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Traditional Tobacco Use and Commercial tobacco Abuse Among Native Students in Wisconsin

Introduction

Using a five year average from 2003 – 2007 BRFSS data files, it is estimated that 57.9% of American Indians in the three state area including Minnesota, Wisconsin and Michigan currently smoke. The age adjusted mortality rate per 100,000 population identified in WISH (Wisconsin Interactive Statistics on Health), 2004-2007, finds striking disparities in four tobacco related causes of death:

Broad Causes of Death	American Indian/ Alaska Native	All Races
Malignant Neoplasms	226.30	179.62
Diseases of the Heart	207.42	180.91
Diabetes Mellitus	67.37	19.96
Chronic Lower Respiratory Diseases	60.52	38.78

Wisconsin Youth Tobacco Survey (WYTS) was first adapted for use and administered in Wisconsin during the spring semester of the 1999-2000 academic year to a random sample of public middle school students. The survey is conducted on a biennial basis for public middle and high school students. A report produced by the Wisconsin Department of Health and Family Services, Division of Public Health together with the Wisconsin tobacco Prevention and control Program combined data sets for three years (2000 – 2003) to create a large enough sample size to examine racial and ethnic characteristics of Wisconsin's middle school students. The report revealed that American Indian youth compared with White, Black, Hispanic and Asian/ Pacific Islanders had the highest rates of exposure to secondhand smoke, second highest rates of current cigarette smoking, highest use of smokeless tobacco, and the highest rates of cigar smoking.

[1] Community Health Data Profile:
Minnesota, Wisconsin, and Michigan Tribal Communities, 2009.
Great Lakes Inter-Tribal Epidemiology Center.
Great Lakes Inter-Tribal Council, Inc. 2009.

While American Indians smoke at higher rates, they have unique relationships with tobacco that is not often considered in research, prevention, or intervention. Historically and currently, American Indians use tobacco in spiritual ceremony and traditional medicine practices. American Indian stories explain that tobacco (Nicotiana Rustica) was given as a gift to the people, not to be bought or sold. Given this unique relationship and small American Indian sample sizes when implementing the biannual WYTS, the Great Lakes Inter-Tribal Epidemiology Center (GLITEC) partnered with the Wisconsin Native American Tobacco Network, the Wisconsin tobacco Prevention and Control Program, the Wisconsin Department of Public Instruction and Wisconsin Tribal communities and schools to create and implement Wisconsin's first Native Youth Tobacco Survey (NYTS).

Methods

A Native specific survey instrument was created with input from the Centers for Disease Control (CDC) and the American Indian Community Tobacco Project (AICTP). The project is modeled on community-based participatory research principles and reality-based research practices.

The survey tool featured fewer questions than the state version and includes American Indian aesthetics, graphics and drawings drawn from the Bemidji Area's predominantly Ojibwe Tribal arts and customs. The tool was approved by WNATN with state assent and pilot tested on Indian youth. Following instrument adjustments, sampling included ALL Indian youth in grades 6 –12 on reservations in Wisconsin and the Milwaukee urban area. All on reservation schools, off-reservation schools serving reservation students and Indian schools in Milwaukee were included. The survey was self administered, anonymous with unique questions addressing traditional/ceremonial use, tobacco

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abuse, thoughts/beliefs/attitudes regarding tobacco and environmental exposure. A parental letter preceding survey administration was distributed with the option of denying permission to participate in the survey. Consent was obtained from student participants. Schools were offered options and incentives to engage participation and students were offered incentives.

Implementation Challenges and Successes

Two GLITEC Epidemiologists and the WNATN Coordinator implemented the survey process at the appropriate schools statewide. An algorithm was developed to outline the steps of survey administration for both schools with high percentages of American Indian students greater than 20% and schools with fewer than 20% American Indian students. Since schools were included that were situated both on and off reservations, discussions among community members and with school officials challenged issues of racial tension both within and between Tribal and non-Tribal communities. Another challenge pitted geographic distances between participating schools and the scheduling demands of school administrators pressured by numerous social and educational expectations against the need to systematically collect the data within a project timeline.

Successes included the completion of the first ever statewide Native youth tobacco survey with a significant sample size using a culturally relevant survey instrument contributing to improved data quality. Community based participatory approaches were used and relationships were strengthened throughout the process.

Results

A total of 1,826 surveys were completed by American Indian Students, far exceeding the anticipated response. The response was comprised of 50% middle school students; 26% freshmen and sophomores and 24% juniors and seniors. The data confirms elevated tobacco use and increased exposure among American Indian students at each age group compared to all races. ***Most striking, the data describes an association between use of cigarettes in traditional ways (as the tobacco source during ceremony) versus using the loose, unrolled traditional tobacco often grown for traditional purposes. Use of cigarettes in ceremony is positively associated with increased use of commercial tobacco among American Indian youth.***

For more information,
please contact Kristin Hill, Director
Great Lakes Inter-Tribal Epidemiology Center.

Urban Indian C.A.R.E.S. (Colon and Rectal Education and Screening)

Cancer is the second leading cause of death among American Indians/Alaska Natives. American Indians/Alaska Natives (AI/AN) are less likely to be diagnosed with colorectal cancer at the localized stage and more likely to be diagnosed at the distant stage compared to whites. Additionally, AI/AN have a lower probability of survival and higher risk of death once diagnosed compared to whites[1]. Colorectal cancer is one of the most preventable cancers, because you can stop the cancer from developing by removing growths before they become cancerous. With 67% of AI/AN living in urban areas, determining how best to expand colorectal cancer screening services to urban AI/AN is urgently needed.[2] A network of 34 urban Indian health organizations (UIHO), which are on contract with the Indian Health Service (IHS) and provide primary care or outreach and referral services, is a mechanism through which healthcare is provided to the urban AI/AN community in select cities. In May 2007, prompted by data showing that colon cancer screening rates are significantly lower for AI/AN living in UIHO service areas compared to non-Hispanic whites, and that AI/AN are more likely to be uninsured, UIHO representatives formed the Urban Indian C.A.R.E.S. (Colon and Rectal Education and Screening) project.

The goal of Urban Indian C.A.R.E.S. is to promote education, testing, and treatment of colorectal cancer through the UIHO nationwide. Initially funded by Prevent Cancer Foundation with additional funding from Spirit of Eagles, the project has established a workgroup of UIHO and other stakeholders to promote increased colorectal health screening and treatment among AI/AN living in urban settings of the United States.

Monthly conference calls are held with the workgroup and a website portal was created. The project completed background work to identify attitudes towards colorectal cancer screening among urban AI/AN, including a community survey, focus groups and research on existing materials.

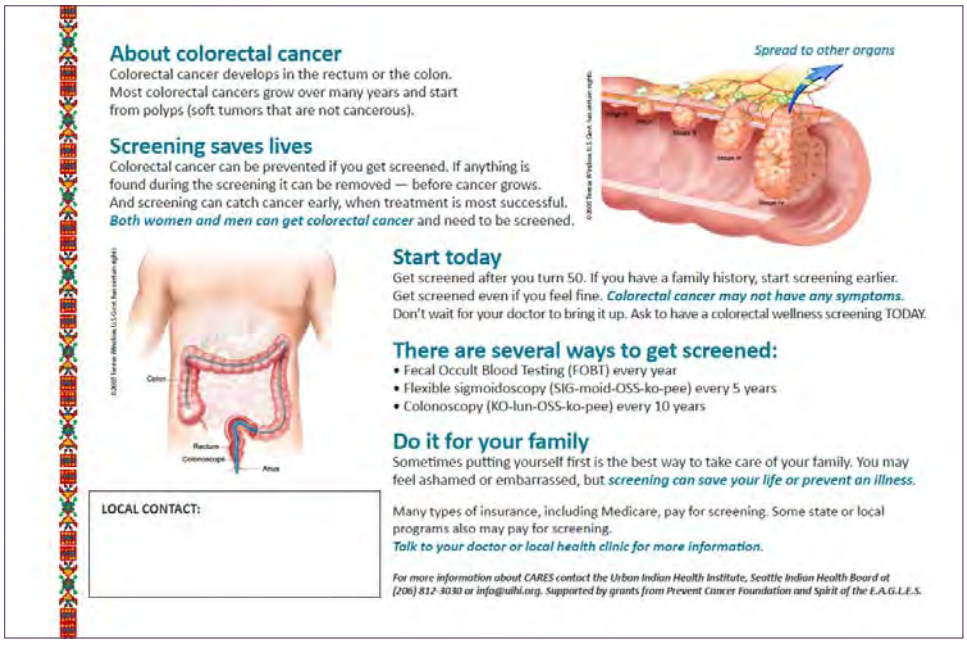
"Best to check for cancer early, 'cause you can beat it! Be on the safe side and get screened." – David Shippentower (Umatilla), colon cancer survivor

Using this information, the Urban Indian CARES project developed materials for a health promotion campaign to be used in conjunction with March Colorectal Cancer Awareness month. The materials include:

- Community poster featuring an AI/AN colorectal cancer survivor
- Community postcards (a male and female version) featuring an AI/AN colorectal cancer survivor
- Postcard and factsheet targeted at policymakers
- Factsheet targeted at providers
- Media toolkit

All materials may be customized, such as to replace the photo and story with a local survivor, to make the information more meaningful to the local community.

For more information about the Urban Indian CARES project or to request materials, contact the Urban Indian Health Institute at (206) 812-3030, email: info@uihi.org



[1]ACS 2005 Colorectal Cancer Facts & Figures
[2]2005 American Community Survey, U.S. Census Bureau

IHS Immunization Program

The IHS Immunization Program is a partnership between CDC and IHS, working with IHS, Tribal and Urban immunization programs across the country. The immunization program is based in the IHS Division of Epidemiology & Disease Prevention in Albuquerque, NM. IHS National Immunization Program staff are assigned from the CDC Immunization Services Division. Each IHS Area also has a designated Immunization Coordinator. Some of the projects the IHS Immunization Program is currently engaged in are described below.

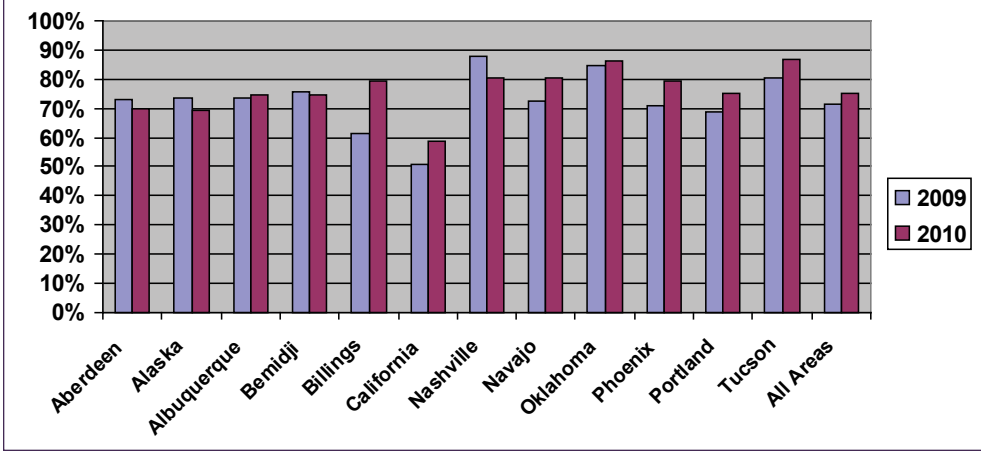
IHS Initiative: Influenza Vaccination of Health Care Personnel (HCP)

The Department of Health and Human Services (HHS) launched an initiative to improve influenza vaccination rates among Health Care Personnel (HCP) with the goal of reaching the Healthy People 2010 objective of a 60 percent influenza vaccination rate among HCP. In 2006, influenza vaccination rates were 42% for HCP. As part of this initiative, HHS asked all HHS agencies, including IHS, to develop a plan to promote vaccination of HCP with influenza vaccine, and collect and report data on HCP vaccination coverage to HHS.

In response to the HHS initiative to promote influenza vaccination of HCP, IHS developed a plan to report on influenza vaccine coverage for their HCP. Each IHS Area has designated an Area Influenza Coordinator who worked with facilities to collect reports on HCP influenza vaccination coverage. For 2010, all 12 IHS Areas submitted reports, representing 153 facilities and 27,239 HCP. Figure 1 depicts coverage data for the 2009 and 2010 seasonal influenza seasons by IHS Area. Figure 2 shows coverage data for the 2010 H1N1 influenza season by IHS Area.

As an agency, IHS achieved 74.9% coverage with seasonal influenza vaccine among HCP in 2010, a 3.6% increase over the 2009 influenza season. This is higher than the coverage reported nationally for HCP (61.9%), and surpasses the HP 2010 goal of 60%. In addition, IHS achieved higher coverage with H1N1 vaccine among its HCP compared to reported national levels (61.7% for IHS vs. 37.1% nationally). There is, however, variation between Areas and facility type.

Figure 1: Seasonal Influenza Vaccination Coverage of HCP by IHS Area IHS, Tribal, and Urban Facilities

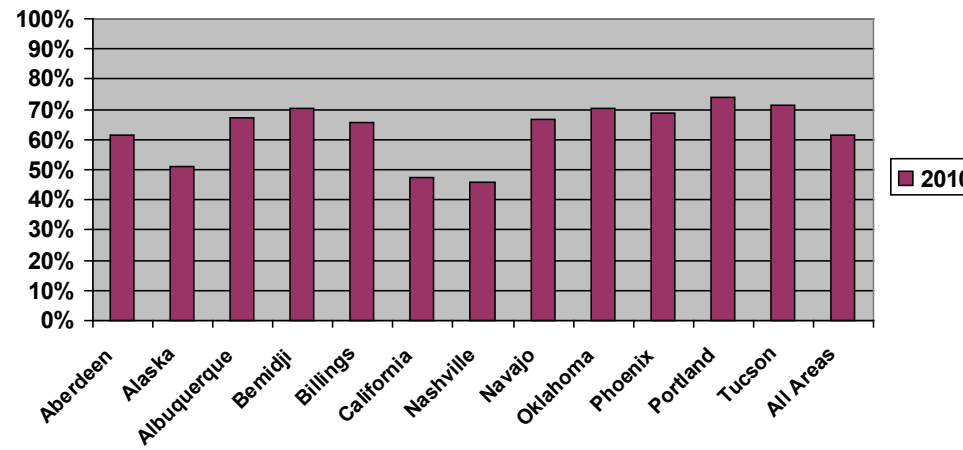


Immunization Data Exchange

Medical record scattering is a common problem and can affect patient care. For immunizations, incomplete information can lead to over or under immunization and wasted resources. CDC has supported the development of state immunization registries to address these issues. Immunization data stored in the IHS RPMS, however, are usually not included in state immunization registries as it may not be feasible for sites to enter the immunizations they provide into two systems (the RPMS and the state immunization registry).

The Immunization Data Exchange initiative has

Figure 2: H1N1 Influenza Vaccination Coverage of HCP by IHS Area IHS, Tribal, and Urban Facilities



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IHS Immunization Program

resulted in the development of software that extracts immunization data from the RPMS system and sends it to state immunization registries using standard Health Level Seven (HL7) messages in accordance with CDC's national immunization registry data exchange standards. In response to the data sent from the RPMS, the state registry creates a file of immunizations missing in the RPMS data and sends that back to the facility. This information can then be downloaded into the RPMS, alleviating the need for staff to enter the information into the RPMS, and ensuring that a patient's complete immunization history is available to the provider.

The software was released nationally in August 2005, and is currently in use in Washington, Oregon, California, Montana, Utah, Arizona, New Mexico, Minnesota and Wisconsin, with plans to expand to additional sites and states. As more state registries become able to send immunization information back to facilities, this initiative will improve patient care by allowing any IHS, Tribal or Urban provider who uses RPMS to have access to a child's complete immunization history, thereby ensuring appropriate immunization. For more information about this initiative and how it is working in your state, contact Cecile Town.

National Immunization Reporting System (NIRS)
NIRS is a web-based reporting tool used to collect quarterly immunization data from IHS/Tribal/ Urban facilities nationwide. NIRS was developed in partnership with the IHS Public Health Nursing Program to improve the quality and timeliness of immunization data. Please see our policies/resources page for a PowerPoint presentation and a WebEx recording of a NIRS training. We plan to enhance the NIRS reports in 2010 to include options for users to develop trend graphs for their facility and Area. For more information on NIRS please contact Cheyenne Jim or Amy Groom.

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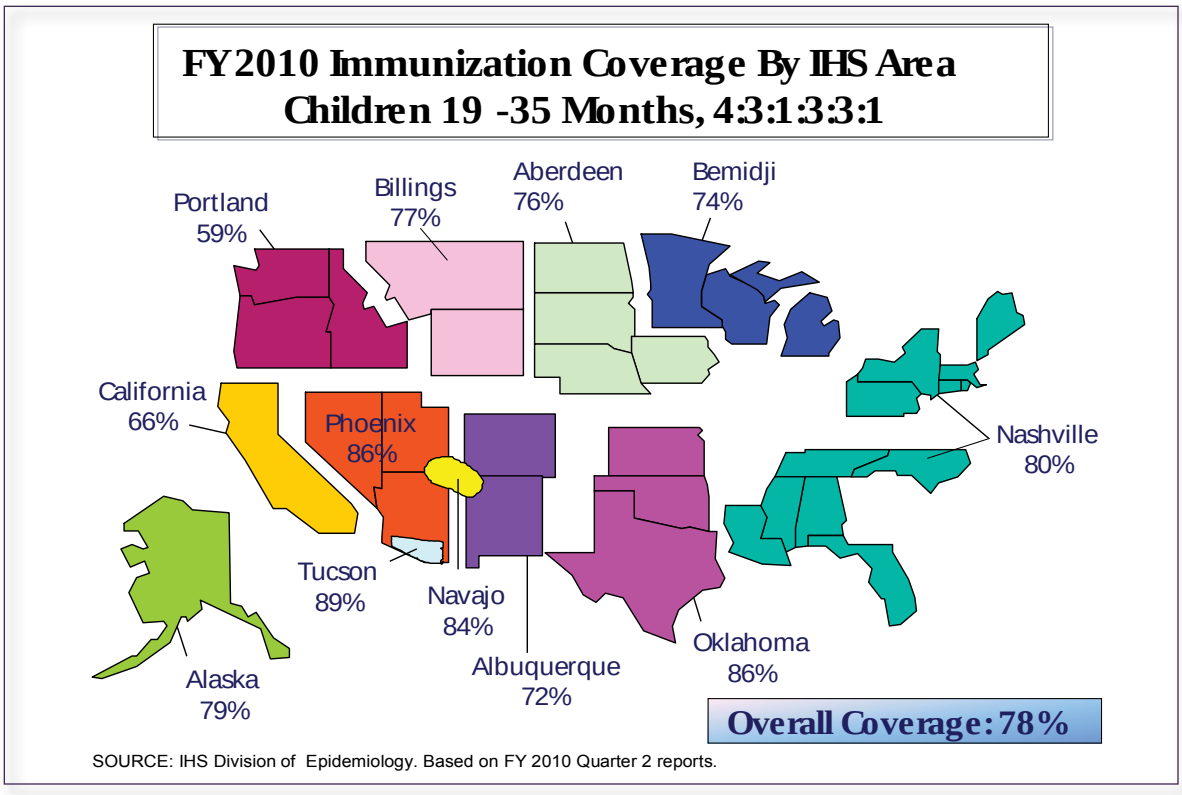

Native STAND (Students Together Against Negative Decisions)

Youth in the U.S. have very high-risk behaviors, ranging from personal safety issues (such as wearing seatbelts, driving with drunk drivers, and getting into physical fights), to risk behaviors related to drug and alcohol use and sexual activity. Although data are limited, these risk behaviors among American Indian/Alaska Native (AI/AN) youth are especially high.

There are many curricula developed for youth that address some of these high-risk behaviors, including the prevention of STDs, HIV, teen pregnancy and interpersonal violence. However, few curricula take a comprehensive healthy decision-making approach, and even fewer that are culturally relevant for AI/AN youth.

Recognizing this gap, the National Coalition of STD Directors, the Centers for Disease Control and Prevention/Division of STD Prevention and the Indian Health Service/National STD Program sought to develop a culturally appropriate peer education curriculum to support AI/AN youth to make healthy decisions for themselves in all areas of their lives.

Native STAND (Students Together Against Negative Decisions) is a comprehensive curriculum for training peer educators that promotes healthy decision-making among AI/AN youth. The curriculum was developed by a multi-disciplinary workgroup that included Native youth, a Native elder, and public health and youth development experts. Portions of the curriculum were pilot tested with various AI/AN groups.
Native STAND is based on an earlier peer program (STAND) designed at Mercer University School of Medicine for rural youth. The curriculum has been extensively tailored to be culturally sensitive and relevant to AI/AN youth. Native STAND is theoretically based, using both the Transtheoretical Model (Stages of Change) and the Diffusion of Innovations Model (identifying and relying on popular opinion leaders to promote change). Its approach is comprehensive, and includes STD, HIV, and teen pregnancy prevention, as well as drug and alcohol issues and dating violence. Sessions focus on positive personal development, including team building, diversity, self-esteem, goals and values, decision-making, negotiation and refusal skills, peer educator skills, and effective communications.

Pilot testing of a year-long implementation of Native STAND in four Native boarding schools in California, Oklahoma, Oregon, and South Dakota has just been completed. Analysis of the resulting quantitative (pre- and post-testing via CASI) and qualitative assessment data (process evaluations, interviews, and focus groups) is currently underway. Revisions based on these data will be used to inform and strengthen the final curriculum that will be made available widely. For more information please contact:

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