

**REGION I IPP
CHLAMYDIA EPIDEMIOLOGIC PROFILE:
A FOCUS ON AMERICAN INDIANS/ALASKA NATIVES**



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I. Introduction

The Region I Infertility Prevention Project (IPP) is part of a National IPP project funded by the Centers for Disease Control and Prevention (CDC), as a collaboration with the Office of Population Affairs, Office of Family Planning (OPA). The overall goal of the Region I Infertility Prevention Project is to support Chlamydia and Gonorrhea screening activities that help reduce Sexually Transmitted Disease (STD)¹-related infertility. This is achieved through collaboration with Family Planning (FP), Sexually Transmitted Disease and laboratory service providers within the six states that comprise Region I – Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. IPP targets screening to at-risk populations, including sexually active adolescent and young adult women and women who present with risk factors.

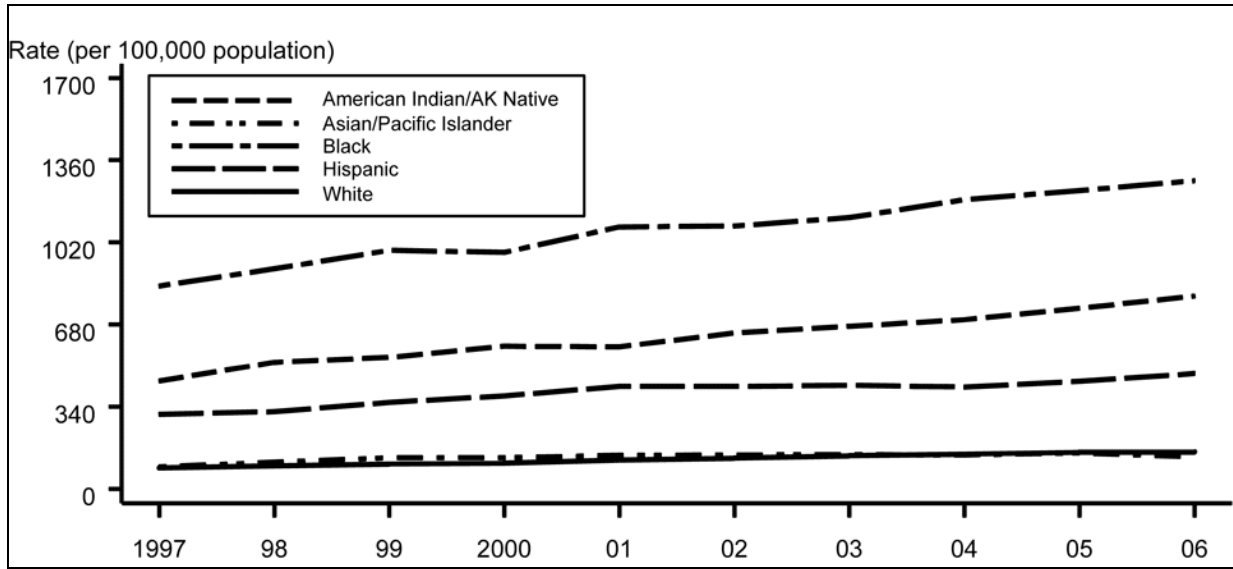
Among the U.S. general population and the AI/AN population in particular, Chlamydia infection is most prevalent among young women. Sixty-eight percent of all AI/AN Chlamydia cases, and 60% of all AI/AN Gonorrhea cases occur among those aged 15 to 24 years.ⁱ Because of the higher prevalence among younger women less than 25 and the increased risk for sequelae, sexually active young women less than 25 are the priority population for Chlamydia screening in general and for the IPP project in particular.

Nationally, the rates of both chlamydia and gonorrhea among Native Americans, or American Indian/Alaska Natives, (AI/AN) are four times that of Non-Hispanic Whites.ⁱⁱ Historically, American Indians/Alaska Natives have been underserved by health care programs. In response to this disparity, in 2008, the National Infertility Prevention Project made it an objective of each of the ten regional IPP infrastructure projects to disseminate a regional epidemiologic profile of the Chlamydia and Gonorrhea burden among American Indians/Alaska Natives². AI/AN populations in the United States are at increased risk (compared to Whites) for sexually transmitted diseases, especially Chlamydia and Gonorrhea (Figure 1).

¹ In this report Sexually Transmitted Disease (STD) is used instead of Sexually Transmitted Infection (STI). STD is used because it is the term currently used by CDC.

² In keeping with the 1977 National Congress of American Indians and the National Tribal Chairman's Association resolution, we use the term American Indians and Alaska Natives, abbreviated to AI/AN in this paper.

Figure 1: Chlamydia rates by Race/Ethnicity 1997-2006



Content Source: Division of STD Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

The purpose of this profile is to describe the ways in which AI/AN populations are accessing family planning and STD screening services in Region I, and to identify barriers to care. The profile also was created to make recommendations for better serving AI/AN in the Northeast, which include nine federally recognized tribes located throughout the Northeast, as well as the Abenaki Nation, non-federally recognized tribes that have members living in Vermont and New Hampshire, and the wider AI/AN population. Within the profile there is a description of each tribe’s population size, socio-economic demographics, and geographical location; the historical and social context of AI/AN population’s access to health care; the Chlamydia and Gonorrhea burden among AI/AN’s compared to other races, and state-specific profiles, including current sexual health programs working with AI/ANs; and recommendations for future outreach opportunities.

Overview of Socio-Economic Status of AI/AN in Region I

Region I, or the “New England” Region, makes up the Northeast corner of the continental United States and is comprised of the six states – Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont. The Northeast has a total population of about 14 million people.ⁱⁱⁱ The majority of the population is White (76.0%), while Blacks/African Americans comprise the largest minority population (11.5%) Asians account for 5.0% and Native Hawaiians and Other Pacific Islanders make up less than 1%. American Indians and Alaska Natives also make up less

than one percent of population in the Northeast (0.3%). Around 11% of the population self-identifies as Hispanic or Latino Ethnicity. ^{iv}

It should be noted that the racial category American Indians/Alaska Natives represents a diverse group of people across the United States. There are more than 560 federally recognized sovereign tribes in the U.S and many other tribes with only state recognition, or no official recognition.^v While AI/AN represent less than 1%³ of the Northeast's population according to the 2009 Census estimates,^{vi} they are a diverse group, representing not only the nine federally recognized tribes in the Northeast, but also representing tribes from across the US.^{vii} In short, AI/AN from all over the United States live and work in the Northeast.^{viii}

Tribal Recognition

In 2000, 4.3 million people reported that they were American Indian/Alaska Native.^{ix} Of these, 2.4 million people identified as AI/AN alone, meaning they did not report other races in addition to their tribal grouping. Although the 2010 U.S. Census data has not yet been released, recent projections estimate that the AI/AN alone population has grown to 3.2 million by 2010. Although there is no definitive number of total tribes within the U.S., there are 562 federally-recognized tribes. Several hundred other tribes in the U.S. are either state-recognized or unrecognized.

Federally-Recognized Tribes

Federally-recognized tribes have a formal relationship with the U.S. government. These tribes have the right to self-govern and be recognized as a sovereign entity. This acknowledgment gives the tribe rights, privileges, limitations and obligations to the government, and vice versa. Federally recognized tribes receive federal financial support, including funded health care via the Indian Health Service (IHS).

State-Recognized Tribes

State-recognized tribes are recognized only by the states in which they are located, but are not recognized by the federal government. There is no consistency among states regarding the definition of state-recognized, however state-recognized tribes generally are not afforded the same benefits that are extended to federally-recognized tribes.

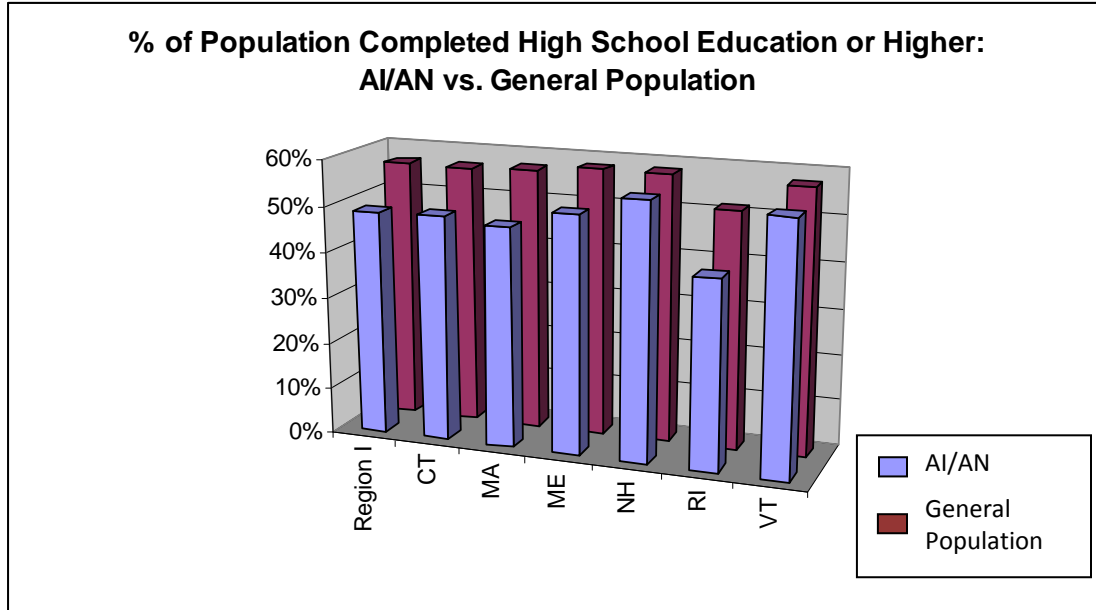
Unrecognized Tribes

There are many native tribes that exist in the U.S. that remain unrecognized and therefore do not receive financial support from the government. Within this group are tribes that have applied for recognition, those that have applied and were rejected, those in the process of applying, and those that lost their federally-recognized status.^x

³ 117,901 AIAN alone and in combination with one or more other races.

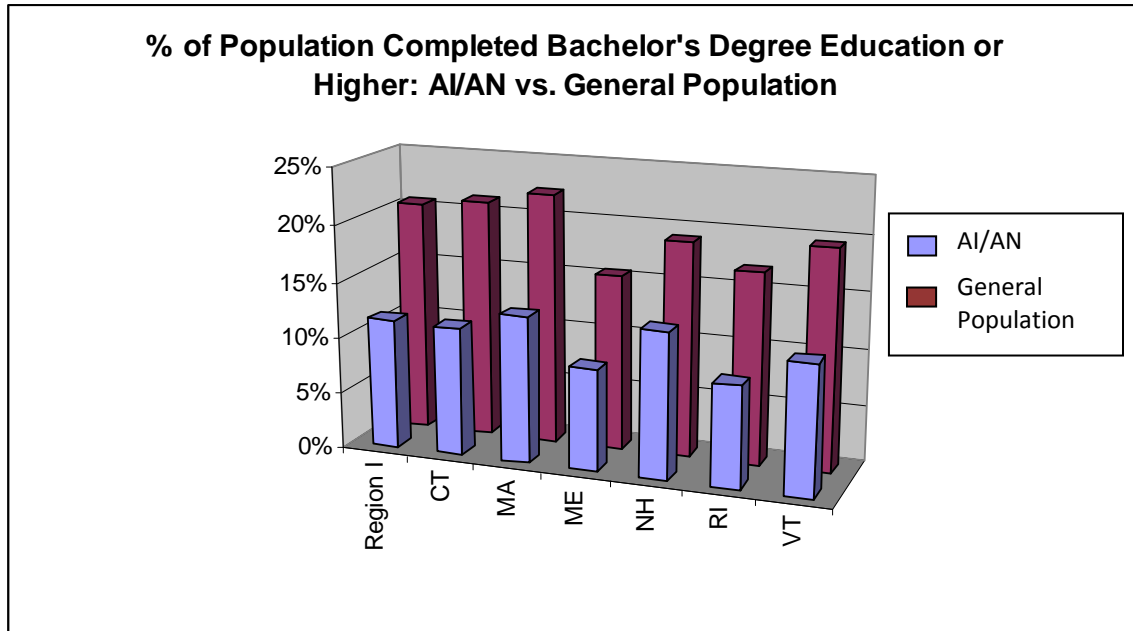
When compared to the U.S. as a whole, the population in the Northeast is slightly more urban and better educated. Nearly 85% of residents live in urban settings (compared to 79% of US residents), and 86% of the population 25 years and over have a High School degree, or higher with over 32% of the population reporting that they have a bachelor's degree or higher. This is compared to 84% (High School degree or higher) and over 28% (bachelor's degree or higher) nationally. Regionally, AI/AN are more likely to live in rural areas and have lower educational attainment (Figures 2 and 3).^{xi}

Figure 2



Content Source: 2000 Census Data

Figure 3



Content Source: 2000 Census Data

Overall, poverty rates are slightly lower in Region I than nationally. Despite low poverty rates in the Region I as a whole, AI/AN tend to have higher poverty rates: 22% compared to the regional rate of 11.6% and Non-Hispanic White rate of 7.9%. AI/AN in the Northeast have a lower median family income of \$ 47,751 compared to non-Hispanic Whites, whose median family income is \$77,706. The AI/AN income is also lower than the overall median family income for the Northeast (\$70,709). Similarly, AI/AN per capita income is significantly lower (\$18,788) than Non-Hispanic Whites (\$35,056).^{xii} Approximately 6.5% of White households received Food Stamps/SNAP benefits in the past 12 months, compared to 24.7% of AI/AN households.^{xiii}

In addition to having higher poverty rates, AI/AN were slightly younger than both the total population and Whites in the Northeast: 22.7% AI/AN were under 18, while Whites under 18 make up about 20.6% of that population.^{xiv} The median age of AI/AN is 35 compared to 41.9 for Non-Hispanic Whites.^{xv}

The reasons for why AI/AN are more likely to have lower socioeconomic status than their White counterparts are complex and beyond the scope of this report. The information in this report is presented to inform access to care for AI/AN populations for a limited scope of services – namely STD screening, prevention and treatment. The Infertility Prevention Program (IPP) is a safety net program that targets youth and young adults who are uninsured or underinsured. A higher percentage of the AI/AN population fall within the target population for IPP than for

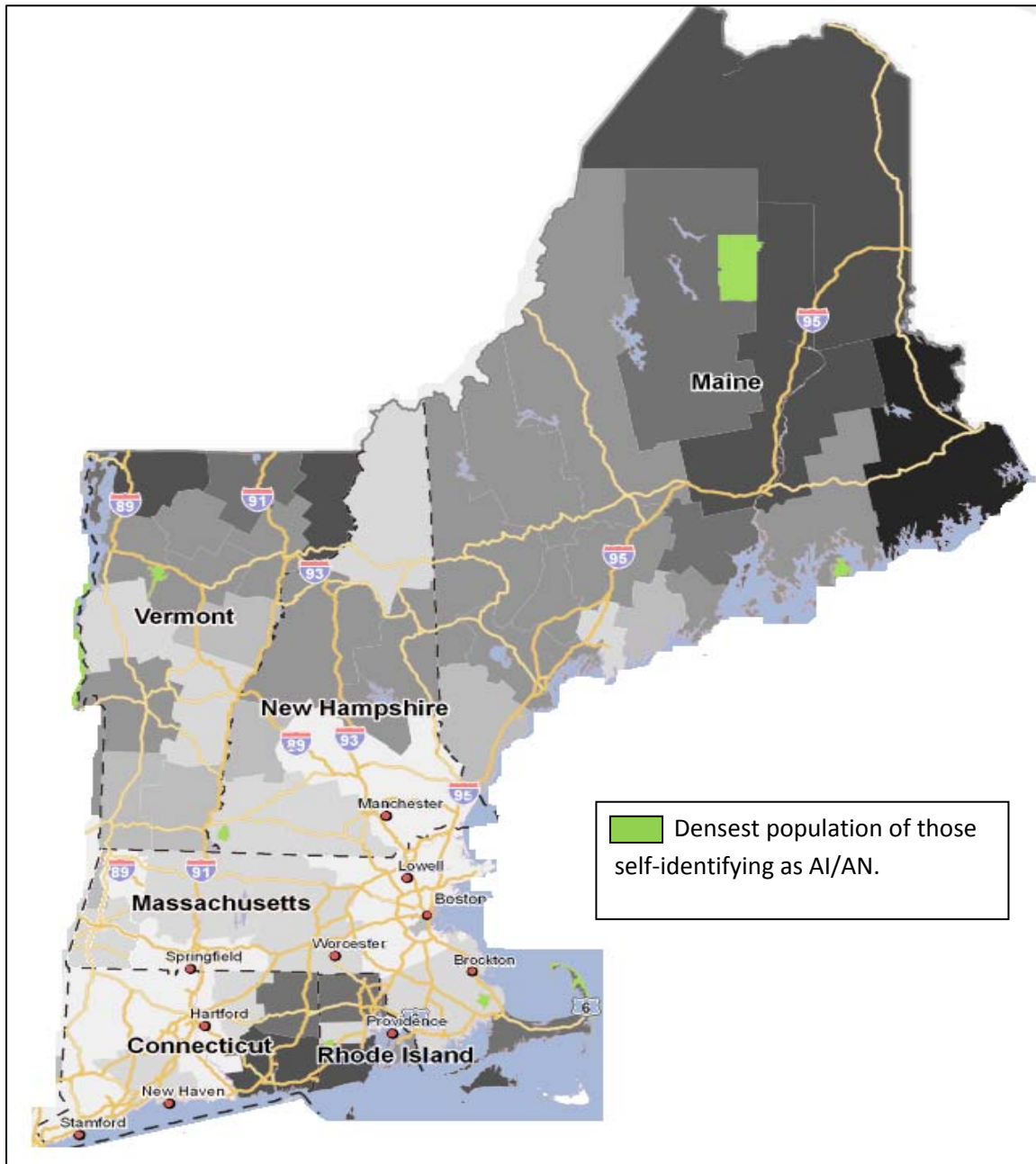
some racial/ethnic groups; IPP may be a natural partnership for other programs serving AI/AN in the Northeast.

Geographical Distribution of AI/AN in Region I

Four of the states in Region I have federally recognized tribes: Connecticut, Maine, Massachusetts and Rhode Island. New Hampshire and Vermont do not have any Federally Recognized tribes, but both states have populations of people who associate with the Abenaki Nation, a non-federally recognized tribe. For a short description of each of these tribes in the Northeast see Appendix A. Massachusetts has the largest population of Native Americans in the Region (12,811), followed by Connecticut (8,169), Maine (6,636) and Rhode Island (4,520), according to the *2005-2009 Community Survey 5-Year Estimates*, New Hampshire (3,210) and Vermont (1,713) have the smallest AI/AN populations and also don't have any federally recognized tribes residing in them.

According to U.S. Census data, there are concentrations of AI/AN populations living in several rural areas in Region I. There are concentrations of AI/AN peoples living in northern Maine, northern Vermont, and the counties surrounding the Connecticut-Rhode Island border (Figure 4).

Figure 4: Graphical representation of densest populations of AI/AN in Region I



Content Source: 2000 Census Data

The densest population of AI/AN peoples in urban settings are in Bangor, Maine; Saint Albans, Vermont; and Norwich, Connecticut, with relatively large populations in Providence, RI and Portland, ME .

Overview of Access to Health Care for AI/AN Populations

The Native American, or AI/AN population, has a distinct history and relationship with the federal government that differs from that of any other racial or ethnic category in the U.S. The U.S. government is obligated to maintain the health of American Indians and Alaskan Natives by providing funding and services to the tribes, as determined most notably by the Snyder Act of 1921. Borne of this obligation, the Indian Health Service (IHS) is now responsible for providing federal health services to almost 2 million members of the 564 federally recognized AI/AN tribes.^{xvi}

The IHS currently provides health care to AI/AN through three types of programs described below.^{xvii}

IHS Direct Care

Tribes can elect to receive care directly from the IHS. As with most forms of insurance, there are limitations to the services and providers covered by the IHS. The IHS provides funding for services obtained in hospitals on reservations or by providers who contract with the IHS. Not counting reservation sites, the IHS federal delivery system includes 28 hospitals, 58 health centers, 31 health stations, and 5 school health centers nationally.^{xviii}

Tribally Managed Services

The Indian Self-Determination and Education Assistance Act, passed by Congress in 1975, enabled Indian tribes, tribal organizations, and Alaska Native health organizations to contract with facilities for the provision of health care services to American Indians and Alaska Natives.^{xix} According to these contracts, services are then directly billed to Medicare, Medicaid or another third party payer.^{xx} These funding agreements total approximately \$1.8 billion and now represent roughly half of the IHS budget.^{xxi}

Tribal Services

Tribal clinics can offer a range of services, from primary and specialty care to outreach programs. Some tribal clinics, however, cover only life-threatening illnesses and provide health care only to American Indians and Alaska Natives who can document federal tribal status.^{xxii}

Urban Indian Health Programs

The Urban Indian Health Program seeks to improve access to both primary care and specialty care for AI/AN living off-reservation in urban areas.^{xxiii} Approximately 60% of the AI/AN population in the U.S., or roughly 2.5 million AI/AN, now live in urban areas. When AI/AN began moving to urban areas in large numbers, in the 1950s, this population had little access to health care services. Since then, urban AI/AN health facilities have been established via Title V; there are now 34 urban programs, ranging from community health to comprehensive primary health care services. These facilities serve approximately 600,000 AI/AN residing in urban areas, but

still account for only roughly 1% of the IHS budget. There was an urban program in Boston, MA that closed in early 2010. There are currently no urban Indian health clinics in Region I.

IHS in Region I – Nashville Area

IHS has divided the United States into 12 geographic regions called “Areas.” Each Area Office provides administrative support to the hospitals, clinics, and other facilities and personnel within its region. The Areas are further subdivided into Service Units, comprised of a hospital and perhaps several satellite clinics and field health stations.

Region I is part of the largest IHS service area: the Nashville Area. In addition to the six New England states, there are 22 states that constitute the Nashville Area. According to information provided by IHS, there are Indian health centers in Indian Island, ME, Peter Dana Point, ME, and Pleasant Point, ME.^{xxiv}

Table 1: AI/AN Systems by State

State	Funding Sources	Facilities
CT	Federal and tribal	Federally funded Indian Health Service primary care facility; tribal insurances; tribal contract care services; tribally managed
MA	Federal (may also be some tribal funding)	Federally funded Indian Health Service primary care facility; tribal contract care services; tribally managed
ME	Federal, state, and private	Federally funded Indian Health Service primary care facilities that are tribally managed; tribal contract care services
NH	State and private funding	Non-profit education and prevention programs
RI	Federal	Federally funded Indian Health Service primary care facility; tribal contract care services; tribally managed
VT	NA	NA

Nationally, fewer AI/AN have private insurance coverage when compared to most other racial and ethnic populations, and a greater share rely on Medicaid or other public programs as

described above.^{xxv} The Indian Health Service is the primary mechanism for provision of medical care by the U.S. government to AI/AN populations.

A primary focus of IPP is in working with Title X funded family planning agencies. In Region I, all Title X grantees in the region are also IPP-funded agencies (although not all clinics are IPP sites). A small number of Title X users self-identify as AI/AN in Region I. Overall in Region I, in 2008, only 461 or 0.25% of all Title X female family planning users were classified as AI/AN (either alone or in combination with another race; these users could also be Hispanic or non-Hispanic). Of these, 115 were in CT, 115 in ME, 127 in MA, 56 in NH, 47 in RI, and 22 in VT^{xxvi}.

Chlamydia Burden among AI/AN in Region I

American Indian/Alaska Native populations tend to shoulder a disproportionate burden of disease. The causes of racial/ethnic health STD disparities are complex. Socioeconomic cofactors are so entangled with issues of race and ethnicity—and in the case of STDs, sexual behavior—that the causal relationships are often hard to discern. But research has shown that socioeconomic status, and geography are associated with STD disparities—while risky sexual behavior does **not** explain the disparities.^{xxvii} Many social and cultural factors may be involved in varying infection rates within communities, including poverty, racism and discrimination, community prevalence, male-to-female ratio, incarceration rate and racial segregation.^{xxviii} Although STDs are a concern for the population at large, studies indicate that they are an even greater public health concern for AI/ANs. In the 1980s and 1990s, a Chlamydia prevalence of 24% to 30% was observed among AI/AN prenatal women in the Southwest, while a prevalence of 23% was identified among all women screened in a remote Alaskan village.^{xxix} Although Chlamydia rates among AI/AN women have since improved, data suggests that disparities persist. One study looked at AI/AN women screened specifically in 23 IHS clinics across three states. The data, which was collected during 2003, indicated a Chlamydia prevalence of 13.3% among young AI/AN women, which is five times greater than the prevalence among white women.^{xxx} A similar study conducted in family planning clinics in Region X found that AI/AN women aged 15 to 24 years consistently had higher levels of Chlamydia (CT) positivity.^{xxxi}

Health Disparities

We know that health disparities are often highly correlated with socioeconomic disparities. The prevalence of poverty, unemployment, and a lack of education among AI/AN impacts the health outcomes documented in this population. As described, there are higher rates of poverty, unemployment, and lower educational achievement among AI/AN populations. Additionally, AI/ANs are disproportionately likely to die from alcoholism, firearm wounds, and motor vehicle-related injury, as compared to the U.S. general population.^{xxxii}

Individual Risk-Factors

Sexual risk-taking behaviors are more common among AI/AN youth across the US than their white youth counterparts according to a national study. However, it should be noted that it is unclear if this national study is representative of risk-taking behaviors among AI/AN youth in

Region I. A 2000–2001 survey of over 5,600 high school students enrolled in Bureau of Indian Affairs (BIA) schools found that 59% of high-school students reported having had sex, compared with 46% of the national sample of youth. Twenty-four percent of surveyed students reported having four or more partners during their lifetime versus 14% of the national sample, and 56% of sexually active surveyed students reported using a condom at last intercourse versus 58% nationally. (Note that important methodological differences between the two studies precluded significance testing of differences.) Of those who had already had sex, 11% of AI/AN youth reported initiating sex before the age of 13, compared with 7% nationally. The results indicate that sexual risk-taking is slightly higher among AI/AN youth, even though condom use appears to be roughly equivalent. An earlier study (1992), also based on a survey with BIA high school students, found similar patterns.^{xxxiii}

AI/AN Served by IPP in Region I

The Chlamydia and Gonorrhea screening that is reported to the IPP Prevalence Monitoring Database reflects IPP supported screening in STD and Family Planning Clinics as well as some School-based health centers and juvenile detention centers throughout the region. As discussed, only a small percentage of the overall population is classified as AI/AN in Region I. According to the U.S. Census data, AI/AN comprise just 0.4% of the women ages 15-24, in Region I.^{xxxiv} The total population of AI/AN women in this target age group for the New England region is just 3,467 (total female population ages 15-24 is 878,175), and we are reaching approximately 2% of these women per annum through IPP. From 2005-2009, just 542 of the female IPP reported Chlamydia tests were performed for women classified as AI/AN, or just 0.25% of the tests in women during this time period. These data must be interpreted with caution, however, since there is a high rate of missing race and ethnicity data; it is difficult to know if AI/AN are being missed and therefore disparities could be masked by lack of accurate race data.

These small numbers do, however, correspond with the overall small numbers of patients identified as AI/AN seen in Region I, especially in Title X family planning clinics, the most significant partner for IPP. According to the Family Planning Annual Report, in Region I only 0.25% of the women served in 2009 by Title X were AI/AN compared to 1% of Title X clients in the nation as a whole.^{xxxv} Overall, the numbers of AI/AN served are very small, consistent with the small numbers of AI/AN in New England. The numbers may be even smaller among the IPP-served population than the population as a whole given that AI/AN populations may access IHS-funded facilities instead of Title X-funded facilities.

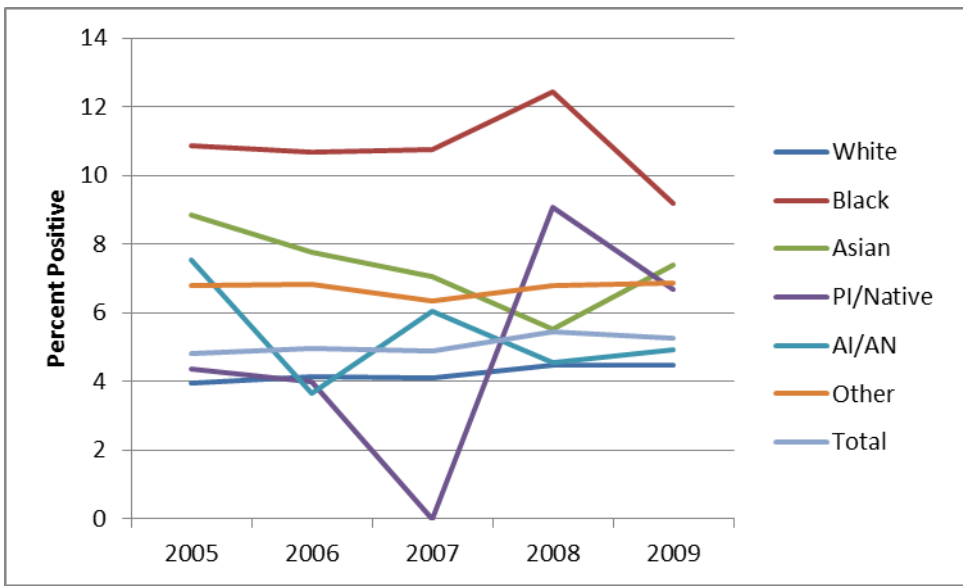
Chlamydia positivity for AI/AN in Region I

Although the numbers are small, we have compared the positivity rates for AI/AN women compared to white women (who have the lowest rates in the Region) and compared to the population as a whole. While nationally chlamydia positivity rates are consistently reported as

higher among AI/AN populations, the Region I prevalence monitoring data shows *some* higher, but not consistently higher, rates in this population. Because of the small numbers, the large numbers of “missing” race data, and possible misclassification of AI/AN, however, these data must be looked at cautiously.

Among AI/AN women under 24/25, the positivity rates were slightly higher in 2005 and 2007, than the positivity for white women. The rates, however, were virtually identical in years 2006, 2008, 2009; in these years the positivity was actually lower than every other category – except for white. Among women over 25/26, the positivity rate is higher than for whites, but this is based on very small numbers – with either one or zero cases positive each year. Out of the 542 cases of AI/AN women tested of all ages, there were 27 positive cases, for a positivity of 5.0%; in comparison, the overall positivity for women in Family Planning Clinics in Region I in 2009 was 5.1%.^{xxxvi} In Region I, the highest positivity is among Black/African-American – with a positivity rate two or more times higher than that of AI/AN (Figure 7).

Figure 7: Region I Chlamydia Positivity Rates in Women 24/25 and Younger by Race (2005-2009)*



*From 2005-2009, 7,271 tests were missing race data and they were not presented. When race was not indicated, data were omitted.

Content Source: Region I IPP Prevalence Monitoring System

The numbers served, and numbers positive, did not fluctuate greatly from year to year, with consistently small numbers throughout. The numbers of AI/AN served does vary, however, from state to state. Looking at just the most recent year, 2009, at the target population for IPP, the percent of women under 24/25 served that was made up of AI/AN ranged from 0.1% in NH to

1.1% in RI – with the other states in the middle. In both NH and RI, however, there was a zero percent positivity in this population, with 11% in MA (3 cases) and 7% in CT (1 case). Because of the small numbers, the positivity rate is highly unstable. Overall, however, when multiple years are examined, the positivity in the AI/AN population is slightly higher than the white, but not higher than the “total” population.

Table 2: IPP Region I 2009 Screening of Males and Females in Family Planning Clinics by Race and Positivity

RACE/ETHNICITY	No. Tests	% Tests	No. Positive	% Positive
ASIAN	528	1.5%	39	7.4%
AI/AN	98	.3%	5	5.1%
BLACK	3356	9.3%	396	11.8%
HAPI	46	.1%	4	8.7%
Other Race	4281	11.8%	314	7.3%
WHITE	27712	76.7%	1275	4.6%
Hispanic	5443	15.1%	426	7.8%
Non-Hispanic	30404	84.2%	1583	5.2%
Missing	281	.8%	26	9.3%

Content Source: Region I IPP Prevalence Monitoring System

II. Qualitative Regional Assessment

IPP Key Informant Interviews Summary

Background/Methods

The IPP Infrastructure for Region I contracted with a Medical Anthropologist, Diane Weiner, PhD, with extensive experience working with the native populations in the Northeast. She conducted 7 interviews in Region I between February 28 and May 10, 2011. Interviews lasted between 20 and 90 minutes.

Contacts from each state were made in distinct manners. Using a variety of contacts across the region, every attempt was made through numerous phone calls and in-person visits, to interview a tribal representative with direct knowledge of the reproductive health services offered in their community. In most states this was possible, although in VT the interviewer was referred to the VT STD Director, Daniel Daltry, who was interviewed.

One thing that is important to note is that the interview participants do not speak for other Natives or Native programs in the state or region – to do so is culturally, socially, and politically unacceptable. These individuals recognize that each tribe and tribal regions have distinct political and health histories and health conditions. Indeed most interview participants inferred such ideas, the interviewees in Maine, specifically, identified this matter as critical to understanding tribal and regional variation. An important lesson for potential collaboration with AI/AN communities is that tribal political mechanisms may at times necessitate lengthy planning of activities. This must be anticipated and included in the planning for any collaborative initiatives.

State Summaries:

Connecticut:

Conversations held with representatives of Wuttooantam Foundation (a non-profit organization of the Eastern Pequot Tribal Nation) and director of Mashantucket Pequot Tribal Health Services (Mashantucket Pequot) (N=4); no clinicians interviewed

Access to sexual health services: Native Americans who are federally recognized and reside in CT or are enrolled in a state recognized tribe have access to services at Mashantucket Pequot Tribal Nation (MPTN) Health Services, the only direct care clinic in the state. STD screening is done at this facility. Moreover, all women who receive PAP tests also receive STD screenings. A current goal of MPTN Health Services is to assess current diagnoses and develop service plans related to such diagnoses and associated manifestations for the future - 10 or 20 years from now. In order to achieve this goal, an objective is to collect accurate data in a confidential manner. Native people may also access Planned Parenthood, private medical services or emergency services but reportedly the largest portion of Natives, at least those in New London County, uses MPTN Health Services. The general perspective is, if a person does not have medical insurance he/she will obtain services through MPTN or Planned Parenthood. Two tribes offer tribal members private health insurance.

Barriers to care: Purportedly, the greatest challenge for youth to obtain treatment and screening relates to confidentiality issues such that youth may fear that parents might learn about their behaviors. A secondary challenge is that definitions of sex have changed with this generation and thus prevention needs may be distinct for this group. Although not mentioned by participants, prior research suggests transportation may be a challenge to Native people who live in other areas of the state and are unable to visit MPTNTHS.

Community Perceptions and Beliefs about Family Planning and STD clinics: There seemed to be limited familiarity with such agencies. They know they exist and where they exist, but utilization is limited.

Other: Youth would benefit from a “place they can go that is discrete... where can get checked out and not have to tell somebody”. Suggestions for such clinical services and education included offices of school guidance counselors and nurses. Services should be available to those in eighth grade and higher. The community members who shared this view, three tribal leaders of distinct ages, felt tribal youth needed supervised activities such as dances to prevent “hanging out and getting into trouble”, thus decreasing the need for STD screening and treatment.

New Hampshire:

Interview with one non-clinician who identifies as Abenaki.

Access to sexual health services: There is no federally recognized tribe with a land base in NH. Like those in VT, the NH Abenaki communities are geographically dispersed throughout the state and according to the interview participant face similar access to quality services as other members of NH face. There are 12,000 Native households in NH. The interviewee notes that the 2010 census data reveals that Native households have much lower income than the average general NH population and a “disproportionate amount don’t have good health insurance and struggle in how get health care”. The interviewee believes NH Abenaki may use Title X programs for services.

Wijokadoak, Inc. offers screening information and referral services as well as education through “Health Tents” at NH and VT pow-wows. In all cases, the staff tries to “normalize” screening and education in order to reduce potential stigma. For example, HIV/AIDs testing is offered along with blood sugar screening and other testing, as part of a holistic health service. The HIV/AIDs tests are home tests due to state laws. The project staff assists people to mail the test and participants get a phone call with results. The state provides lists with STD clinical information for positive results. Funded primarily through Dartmouth Family Medicine Program, this project was initiated in 2006 in order to provide culturally specific HIV/AIDs information to NH and VT Natives with seven education circles. Funding has been and continues to be obtained from various partners including the NH AIDS and Education and Training Center at Dartmouth Medical School, the NH Endowment for Health, Dartmouth Family Aids program and CDC. In 2008 Wijokadoak contracted directly through Dartmouth, without the Minority Health Coalition doing a fiscal pass through – it was a mutual agreement. The director explained:

We found by conducting talking circles ... specifically for Native Americans, the Native American people took the [education] more seriously . Once specific education [materials were created and distributed], Native Americans tune in more. It was more relevant personally. We recognize you have unique culture! And that became extremely meaningful for people – part of empowerment – this affects our culture and our community and took it more seriously, it got their attention.

Statistics revealed a relatively low incidence of HIV/AIDs among NH Natives, thus program education services became oriented around prevention. In terms of HIV/AIDs, individuals apparently “...used a broad range of services – family doctors or they are going to ER, or they’re using whatever means they have. There are a few folks who offer more traditional, more NA counseling, herbal, services at pow-wows, some people will rely on these– although those people

[herbalists and the like] are very few and far in-between". People who are enrolled in federally recognized tribes but reside in NH also reportedly travel to MA, ME, and CT for STD screening and treatment services.

Barriers to STD Screening: As noted above, economic challenges may impact access to and use of screening. The social, historical, and political legacy of disenfranchisement may deter Natives from using services. Messages that are not culturally specific may have limited influence on Native people.

Community Perceptions and Beliefs about Family Planning and STD clinics: Issues involving Abenaki Native youth tend to be managed by families. Wijokadoak, Inc. also sponsors a multiple generation language and culture camps each summer. The project staff, assisted by a nurse, reviewed the VT and NH adolescent BRFSS data and,

"...pulled out facts on drinking, drug use, and sexual behaviors and abuse – we identified these as contributing to STDS. We wrote out facts from this information on index cards so that the adolescents could read aloud facts to adults. We had [a discussion about are these] understated, were people not being honest? Were kids overstating their behaviors? Were they bragging [and impacting risk behavior data]?"

The staff taught youth to say "no" to these behaviors in their native language of Abenaki so that *"all the grandmothers, mothers, fathers are around you and protecting and helping you to say No. We don't want you to die from AIDs, STDS..."* This same program offers craft projects that separate adult men and women for discussions about sexual behaviors and risk prevention in same sex venues. Project staff noted that STD prevention messages and modes for distributing messages needed to be developed especially for older widowed segments of the populace (people ages 60 and older) who have re-commenced dating. This population was less familiar with STD information than younger community members.

In NH, Native identity may be obscured due to perceptions associated with political rights of recognition and tribal membership. Non-Natives may fear a potential struggle by Natives to gain private land as part of the trust process or the development of Native casinos, so Natives may defer identification as such. As in much of the Northeast, Natives feel that "there is an expectation they won't be recorded, or listened to 'cause there is not state or federally recognized tribe in NH".

Critical challenges to prevention education purportedly also relate to local Native history, especially the eugenics movement in VT whereby Natives were sterilized by the state from 1931 through the 1950s (see Gallagher 1999; Wiseman 2001). Such issues are deemed to be difficult but imperative to discuss in order that Natives do not continue a legacy of infertility. Messages,

especially for youth should emphasize the statistics, the asymptomology, and the “dire consequences” of infertility. Adults should be educated to enable them to educate their children. Materials should be specific to NH Native culture(s), or Native culture in general with resources specific to the state. The health educator would prefer on-line access to materials.

Opportunities to partner with state STD Directors or Family Planning Facilities: Program staff is willing to partner with state and state based programs. Fiscal and educational partnerships are desired.

Vermont:

Interview was conducted with state health officer from HIV/AIDs, STD and viral Hepatitis program. Interviewee has worked with this program for five years.

For the first time in the history of the state and the U.S., two bands of Abenaki were state recognized on April 22, 2011. Preliminary 2010 census results estimate about 2,000 Natives in VT.

Access to sexual health services: VT Natives do not have access to any tribally specific Native health programs or services. In VT, the Planned Parenthood system is the main provider of STD and Title X services. Any individual 24 years of age or younger may obtain free screening. Those persons 25 years of age and older need to present certain risks (symptoms, a new partner, partner with multiple partners) in order to obtain free testing. There are 11 Planned Parenthood clinics in the state. There is a clinic in St. Albans – a region with a sizable Native population. The data for use by race/ethnicity is limited although there are reports of use by Abenaki. In the rural parts of the state, the incidence of STDs is relatively low and reportedly “providers are not prepared to do testing at regular basis”, instead screening takes place in association with presentation of symptoms.

Barriers to STD screening: A key challenge to STD screening and treatment among youth and young adults is transportation. Ideally clinics are located so that people can travel to facilities in 45 minutes or less, however if a person does not have a car, fuel, or a license, s/he must depend on another person for STD clinic access. Public transportation is rare. About four schools have considered STD screening as part of comprehensive services to students. The interviewee notes that “It is challenging for any school to do, and without financial resources and no money from the state” it is very difficult to create such a program.

Community Perceptions and Beliefs about Family Planning and STD clinics: An additional challenge relates to ethnic identity. VT has a very rural and relatively small population of 625,741 of which 95% is White. This situation may lead to “a compromise of confidentiality of anonymity” since characteristics might be matched with personal identity. Providers need training to enable and encourage self-reports of identity in order to acquire accurate data. The interviewee feels gender may also play a part in utilization such that males might consider Planned Parenthood to be “women centered” and defer use.

Other: Needed resources include funding, school-based clinics, and media campaigns. The latter should encourage males to use Planned Parenthood and all individuals to get screened for STDs. The GYT campaign – “Get Yourself Tested” was explained as a model media campaign. A goal

should be to integrate other STD screening messages with those of HIV, especially since the latter has greater funding streams.

Rhode Island:

Interview of non-native clinician who has worked with organization for three years.

Access to sexual health services: There are approximately 12,500 Natives in this state. Narragansett Indian Health Center (NIHC) is the primary STD prevention and screening facility for tribal members and eligible Natives in RI. It is an ambulatory health facility. Services include clinical care, community outreach, and community and personal education. The physician is male and the NP is female. Some tribal members who have private insurance may use private services. There do not seem to be distinct services for youth as compared to young adults. The interviewee is unaware of any school-based clinics in the area. The clinic holds an annual “Women’s Days” event and distributes STD prevention and screening information. Guest presenters have discussed this topic.

Transportation to the clinic is available to clients in the South County area but not in Providence or elsewhere. Those residents reportedly have access to community clinics and a “Women and Infants Health Center”. NIHC pays for services based on referral. For example, one of the NHC clients has been referred to an outside facility for “infertility or multiple miscarriages – not sure if it is STD related...” according to the interviewee.

Barriers to STD Screening: Apparently youth may feel uncomfortable discussing STD matters with clinic staff, if parental notification is involved. The interviewee was unsure if parents had to be legally notified. Young adults may associate stigma with STD services as “... a lot of times patients make appointments and don’t say what they want to be seen for until they are in the room with the provider...It’s embarrassing - asking for screening and the whole subject in general”. The provider is unsure if transportation to non-Native based facilities is difficult. The state is geographically small, but a drive of more than 20 minutes is deemed “long for Rhode Islanders”, thus access to care may be a challenge. It is imperative to note that the interviewee did not feel her clients associate infertility with STDs. Future education programs should connect these issues.

Community Perceptions and Beliefs about Family Planning and STD clinics: Prevention information is impacted by the notion that adolescents believe that “...nothing can happen to them” and may not feel prevention messages address them. Young adults in this community tend not to be “...interested in reading a lot of words:” Posters and visual messages that include knowledge and ideas from a tribal member are the most appropriate and trusted means of education. The age and gender of the messenger should match that of the intended audience. Potential messaging avenues might include TV, i-phones, smart phones, Facebook, and the internet for younger people. Youth would also be served by school-based clinics.

Home visits and presentations are also worthwhile for adults. Another suggestion for urban Native populations,

“...is to [try] putting message on buses. They sort of jump out of you ‘cause they are so large and in urban areas there are more buses than rural areas. We don’t have subways in Providence but sure cities that do, that might be another way.”

Opportunities to partner with state STD Directors or Family Planning Facilities:

This provider is not aware of outside Family Planning or STD clinics that tribal members use.

Maine, urban:

Interview was conducted with clinician from Passamaquoddy tribe.

Access to sexual services: This urban program offers culturally sensitive clinic and field based HIV/AIDs prevention programs and STDs prevention, testing, counseling, and referrals. The interviewee asserts that local individuals most likely use Penobscot Nation clinic (I.H.S. clinic) as well as Wabanaki Mental Health Services. A number of people also supposedly use Penobscot Community Health Center (not a Native clinic) and the city of Bangor STD clinic. They also do fee for service care at such facilities as Eastlery, a family practice clinic – a federally qualified health clinic in Bangor. The Bangor STD clinic has state funding and the others offer fee for service and sliding scale fees. Clients of Wabanaki Mental Health claim they also receive extensive STD counseling and screening at tribally operated clinics during prenatal visits.

The youth focused program “Be proud, be responsible” is a curriculum based program for STDs and Maine Natives. The project staff travels to ME tribal communities to conduct activities and education through peer training, interactive games, film, and incentives. Tribal youth are trained to be presenters and they in turn present to communities. The program has been adapted from one used in the African-American community. The interviewee stated:

“...On March 18th we went to Indian Township and did a day long program. We had educational counseling for providers at lunch. At 1:30 the peer trainers go to the school and do a training – play games, incentives, role play, we include the influence of substance abuse, cause that’s really big in the Indian community. Like how substance influences decisions. The curriculum goes with the film – dedicated to a young man who passed away with AIDs. (The film is one they wrote and produced titled, “our Story”).”

Barriers to STD screening: Young adults have particular considerations, especially about condom education and access. The knowledge base of this segment of the population is reportedly thorough, but young adults have asserted to program staff that 1) certain types of preferred condoms are not available at tribal clinics and/or 2) they do not like using condoms in general. Therefore, program infection prevention focuses on education about distinct types of condoms and prevention choices. Project staff is trained by the state and counsel clients on HIV and risk prevention in culturally appropriate manners. The non-Native STD approach is to ask a list of queries such as “Do you have sex with men? Do you have sex with women? “Do you have anal sex?” Such a protocol is viewed as inappropriate and some of the questions may be deemed “vulgar” by ME Natives. The Native approach is based on education followed by a discussion of possible risks – direct questioning is avoided.

Challenges to treatment for youth may include transportation and confidentiality. As the participant notes, clients may be concerned that “my auntie is at the front desk” – and are more worried, “oh my god will someone find out, if testing for Chlamydia, they’ll assume I’m sexually active”. Although the clinics maintain confidentiality, there is a fear that a relative may see a medical record at a tribal clinic and become aware of a person’s health status. Among older adults, the greatest challenge may be fiscal. After the age of 21, access to state insurance may be limited.

A major health risk involves substance abuse among members of this population. Tomah explained:

“There are increased rates of substance use and when using, people don’t tend to care for selves and take health as a priority and put self in compromising positions, you [hang out] with a rough crowd, and things happen. ...when there is substance abuse, there is just a general lack of caring, put yourself in riskier places. Is the sex consensual? Sometimes I think it is marginal and I don’t think they are going to use condoms when they are impaired. ... High risk with Chlamydia is different, than with HIV - someone having unprotected sexual contact with HIV+ person or men unprotected sex with other men; and injecting drugs; others using substances, having sexual contact with multiple partners – and I don’t see this so much on the reservation but in Bangor,

The challenges for this urban population may differ from those of reservation or rural based populations. Urban Natives may have to wrestle with paperwork and “red tape” in order to access services.

Community Perceptions and Beliefs about Family Planning and STD clinics:

Unfamiliar programs may also trigger feelings of fear or anxiety. These emotions may also occur in association with the use of rural non-Native based programs. Moreover, while Bangor is considered to be diverse, other towns and areas are not; Natives may feel they are “treated differently” than other clients, and “there is a fear of discrimination and racism” held by some Natives.

Opportunities to partner with state STD Directors or Family Planning Facilities:

HIV and risk prevention training of project staff occurs in association with the state and counsel clients on HIV and risk prevention. It is unclear what other specific types of partnerships would be of interest to the staff.

Other: The interviewee claimed beneficial resources would include relatively low literacy written materials with details about all STDs. As she relates

there is one pamphlet I had, it was the best pamphlet we ever had – it was easy to read and had every STD on it – in every form, and it had resources for local places to get tested for everything. I love that brochure. It's called 'STDs'. It has a little graph, it is easy to read, and colorful.

Information should include potential symptoms of conditions as well as testing sites. Other methods to deliver messages about screening resources and awareness might take different forms such as the continuation of local events about global issues (National HIV testing day programs at distinct tribal locales), the placement of information in tribal newsletters, and the revision of the STD pamphlet to include Native and non-Native local resources for Aroostock and Washington Counties.

Maine, rural:

Interviews conducted with clinicians from distinct tribal health facilities. One interviewee is Penobscot, the other is Passamaquoddy (N =2). It must be clarified that these interview participants do NOT claim to represent the state at large, merely two facilities.

Access to sexual services: According to the health directors, tribal members use their respective tribal health services. Funding is obtained through Indian Health Services but the clinics operate as local comprehensive Health Care Delivery Systems under the “P.L. 638, Indian Self Determination Act.” Any enrolled member of any American Indian or Alaska Native tribe may obtain services from these facilities. Women pregnant with a Native child may also obtain services. There are 26 staff members at Pleasant Point Health Services, none of whom are dedicated to STD prevention and health.

The Pleasant Point facility offers services to adults and youth that are deemed age appropriate. For example, they “offer HPV screenings and vaccines to the younger age group”. Importantly, youth do not need parental consent to obtain clinic services and the director does not feel youth encounter barriers to services. There is no school based clinic in the area.

The Penobscot Nation Health Department focuses on gender appropriate services with both a male and a female NP. The director stated, “basically you can come to health center and we’ll try to provide whatever you need, if we can’t”, we will obtain assistance for the person “through another provider and contract care services”. They provide “overall prevention” of chronic and acute diseases through health promotion and education. Similar to Pleasant Point, this clinic offers HPV vaccines for youth. They also have a summer youth employment program for those 14-18 years of age. In the program the youth work 20 hours a week, while two of the 20 hours per week are focused on mandated preventive education on topics such as substance abuse, oral health immunizations, and chronic conditions.

As in other tribal areas, the Pleasant Point population apparently uses tribal health services rather than Title X or other STD clinics. The exception to this rule may occur when and if “...a

direct family member is providing Pap or lab draw”; in such cases an individual may forego tribal services. At Penobscot, tribal members may use services in Bangor, especially for STD screening but generally the populace accesses tribal services. This utilization of tribal services has increased as the stigma associated with HIV/AIDs has decreased.

Barriers to STD screening: Perceived and actual discrimination enacted by non-Natives dissuades Native people from reservations to access off-reservation services. Family planning providers would facilitate interactions with Natives by considering

.... the big issue of cultural sensitivity, just to recognize there are differences, spirituality, religious differences, racial differences and be respectful of that.

The cost of automobiles and gasoline and limited public transportation may limit the use of off-reservation services. This situation becomes more complex for younger populations, since youth may be wary of confidentiality issues at tribal clinics and desire off-reservation programming but may be unable to get to such services. Certain facilities in ME do provide transport to distinct health services. Adults may not be comfortable discussing sexual health with their children or in groups and thus ignore the topic.

Community Perceptions and Beliefs about Family Planning and STD clinics: The Pleasant Point health director asserted that “...the attitude is pretty comfortable for sexual health, and maintaining good sexual health”. Females tend to use services more than males. This situation is attributed to the fact that “...women outnumber men in our community 2 to 1” and females in heterosexual relationships are viewed as responsible for sexual health. Clients also include a gay population. This interviewee noted that living on the reservation is a protective factor for being gay. Tribal members are tolerant of distinct sexual identities and non-Native Maine residents may discriminate against gays.

The reservation populations are relatively small. The greatest challenges include education among those who do not want to know STDs and related conditions happen or exist as well as financial limitations and associated staff hires. As one person mentioned “Although we’re a small community, we’re short staffed, and have financial [needs], cause that would allow us to have more staff to educate and to promote” prevention.

Other: The preferred approach to education messaging is via word-of-mouth, television, brochures, and posters.

Cross Regional Issues:

- Transportation challenges may affect rural and youth populations. The former may not be able to access services in general, especially if a person resides off-reservation or tribal based services are unavailable. The latter may be dependent on adults to obtain access to services – adults to whom youth may not wish to reveal such service needs or interests.
- Fears of breached confidentiality may cause people to defer or forego use of services at local Native clinics, especially if a relative is an employee. Importantly, the perspective that “we are all related” may refer to nuclear, extended, tribal, or inter-tribal relations; this view may influence utilization choices.
- Based on a variety of infrastructural and social challenges, it is critical to understand how youth obtain services and information.
- Concerns of perceived illness connected stigma, socio-cultural prejudice, and racism reportedly may incline individuals to not identify as Natives among non-Natives. Moreover, concerns about identity may alter the use of non-Native STD services. Both of these situations can and do skew associated statistics.
- Appropriate messaging must be culturally relevant and competent. Factors to consider are the messengers (gender and tribal specific), message technology, methods of dissemination, and literacy levels. More rural, older and northern populations tend to emphasize personal oral transmission of knowledge and information.
- Southern, as opposed to urban, communities may have greater access to education through smart phones and internet technologies.

Recommendations and Conclusions:

- Facilitate the collection and analysis of accurate data on Native screening. This data collection must include training of health professionals and their assistants on ways to encourage Natives to self-report ethnicity/race when using non-Native services.
- Conduct additional conversations with tribal health contacts to elicit culturally specific message content. Collaborate with tribal health leaders to disseminate messages using locally specific approaches.
- Due to challenges associated with transportation, fears of limited confidentiality, and preventive education levels, youth, especially should be offered culturally appropriate education and screening conducted in a confidential manner. Wabanaki Mental Health Services and Wijkadoak offer two distinct models of education and screening. Staff from these programs might train persons affiliated with other facilities.
- At a structural level, services should be provided in association with transportations services.
- Education and prevention messages should employ local technologies embraced by targeted age groups. For instance, interactive electronic programs may be suitable and preferred modes of information dissemination, especially in Southern areas. There are Native health education organizations, such as the Healthy Aboriginal Network, National Native American AIDs Prevention Center, that have developed web based education or resource distribution of materials for youth and young adults.
- Non-Native facilities must actively train staff about perceived discrimination and its impact on Native clients. Furthermore, training on the overt and covert causes of medical mistrust by Natives might alleviate fears of discrimination.
- Media messages should address both genders and a variety of ages. Multi-generational audiences might encourage other participants to actively engage in education. Messages should “normalize” and de-stigmatize prevention and screening services and education.

III. Region I IPP-specific Recommendations:

As described, the AI/AN population of the Northeast, or Region I, is small. In this region, the data indicate a relative lack of documented disparities in STI rates among AI/AN in Region I, compared to other racial/ethnic minority groups (most notably Black/African-American). Given small size of the population, combined with the lack of documented disparity, and limited (shrinking) resources available for targeting STD prevention, screening, and treatment, the evidence does not support putting specific outreach to the AI/AN tribal communities at the top of the list of priorities for Region I.

Regardless, it is important that the Region try to reach out to the communities most in need, to meet the needs of all racial and ethnic groups, and to provide culturally appropriate services to all. Each project area needs to evaluate their own local data to determine who the high-risk, under-served communities are, and where they are located. It is important to continue to collect, and to improve on our race and ethnicity data, and to continue to monitor and address disparities as they are identified. All lab slips should be filled out completely, and every attempt should be made to capture complete and accurate data. Training and quality assurance activities should be conducted as needed in order to ensure that data are complete, and that race is classified according to the client's self-selected identity and not assumed or guessed by the staff based on appearance. Without 100% of the race and ethnicity data, and a confidence that it Race/Ethnicity are accurately identified, disparities may easily be missed.

IPP Prevalence Monitoring regional and state data are stratified by race and ethnicity, and will be presented to the Regional Advisory Board. Project areas will be asked to identify the highest risk populations by demographic and geographic information, and will be expected to reach out to those populations – including AI/AN - if that is one of the populations identified as at increased risk. Over time, as more clinics are identified as not reaching the 3% minimum positivity threshold for participation in the IPP project, identification of additional clinic sites may be possible. In considering additional partners and clinic sites, AI/AN will be given particular consideration. If a specific tribal community is selected to be approached for a possible partnership with IPP, it is important to remember the specific needs of the community and expect the process to take more time and communication than other sites might require.

Recommendations:

A. Training and Capacity Building

1. Continue to improve data collection and analysis. All lab slips should be filled out completely, including the race & ethnicity variables.
2. Race and ethnicity should be classified according to the client's self-identity; it should not be determined by the clinic staff guessing by appearance.

B. Analysis and Assessment

1. Annually, project areas will be asked to describe their efforts to reach the highest risk and most vulnerable populations through the IPP project.
2. IPP data stratified by race and ethnicity will be presented quarterly and discussed bi-annually at the IPP Advisory Board meetings.

C. Partnerships

1. Consider reaching out to Tribal Communities when selecting new IPP sites in the Region.
2. If reaching out to a Tribal Community, build in additional time for communication, and relationship-building in order to identify the community's concerns and meet their needs - to ensure a culturally appropriate intervention.
3. Health promotion messages targeted to Native Americans should be tailored and culturally appropriate.

Appendix A: American Indian Tribes in Region I

Connecticut

Federally Recognized: Mashantucket Pequot Tribe, Mohegan Indian Tribe

Non-Federally Recognized: Nipmuc Indian Bands



Mashantucket Pequot Tribe

This tribe resides on one of the oldest American reservations being established in 1666. It is located in Southeastern Connecticut and spans 1,250 acres. In 2000 the tribe had a total of 552 members, 325 on the reservation and 227 that claimed the heritage. By 2005 the total population had increased to 785.

The Mashantucket Pequot Indians run one of the more famous casinos, Foxwoods as well as their own museum and research center. The tribe is run by a seven member council.

<http://www.mashantucket.com/default.aspx>



Mohegan Indian Tribe

This tribe lives in the upper east Thames River valley in Montville, CT on 700 acres of reservation. There are currently 1,700 members. The tribe was originally combined with the Pequot Tribe, but by the early 17th century they had separated, warred and the dominating tribe was defeated.

The tribe has a Tribal Constitution that is enforced by a nine member Tribal Council as well as a seven member Elders Council. The Tribal Council has the powers that do not fall to the Elders Council. The Mohegan Tribe owns and runs Mohegan Sun, including two casinos, a luxury hotel and multiple entertainment venues, in Uncassville, CT.

<http://www.mohegan.nsn.us/default.aspx>

Nipmuc Indian Bands

None of the Nipmuc tribes are federally recognized, but two in Massachusetts are acknowledged by the state. There are Nipmuc tribes in multiple states including Connecticut, but Massachusetts is the home of its greatest populations.

Maine

Federally Recognized: Aroostook Band of Micmac Indians, Houlton Band of Maliseet Indians, Passamaquoddy Tribe, Penobscot Tribe

Aroostook Band of Micmac Indians



This band is one of about 29 bands totaling 30,000 members. The Aroostook Band has about 1,000 members all residing in Aroostook County in Northern Maine. The tribe combined forces with the Maliseet Indians, creating the Association of Aroostook Indians, to receive recognition from the government. After the Maliseet Indians were recognized, they moved on and the Micmac had to wait about a decade to receive their own recognition.

The tribe of Micmacs utilizes the common tribal council form of government. There is a chief, a vice chief and a nine member council. All types of economic progress are nurtured within the tribe. The administrators set up an Economic Development Program to support and assist those members with entrepreneurial ideas, who may lack the resources to achieve them.

<http://www.micmac-nsn.gov/index.html>

Houlton Band of Maliseet Indians



This tribe consists of 800 members all led by a chief. There is a second, smaller band in New Brunswick, Canada called the Meduxnekeag River home. The tribe occupies a large portion of the border between Maine and Canada along the Meduxnekeag River. Since 1794 the tribe has had free border-crossing privileges since their tribe spans into both countries.

The tribe has been known as a hunter-gather group. In addition to the chief there is a six member council governing the tribe.

This tribe runs its own health department allowed by IHS.

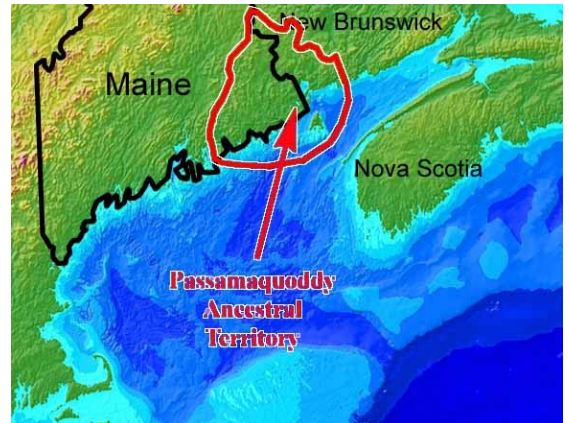
<http://www.maliseets.com/index.htm>

Passamaquoddy Tribe

This tribe lives on two separate reservations, both located in Maine. The Indian Township Reservation is located in Princeton, ME while the Pleasant Point Reservation can be found in Perry, ME. There are a total of 3,369 members. At Indian Township there are 1,364 members while Pleasant Point shelters 2,005 tribal members. This tribe is also located on the American/Canadian border in Maine. The St. Croix River cuts through the tribal reservations so the tribal members live in both Canada and Northern Maine.

The tribe has a more hierarchical governing set-up. There is a chief (also known as a governor), a Lt. Governor, as well as a tribal council consisting of six members. This tribe is a hinter-gatherer group with a specialty in seafood.

<http://www.passamaquoddy.com/>



Penobscot Tribe



This tribe consists of 2,365 members. The reservation is located near Old Town, ME. Originally part of the Abenaki Nation, the Penobscot Tribe was federally recognized and separated from the larger group.

The governing system consists of a Chief, Sub-Chief, and a twelve-member tribal council. There is also a Penobscot representative in the state of Maine legislation. This tribe was a hunter-gatherer group. There was some agriculture, but not as much as in the Southern New England areas. The tribe had skills in basket weaving as well as canoe making.

<http://www.penobscotculture.com//index.php>

Massachusetts

Federally Recognized: Mashpee Wampanoag Tribe, Aquinnah Tribe

Non-Federally Recognized: Nipmuc Nation (Hassanamisco & Chaubunagungamang Bands), Narragansett Tribe (recognized in RI)

Mashpee Wampanoag Tribe



The tribe has 1,200 members, most of which live on the reservation in Mashpee, MA. The leaders of the tribe are a chief and a traditional medicine man. In addition to the two traditional leaders, there is an eleven person tribal council. The Wampanoag Indians have more than one tribe in MA; however, this one has purchased land in Middleboro, MA with the intentions of building a casino. Every year the Wampanoag people have what is called a 'Powwow' with other tribes and select a 'Powwow' Princess. In addition to the more entertainment-type endeavors, the tribe runs its own museum.

<http://mashpeewampanoagtribe.com/home.php>

Aquinnah Tribe

The Aquinnah are one faction of the Wampanoag tribe in the large group called the Wampanoag Nation. This tribe lives on the southwest portion of the island of Martha's Vineyard in the town of Gay Head. Since 1987 the tribe has owned 485 acres of land. Of those 485 acres, 160 are private and 325 are common land. The common lands include areas such as the Gay Head Cliffs and Herring Creek. There are 1,121 members enrolled in the tribe. Of these, 68 live on the tribal lands of Aquinnah and 298 live within the tribe's service area (Duke's County). The remaining members are registered, but do not live on tribal lands.

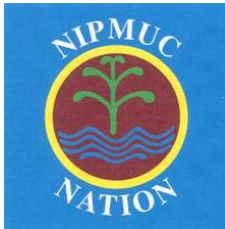


The tribe owns and runs a few businesses including a shellfish hatchery. There are also plans to build a community center that will house a daycare facility. The land has a multi-purpose building in addition to its housing that shelters approximately 30 families. The Aquinnah make it important in their culture to pass on tradition while also taking steps to economic sufficiency and modernization.

Just as most other tribes, the Aquinnah instated a tribal council government. There is no chief, but a chairperson. There is a vice chairperson as well as nine other members. The general population can call to override the council if they deem it necessary through a vote.

<http://www.wampanoagtribe.net/Pages/index>

Nipmuc Indian Nation (Hassanamisco & Chaubunagungamaug Bands)



The Hassanamisco Band is the largest group of Nipmuc people with over 500 citizens. There are a few other bands of Nipmuc, but this and one other are the only 'officially recognized' bands. True and official federal recognition still has not been obtained by any Nipmuc band, but the Hassanamisco are recognized by the Commonwealth of MA. The Hassanamisco Band owns 3 acres of land in Grafton, MA. Historically, this group was a hunter/gatherer, planter/harvester society.

The Chaubunagungamaug Band lives on the Chaubunagungamaug Reservation located in Webster/Dudley, MA. It is the other 'officially recognized' tribe. The members descend from a single family, the Morses, and came together in 1981 to regroup the Nipmuc in the area.

The governing system for the Nipmuc band is a two-council government. Both the Elders Council and Tribal Council are limited to no more than 10 members and make decisions concerning the tribe and its Constitution.

<http://www.nipmucnation.org/>

http://webpages.charter.net/cheryll.toney/Museum/a_brief_nipmuc_history.htm

Narragansett Tribe

This tribe is unrecognized in Massachusetts. There are a few scattered tribes in the state, but the larger and recognized population is in the state of Rhode Island.

New Hampshire

Non-Federally Recognized: Abenaki Nation

Abenaki Nation

This tribal nation is broken into eastern and western parts. The Western Abenaki are spread across multiple states including New Hampshire. Other tribes, members of the Eastern Abenaki, live on the Eastern side of the White Mountains and stretch into Maine. There are 12,000 Abenaki people total.

The main tribe in New Hampshire is the Ossipee tribe that is located near the lake of the same name.

<http://www.abenakination.org/front.html>



Rhode Island

Federally Recognized: Narragansett Tribe

Narragansett Tribe



The Narragansett people totaled 2,400 in the 1990s. The tribe is an Algonquian tribe within the recognized Narragansett Indian Tribe of Rhode Island. The reservation is made up of 1,800 acres and is located in the southwest of Rhode Island in Charlestown. The tribe is federally recognized in Rhode Island, but there are also unrecognized tribes in Massachusetts. The actual reservation has a population of 60 people according to the 2000 census.

The tribe is led by a chief and a medicine man. In addition to the more traditional leaders there is a 9-13 member board that makes decisions concerning the tribe, its activities and members. Historically the Narragansett Indians' economy was mainly based on agriculture. In addition, they were a hunter/gatherer society and were skilled fishers.

<http://www.narragansett-tribe.org/index.html>

<http://pluralism.org/profiles/view/71802>

Vermont

Non-Federally Recognized: Abenaki Nation

Abenaki Nation

This tribal nation is broken into eastern and western parts. The tribe in Vermont is known as the Sokoki Tribe and is grouped with the western portion of the Abenaki. This tribe is located in the Wabanaki region that is now Northern Vermont. The base of this tribe is in Swanton, VT. The tribe is made up of about 1,200 members and is recognized by Canadian tribes as true Abenaki.



The government is similar to other tribes where there is a chief as well as a tribal council. This tribe, again similar to many others, created a constitution. The Sokoki maintain traditional livelihoods such as basket weaving. There are also more modern aspects to the tribe's economy including the tourist industry, as well as community developing projects.

<http://www.abenakination.org/front.html>

Appendix B: Region I: IPP Key Informant Interview Guide

Goal of the interview: Is there a gap in the delivery of sexual health and reproductive health care that IPP could help to fill? Is there a role / a missed opportunity to help prevent infertility in young AI/AN (Native American) women by bringing tribal communities into the IPP project? If so, which ones, where, and in what ways?

Interviewees: Tribal leaders and health care professionals who serve Native American populations in Northeast and who would be knowledgeable about community knowledge, attitudes and perceptions of STDs in the Native American community, and knowledge, access, utilization and barriers to services of sexual health services by Native Americans in the Northeast.

Note to interviewer: This is meant to be a guide – not a script. Each person will have a different set of expertise but these are the general kinds of questions we’d like to answer – you may have to use discretion in adapting the guide to each individual as appropriate. Interviews should be recorded if possible....

Introduction to the Project:

My name is Diane Weiner and I am a Medical Anthropologist conducting interviews on behalf of the Region I Infertility Prevention Project, otherwise known as IPP. The Infertility Prevention Project is a nation-wide project funded by the CDC and the Office of Population Affairs. It aims to alleviate problems of chlamydia and gonorrhea through the collaborative efforts of Sexually Transmitted Disease (STD), Family Planning (FP) and Laboratory Services providers throughout the Northeast. Region I is comprised of six states: Maine, New Hampshire, Vermont, Massachusetts, Rhode Island and Connecticut.

JSI Research & Training Institute, Inc. serves as the coordinating infrastructure grantee for the region. The project works to promote innovative, high quality and cost-effective approaches in the prevention of STD-related infertility, especially in adolescent girls and young adult women. Prevention approaches are designed to link behavioral and epidemiologic activities to prevent transmission of bacterial STDs that result in pelvic inflammatory disease, infertility, and ectopic pregnancy, primarily chlamydia and gonorrhea.

Each of the ten regions has been asked by CDC to write an Epidemiological profile of Chlamydia disease burden among Native Americans. As part of this profile, it is our goal to identify any challenges to access to preventative sexual health or reproductive health care for Native Americans, to identify opportunities to help prevent infertility among young Native American women, and to make recommendations to each of the state programs of how the IPP project can enhance its programs and build partnerships with the local Native American communities.

The information that we collect will be summarized. There will no names or identifiers except for the geographical location at the state level. The report will be shared with the CDC and IPP advisory board members, who are STD Directors, Family Planning Directors and State Public Health Lab Directors from six Northeast states. We will be happy to provide you with a copy of this report upon its completion at the end of the summer 2011.

A. Introduction

1. What is your title and role?
 - o clinician Yes/No
2. Would you mind sharing what if any tribe you're a member of?
3. How long have you been working with the tribe. _____
4. Please note contact information, phone, email and mailing address so that we can follow up with copy of the report.

B. Access – We want to ask a few questions about access to preventive sexual and reproductive health care. As we discussed, the main focus of this project is screening for STDs, especially Chlamydia and Gonorrhea....but in general:

Prompts:

- What types of facilities do community members receive preventive medicine for sexual & reproductive health services?
- Sponsored by tribe or not?
Please list and describe:
- Are there different services for youth (14-18) vs young adults (19-25)? (eg. School clinics for school aged?)

- Do tribal members receive STD Screening as part of these services?
 - How?
 - Where?
 - When?
 - Are there fiscal, geographic, membership or other limitations to sexual & reproductive health services?

C. Barriers

- What are the challenges you perceive, if any, to receiving *STD screening and treatment*?
 - For youth (14-18)
 - For young adults (19-25)?
- Are there reason why members may not identify as Native American (or American Indian) for such services?

- What if any are some of the main challenges to *STD prevention* messages among community members?
 - For youth (14-18?)
 - For young adults (19-25)?

D. Perceptions / Belief

- Do members of your tribe regularly use Family planning clinics or STD clinics?
 - If not, are there particular perceptions or beliefs that prevent them from utilizing these clinics?

E. Opportunities

- What key resources (financial, personnel or information) do you think are needed to improve access to STD screening for youth? For young adults?
- What are ways that Family Planning or STD clinics or programs can be more user friendly to members?
- What are ways that STD directors or Family Planning sites could reach out to the community?

Who would be the main contact for them to initiate a conversation?

F. Other

- Is there anything you would like to add that we haven't discussed?

G. Review of interview

- Is there anything that you have said today that you would not want summarized and identified according to the state you live in? Or Rural vs Urban?

Appendix C: AI/AN Socio-Economic Status Tables by States in Region I

Table 1: Education Rates of AI/AN Populations Compared to Total Population

Population	High school graduate or higher (%)	Bachelor's degree or higher (%)
AI/AN Region I	49,158 (48.8%)	11,642 (11.6%)
Total Region I	7,903,795 (56.8%)	2,871,195 (20.6%)
AI/AN Connecticut	11,995 (49.0%)	2,788 (11.4%)
Total Connecticut	1,927,961 (56.6%)	720,994 (21.2%)
AI/AN Massachusetts	18,140 (47.7%)	4,950 (13.0%)
Total Massachusetts	3,622,182 (57.1%)	1,418,295 (22.3%)
AI/AN Maine	6,788 (51.6%)	1,189 (9.0%)
Total Maine	742,605 (58.2%)	198,960 (15.6%)
AI/AN New Hampshire	4,373 (55.5%)	1,018 (12.9%)
Total New Hampshire	720,233 (58.3%)	236,104 (19.1%)
AI/AN Rhode Island	4,389 (40.9%)	963 (9.0%)
Total Rhode Island	541,487 (51.7%)	177,817 (17.0%)
AI/AN Vermont	3,473 (54.3%)	734 (11.5%)
Total Vermont	349,327 (57.4%)	119,025 (19.5%)

Table 2: Median Household Income and Percent of Individuals Below Poverty Level among AI/AN Populations Compared to Total Population

Population	Median household income in 1999 (\$)	Individuals below poverty (N, %)
AI/AN Region I	\$32,130	(19,885, 19.7%)
Total Region I	\$45,682	(1,223,020, 8.8%)
AI/AN Connecticut	\$40,286	(3,404, 13.9%)
Total Connecticut	\$53,935	(259,514, 7.6%)
AI/AN Massachusetts	\$35,733	(6,644, 17.5%)
Total Massachusetts	\$50,502	(573,421, 9.0%)
AI/AN Maine	\$25,446	(4,098, 31.1%)
Total Maine	\$37,420	(135,501, 10.6%)
AI/AN New Hampshire	\$36,744	(1,262, 16.0%)
Total New Hampshire	\$49,467	(78,530, 6.4%)
AI/AN Rhode Island	\$26,202	(3,222, 30.0%)
Total Rhode Island	\$42,090	(120,548, 11.5%)
AI/AN Vermont	\$28,369	(1,255, 19.6%)
Total Vermont	\$40,856	(55,506, 9.1%)

Appendix D: Regional Contacts

CT: Barbara Poirier, Director, Tribal Health Services, **Mashantucket Pequot Tribal Nation**, 75 Route 2 PO Box 3260 , Mashantucket, CT 06338-3260; 860.312.8014 FAX: 860.312.8001; bpoirier@mptn.org

MA: Rita Gonsalves, RN, Health Systems Administrator or Cheryl Frye-Cromwell, Tribal Councilwoman/Interim Tribal Health Manager, 33 Great Neck Road, South Mashpee, MA 0264; 508-477-0209; Fax: 508-477-1936; RGonsalves@mwtribe.com

ME: Patricia Nicola-Knox, Penobscot Nation Health Department, 23 Wabanaki Way, Indian Island, ME, 04666; 207-817-7400; Patricia.knox-nicola@ihs.gov

Sandra Yarmal Pleasant Point Health Center, Passamaquoddy Tribal Nation, PO Box 351, Perry, ME 04667; 207—853-0644, ext 290; sandi@nsppp.nashville.ihs.gov

Sharon Tomah, Executive Director and Program Manager, Wabanaki Mental Health Services, 277 State St., Bangor, ME 04401; 207-990-0605; ext 5684; stomah@wabanaki.org

NH: Sherry Gould, Director, Wijokadoak, Inc., 3210 State Route 114, Bradford, NH, 03221; (603) 938-2613, Fax (603) 938-5912; sherrygould@tds.net

RI: Cathy Bernardston, Community Health Nurse Supervisor, Narragansett Indian Health Center, 4533 South County Trail, Charlestown, RI 02813; 401-364-1286, ext 27; FAX: 401-364-6427;cathyb@narraind.nashville.ihs.gov. (Autumn Leaf Spears, Director)

Appendix E: Region I: Agencies Serving American Indians and Alaska Natives

Clinic/Agency	Type	Provided Services	Address	Contact Information
Micmac Tribe-Contract Health Services*	Tribal Program	Health Education Preventative Health Exams Chronic Disease Management Acute Symptomatic Visits HIV/AIDS & STD Testing/Counseling Tobacco Cessation Alcohol/Substance Abuse Counseling Lab Services Immunizations Pharmacy Case Management Referrals	Unit 8 Northern Road Presque Isle, ME 04769	John Ouellette, Health Director jouellette@micmac-nsn.gov 207-764-1792 http://www.micmac-nsn.gov/html/micmac_health.html
Houlton Band of Maliseet Indians Tribal Health Program*	Tribal Program	Medical appointments two days/week Transportation Department Contract Medical Care Community Health Representatives Registered Nurse Diabetes Program Youth Program Coordinator Substance Abuse Counselor Behavioral Health Counselor Domestic Violence Response Program Maliseet Wellness Center Clients are referred to local OB/GYN for reproductive health services, approx. five minutes away.	12 Clover Circle Houlton, ME 04730	Ann Stevens health.dir@maliseets.com 207-532-4229 207-532-2240 http://www.maliseets.com/index.htm
Passamaquoddy Tribe of Indian Township Health Center	Tribal Program	Environmental health Link patients to health centers.	PO Box 97 Princeton, ME 04668	207-796-2322

Passamaquoddy Tribe of Indian Pleasant Point Health Center	Tribal Program		PO Box 351 Perry, ME 04668	207-853-0644 http://www.epa.gov/NE/govt/tribes/passamaquoddypleasantpoint.html
North American Indian Center of Boston, Inc.	Urban Program	Primary Care Behavioral Health Women's Health Diabetes Clinic Senior Program Transportation	105 South Huntington Avenue Jamaica Plains, MA 02130	Barbara Namias, Health Director Barbara.Namias@ihs.gov Joanne Dunn, Executive Director Joanne.Dunn@ihs.gov 617- 232-0343 http://www.naicob.org/about
Mashpee Wampanoag Tribe – Contract Health Services	Tribal Program CHA Program		33 Great Neck Road Mashpee, MA	Rita Gonsalves, Director Cheryl Frye-Cromwell, Health Liaison cfrye-cromwell@mwtribe.com 508-477-0209 http://mashpeewampanoagtribe.com/home.php
IHS Clinical Reporting System (CRS)	General Source – IHS Connection		Indian Health Service (HQ) – The Reyes Building 801 Thompson Avenue Suite 400 Rockville, MD 20852	Mary Wachacha mary.wachacha@ihs.gov Lori de Ravello, STI Coordinator Lori.deRavello@ihs.gov http://www.ihs.gov/cio/crs/

United South and Eastern Tribes Inc.	Tribal Program Support		711 Stewarts Ferry Pike Suite100 Nashville, TN 37214	<p>Michelle Ruslavage mruslavage@usetinc.org</p> <p>Alison Sanders asanders@usetinc.org</p> <p>Christine Compber Christina.Compber@ihs.gov</p> <p>615-872-7900</p> <p>http://www.usetinc.org/Programs/USET-THPS/TribalHealthProgram.aspx</p>
National Indian Health Board	Tribal Program Support	<p>Allows for special programs in tribes such as:</p> <p>Youth Leadership Suicide Prevention Violence Prevention Drug & Alcohol Prevention Tobacco Use Prevention Historical/Multi-Generational Trauma Healthy Eating Diabetes Prevention Female Health</p>	926 Pennsylvania Ave, SE Washington, DC 20003	<p>Rick Haverkate rhaverkate@nihb.org</p> <p>Judith Thierry, Director for the Indian Health Services Judith.Thierry@ihs.gov</p> <p>202-507-4074</p> <p>http://www.nihb.org/index.php</p>
National Native American AIDS Prevention	<p>Community Building Program</p> <p>Capacity Building Assistance Program</p>		720 S. Colorado Boulevard Suite 650-S Denver, CO 80246	<p>Robert Foley, Executive Director rfoley@nnaapc.org</p> <p>Hannabah Blue, CBA Specialist hblue@nnaapc.org</p> <p>information@nnaapc.org 720-382-2244</p> <p>http://www.nnaapc.org/programs/capacity.htm</p>

Rhode Island Indian Council	Urban Services		807 Broad Street Providence, RI 02907	info@rhodeislandindiancouncil.org 401-781-1098 http://www.rhodeislandindiancouncil.org/matriarch/default.asp
Abenaki Indian Center	Urban Program		381 Chestnut Street Manchester, NH 03101	603 -644-4555
Narragansett Indian Health Center*	Tribal Program	<u>Onsite:</u> Medical Community Health Nursing Behavioral Health Services <u>Offsite:</u> CHS Advocacy and Outreach Injury Prevention Nutrition Services Rx	4375-B South County Trail Charlestown, RI 02813 mailing address: PO Box 268 Charlestown, RI 02813	Autum Spears, Director 401-781-1098 (ext.10) http://www.narragansett-tribe.org/directory.html
Mashantucket Pequot Health Department	Tribal Program		75 Route 2 P.O. Box 409 Ledyard, CT 06339	860-312-8000
Mohegan Tribal Health & Human Services	Tribal Program		5 Crow Hill Road Uncasville, CT 06382	860-862-6100 http://www.mohegan.nsn.us/government/default.aspx

Wampanoag Tribal Health	Tribal Program	Primary service is a Community Health Center (CHS) program; it appears the main focus is to help members find quality outside medical/health care.	20 Black Brook Road Aquinnah, MA 02535-1546	Ryan Malonson, Acting Health Director/Contract Health Supervisor 508-645-9265 (ext.127) http://www.wampanoagtribe.net/Pages/Wampanoag_Health/index
Native STAND (Students Together Against Negative Decisions)	Tribal Program		1029 Vermont Avenue, NW Suite 500 Washington, DC 20005	Dana Cropper Williams dcropper@ncsddc.org 202-842-4600 http://www.ncsddc.org/2505.xml

*Programs with substance abuse focus.

Notes: No Urban Programs in: Vermont, Maine, or Connecticut. No Tribal Program in: New Hampshire or Vermont.

This information was put together in August, 2010.

Appendix F: State Specific and Region I Chlamydia Positivity Tables

Table 1: Number of AI/AN* Served in Region I. 2005-2009 Pooled Data for Females.

Age Breakdown by State	Percent Positive (Number)	Total Tested
24/25 and Younger**	5.5 (23)	421
25/26 and Older	3.3 (4)	121
Total	5.0 (27)	542

*Women were included if they marked AI/AN only or if they marked AI/AN along with another race.

**State IPP Screening guidelines vary by state in Region I. NH, VT, ME recommend CT screening for all sexually active women 24 and younger, and Conn., MA and RI recommend screening for all sexually active women 25 and younger.

Table 2: CT Chlamydia Positivity Rates in Women 25 and Younger by Race (2005-2009)*

Race/Age	2005		2006		2007		2008		2009	
	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested
White	4.8 (196)	4105	4.3 (175)	4086	5.2 (188)	3608	5.5 (171)	3112	4.9 (167)	3412
Black	13.4 (152)	1135	11.9 (137)	1150	12.6 (139)	1104	13.2 (141)	1068	9.1 (97)	1062
Asian	5.9 (5)	85	5.7 (5)	88	6.2 (5)	81	11.7 (9)	77	3.3 (3)	90
PI/Native	50.0 (1)	2	0.0 (0)	5	0.0 (0)	3	0.0 (0)	5	11.1 (1)	9
AI/AN	8.3 (1)	12	0.0 (0)	6	0.0 (0)	13	0.0 (0)	6	7.1 (1)	14
Other	5.1 (85)	1668	5.4 (96)	1776	6.0 (106)	1768	6.6 (118)	1796	6.7 (90)	1336
Total	6.3 (440)	7007	5.8 (413)	7111	6.7 (438)	6577	7.2 (439)	6064	6.1 (359)	5923

*From 2005-2009, 127 tests were missing race data and they were not presented. When race was not indicated, data were omitted from the tables.

Table 3: CT Chlamydia Positivity Rates in Women 26 and Older by Race (2005-2009)*

Race/Age	2005		2006		2007		2008		2009	
	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested
White	1.3 (16)	1206	1.7 (22)	1292	2.4 (30)	1255	2.1 (22)	1047	1.8 (19)	1051
Black	5.7 (21)	368	3.5 (14)	403	4.4 (15)	340	3.0 (9)	298	5.2 (15)	287
Asian	3.9 (1)	26	2.8 (1)	36	2.9 (1)	34	3.1 (1)	32	4.0 (1)	25
PI/Native	0.0 (0)	0	20.0 (1)	5	0.0 (0)	1	0.0 (0)	0	0.0 (0)	2
AI/AN	0.0 (0)	2	0.0 (0)	2	0.0 (0)	3	0.0 (0)	2	0.0 (0)	2
Other	2.0 (17)	874	2.9 (24)	835	2.4 (18)	741	2.2 (14)	624	2.1 (10)	479
Total	2.2 (55)	2476	2.4 (62)	2573	2.7 (64)	2374	2.3 (46)	2003	2.4 (45)	1846

**From 2005-2009, 127 tests were missing race data and they were not presented. When race was not indicated, data were omitted from the tables.*

Table 4: MA Chlamydia Positivity Rates in Women 25 and Younger by Race (2005-2009)*

Race/Age	2005		2006		2007		2008		2009	
	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested
White	3.6 (229)	6330	4.1 (262)	6399	3.7 (215)	5893	4.2 (198)	4759	5.1 (249)	4884
Black	8.7 (92)	1061	9.6 (94)	980	9.7 (99)	1019	11.9 (123)	1031	9.0 (107)	1189
Asian	9.3 (27)	292	7.9 (20)	254	3.4 (7)	208	4.7 (8)	172	10.2 (19)	186
PI/Native	20.0 (1)	5	0.0 (0)	0	0.0 (0)	7	0.0 (0)	5	0.0 (0)	5
AI/AN	12.5 (1)	8	0.0 (0)	3	23.1 (3)	13	0.0 (0)	10	11.1 (3)	27
Other	6.6 (39)	594	7.6 (89)	1166	7.0 (75)	1066	6.9 (77)	1121	6.5 (63)	965
Total	4.7 (389)	8290	5.3 (465)	8802	4.9 (399)	8206	5.7 (406)	7098	6.1 (441)	7256

*From 2005-2009, 6,757 tests were missing race data and they were not presented. When race was not indicated, data were omitted from the tables.

Table 5: MA Chlamydia Positivity Rates in Women 26 and Older by Race (2005-2009)*

Race/Age	2005		2006		2007		2008		2009	
	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested
White	1.8 (33)	1885	1.9 (28)	1514	2.7 (37)	1364	2.5 (30)	1224	3.4 (40)	1181
Black	3.5 (19)	537	2.7 (6)	225	3.3 (9)	272	3.7 (8)	217	3.0 (6)	203
Asian	6.4 (6)	94	5.6 (4)	71	3.9 (2)	52	0.0 (0)	35	10.4 (5)	48
PI/Native	0.0 (0)	1	0.0 (0)	0	0.0 (0)	1	0.0 (0)	1	0.0 (0)	1
AI/AN	0.0 (0)	1	0.0 (0)	0	0.0 (0)	3	0.0 (0)	3	0.0 (0)	2
Other	3.8 (11)	292	3.1 (10)	325	3.7 (9)	245	3.9 (8)	205	5.4 (16)	296
Total	2.5 (69)	2810	2.2 (48)	2135	2.9 (57)	1937	2.7 (46)	1685	3.9 (67)	1731

*From 2005-2009, 6,757 tests were missing race data and they were not presented. When race was not indicated, data were omitted from the tables.

Table 6: ME Chlamydia Positivity Rates in Women 25 and Younger by Race (2005-2009)*

Race/Age	2005		2006		2007		2008		2009	
	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested
White	4.5 (221)	4941	4.8 (152)	3191	6.1 (177)	2925	6.1 (179)	2949	4.7 (125)	2676
Black	8.6 (5)	58	10.5 (4)	38	10.0 (5)	50	16.4 (10)	61	2.2 (1)	45
Asian	7.7 (1)	13	25.0 (3)	12	4.9 (2)	41	0.0 (0)	34	16.7 (4)	24
PI/Native	0.0 (0)	23	7.7 (1)	13	0.0 (0)	4	25.0 (1)	4	33.3 (1)	3
AI/AN	4.4 (2)	46	4.0 (1)	25	0.0 (0)	0	20.0 (3)	15	0.0 (0)	9
Other	0.0 (0)	8	0.0 (0)	12	0.0 (0)	23	5.3 (1)	19	0.0 (0)	21
Total	4.5 (229)	5089	4.9 (161)	3291	6.0 (184)	3043	6.3 (194)	3082	4.7 (131)	2778

*From 2005-2009, 136 tests were missing race data and they were not presented. When race was not indicated, data were omitted from the tables.

Table 7: ME Chlamydia Positivity Rates in Women 26 and Older by Race (2005-2009)*

Race/Age	2005		2006		2007		2008		2009	
	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested
White	2.3 (29)	1245	4.2 (14)	336	3.5 (8)	230	5.6 (15)	267	4.5 (14)	311
Black	0.0 (0)	14	0.0 (0)	8	0.0 (0)	6	0.0 (0)	5	0.0 (0)	4
Asian	0.0 (0)	4	50.0 (1)	2	0.0 (0)	2	16.7 (1)	6	0.0 (0)	2
PI/Native	0.0 (0)	10	0.0 (0)	2	7.7 (1)	13	0.0 (0)	0	0.0 (0)	0
AI/AN	0.0 (0)	13	0.0 (0)	3	0.0 (0)	0	0.0 (0)	2	0.0 (0)	0
Other	0.0 (0)	4	0.0 (0)	3	0.0 (0)	1	0.0 (0)	1	0.0 (0)	4
Total	2.2 (29)	1290	4.2 (15)	354	3.6 (9)	252	5.7 (16)	281	4.4 (14)	321

*From 2005-2009, 136 tests were missing race data and they were not presented. When race was not indicated, data were omitted from the tables.

Table 8: NH Chlamydia Positivity Rates in Women 24 and Younger by Race (2005-2009)*

Race/Age	2005		2006		2007		2008		2009	
	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested
White	3.8 (293)	7805	3.9 (320)	8189	3.7 (257)	6951	3.9 (195)	4999	3.7 (169)	4623
Black	10.8 (15)	139	7.8 (11)	141	9.5 (13)	137	7.8 (7)	90	7.5 (8)	107
Asian	12.0 (6)	50	1.6 (1)	61	8.3 (5)	60	1.6 (1)	62	3.5 (2)	58
PI/Native	0.0 (0)	10	0.0 (0)	2	0.0 (0)	4	33.3 (1)	3	0.0 (0)	7
AI/AN	0.0 (0)	9	4.6 (1)	22	0.0 (0)	30	0.0 (0)	11	0.0 (0)	11
Other	7.7 (10)	130	8.8 (7)	80	3.1 (3)	97	3.9 (5)	127	4.8 (4)	83
Total	4.0 (324)	8143	4.0 (340)	8495	3.8 (278)	7279	3.9 (209)	5292	3.7 (183)	4889

*From 2005-2009, 133 tests were missing race data and they were not presented. When race was not indicated, data were omitted from the tables.

Table 9: NH Chlamydia Positivity Rates in Women 25 and Older by Race (2005-2009)*

Race/Age	2005		2006		2007		2008		2009	
	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested
White	1.8 (42)	2395	2.0 (54)	2735	1.1 (27)	2424	2.0 (23)	1149	2.1 (22)	1061
Black	0.0 (0)	35	2.3 (1)	43	5.8 (3)	52	0.0 (0)	22	0.0 (0)	23
Asian	12.5 (3)	24	5.7 (2)	35	0.0 (0)	24	4.8 (1)	21	0.0 (0)	12
PI/Native	0.0 (0)	2	0.0 (0)	3	0.0 (0)	1	0.0 (0)	1	0.0 (0)	0
AI/AN	0.0 (0)	3	33.3 (1)	3	33.3 (1)	3	0.0 (0)	3	25.0 (1)	4
Other	2.6 (1)	38	0.0 (0)	21	8.0 (2)	25	2.3 (1)	43	0.0 (0)	25
Total	1.8 (46)	2497	2.0 (58)	2840	1.3 (33)	2529	2.0 (25)	1239	2.0 (23)	1125

*From 2005-2009, 133 tests were missing race data and they were not presented. When race was not indicated, data were omitted from the tables.

Table 10: RI Chlamydia Positivity Rates in Women 24 and Younger by Race (2005-2009)*

Race/Age	2005		2006		2007		2008		2009	
	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested
White	5.7 (73)	1285	5.4 (101)	1861	4.8 (111)	2312	7.7 (79)	1022	8.0 (77)	966
Black	9.8 (34)	348	11.4 (41)	360	10.0 (40)	400	13.1 (40)	306	13.1 (35)	267
Asian	11.4 (14)	123	9.9 (15)	152	12.0 (17)	142	8.2 (7)	85	8.1 (5)	62
PI/Native	0.0 (0)	1	0.0 (0)	4	0.0 (0)	4	0.0 (0)	0	0.0 (0)	2
AI/AN	15.4 (2)	13	8.3 (1)	12	15.4 (2)	13	0.0 (0)	2	0.0 (0)	11
Other	9.6 (96)	996	8.5 (80)	940	7.0 (49)	703	6.9 (55)	800	7.9 (57)	723
Total	7.9 (219)	2766	7.1 (238)	3329	6.1 (219)	3574	8.2 (181)	2215	8.6 (174)	2031

*From 2005-2009, 1 test was missing race data and was not presented. When race was not indicated, data were omitted from the tables.

Table 11: RI Chlamydia Positivity Rates in Women 25 and Older by Race (2005-2009)*

Race/Age	2005		2006		2007		2008		2009	
	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested
White	1.6 (15)	920	1.6 (24)	1487	1.9 (35)	1812	1.1 (9)	835	2.4 (10)	409
Black	1.6 (4)	246	3.1 (8)	259	1.7 (4)	236	4.9 (9)	183	3.4 (3)	89
Asian	3.3 (3)	91	1.7 (2)	121	2.6 (2)	77	0.0 (0)	51	0.0 (0)	17
PI/Native	0.0 (0)	1	0.0 (0)	4	0.0 (0)	1	0.0 (0)	2	0.0 (0)	0
AI/AN	0.0 (0)	3	0.0 (0)	10	0.0 (0)	11	0.0 (0)	3	0.0 (0)	0
Other	1.5 (19)	1231	1.6 (16)	1000	1.3 (9)	678	2.0 (12)	596	3.1 (9)	288
Total	1.6 (41)	2492	1.7 (50)	2881	1.8 (50)	2815	1.8 (30)	1670	2.7 (22)	803

*From 2005-2009, 1 test was missing race data and was not presented. When race was not indicated, data were omitted from the tables.

Table 12: VT Chlamydia Positivity Rates in Women 24 and Younger by Race (2005-2009)*

Race/Age	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested
White	3.3 (229)	6870	3.8 (272)	7184	3.4 (255)	7540	3.5 (254)	7232	3.4 (150)	4402
Black	10.7 (11)	103	8.9 (11)	124	7.0 (8)	115	9.8 (11)	112	5.9 (4)	68
Asian	0.0 (0)	36	7.7 (3)	39	10.2 (5)	49	2.6 (1)	39	0.0 (0)	27
PI/Native	0.0 (0)	5	0.0 (0)	1	0.0 (0)	3	0.0 (0)	5	0.0 (0)	4
AI/AN	20.0 (1)	5	0.0 (0)	14	0.0 (0)	17	0.0 (0)	22	0.0 (0)	9
Other	9.3 (4)	43	3.3 (1)	30	4.3 (2)	47	22.0 (9)	41	11.8 (2)	17
Total	3.5 (245)	7062	3.9 (287)	7392	3.5 (270)	7771	3.7 (275)	7451	3.4 (156)	4527

*From 2005-2009, 117 tests were missing race data and they were not presented. When race was not indicated, data were omitted from the tables.

Table 13: VT Chlamydia Positivity Rates in Women 25 and Older by Race (2005-2009)*

Race/Age	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested
White	1.7 (53)	3127	1.9 (64)	3378	1.4 (52)	3790	1.8 (70)	3923	1.5 (33)	2181
Black	3.9 (2)	52	3.1 (2)	64	1.8 (1)	56	3.6 (3)	83	0.0 (0)	47
Asian	0.0 (0)	31	15.0 (3)	20	0.0 (0)	36	0.0 (0)	50	4.2 (1)	24
PI/Native	0.0 (0)	7	0.0 (0)	0	0.0 (0)	0	0.0 (0)	1	33.3 (1)	3
AI/AN	0.0 (0)	5	0.0 (0)	9	0.0 (0)	9	11.1 (1)	9	0.0 (0)	8
Other	4.6 (1)	22	7.1 (1)	14	0.0 (0)	26	0.0 (0)	15	9.1 (1)	11
Total	1.7 (56)	3244	2.0 (70)	3485	1.4 (53)	3917	1.8 (74)	4081	1.6 (36)	2274

*From 2005-2009, 117 tests were missing race data and they were not presented. When race was not indicated, data were omitted from the tables.

Table 14: Region I Chlamydia Positivity Rates in Women 24/25 and Younger by Race (2005-2009)*

Race/Age	2005		2006		2007		2008		2009	
	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested
White	4.0 (1241)	31336	4.2 (1282)	30910	4.1 (1203)	29229	4.5 (1076)	24073	4.5 (937)	20963
Black	10.9 (309)	2844	10.7 (298)	2793	10.8 (304)	2825	12.4 (332)	2668	9.2 (252)	2738
Asian	8.9 (53)	599	7.8 (47)	606	7.1 (41)	581	5.5 (26)	469	7.4 (33)	447
PI/Native	4.4 (2)	46	4.0 (1)	25	0.0 (0)	25	9.1 (2)	22	6.7 (2)	30
AI/AN	7.5 (7)	93	3.7 (3)	82	6.1 (6)	99	4.6 (3)	66	4.9 (4)	81
Other	6.8 (234)	3439	6.8 (273)	4004	6.3 (235)	3704	6.8 (265)	3904	6.9 (216)	3145
Total	4.8 (1846)	38357	5.0 (1904)	38420	4.9 (1789)	36463	5.5 (1704)	31202	5.3 (1444)	27404

*From 2005-2009, 7,271 tests were missing race data and they were not presented. When race was not indicated, data were omitted from the tables.

Table 15: Region I Chlamydia Positivity Rates in Women 25/26 and Older by Race (2005-2009)*

Race/Age	2005		2006		2007		2008		2009	
	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested	Percent Positive (Number)	Total Tested
White	1.7 (188)	10778	1.9 (206)	10742	1.7 (189)	10875	2.0 (169)	8445	2.2 (138)	6194
Black	3.7 (46)	1252	3.1 (31)	1002	3.3 (32)	962	3.6 (29)	808	3.7 (24)	653
Asian	4.8 (13)	270	4.6 (13)	285	2.2 (5)	225	1.5 (3)	195	5.5 (7)	128
PI/Native	0.0 (0)	21	7.1 (1)	14	0.0 (0)	4	0.0 (0)	5	16.7 (1)	6
AI/AN	0.0 (0)	27	3.7 (1)	27	3.5 (1)	29	4.6 (1)	22	6.3 (1)	16
Other	2.0 (49)	2461	2.3 (51)	2198	2.2 (38)	1716	2.4 (35)	1484	3.3 (36)	1103
Total	2.0 (296)	14809	2.1 (303)	14268	1.9 (265)	13811	2.2 (237)	10959	2.6 (207)	8100

*From 2005-2009, 7,271 tests were missing race data and they were not presented. When race was not indicated, data were omitted from the tables.

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