health and Health Disparities (OMHD), Office of Strategy and Innovation, will be responsible for ensuring agency-wide adherence to CDC and HHS tribal consultation policies. The TCAC Executive Secretary will be designated by OMHD. The Executive Secretary and the CDC Senior Tribal Liaisons will support TCAC functions and serve as scientific and programmatic resources for the TCAC.

In addition, key CDC managers and staff with programmatic expertise, as determined by the CDC Director, shall serve as resources to the TCAC by providing leadership, technical assistance, and subject matter expertise to the TCAC in carrying out its duties and responsibilities. As part of these responsibilities, CDC staff will monitor Tribal access to CDC and ATSDR programs by tracking the total resources allocated annually to serve AI/ANs, and prepare an inventory of new programs and policies affecting AI/AN communities.

Because the TCAC is a high level agency advisory committee, it should be understood that the Director and her/his immediate staff as well as Coordinating Center Directors and Directors of Centers, Institutes, and Offices should prioritize and attend the TCAC meetings so that the TCAC can fulfill its purpose. In addition to the executive leadership of the agency, other CDC staff with particular programmatic and technical expertise should be available and responsive to issues and inquiries to allow the TCAC to achieve their role and responsibilities realized through an established trust relationship with CDC and ATSDR.

NIHB SUPPORT

In keeping with the responsibilities outlined in its Cooperative Agreement with the CDC/ATSDR, NIHB will provide a broad spectrum of services for the support, implementation and advancement of the TCAC. Some of these responsibilities include; maintaining a TCAC charter list; assisting the TCAC and CDC in the solicitation of AI/AN Tribal Leader input on public health issues and disseminate information to Indian country (via Tribal Leader letters, website notices, etc); develop meeting agendas and compile briefing booklets/materials for meetings; document principal discussions and recommendations from TCAC meetings. NIHB also will provide policy, outreach and communication services to and on behalf of TCAC to the Tribes and CDC. Further, NIHB will support the TCAC with its preparation of testimony and comments during the budget consultation process. (These functions are in addition to the logistical operations and meeting planning services discussed later in this document). The Director of Public Health Programs and Outreach: This National Indian Health Board (NIHB) position will serve as the technical support for policy, outreach and communication to the TCAC.

APPOINTMENT PROCESS

The Area Health Boards or Area Tribal Consortia, or Area Tribal Caucus (hereinafter referred to as the appointing body) may choose how their TCAC representatives are selected from each Area but should institute clear procedures as to how these representatives will keep their constituents informed of TCAC activities. The NIHB staff

will work with the Tribal Leaders and the Area Health Boards and CDC to ensure that representatives from each of the Areas and national Tribal organizations are designated. The CDC Senior Tribal Liaison for Policy and Evaluation is responsible for ensuring the representatives (and alternates) meet the Federal Advisory Committee Act (FACA) exempt requirements for representation. The NIHB will maintain a chart listing the names and contact information of each representative (and alternate), attached as an addendum to this Charter.

LEADERSHIP

Chair: A Chair will be elected by and from among the TCAC members for a one calendar-year term of service. The Chair will be an elected Tribal leader. The number of terms is not limited.

Co-Chair: The Co-Chair will be elected by and from among the TCAC members for a one calendar-year term of service. The Co-Chair will be an elected Tribal leader. The number of terms is not limited.

Executive Secretary: The Executive Secretary will provide administrative support and will be designated by the CDC Office of Minority Health and Health Disparities (OMHD).

Re-election: The Chair and Co-Chair may be reelected by the TCAC.

PERIOD OF SERVICE

There is no limit to the length of service on the TCAC. The appointing group may remove or change their representative at any time.

Vacancy: When a vacancy occurs, Tribal and national Tribal organizations will be notified of the vacancy by the Chairman of the TCAC and the affected Area or the national Tribal organization will be asked to work with their respective Tribal Leadership and Area Health Board or Area Caucus to select another representative. Tribal leaders, Area Health Boards or Area Caucus' will notify CDC and the NIHB staff in writing as to the name and contact information of the new appointee. In the event of a vacancy, the alternate will attend meetings until such a time as the vacancy is officially filled.

Removal: If a designated representative does not participate in a meeting or teleconference on three successive occasions, the appointing body will be notified by the Chairman of the TCAC and requested to replace their representative with one who is able to participate regularly.

MEETINGS

Depending on availability of funds, the TCAC will convene four (4) face-to-face meetings on a fiscal year basis. Two of these face-to-face meetings will be held in conjunction with formal CDC tribal consultation sessions twice each year. Each year, CDC will invite all elected tribal leaders, or their designees, to attend the two CDC tribal consultation sessions; one in Atlanta hosted by CDC and one in a second location hosted

by an Area Health Board or the National Indian Health Board. The TCAC will assist in the planning and coordination of each consultation session. TCAC conference calls will be held as needed and additional meetings may be scheduled depending on need and availability of funds.

VOTING

The TCAC will operate by consensus and where a consensus cannot be reached, then the TCAC will vote to resolve any differences. Each TCAC member (primary member, alternate member or their designee) will be allowed one vote.

QUORUM

A quorum is established with a majority of voting members present (9 of 16). In the event TCAC is not able to establish a quorum for its meeting, then in the alternative, the co-chairs in their discretion can arrange for polling of members via conference call or other manner.

COMPENSATION

Members who are not Federal employees shall be paid a rate of \$250 per meeting, plus per diem, and travel expenses in accordance with Standard Government Travel Regulations (e.g., two week minimum advance airline reservations, unless prior approval.) Attendance is necessary to receive this benefit.

REPORTS

NIHB will assure that all TCAC meeting proceedings and recommendations are formally recorded and provided to TCAC primary and alternate members, and the CDC Executive Secretary through written minutes provided within 15-days following the TCAC meeting. Once approved, they also will be posted on NIHB's website so that the information is accessible to all AI/AN Tribal Governments. Meeting summaries will be made available within 15-days following the TCAC meeting.

The Executive Secretary will ensure that all TCAC meetings and recommended actions are made available to CDC leaders and will post minutes and reports on the CDC website within 15 days following the TCAC meeting.

Recommended follow-up actions requiring federal actions and/or attention will be implemented and tracked within CDC and reported to TCAC in a timely manner.

MEETING LOGISTICS:

The NIHB, working with CDC and TCAC Chair and Co-Chair, will arrange meeting logistics. This includes coordinating hotel and airline travel arrangements for TCAC members, audio/visual coordination, providing travel reimbursements and applicable honoraria to TCAC members.

The CDC will provide onsite meeting coordination for the annual TCAC meeting and consultation meetings that take place at CDC in Atlanta, Georgia.

TCAC BUDGET

On an annual basis, NIHB will work with TCAC to develop the TCAC budget, including travel, per diem, communication, printing, personnel and other related expenses. This proposal will be provided to CDC/ATSDR on an annual basis for each subsequent fiscal year.

MEANINGFUL ACCESS

As stated in the “CDC Support” section, a portion of the agenda for each TCAC meeting will include time with CDC/ATSDR leadership. This will ensure that the input and recommendations provided by Tribal leaders will impact CDC decision-making processes and help guide CDC as it strives to protect people’s health and safety, provide reliable health information, and improve health through strong partnerships. CDC OMHD will track the progress of recommendations and follow-up actions and report to TCAC primary and alternate members during subsequent meetings.

TERMINATION DATE

This TCAC Charter shall be effective as long as the CDC Tribal Consultation Policy is in effect.

Glossary of Terms:

CDC	Centers for Disease Control and Prevention
ATSDR	Agency for Toxic Substance and Disease Registry
OMHD	Office of Minority Health and Health Disparities
OSI	Office of Strategy and Innovation
COTPER	Coordinating Office for Terrorism Preparedness and Emergency Response
NIHB	National Indian Health Board
TCAC	Tribal Consultation Advisory Committee
FACA	Federal Advisory Committee Act
AI/AN	American Indian/Alaska Native

APPENDIX TWO

CDC Tribal Awardees, FY 2006

(Tribal governments [TG], tribal organizations [TO], tribal health boards/coalitions [HB], Alaska Native health corporations [ANC], urban Indian health centers [UC], tribal colleges and universities [TCU])

1. ABERDEEN AREA TRIBAL CHAIRMEN'S HLTH. BOARD [HB]
2. ALASKA NATIVE TRIBAL HEALTH CONSORTIUM (3 awards) [ANC]
3. ALBUQUERQUE AREA INDIAN HLTH BOARD, INC. [HB]
4. ARTIC SLOPE NATIVE ASSOCIATION [ANC]
5. ASSOCIATION OF AMERICAN INDIAN PHYSICIAN (2 AWARDS) [TO]
6. BLACK HILLS CENTER FOR AMERICAN INDIAN HEALTH [TO]
7. CALIFORNIA RUAL INDIAN HEALTH BOARD (2 awards) [HB]
8. CHEROKEE NATION (4 awards) [TG]
9. CHEYENNE RIVER SIOUX TRIBE [TG]
10. CHOCTAW NATION OF OKLAHOMA [TG] (2 awards)
11. CHUGACHMIUT [ANC]
12. EASTERN BAND OF CHEROKEE INDIANS [TG]
13. FOND DU LAC RESERVATION [TG]
14. HO-CHUNK NATION [TG] (2 awards)
15. HOPI TRIBE [TG] (2 awards)
16. INDIAN HEALTHCARE RESOURCE CENTER TULSA [UC]
17. INDIGENOUS PEOPLES TASK FORCE (2 awards) [UC]
18. INTER TRIBAL COUNCIL OF ARIZONA, INC. [HB]
19. INTER-TRIBAL COUNCIL OF MICHIGAN [HB]
20. KAW NATION OF OKLAHOMA [TG]
21. KICKAPOO TRIBE (TX) [TG]
22. LUMMI INDIAN BUSINESS COUNCIL [TG]
23. MISSISSIPPI BAND OF CHOCTAW INDIANS [TG]
24. MUSCOGEE (CREEK) NATION [TG]
25. NARA OF THE NORTHWEST, INC. (2 awards) [UC]
26. NATIONAL INDIAN COUNCIL ON AGING, INC [TO]
27. NATIONAL INDIAN HEALTH BOARD [HB]
28. NATIONAL INDIAN JUSTICE CENTER [TO]
29. NATIONAL INDIAN WOMENS HLTH RESOURCE CTR [TO]
30. NATIONAL INDIAN YOUTH LEADERSHIP DEVELOPMENT [TO]
31. NATIONAL NATIVE AMERICAN AIDS PREV CENTER [TO]
32. NATIONAL NATIVE AMERICAN EMA ASSOC. [TO]
33. NATIVE AMERICAN COMMUNITY HEALTH CENTER [UC]
34. NATIVE AMERICAN HEALTH CENTER [UC]
35. NAVAJO NATION (2 awards) [TG]
36. NORTHWEST PORTLAND AREA IND. HLTH BOARD (4 awards) [HB]
37. POARCH BAND OF CREEK INDIANS [TG]
38. SALISH-KOOTNAI TRIBAL COLLEGE [TCU]
39. SAN CARLOS APACHE TRIBE [TG]
40. SANTEE SIOUX (NEBRASKA) [TG]

41. SOUTH PUGET INTERTRIBAL PLANNING AGENCY [HB] (2 awards)
42. SOUTHCENTRAL FOUNDATION (2 awards) [ANC]
43. SOUTHEAST ALASKA REGIONAL HEALTH CONSORT (2 awards) [ANC]
44. SOUTHERN UTE INDIAN TRIBE [TG]
45. STOCKBRIDGE-MUNSEE COMMUNITY [TG]
46. TOHONO O'ODHAM NATION [TG]
47. UNITED AMERICAN INDIAN INVOLVEMENT, INC. [UC]
48. UNITED SOUTH AND EASTERN TRIBES, INC. [HB]
49. WHITE MOUNTAIN APACHE TRIBE [TG]
50. YUKON-KUSKOKWIM HEALTH CORPORATION [ANC]

- Total number of awards: 69 awards to 50 awardees
- Geographic distribution = 19 states plus D.C.
(Arkansas, Alaska, Arizona, California, Colorado, Michigan, Minnesota, Mississippi, Montana, North Carolina, New England, New Mexico, Oklahoma, Oregon, South Dakota, Tennessee, Texas, Washington, Wisconsin and the District of Columbia)

Awardee categories:

- Tribal governments, N= 20
- Tribal organizations, N= 8
- Tribal health boards/coalitions, N= 9
- Alaska Native health corporations, N= 6
- Urban Indian health centers, N= 6
- Tribal colleges/universities, N= 1

APPENDIX THREE

FY 2006 CDC Coordinating Center/Institute/Office Comparison Table

Centers for Disease Control and Prevention American Indian/Alaska Native (AI/AN) Funding			-
FY 2006			-
<u>Coordinating Center - Center/Institute/Office</u>	FY 2006 Total Funding	FY 2006 Total Funding w/o VFC	FY 2006 Total Funding w/o Indirect
Coordinating Center for Infectious Diseases:	\$59,982,937	\$9,260,086	\$9,260,086
Coordinating Center for Health Promotion:	\$24,741,059	\$24,741,059	\$24,741,059
Coordinating Center for Health Information and Service:	\$1,277,221	\$1,277,221	\$120,000
Coordinating Center for Environmental Health and Injury Prevention:	\$1,117,548	\$1,117,548	\$1,117,548
National Institute for Occupational Safety and Health	\$276,512	\$276,512	\$276,512
Coordinating Office for Terrorism Preparedness & Emergency Response:	\$3,668,822	\$3,668,822	\$3,668,822
Office of the Director:	\$2,841,177	\$2,841,177	\$2,841,177
TOTAL, CDC	\$93,905,275	\$43,182,424	\$42,025,204