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April is STD Awareness Month

This is the third year that the National STD Program has presented a special April issue of *The IHS Provider* to draw attention to STD Awareness Month; the noteworthy efforts of the program and its partners are reflected throughout the articles.

For more information about the IHS National STD Program, visit <http://www.ihs.gov/epi>.

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Challenging Horizons: Identifying the Burden of Sexually Transmitted Disease (STD) in Indian Country

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Introduction

Sexually transmitted diseases (STDs) including chlamydia, gonorrhea, and syphilis continue to impose a significant health burden on American Indians and Alaska Native (AI/AN) people as compared to other race/ethnicity groups. In 2009, among all races and ethnicities, AI/AN had the second highest rates of chlamydia and gonorrhea, and the third highest rates of primary and secondary syphilis (P&S). In 2009, reported case rates of chlamydia, gonorrhea, and P&S among AI/AN were up to four times higher than comparable rates for whites. The publication of the *Indian Health Surveillance Report on Sexually Transmitted Diseases (STD), 2009* is a collaborative effort between the Centers for Disease Control and Prevention (CDC) and the Indian Health Service (IHS). The most recent report uses 2009 data, and is an update to an earlier report that used data from 2007. Findings from this report are intended to increase awareness regarding the burden of STDs in AI/AN populations, which may lead to improvements in STD testing and clinical care, and increases in funding and research activities related to STD prevention and control in these communities.¹ The surveillance report can be accessed at <http://www.cdc.gov/std/stats/IHS/IHS-Surv-Report-2009.pdf>.

Key Points and National Trends in STDs among AI/AN Chlamydia

- Chlamydia is the most common nationally notifiable disease in the US. Chlamydial infections disproportionately affect young women and are frequently asymptomatic. If untreated, chlamydial infections can result in serious complications, including pelvic inflammatory disease (PID), infertility, and ectopic pregnancy. Chlamydia can be transmitted from mother to child during delivery and can facilitate the transmission of HIV.
- In -2009, among all race/ethnicities, AI/AN had the second highest chlamydia rate (776.5 cases per 100,000 population), which was 4.3 times higher than the rate for whites (178.8 cases per 100,000 population). African-Americans had the highest chlamydia rate (1,559.1 cases per 100,000 population).
- In -2009, 19,618 of 1,244,180 chlamydial infections (1.6%) were reported among AI/AN. The AI/AN chlamydia rate increased by 1.5% during 2008 - 2009 (2008 rate: 788.3 cases per 100,000 population) (Figure 1).
- In 2009, the chlamydia rate among AI/AN women in the US (1,214.9 cases per 100,000 females) was nearly 4 times higher than the rate among AI/AN men (323.8 cases per 100,000 males), likely reflecting a greater number of women screened for this infection.
- Among AI/AN women, the highest age-specific rates of reported chlamydia in 2007 were among 20- to 24-year olds (5,104.4 per 100,000 females) and 15- to 19- year olds (4,619.3 per 100,000 females). These two age groups also represented the highest age-specific rates among all women in the U.S.
- Age-specific - rates among AI/AN men, while substantially lower than the rates in AI/AN women in 2009, were highest among 20-to 24- year-olds (1,367.0 cases per 100,000 males). This age group also had the highest rates among all men in the U.S. (1,120.6 cases per 100,000 males).

Figure 1. Total Chlamydia Rates, AI/AN Non-Hispanic and US, 1996 - 2009

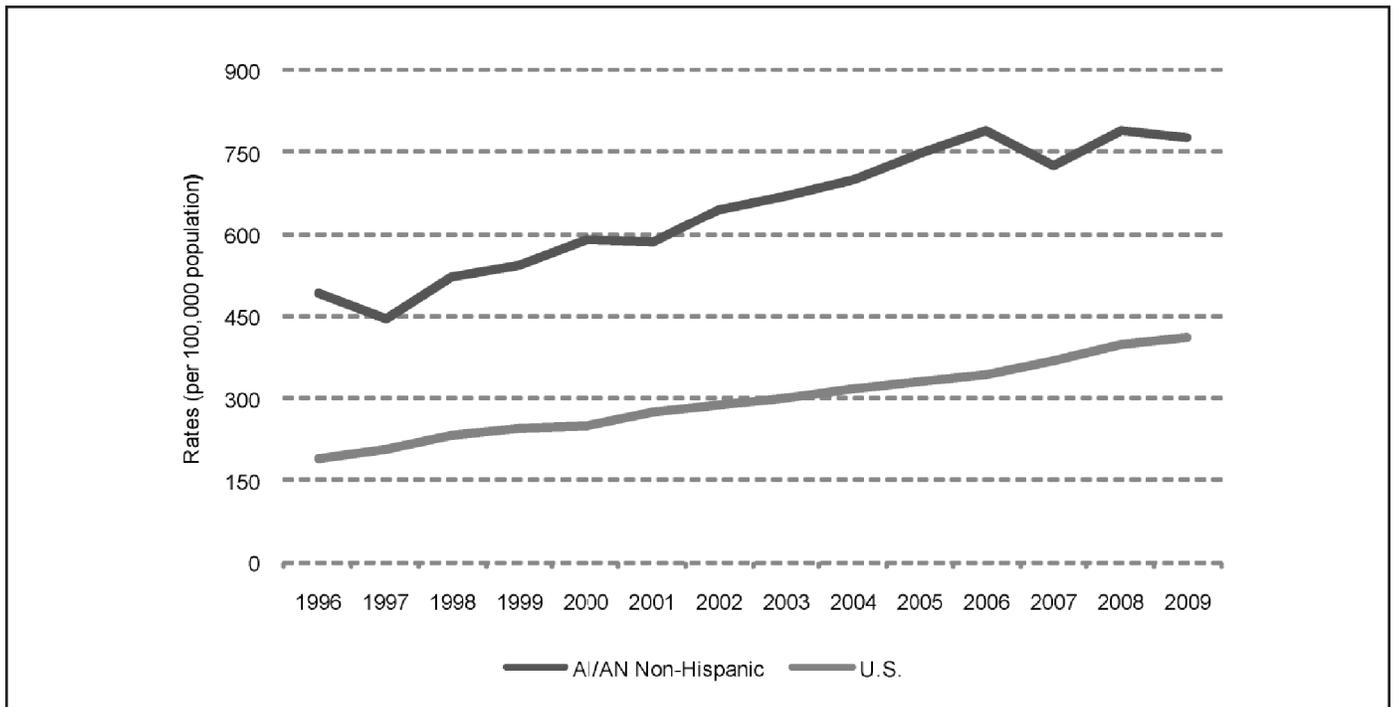
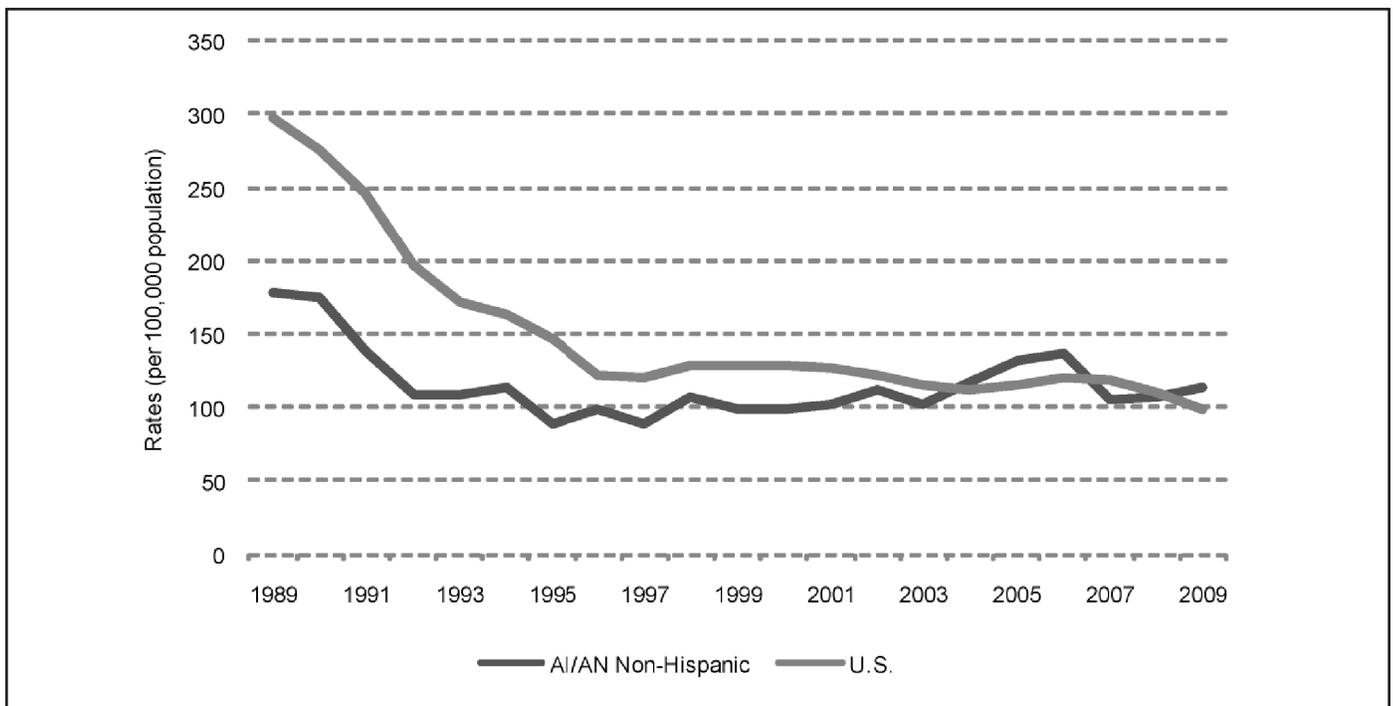


Figure 2. Total Gonorrhea Rates, AI/AN Non-Hispanic and US, 1989 - 2009



Gonorrhea

- Gonorrhea is the second most common nationally notifiable disease in the US; like chlamydia is a major cause of PID, infertility, and ectopic pregnancy. Gonococcal infections may be transmitted from mother to infant during delivery and can facilitate the transmission of HIV.
- In 2009, among all race/ethnicities, AI/AN had the second highest gonorrhea rate (113.3 cases per 100,000 population), which was 4.2 times higher than the rate for whites (27.2 cases per 100,000 population). African-Americans had the highest gonorrhea rates (556.4 cases per 100,000 population)
- In 2009, 2,917 of 301,174 gonococcal infections (1.0%) reported to CDC occurred among AI/AN. The AI/AN gonorrhea rate increased by 5.5% during 2008 - 2009 (2008 rate: 107.4 cases per 100,000 population). Comparatively, the total US gonorrhea rates decreased by 10.4% during 2008-2009 (Figure 2).
- In 2009, the gonorrhea rate among AI/AN women in the US (147.3 cases per 100,000) females was 1.9 times higher than the rate among AI/AN men (78.2 cases per 100,000 males)
- Among AI/AN women, the highest age-specific rates of reported gonorrhea in 2009 were among 20- to 24- year olds (570.0 cases per 100,000 females) and 15- to 19- year olds (494.9 cases per 100,000 females). These two

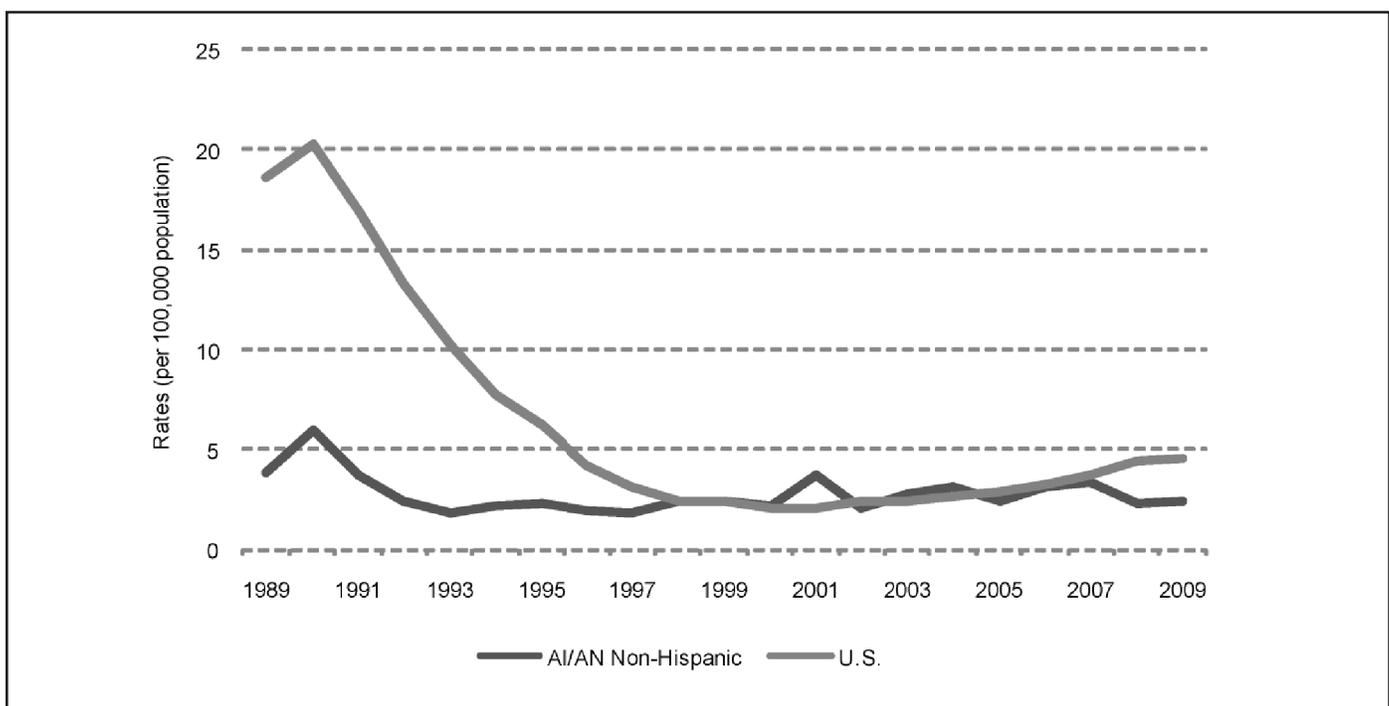
age groups also represented the highest age-specific rates among all women in the US.

- Age-specific gonorrhea rates among AI/AN men, while substantially lower than the rates in AI/AN women in 2009, were highest among 20- to 24-year olds (244.4 cases per 100,000 males). This age group also had the highest rates among all men in the US. (407.5 cases per 100,000 males).

Primary and Secondary Syphilis

- Syphilis, in its primary and secondary stages, is a highly infectious, but easily curable STD. If untreated, syphilis can lead to serious long-term complications including stroke, heart disease, and death. Syphilis can be transmitted from untreated mothers to their fetuses, potentially leading to stillbirths and congenital deformities. Syphilis has been shown to facilitate the transmission of HIV two-to-five fold.
- In 2009, among all race/ethnicities, AI/AN had the third highest primary and secondary syphilis (P&S) rate (2.4 cases per 100,000 population), which was similar to the rate for whites (2.1 cases per 100,000 population). African-Americans had the highest P&S rate (19.2 cases per 100,000 population), followed by Hispanics (4.5 cases per 100,000 population)
- In 2009, 61 of 13,997 P&S infections (0.4%) reported to CDC occurred among AI/AN. The AI/AN P&S rate

Figure 3. Total P&S Syphilis Rates, AI/AN Non-Hispanic and US, 1989 - 2009



increased slightly to 2.4 cases per 100,000 population during 2008 - 2009 (2008 rate: 2.3 per 100,000 population) (Figure 3).

- In -2009, the male-to-female P&S rate ratio among AI/AN was 4:1, indicating a higher number of cases being diagnosed among men than women. Similarly, for the total US, the male-to-female P&S rate ratio has risen steadily since 1996 to 6.1 in 2009 reflecting an increase in syphilis among men who have sex with men (MSM) during this time.
- In 2009, among AI/AN, age-specific P&S syphilis rates were highest among women aged 25 - 29 years (3.1 cases per 100,000 population) and among men aged 35 - 39 years (11.4 cases per 100,000) population. For the total US, the highest age-specific P&S rates were reported among men and women aged 20 - 24 years (20.7 and 5.6 cases per 100,000 population respectively).

Summary of IHS Area STD Profiles

Chlamydia

- The overall IHS chlamydia rate in 2009 was 816.2 cases per 100,000 population. This was 2.0 times higher than the corresponding US rate (Figure 4).
- Ten of 12 IHS Areas had higher 2009 chlamydia rates compared to the US rate, ranging from 1.2 to 5.7 times higher than the US rate.
- In 2009, all IHS Areas had female chlamydia rates that

were between 2.5 and 5.5 times higher than male rates, likely reflecting greater numbers of women screened for this infection.

- During 2008 - 2009, overall chlamydia rates in the US increased 2.8% (from 398.1 to 409.2), while overall IHS chlamydia rates decreased by 0.3%; the IHS Area with the greatest increase was Nashville (14.0%); the California Area had the largest decrease (-13.9%).

Gonorrhea

- In 2009, the overall IHS gonorrhea rate was higher than the US rate (111.6 and 99.1 cases per 100,000 population respectively) (Figure 5).
- Four IHS Areas (Aberdeen, Alaska, Bemidji, Oklahoma City) had 2009 gonorrhea rates that were 1.3 to 6 times higher than the US rate.
- In 2009, the overall IHS female gonorrhea rate was 2.0 times higher than the male gonorrhea rate; all but 2 IHS Areas (Billings and Navajo) had higher female gonorrhea rates than male rates.
- During 2008 - 2009, overall gonorrhea rates in the US decreased 10.5% (from 110.7 to 99.1), while overall IHS gonorrhea rates increased by 11.9%.
- IHS areas with the greatest increases were Alaska Area (88.9%) and Bemidji Area (11.8%); the IHS Areas with the greatest decreases were California (-56.3%) and Portland (-40.9%).

Figure 4. Chlamydia Rates by IHS Area, 2009

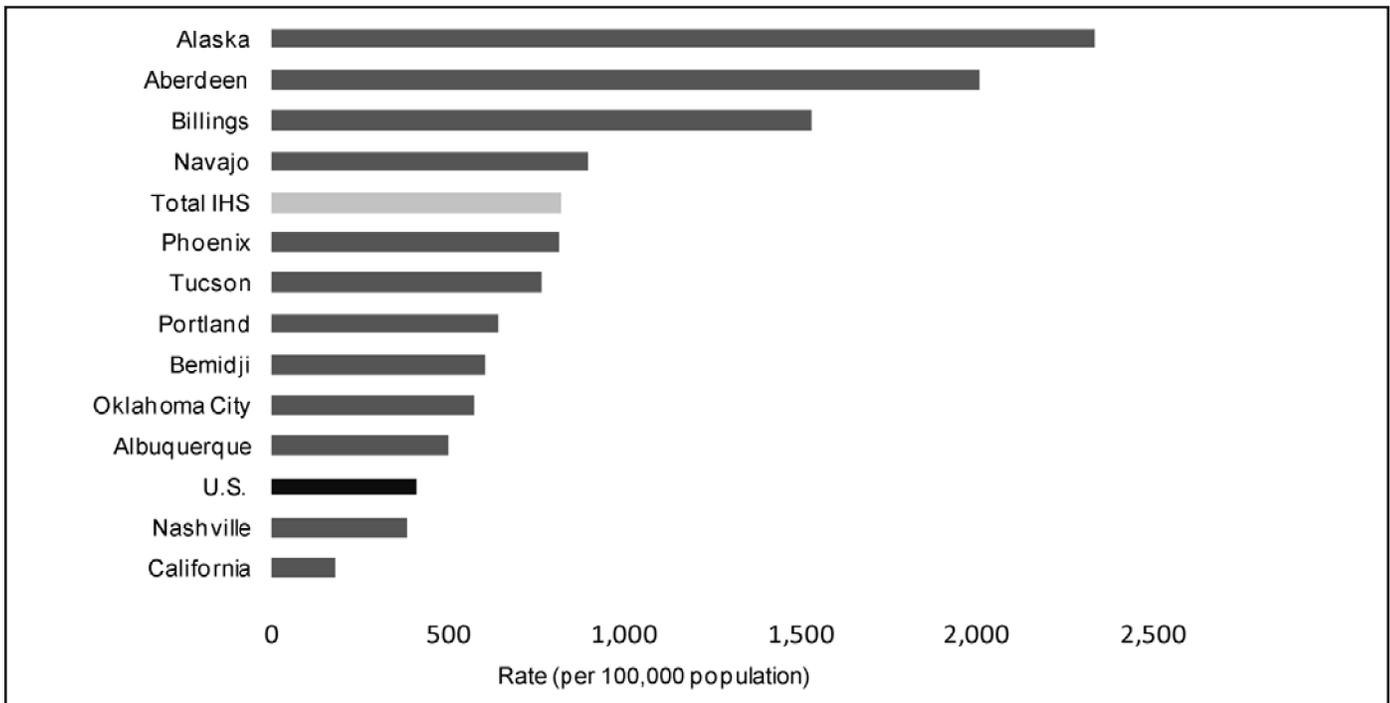


Figure 5. Gonorrhea Rates by IHS Area, 2009

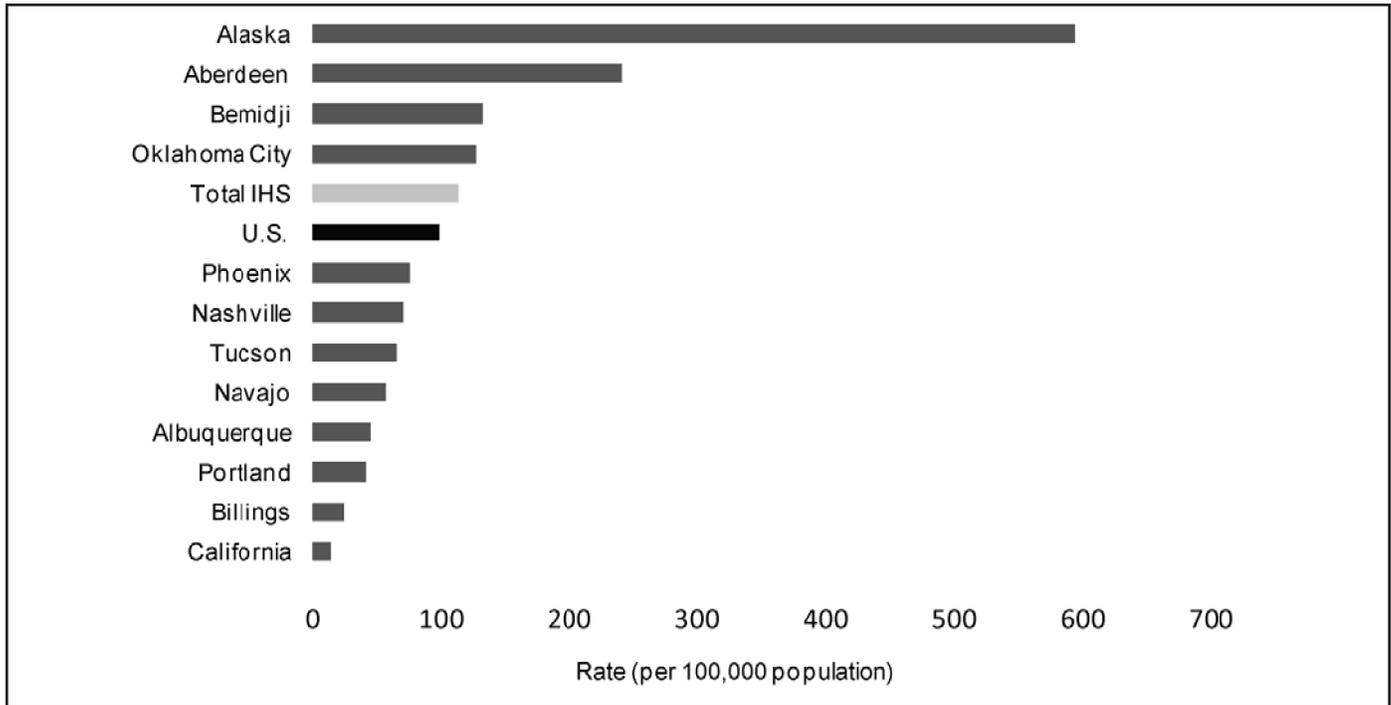
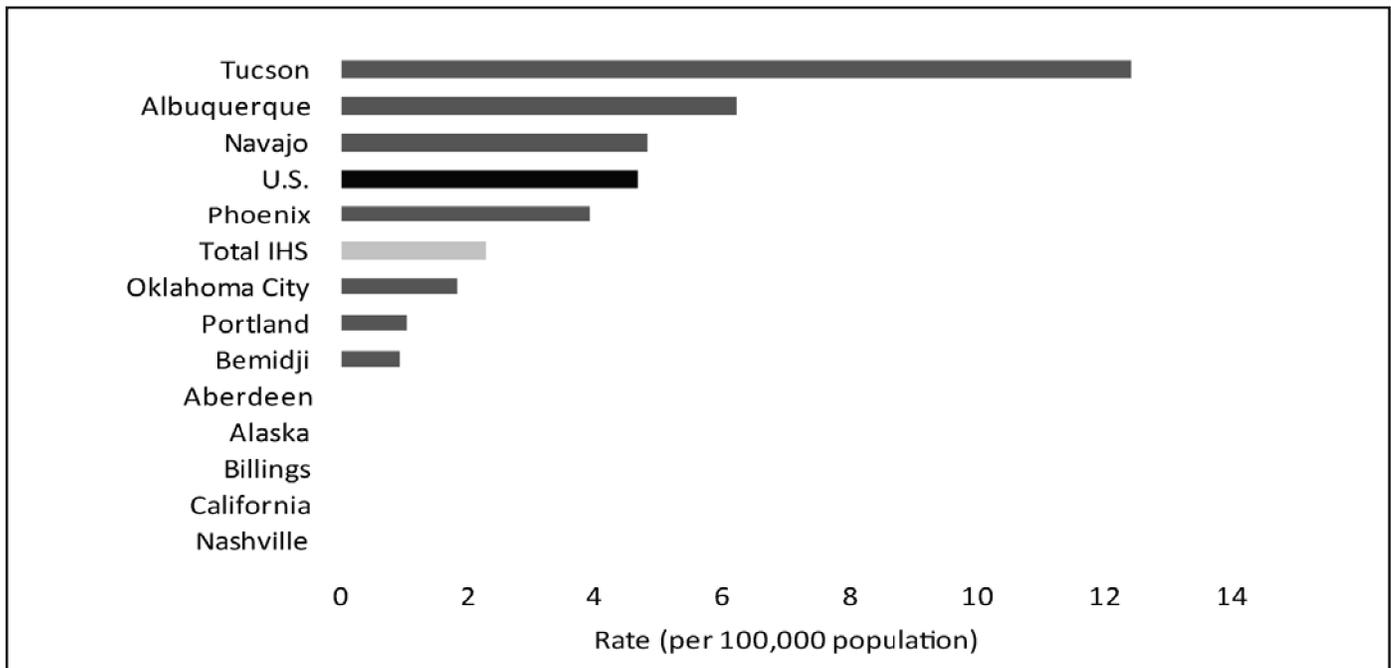


Figure 6. P&S Syphilis Rates by IHS Area, 2009



Primary and Secondary Syphilis

- In 2009, the overall IHS P&S rate was 2.2 cases per 100,000 population, compared to 4.6 cases per 100,000 population for the overall US.
- Within IHS, 38 of 41 (93%) P&S cases occurred in 5 IHS Areas in the southwest: Albuquerque (6 cases), Navajo (11 cases), Oklahoma City (6 cases), Phoenix (10 cases), and Tucson (5 cases); 5 IHS Areas had no P&S cases in 2009.
- In -2009, the male-to-female P&S rate ratio among AI/AN was 3:1, indicating more cases being diagnosed among men than women. The US male-to-female ratio was 6:1.
- During 2008 -- 2009, overall P&S rates in the US increased from 4.4 to 4.6 cases per 100,000 population; overall IHS rates increased from 2.1 to 2.2 cases per 100,000. The largest increase occurred in the Albuquerque Area (from 0.9 to 6.2 cases per 100,000); the Oklahoma City and Tucson Areas had the largest decreases (-25% and -17% cases per 100,000 population, respectively).

Addressing High STD Rates in AI/AN Communities:

CDC, IHS, Cardea, and partnering tribal organizations developed standard recommendations for STD/HIV testing, treatment, and partner management for AI/AN clinical care sites http://www.npaihb.org/epicenter/project/prt_std_policies. These are described in greater detail in this special issue by Nakatsukasa-Ono, et al. These guidelines are currently in use by multiple IHS service units and comply with IHS Government Performance and Results Act (GPRA) measures on HIV and STD screening. Many of these screening and treatment guidelines can be customized for implementation within electronic health/medical records. In addition to these standard protocols, providers are encouraged to keep the CDC STD treatment guidelines readily available for use in choosing appropriate STD treatment regimens, complying with nationally recommended screening practices, and for use in counseling patients regarding safer sex behaviors. These guidelines can be viewed and downloaded from the CDC's Division of STD

Prevention's website at <http://www.cdc.gov/std/treatment>.

High rates of STDs in AI/AN communities mainly affect youth. Adolescents are at higher risk for STDs due to biological predisposition, participation in unprotected intercourse, engagement in multiple sexual partnerships of limited duration, alcohol and drug use, and obstacles in seeking health care. High STD rates in youth are an indicator of unprotected sexual practices that can also lead to unintended pregnancy and HIV infection. High STD rates can also be indicators of limited knowledge; unclear perception of risk; and lack of, inconsistent, or incorrect use of prevention methods, such as condoms. These challenges support the need for increased efforts to improve access, quality, and delivery of STD testing and partner management, and to encourage safer sex practices, including condom use, among populations at risk within AI/AN communities.

References

1. - Centers for Disease Control and Prevention and Indian Health Service. Indian Health Surveillance Report—Sexually Transmitted Diseases 2009, Atlanta, GA: US Department of Health and Human Services, August 2009.
2. - Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2010. *MMWR*. 2010;59 (No RR-12).
3. - Centers for Disease Control and Prevention (CDC). Recommendations for partner services programs for HIV infection, syphilis, gonorrhea, and chlamydial infection. *MMWR*. 2008 Nov 7;57(RR-9):1-83.
4. - Centers for Disease Control and Prevention (CDC) Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings. September 2006. <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm>.

For a copy of the IHS STD Surveillance Report, 2009 or for additional information on implementing STD prevention and control activities in Indian Country, contact Scott Tulloch at (505) 248-4344; or e-mail scott.tulloch@ihs.gov.



HIV/STI Screening: Four Key Indicators Tracked at the Service Unit and National Level.

How is your Facility Performing?

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Transmission of the human immunodeficiency virus (HIV) via blood transfusions and mother-to-child is extremely rare. This success is based on screening all blood donors (since 1996) and prenatal patients (since 2001) for HIV, regardless of risk factors. Screening can be an extremely effective intervention.

IHS tracks four HIV/sexually transmitted infection (STI) screening indicators considered the most important measures for quality of care and public health practice.

Why Screen for HIV/STIs?

1. - The tests are reliable, noninvasive, and affordable.
2. - Early detection and treatment can greatly improve patient outcomes. In addition, with HIV and STIs, treatment prevents further spread to the community.

These are the same criteria for all screening recommendations made by the US Preventive Services Task Force and the Centers for Disease Control and Prevention. The rationale that applies to screening for HIV/STIs is the same as that for cancer, heart disease, and for many other conditions that are included in the national Government Performance and Results Act (GPRA) measures. Let's look at the four measures that are tracked. Please note that IHS data cited below refer only to federal sites.

Measure 1: Prenatal HIV Screening

National IHS screening rate: 86%

Highest facility screening rate: 100%

Lowest facility screening rate: 7%

This measure has improved dramatically since 2006, when we began providing service units with feedback on their screening efforts and documenting and sharing best practices. Notably, this is the only IHS GPRA measure that exceeds the Department of Health and Human Service national goal of 74% by the year 2020.

We learned that service units with the highest screening rates had systems in place to ensure the HIV test did not have

to be ordered separately. The HIV test was “automatically” ordered for prenatal patients by bundling it into a standardized prenatal laboratory panel. The HIV test could be removed if the patient declined the test, but otherwise HIV was included with other tests rather than being ordered separately.

For sites with sub-optimal screening rates, we found that in addition to clinical practice oversight, data issues also adversely affected the prenatal HIV screening rates. Most frequently, these resulted from data taxonomy issues (e.g., the HIV test code not picked up by the Resource and Patient Management System [RPMS]) or historical data (such as HIV test done in external facility). Most sites have found ways to fix or mitigate these data issues, and their prenatal HIV screening rates have improved accordingly.

IHS sites have done a tremendous job on this measure and many of their best practices can apply to the remaining three measures of interest.

Measure 2: Annual Chlamydia Screening of Sexually Active Young Women Ages 15 - 24

National IHS screening rate: 26%

Highest facility screening rate: 49%

Lowest facility screening rate: 1%

With elevated rates of STIs in most IHS Areas, this measure is a priority and needs some improvement. The recommendation targets women because of the long term sequelae they can experience from chlamydia, including ectopic pregnancies, pelvic inflammatory disease, and infertility. At least one IHS facility routinely screens young men for chlamydia during sport physicals.

Measure 3: HIV Screening of Patients with STIs Within 60 Days of Diagnosis

National IHS rate screening rate: 31%

Highest facility screening rate: 67%

Lowest facility screening rate: 1%

Patients diagnosed with an STI have engaged in risky sexual behavior and should be screened for HIV. A chart review of IHS patients showed that 90% of missed screening opportunities were among patients who tested positive for chlamydia but did not receive a follow-up HIV screen. Prenatal

patients with a positive chlamydia test were more likely to receive HIV screening, since, as was previously discussed, it is bundled with the prenatal panel. Ideally, patients with STIs should also receive a bundled screening panel that includes HIV.

Measure 4: HIV Screening of 13 - 64 Year Olds (at least one HIV screen not related to risk is recommended)

National IHS rate screening rate: 8.7%

Highest facility screening rate: 20%

Lowest facility screening rate: 1%

With the efficacy of antiretroviral drugs, early detection of HIV/AIDS is paramount. The 2006 Centers for Disease Control and Prevention's (CDC's) recommendation for HIV screening of 13 - 64 year olds is that all patients should get at least one routine test, with repeat testing based on individual risk and clinical judgment. The CDC based this recommendation on 1) numerous studies that many HIV cases would have been detected earlier by screening, as most patients do not disclose risk factors to their providers, and 2) HIV infection can remain asymptomatic for years. The CDC hopes this recommendation will emulate the impact that HIV screening has had in nearly eliminating HIV transmission from blood transfusions (screening of all blood donors started in 1996) and mother-to-child transmission (screening for prenatal patients started in 2001).

According to CDC statistics, AI/AN patients have the fastest progression from diagnosis to death of any race/ethnicity, which suggests late detection.

How Is My Facility Doing on These Four Measures?

All IHS facilities can check their own screening rates for any of these measures via the IHS Clinical Reporting System (CRS) or iCare. If you experience technical difficulties, please contact the author for assistance in obtaining your facility's most recent screening rates for these national measures.

How Have Other Facilities Improved Their Measures?

Based on discussions with nine IHS sites that met all 19 GPRA measures, these are some of the key recommendations to improve screening measures:

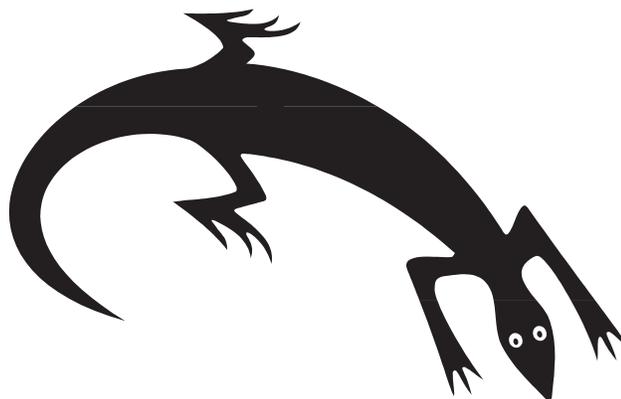
Update RPMS. Ask your Clinical Applications manager to generate a monthly RPMS report of patients whose care does not meet national recommendations. This will help identify which patients are not getting screened and opportunities to better screen the appropriate patients as per national recommendations. The list of unscreened patients may also reveal that true screening rates are higher, but some results are not being captured in RPMS because of a data glitch (such as failure to update a lab test code).

Share the findings. Share the reports among all members of the care team, both clinical and non-clinical. In weekly meetings, informal huddles, or in special committees, discuss the data and share ideas on how to screen hard-to-reach patients or better identify which patients are due for screening.

Delegate screening away from provider. Nurses or even nursing or medical assistants can offer and order certain types of screenings, depending on their experience. If training is needed, the IHS National HIV/AIDS program can provide it.

Make systems and technology work for you. Use proven tools to manage the increasing number of screening measures without overloading providers. These include standing protocols, clinical reminders in the electronic health record (EHR) that can be made "visible" only to the member of the medical team responsible for offering the screening, and iCare to track provider-specific screening rates.

For further detail on the above, or to obtain program support or training to target these four measures, please contact Brigg.Reilley@ihs.gov.



Weaving Systems of Care: Increasing Chlamydia Screening and Follow-Up in IHS, Tribal, and Urban Indian Health Programs

Wendy Nakatsukasa-Ono, MPH, Program Director, Cardea, Seattle, Washington

In 2010, Cardea (formerly the Center for Health Training), in partnership with the Alaska Native Tribal Health Consortium; the IHS National STD Program; JSI Research and Training Institute, Region VIII Infertility Prevention Project; the Northwest Portland Area Indian Health Board; and Phoenix Indian Medical Center, received a grant from the National Chlamydia Coalition to develop and disseminate a set of documents to guide standard delivery of sexually transmitted disease (STD) care to American Indian and Alaska Native (AI/AN) populations at risk for chlamydia and other STDs.

The goal of the project was to increase chlamydia screening and follow-up care among AI/AN people and specifically to:

- Increase IHS, tribal, and urban Indian health programs' (ITU's) awareness of the importance of chlamydia screening for AI/AN people, particularly adolescents and young women ages 15 - 24.
- Increase ITU's capacity to provide chlamydia screening and follow-up care.

Cardea and its partners developed five sets of documents including:

1. - Sample policy for STD and HIV screening and patient and partner management in ITUs.
2. - Sample protocol and guidelines for STD and HIV screening and epidemiologic STD treatment.
3. - STD screening recommendations chart.
4. - Sexual risk assessment charting form.
5. - Expedited partner therapy considerations and materials for patients.

We submitted the documents to CDC and IHS for clearance; in May 2011 we received clearance from both agencies, permitting agency branding of the documents. Over the last year, we have engaged in a number of dissemination activities including:

- Presenting a poster on the project at the 2012 National STD Prevention Conference.

- Distributing the documents at the 2012 IHS Women and Children's Health Conference.
- Highlighting the documents in a provider training at Phoenix Indian Medical Center in January 2012.
- Presenting the -documents to the IHS Chief Medical Officers during a conference call in December 2011.
- Presenting the documents during an Urban Indian Health Institute webinar in June 2011.
- Distributing -the documents to IHS Chief Medical Officers and hosting a Grand Rounds for IHS Chief Medical Officers in June 2011.
- Presenting -the materials at the 2011 IHS National HIV/AIDS Workshop.
- Posting the documents to key websites and distributing the documents via various IHS listservs and through Project Red Talon's e-mail distribution list.
- Distributing -the documents to ITUs, with targeted distribution to:
 - Aberdeen - Area IHS, including an area-wide conference call hosted by Mr. Greg Welch to address ongoing high rates of chlamydia and recent spikes in gonorrhea among AI/AN in the Aberdeen Area (participation from more than 40 individuals across the Aberdeen Area)
 - Portland Area IHS
 - Urban Indian Health Institute
 - Eight programs in Alaska; four in Montana; three in South Dakota; two in Arizona; and one each in Oregon, Washington, and Wyoming
 - Navajo -Nation, including endorsement by Dr. Jonathan Iralu as a means for addressing recent increases in gonorrhea on the Nation
- Distributing -the documents via other organizations, including the New Mexico Medical Society.

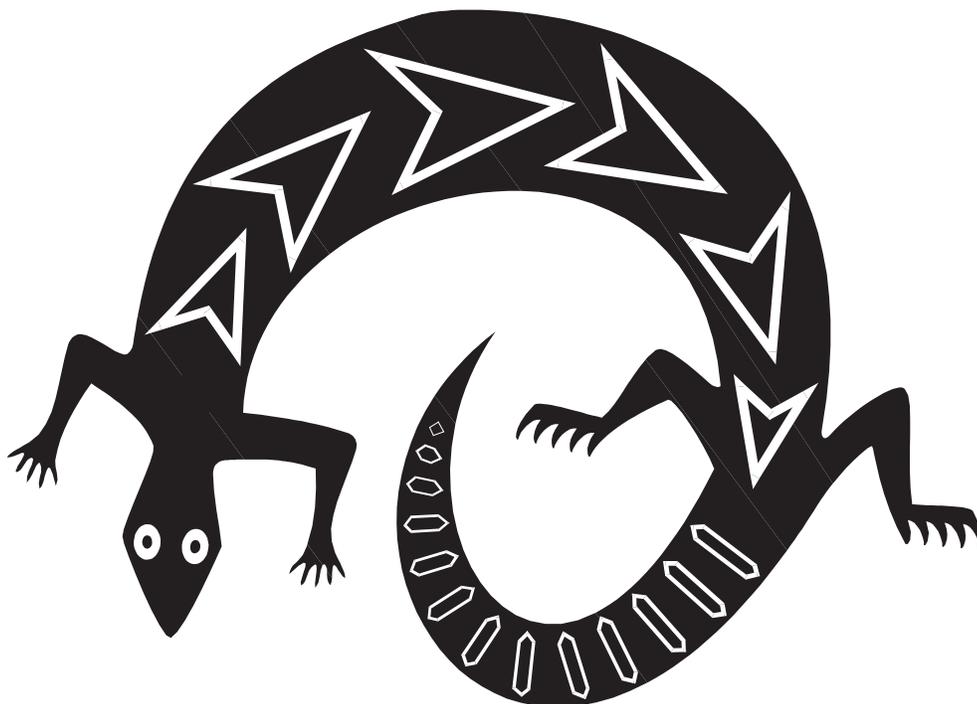
For copies of the completed materials and/or more information, please contact Wendy Nakatsukasa-Ono, MPH, Program Director, Cardea at (206) 447-9538; or e-mail wono@cardeaservices.org.

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STD Screening and Treatment in Pregnancy

Sharon Adler MD MPH, California STD/HIV Prevention Training Center, San Francisco, California.

Sexually transmitted diseases (STDs) are common among women of childbearing age and may be asymptomatic. The goals of STD screening during pregnancy are 1) early detection and treatment of infection; 2) prevention of maternal complications; and 3) prevention of vertical transmission and neonatal disease. This document is intended to provide an overview of STD screening and treatment guidelines and does not address issues regarding diagnostic work-up, STD counseling, or partner management. Additionally, treatment of HIV, including prophylaxis for HIV-positive pregnant women, hepatitis B, and hepatitis C, is beyond the scope of this document.

STD Screening in Pregnancy

The Centers for Disease Control and Prevention (CDC) 2010 STD Treatment Guidelines recommend screening pregnant women for STDs. The CDC screening recommendations are incorporated into the recommendations below. Note that these are screening recommendations for asymptomatic pregnant women. Women presenting with signs or symptoms of STDs at any time during pregnancy should be examined, tested, and treated if an STD is suspected or confirmed. See Table 1 for summary screening recommendations.

Bacterial STDs

Chlamydia

- Screen *all pregnant women* at the first prenatal visit.
- Re-test in the third trimester for at-risk women (ages 25 years or younger, new or multiple sex partners, tested positive earlier in pregnancy).
- Note: Nucleic Acid Amplification Tests (NAATs) are the most sensitive testing technology to detect chlamydial infection and are the preferred test technology for screening. NAATs for chlamydia using urine or vaginal swabs have the advantage of being non-invasive and can be obtained when a pelvic exam is not being done or when there is a risk to the pregnancy in taking cervical specimens. Vaginal swabs are the preferred specimen type as they are at least as sensitive as cervical swabs and are more sensitive than urine for the detection of chlamydia.

Gonorrhea

- Screen *pregnant women at risk* at the first prenatal visit.

- At-risk women include those ages 25 years or younger and those with a history of gonorrhea in the prior two years, more than one sex partner in past year, a partner with other partners, commercial sex, drug use, or living in an area with high gonorrhea prevalence (certain geographic regions).
- Re-test in third trimester for women at continued risk or if tested positive earlier in pregnancy.
- As with chlamydia, NAATs are the most sensitive testing technology to detect gonorrhea infection and are the preferred test technology for screening.

Syphilis

- Screen *all pregnant women* at the first prenatal visit with a non-treponemal test (Venereal Disease Research Laboratory (VDRL) or rapid plasma regain (RPR)), and if positive, confirm with a treponemal test (Treponema pallidum particle agglutination (TP-PA) preferred over Fluorescent Treponemal Antibody-Absorption (FTA-ABS)).
- Re-test at 28 to 32 weeks and at delivery for women living in areas with high syphilis morbidity. Contact your local health department to find out about areas with high syphilis morbidity where the risk for congenital syphilis is high.
- Stat RPR should be performed at delivery for women with no prenatal care.
- No infant or mother should leave the hospital without having the maternal syphilis status documented at least once either during pregnancy or at delivery.
- Any woman who delivers a stillborn after 20 weeks' gestation should be tested for syphilis.
- If a treponemal EIA (enzyme immunoassay) -or CIA (chemiluminescence immunoassay) test is used for syphilis screening, all positive EIA/CIA tests should be reflexed to a non-treponemal test (RPR or VDRL). If the non-treponemal test is negative (e.g., EIA-positive/RPR negative), then the results are discrepant and a second treponemal test (TP-PA preferred) should be performed, preferably on the same specimen.
 - If the second treponemal test is positive (e.g., EIA positive/RPR-negative/TP-PA positive), then a diagnosis of syphilis (past or present) is confirmed. For patients who have been treated for syphilis in the past and who do not have ongoing risk, no further treatment is necessary. Patients with no prior history of treatment should be staged and treated

with a recommended antibiotic regimen.

- If the second treponemal test is negative (EIA-positive/RPR-negative/TP-PA negative), then the positive EIA most likely represents a false positive test result. If the woman is at high risk for syphilis, repeat serologic testing in three to four weeks. If both the RPR and TP-PA remain negative, then no further treatment is necessary.

Vaginitis

Bacterial Vaginosis

- Screening - for bacterial vaginosis (BV) is not recommended in asymptomatic pregnant women. There is insufficient evidence to support routine screening in pregnant women, including those at high risk for preterm labor. BV is associated with adverse pregnancy outcomes; however, studies evaluating screening and treating women at high risk for preterm labor have not demonstrated consistent benefit.
- Women with symptoms should be evaluated and treated appropriately.

Trichomoniasis

- ^a Screening for trichomoniasis is not recommended in asymptomatic pregnant women. Trichomoniasis is associated with adverse pregnancy outcomes, however current evidence does not demonstrate that screening and treating asymptomatic pregnant women reduces perinatal morbidity.
- Women with symptoms should be evaluated and treated appropriately.

Viral STDs

HIV

- Screen -ALL PREGNANT WOMEN as early in the pregnancy as possible. HIV information and testing should be offered to all pregnant women.
- Re-test -in the third trimester in high-risk women (injection drug use, new STD diagnosis in pregnancy, women with multiple sex partners, living in areas with high HIV prevalence or HIV-infected partners).
- Rapid HIV testing for women in labor is recommended if HIV status is undocumented. If rapid test is positive, antiretroviral prophylaxis is recommended prior to confirmatory test results.

Hepatitis B

- Screen ALL PREGNANT WOMEN in the first trimester with hepatitis B surface antigen (HBsAg). Screen in pregnancy even if previously vaccinated or tested negative.
- Re-test at time of admission to hospital for delivery in untested women and high-risk women (more than one sex partner in the prior six months, new STD diagnosis

in pregnancy, recent or current injection drug use, or HBsAg-positive partner).

- Note: Hepatitis B vaccine is safe in pregnancy. Women who are at risk for hepatitis B should be vaccinated. HBsAg serologic testing should be done prior to administering the hepatitis B vaccine as transient positive HBsAg tests can occur post vaccination.

Hepatitis C

- Screen at the first prenatal visit in *high risk women* (history of injection drug use, history of blood transfusion, or organ transplantation before 1992).

Genital Herpes

- Serologic -screening for herpes simplex virus (HSV) types 1 or 2 is not recommended in asymptomatic pregnant women. The evidence is insufficient to support routine HSV serology screening.
- Consider type-specific HSV serology testing in patients whose partner has genital herpes, who have recurrent genital symptoms or atypical symptoms with negative HSV cultures, or who have a clinical diagnosis of genital herpes without laboratory confirmation.
- Although -type-specific HSV-2 serology screening is recommended for HIV-infected patients on entry into care, there is insufficient evidence and lack of consensus to support routine screening of HIV-infected women in pregnancy. Screening should be considered for those not screened on entry into HIV care or those at risk whose current status is unknown.
- Third -trimester serial cultures for HSV are *not* recommended in asymptomatic women with a history of HSV.
- All pregnant women should be examined for evidence of genital herpes at the time of delivery.

Human Papillomavirus (HPV) and Associated Diseases

- Guidelines for cervical cancer screening for pregnant women do not differ from those for non-pregnant women. Refer to national cervical cancer screening guidelines for current recommendations on the frequency.
- Routine -HPV screening in pregnancy (apart from cotesting and management of suspected or confirmed cervical dysplasia) is not recommended.
- Examination to assess for genital warts can be done during prenatal physical examination.
- Note: -the HPV vaccine is *not* recommended in pregnancy. If the series is started prior to pregnancy, it should be discontinued for the duration of the pregnancy. Any exposure to vaccine during pregnancy should be reported to the appropriate vaccine pregnancy registry at (800) 986-8999 (Gardasil-Merck) or (888) 452-9622 (Cervarix-GSK vaccine).

Table 1. Summary STD Screening Recommendations in Pregnancy

| | |
|---|---|
| <p>Time of Screening First prenatal visit</p> | <p>Tests for All Pregnant Women (unless specific risk group noted)</p> <ul style="list-style-type: none"> • Chlamydia • Gonorrhea for women at risk: age 25 years or younger or women with a history of gonorrhea in prior 2 years, more than one sex partner in past year, partner with other partners, commercial sex, drug use, or living in an area with high gonorrhea prevalence (certain geographic regions); African American women are also at higher risk for gonorrhea • Syphilis (RPR or VDRL). Always confirm a positive RPR or VDRL with treponemal test (TP-PA preferred over FTA-ABS) • HIV • Hepatitis B surface antigen (HBsAg) • Hepatitis C if high risk: history of injection drug use, history of blood transfusion or organ transplantation before 1992 • Consider type-specific HSV serology for women at risk: exposure to partner with genital herpes, recurrent genital symptoms or atypical symptoms with negative HSV cultures, or a clinical diagnosis of genital herpes without laboratory confirmation and in HIV infected. • Pap test if indicated by national guidelines |
| <p>Third trimester</p> | <p>Early third trimester (28 - 32 weeks)</p> <ul style="list-style-type: none"> • Syphilis for women living in areas with high syphilis morbidity <p>Anytime during third trimester</p> <ul style="list-style-type: none"> • Chlamydia for women at risk: age 25 years or younger, new or multiple partners, or tested positive earlier in pregnancy • Gonorrhea if continued risk or tested positive earlier in pregnancy • HIV if high risk: injection drug use, new STD diagnosis in pregnancy, multiple partners, living in area with high HIV prevalence, or HIV-infected partner |
| <p>During labor and delivery</p> | <ul style="list-style-type: none"> • Syphilis if woman lives in area with high syphilis morbidity • Syphilis stat RPR if no prior prenatal care • HIV rapid testing if undocumented HIV status • HBsAg on admission to delivery if no prior screening or if high risk: multiple partners prior 6 months, new STD diagnosis in pregnancy, recent or current injection drug use, or HBsAg-positive partner |

STD Treatment in Pregnancy

The following recommendations are based on the CDC 2010 STD Treatment Guidelines. Recommendations for treatment of HIV, including prophylaxis for HIV-positive pregnant women, hepatitis B, and hepatitis C, are not covered in this document. See Table 2 for a summary of recommended treatment regimens.

Bacterial STDs

Chlamydia

- Azithromycin or amoxicillin are the two recommended

regimens. Every effort to use a recommended regimen should be made.

- Test of cure (preferably with NAAT) should be done three to four weeks after completing therapy.

Gonorrhea

- Ceftriaxone -250 mg by intramuscular injection plus azithromycin 1 g orally in a single dose is the preferred antimicrobial regimen for uncomplicated gonococcal infections of the cervix, urethra, rectum, and pharynx.
- Dual antibiotic therapy with ceftriaxone plus

azithromycin 1 g is recommended for all suspected and confirmed cases of gonorrhea regardless of chlamydia test result.

- Though cefixime 400 mg orally in a single dose plus azithromycin 1 g orally in a single dose is an oral treatment option for gonorrhea, cefixime does not provide as high or as sustained a bactericidal level as that provided by ceftriaxone 250 mg. Every effort should be made to use ceftriaxone 250 mg plus azithromycin 1g as the first-line treatment regimen for gonorrhea.
- For -patients with cephalosporin allergy or severe penicillin allergy (e.g., anaphylaxis, Stevens Johnson syndrome, toxic epidermal necrolysis), treat with azithromycin 2 g orally in a single dose. However, because of gastrointestinal intolerance and concerns about emerging resistance to azithromycin, it should be used with caution.
- Test of cure (preferably with NAAT) should be done three to four weeks after completing therapy.
- For current California guidelines on suspected treatment failure visit www.std.ca.gov. Other local, state or tribal health websites may have updated guidance on management of suspected gonorrhea treatment failure.

Cervicitis

- Azithromycin -is the drug of choice for presumptive treatment.
- If local prevalence of gonorrhea is greater than five percent, co-treat for gonorrhea infection.
- Assess for bacterial vaginosis and trichomoniasis and co-treat if infection detected.

Pelvic Inflammatory Disease

- Parenteral therapy in an inpatient setting is necessary because of risk of preterm delivery and maternal morbidity.
- Clindamycin -plus gentamicin is the recommended regimen.

Syphilis

- Benzathine -penicillin G (generic name) is the only recommended treatment for primary, secondary, and latent syphilis in pregnancy and is available in only one long-acting formulation, Bicillin® L-A (the trade name), which contains only benzathine penicillin G.
- Other -combination products, such as Bicillin® C-R, contain both long- and short-acting penicillins and are not effective for treating syphilis.
- Pregnant women allergic to penicillin should be treated with penicillin after desensitization.
- Some -specialists recommend a second dose of benzathine penicillin G 2.4 million units intramuscular 1 week after the initial dose for pregnant women with primary, secondary, or early latent syphilis

- Consider treatment with 2.4 million units of benzathine penicillin G once per week for up to 3 weeks after completion of neurosyphilis treatment for patients with late syphilis (late latent syphilis and latent syphilis of unknown duration) and neurosyphilis.

Chancroid

- Azithromycin, -ceftriaxone, or erythromycin base are recommended treatment regimens.

Lymphogranuloma venereum

- A 3-week course of erythromycin base or azithromycin is recommended.

Vaginitis

Trichomoniasis

- Metronidazole -(pregnancy category B) is the only recommended regimen.
- Some experts defer treatment in asymptomatic women until after 37 weeks gestation.
- For suspected drug-resistant trichomoniasis, evaluate for potential reinfection, and use increased dosage of metronidazole or tinidazole (See 2010 CDC Guidelines, “Trichomonas Follow-up”, for specific treatment regimens: <http://www.cdc.gov/std>). For laboratory and clinical consultations and to evaluate for metronidazole-resistant *T. vaginalis* contact CDC at (404) 718-4141.

Bacterial Vaginosis

- All pregnant women with symptomatic BV should be treated.
- Metronidazole and clindamycin are the recommended regimens.

Viral STDs

Genital Herpes

- The -safety of acyclovir in pregnancy has not been established; however, available data do not show an increased risk of birth defects in women treated with acyclovir in the first trimester.
- Acyclovir is the recommended regimen for women with first clinical episodes or severe recurrent herpes, and intravenous acyclovir should be used in severe infection.
- Symptomatic HSV identified late in pregnancy or at the time of delivery should be managed in consultation with an infectious disease specialist.
- Suppressive acyclovir treatment late in pregnancy (≥ 36 weeks to term) reduces the frequency of cesarean section among women who have recurrent genital herpes by diminishing the frequency of recurrences at term.

Genital Warts

- Cryotherapy, trichloroacetic acid (TCA), bichloroacetic acid (BCA) or surgical removal are recommended

Table 2. Summary Recommended STD Treatment in Pregnancy*

| DISEASE | RECOMMENDED REGIMENS |
|---|---|
| CHLAMYDIA | • Azithromycin 1 g orally once or • Amoxicillin 500 mg orally three times daily for 7 days |
| GONORRHEA | Dual therapy with: • Ceftriaxone 250 mg intramuscular once PLUS • Azithromycin 1 g orally once or, if not an option: • Cefixime 400 mg orally once PLUS • Azithromycin 1 g orally once |
| CERVICITIS | • Azithromycin 1 g orally once Plus • Treat for BV or trichomoniasis if present |
| PELVIC INFLAMMATORY DISEASE | • Clindamycin 900 mg intravenous every 8 hours Plus • Gentamicin 2mg/kg intramuscular or intravenous followed by 1.5 mg/kg intramuscular or intravenous every 8 hours Discontinue 24 hours after patient improves clinically and continue with oral clindamycin 450 mg four times daily for a total of 14 days. |
| SYPHILIS Primary, Secondary, and Early Latent Late Latent and Unknown duration Neurosyphilis | • Benzathine penicillin G 2.4 million units intramuscular once • Benzathine penicillin G 7.2 million units, administered as 3 doses of 2.4 million units intramuscular at 1-week intervals • Aqueous crystalline penicillin G 18-24 million units daily, administered as 3-4 million units intravenous every 4 hours for 10-14 days |
| CHANCROID | • Azithromycin 1 g orally once or • Ceftriaxone 250 mg intramuscular once or • Erythromycin base 500 mg orally three times daily for 7 days |
| LYMPHOGRANULOMA VENEREUM | • Erythromycin base 500 mg orally four times daily for 3 weeks or • Azithromycin 1 g orally once per week for 3 weeks |
| TRICHOMONIASIS | • Metronidazole 2 g orally once |
| BACTERIAL VAGINOSIS | • Metronidazole 500 mg orally twice daily for 7 days or • Metronidazole 250 mg orally three times daily for 7 days or • Clindamycin 300 mg orally twice daily for 7 days |
| GENITAL HERPES First Clinical Episode Episodic Therapy for Recurrent Episode Suppressive Therapy | • Acyclovir 400 mg orally three times daily for 7-10 days or • Acyclovir 200 mg orally 5/day for 7-10 days • Acyclovir 400 mg orally three times daily for 5 days or • Acyclovir 800 mg orally twice daily for 5 days or • Acyclovir 800 mg orally three times daily for 2 days • Acyclovir 400 mg orally twice daily |
| GENITAL WARTS External Genital, Perianal or Mucosal Genital Warts | • Cryotherapy applied once per 1-2 weeks or • Trichloroacetic acid (TCA) applied once per 1-2 weeks or • Bichloroacetic acid (BCA) 80%-90% applied once per 1-2 weeks or • Surgical removal |

* See CDC 2010 STD Treatment Guidelines (www.cdc.gov/std/treatment) for alternative treatment regimens.

treatments in pregnancy.

- Cryotherapy can be used on vaginal, vulvar, and anal mucosal warts.
- TCA or BCA can be used on vaginal, vulvar, and anal mucosal warts.
- Surgical removal is another option for vaginal, vulvar, and anal mucosal warts.
- If surgical removal is performed during pregnancy, wart resolution may be incomplete or poor until post partum period.
- Cervical warts should be managed by a specialist.

STD Resources

Centers for Disease Control and Prevention 2010 STD Treatment Guidelines (<http://www.cdc.gov/std/treatment>).

The California Department of Public Health, STD Control Branch website (<http://www.std.ca.gov>) has many STD resources including clinical guidelines, treatment guidelines, surveillance reports, and links to local STD data.

The California STD/HIV Prevention Training Center (CA PTC) website (<http://www.stdhivtraining.org/>) has a variety of STD resources including information about STD/HIV prevention training courses, resources to assist providers in risk assessment, diagnosis, and management of STDs, as well as STD fact sheets for patients.

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HPV Vaccine and Cervical Cancer Screening: National Recommendations and Strategies to Improve Coverage

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Human papillomavirus (HPV) is the most common sexually acquired infection in the US; over 39.5 million females aged 14 - 59 years of age have prevalent infection with at least one of 37 types of HPV.¹ This infection usually clears without causing health problems; however persistent oncogenic HPV infection results in about 12,000 diagnoses of cervical cancer and 4,000 deaths from cervical cancer in the US each year. In addition to cervical cancer, HPV infection can cause other cancers, such as penile, anal, oropharyngeal, vaginal, and vulvar, as well as genital warts.

Two HPV vaccines with high efficacy for prevention of cervical precancer are currently available: a quadrivalent HPV vaccine, Gardasil®, and a bivalent HPV vaccine, Cervarix®. The quadrivalent vaccine prevents two types of HPV that cause many cancers, including cervical cancer, and two types of HPV that cause genital warts; the bivalent vaccine prevents two types of HPV that cause many cancers, including cervical cancer. CDC recommends that males and females aged 11 or 12 years be vaccinated with HPV vaccine.^{2,3} For females, either quadrivalent or bivalent HPV vaccine is recommended; for males, quadrivalent HPV vaccine is recommended. For those not previously vaccinated, catch up vaccination is recommended through age 26 years for females and through age 21 years for males. Vaccine may be given to males aged 22 - 26 years. Vaccination is recommended even if there are Pap test abnormalities, genital warts, or other clinical findings of HPV, because persons may benefit from preventing HPV types they have not acquired.⁴ A pregnancy test is not recommended for females prior to receiving the vaccine.²

According to data collected by IHS from IHS, tribal, and urban (I/T/U) Indian health care facilities, HPV vaccine coverage for doses 1, 2 and 3 among females aged 13 - 17 years old is 72%, 57%, and 40% as of March 2010.⁵ According

to the CDC's 2010 National Immunization Survey – Teen (NIS-Teen), coverage for females aged 13 - 17 years old in the general US population with > 1 and > 3 doses of HPV was 49% and 32% respectively.⁶ In addition, the NIS-Teen found that coverage for 1 dose of HPV for Non-Hispanic White adolescents was 46% (95% CI 43.8 – 47.9%) compared to 65% (95% CI 46.6 – 79.5%) for AI/AN adolescents.⁶ While both the IHS and CDC data suggest that providers are successfully reaching many AI/AN adolescents, current coverage falls short of the Healthy People 2020 goal of 80%, and completion of the series remains a challenge. In order to continue to increase initiation and completion of the HPV vaccine series (as well as other vaccines), I/T/U facilities have employed a number of evidence-based strategies.

Strategies to increase vaccination include:

1. - Provide education on HPV and HPV vaccine at community events (e.g., health fairs).
2. - Implement standing orders for vaccines.
3. - Expand access to vaccines in clinical settings utilizing walk-in immunization clinics and pharmacy-based immunization clinics.
4. - Expand access to vaccines in non-clinical settings, such as schools.
5. - Use the Resource and Patient management System (RPMS) or other electronic health record system for provider reminders and to support reminder/recall activities.
6. - Use state immunization registries to ensure that a patient's complete immunization history is available to the provider.
7. - Provide on-going monitoring of immunization coverage levels and feedback to providers.

In addition, it is important to address financial barriers that prevent the provision of adult vaccines, including HPV vaccine.⁷

Another important intervention to prevent cervical cancer is cervical cancer screening. Several professional organizations such as American Congress of Obstetricians and Gynecologists, American Cancer Society, and US Preventive Services Task Force have different recommendations regarding cervical

cancer screening. However, all professional organizations recommend women be screened for cervical cancer starting at age 21 years. All women should receive cervical cancer screening, even if they have received HPV vaccine, as the vaccine does not prevent all cervical cancers.

AI/AN women have one of the lowest cervical cancer screening rates of any race/ethnicity (69.4% in 2008).⁸ Barriers to cervical cancer screening for AI/AN women are well documented and include geographic isolation, cultural issues, poverty, and language. Transportation is a major issue because distances to clinics and treatment facilities are often great, and several hours of travel may be required to reach them.⁹ While a recent study found no differences in the prevalence of HPV and cervical abnormalities between AI/AN women and non-Hispanic white women in the US,¹⁰ it has been noted that AI/AN women have higher rates of cervical cancer than non-Hispanic white women and are more likely to be diagnosed with later stage disease,¹¹ emphasizing the importance of screening and appropriate follow-up for abnormalities.

Many I/T/U facilities are utilizing evidence-based strategies to improve cervical cancer screening rates.

Strategies to increase cervical cancer screening include:

1. - Employ traveling mobile mammogram units in tribal communities to allow easier access to clinical breast exam, Pap, and mammography screenings
2. - Provide patient education and outreach in the community. Patients are more likely to ask questions in their community than in a health care facility.

HPV vaccines and cervical cancer screening are opportunities to reduce the burden of cancers and other diseases in AI/AN populations. Although challenging to implement, these interventions should be fundamental prevention activities.

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In Community Spirit: HIV Prevention in Indian Country

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In 2009, the Department of Health and Human Services Office on Women's Health (OWH), began funding American Indian and Alaska Native (AI/AN) community-based organizations across the nation to conduct and promote HIV prevention activities. The three-year project, *In Community Spirit Program — Prevention of HIV/AIDS for Native/American Indian and Alaska Native (AI/AN) Women Living in Rural and Frontier Indian Country*, consists of three types of HIV program components being implemented with women in AI/AN communities: 1) community mobilization, 2) capacity building and technical assistance, and 3) prevention education. The purpose of *In Community Spirit* is to increase HIV prevention knowledge and reduce the risk of contracting HIV among AI/AN women living in rural and remote areas using multi-level interventions and approaches. Throughout these communities, the cohort of *In Community Spirit* grantees is working to integrate the strengths of traditions, values, culture, and spirituality with HIV prevention.

Of note, this synopsis includes two projects funded through the OWH to address AI/AN women and girls: Prevention and Intervention AIDS — Related Services for Girls at Risk for Juvenile Delinquency, and HIV Prevention Program For Young Women Attending Minority Institutions.



NA SISTER

The Inter Tribal Council of Arizona, Inc. (ITCA), tailored a program locally to specifically address STD risk factors among American Indian (AI) women in Arizona. ITCA worked closely with community stakeholders, health educators, and tribes in

Arizona to adapt and modify Sisters Informing Sisters about Topics on AIDS (SISTA), an existing evidence-based HIV prevention intervention.

The curriculum, NA SISTER, is delivered in six, two-hour sessions followed by two optional booster sessions. Participants are exposed to topics such as Being A Proud Native American Woman, Historical Trauma and Cultural Resilience, HIV/AIDS Education, Proactive Skills Training, Behavioral Self-Management Training, and Coping Skills. The sessions are led by female facilitators who engage participants in group discussions, role-playing, and behavioral skill-building activities.

The goals of the project are to increase knowledge about STDs and HIV, including transmission and risk reduction strategies, to increase intention to use condoms in the future, and to increase the number of AI females getting tested for HIV. Currently the project is being evaluated in three different tribal communities in Arizona. If proven effective, the goal is to have the curriculum available for other tribal communities to use.

For additional information about the project, please contact Gwenda Gorman, Health Promotion Director, at gwenda.gorman@itcaonline.com or (602) 258-4822. To view the original SISTA intervention and other evidence-based interventions, visit www.effectiveinterventions.org/en/home.asp.

Native Women Speaking

The National Native American AIDS Prevention Center (NNAAPC) is implementing a home-grown intervention — *Native Women Speaking* (NWS) — in five partner sites across the country. NWS is a comprehensive prevention and capacity building project that seeks to promote growth among agencies that serve Native women at

risk for HIV. NNAAPC works directly with Native agencies located on reservations or in rural communities in three different areas: 1) implementation of a prevention intervention, 2) capacity building, and 3) community mobilization. NNAAPC trains partner agency staff on the NWS intervention and sponsors three-day NWS retreats in their local communities. As part of the capacity building arm, NNAAPC conducts organizational assessments to identify areas of





potential guidance, and then constructs a plan that includes individualized delivery of skills-building, consultation, and assistance to help support the agency in their internal growth and development. Lastly, as part of community mobilization, NNAAPC holds focus groups and speaks to community members to learn about their perception of HIV and prevention efforts. This information is used to construct social marketing messaging and materials that are diffused throughout the community. NNAAPC also helps to sponsor local outreach and awareness events that can mobilize the community around HIV prevention.

For additional information about the project, please contact NNAAPC at (720) 382-2244 or visit the NNAAPC website at www.nnaapc.org.

Taking SHAPE and Native STAND

Planned Parenthood Minnesota, North Dakota, South Dakota partners with American Indian-serving organizations in Duluth and Bemidji, Minnesota to offer intensive sexuality education with a focus on HIV and AIDS. Planned Parenthood's aims are to reduce stigma, foster knowledge, increase testing and health care access, and encourage healthy decisions and behavior. Five Anishinaabe (Chippewa, Ojibwe) reservations are part of the service area in which Planned Parenthood serves.

Education offerings include Taking SHAPE, a six-hour program for women and girls, which can be adapted to fit the scheduling and logistical needs of collaborating partners, and Native STAND, an intensive peer education and youth development program. Planned Parenthood also offers field or in-clinic rapid oral HIV testing to all program participants, as



well as access to other reproductive health care services.

Planned Parenthood educators are present in each community by participating in health fairs and other community events providing information about HIV and AIDS and Planned Parenthood program offerings. Staff also offer presentations to many local groups on reproductive health topics including HIV and AIDS.

For additional information about the project, please contact August Galloway, Northern Minnesota Education Manager, at agalloway@ppmns.org; (218) 722-3267; or visit the website at www.ppmns.org.

Honoring Opportunities to Prevent and Empower (HOPE)

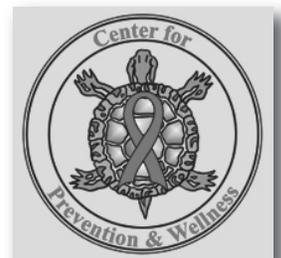
The Center for Prevention and Wellness at Salish Kootenai College (SKC) in Pablo, Montana has been working with Native women since 2006. In 2005, Native women from across Montana were brought together to review the CDC SISTA intervention, which targeted African American women. The intervention has since been tailored to reach Native women attending SKC as well as community members of the Salish and Kootenai tribes. Native Women's Honoring Opportunities to Prevent & Empower (HOPE) groups are conducted over a period of two days. Sessions cover topics on Native pride, reproductive anatomy, sexually transmitted infections/diseases, and HIV/AIDS. Follow up booster sessions are offered with topics ranging from self-defense courses to HPV vaccination information. To-date, approximately 900 women have participated in HOPE, with graduating group members ranging in age from 12 to 82.

The overall goal is to help women understand various risks and protect themselves from harmful diseases and infections. The HOPE group allows women the opportunity to share their struggles and stories without fear or judgment. The women who have participated in our groups are our best resource. Not only do the women and girls seek appropriate medical care when needed but they refer their friends, family members, and loved ones to the group. Native Women's HOPE group empowers women to be strong advocates for themselves and those around them.

For additional information about the project, please contact Niki Graham, Project Director, at niki_graham@skc.edu or (406) 275-4920; or visit their website at <http://prevention.skc.edu>.

Annual Women's HIV/STD Training Conference

As part of the OWH's *In Community Spirit* grant, the HIV/STD Prevention Center at the Alaska Native Tribal Health Consortium (ANTHC) conducts a 3-day HIV/STD training conference annually in Anchorage for



Community Health Aides (CHAs) and practitioners who serve Alaska Native women. The main objectives of the training conference are to promote knowledge about HIV/STD including counseling, testing, and referral services and to address barriers and stigma regarding HIV/STD education and implementing HIV/STD testing in communities. The overarching goal of the program is to increase access to HIV education and screening in rural Alaska Native communities, especially among Alaska Native women seeking women's health care. Through the Annual Women's HIV/STD Training Conference, the HIV/STD Prevention Center has been able to build and foster relationships with CHAs, which have increased the program's ability to provide ongoing technical assistance, infrastructure support, and capacity building assistance more effectively.

Some quotes from prior attendees of the conference include:

- “Awesome training, great having smaller group, made for more interactive dynamic learning environment.”
- “Enjoyed depth and variety of presentations and learning about additional projects.”
- “(I -learned) to speak for myself and for [my] community.”
- “(I learned -about the) Importance of offering HIV screening to all STD patients that come in for screening or/and TX.”

For additional information about the project, please contact Cornelia “Connie” Jessen, STD Program Manager, at cmjessen@anthc.org or (907) 729-3955; or visit their website at www.iknowmine.org.



materials along with speakers and activities such as geocaching and scavenger hunts. In addition, the members write public service announcements and speak on the radio in their community. Each year a directory of HIV/AIDS and STD services is published with input from the HEART Coalition members. These directories are distributed to health care providers throughout the Cherokee Nation jurisdiction, which covers a 14 county area in northeastern Oklahoma.

Other partners include the Cherokee Nation Medical Division, where doctors participate in HIV/AIDS professional training for continuing medical education credits (CEUs) and medical updates. As a result of the provider trainings, physicians have become interested in developing HIV/AIDS care clinics. Also “offering testing” has become routine through policy change that was created as a direct result of this training. Other partnering organizations include Help in Crisis, Northeastern State University, and Green Country HIV/AIDS Coalition.

For additional information about the project, please contact Pamela E. Iron, Executive Director, at pam@niwhrc.org; or (918) 456-6094.



HIV/AIDS Prevention Collaborations – *In Community Spirit*

The National Indian Women's Health Resource Center (NIWHRC) in Oklahoma uses a two-pronged approach — capacity building and community

awareness — to increase knowledge about and access to services for rural Native American women. The goal of the NIWHRC is to increase HIV prevention knowledge and reduce the risk of contracting HIV among American Indian and Alaska Native (AI/AN) women living in Indian Country using multi-level interventions and approaches.

NIWHRC has partnerships with five regional organizations and coalitions including the HIV Education and Resource Training (HEART) Coalition. The members of the HEART Coalition are all AI preventions specialists or medical personnel who have a special interest in HIV prevention and awareness, testing, and treatment. The HEART Coalition sponsors HIV/AIDS prevention activities annually with NIWHRC support to five rural communities with a significant AI population. They provide testing and health education



BeLIEVing In Native Girls (BLING)

BeLIEVing In Native Girls (BLING) is the OWH funded program located at Riverside Indian School in Anadarko, Oklahoma. Riverside is one of four remaining off reservation boarding schools in the US and is operated by the Bureau

of Indian Education. On an annual basis, about 500 students from federally recognized tribes across the US attend this residential education facility. Since 2008, BLING has annually taught approximately 100 adolescent girls between the ages of 12 and 18 about HIV prevention through a 24-module curriculum. The focus is on educating teen girls about healthy sexuality, problem solving, communications, healthy relationships, and building self-esteem.

During Year 1 of the evaluation, 76% of participants reported having used alcohol, 66% reported having experienced hopelessness, 25% reported having tried to harm themselves, and 19% reported feeling that adults do not care about them. It is the hope that through programs like BLING, young Native women will get the tools that they need to build a hopeful and happy future.



For additional information about the project, please contact Deborah Scott, Director of BLING and owner of Sage Associates, Inc., at dsscott@sageways.com or (281) 773-9677.

Initiative of Native Sisters Preventing Infectious Risks through Empowerment

Initiative of Native Sisters Preventing Infectious Risks through Empowerment (INSPIRE HIV Prevention) is a program of First Nations Community Healthsource in Albuquerque, New Mexico. INSPIRE HIV Prevention specializes in working with both urban and rural Native women in the Albuquerque area and surrounding tribal communities throughout the state. INSPIRE HIV Prevention is unique and important in that it is the only program in Albuquerque that provides direct services to Native women, by Native women. Grounded on an indigenous ideological

foundation, the program is rooted in traditional kinship practices, acknowledging clients as an extension of one's family: mother, grandmother, aunt, cousin, sister, daughter.

INSPIRE HIV Prevention:

- Facilitates monthly weekend retreats using a version of the ITCA's HIV prevention curriculum NA SISTER (further adapted to meet the needs of INSPIRE clients). Daycare is provided for mothers attending curriculum sessions.
- Ensures that Native women are directly connected to the services available in the community, throughout the state, and through First Nations Community Healthsource (e.g., medical, mental health, traditional healing, WIC, Medicaid, homeless outreach, and dental services).
- Maintains partnerships with other community programs, conducts educational presentations and testing, conducts street outreach in Albuquerque, in surrounding tribal communities, and throughout the state. Our outreach services are based on the expressed needs of our Native peoples.

For additional information about the project, please contact Whisper C. K. or Devona Kanesta, HIV Preventionists and Sexual Health Advocates for Indigenous Peoples: leah.carpenter-kish@fnch.org, devona.kanesta@fnch.org, (505) 346-7704, (505) 250-9095 or INSPIRE HIV Prevention on FaceBook.



Ahalaya Case Management Model: Cultural Competency and Integration Key in Quality Services for Native People Living With HIV/AIDS

Jamie Folsom, MS, CBA Specialist and Ahalaya Project Coordinator; Robert Foley, MEd, President/CEO and Ahalaya Project Director, National Native American AIDS Prevention Center, Denver, Colorado

More than 20 years ago, the National Native American AIDS Prevention Center (NNAAPC) and partner organizations began a process of creating a case management model that would pioneer quality health services for Native people living with HIV/AIDS (NPLWHA). Ahalaya – the Choctaw word meaning “to care deeply” – was developed as a framework for a unique client-based holistic approach to health service integration, wellness, and cultural competency – all firmly grounded in a Native worldview.

Process and outcome evaluation provided evidence of success (results from client surveys show an increase in positive attitudes in obtaining services and quality of care). Of particular note is the high percentage – 92.3% – of respondents who “liked the AI/AN/NH affiliation of these projects,” which is key in client retention, as well as the 87.7% who said, “the Ahalaya Program made their lives better.”

Despite the success of the program in several sites across the US, funding cuts forced NNAAPC to suspend the diffusion of the model. However, in 2011, a new grant through the Healthy People 2020 Action Initiative (administered through JSI Research and Training, Inc.) began funding the update of the Ahalaya model, its implementation in two sites, and ongoing technical assistance for project partners.

The overall goals of the project are to improve the quality of care for NPLWHA, and to increase access to needed health services by integrating medical, social, mental, cultural, and spiritual components into case management. These goals further the national HP2020 objectives by increasing access to culturally appropriate services for a challenged population, helping increase the lifespan of those living with HIV, and addressing social determinants of health.

The new project is driven by partnerships with individuals and organizations who serve NPLWHA. NNAAPC Board Member and original Ahalaya collaborator, Gloria Bellymule Zuniga, RN, as well as members of NNAAPC’s Community Advisory Council, advised the curriculum revisions. The Native American AIDS Project and the Native American

Health Center in San Francisco, and Partnership Health Center in Missoula, Montana, received mini-grants to host Ahalaya trainings and implement the model within their case management programs. The trainings in California and Montana were held in fall 2011 for case management staff and managers. Both agencies serve a significant number of NPLWHA, and have access to the cultural resources needed to round out the care approach that characterizes Ahalaya.

To understand the unique set of challenges NPLWHA face, health professionals need core knowledge in the areas of history, culture, and tribal health resources – important social determinants of health. Misconceptions about the availability of “free” and “complete” health services in Indian Country abound, which are often reflected in service referrals that ignore cultural factors and the complex relationship between Native individuals, tribes, and federal programs. Finding stable housing, for instance, can prove extremely difficult if service management does not include a background in the factors affecting NPLWHA. HIV stigma and homophobia experienced within tribal communities often pushes NPLWHA to move to urban areas for more discrete care. However, interpersonal violence and stigma in urban Native communities are still barriers, and NPLWHA may often feel their privacy will be violated if they seek out Native-specific services. Ahalaya incorporates these issues and promotes positive ways to integrate cultural competency in case management.

Another challenge is the red tape of bureaucracy and the maze of services. Many NPLWHA lack the necessary skills or familiarity to navigate the labyrinth of paperwork and regulations. Many also carry deep-seated mistrust of the system stemming from negative personal experience and historical trauma. In these areas particularly, a skillful case manager can make a great difference in the individual’s ability to gain the quality health and social services s/he needs. Ahalaya also focuses on integrating traditional healers and spiritual advisers in the array of care to synthesize the mental, physical, spiritual, and emotional aspects of health. Working with the client to organize a successful care plan, Ahalaya case managers build trust and bridges among community resources that are specific to the individual’s needs and desires, as well as meeting the client “where they are.”

Recent updates to the Ahalaya model reflect not only the

changes in care for NPLWHA overall, but also changes in communications technology. The training includes web resources and new media to relate the stories of NPLWHA and Ahalaya case managers who are instrumental in the success of the project. Building on lessons learned, the new iteration of the model also focuses more strongly on cultural components and addresses the needs of non-Native providers who serve Native populations.

Cultural specific models of care are vital components when working with NPLWHA. When marginalized populations

continue to feel that the health care system is ostracizing them, and not addressing their unique needs, then people will naturally distance themselves from the system. Ahalaya strives to increase linkage to care, maintain consistent care, and improve health outcomes all while valuing the individual as a Native person first and a client second.

For more information about the Ahalaya Case Management Model, contact Jamie Folsom at NNAAPC, (720) 382-2244, ext. 302; jfolsom@nnaapc.org.

Response Frequencies Received in Client Satisfaction Survey Regarding Ahalaya Case Management Services (n=130)¹

| SPECIFIC RESPONSE CATEGORIES | PERCENTAGE RESPONDING |
|--|-----------------------|
| Felt they experienced reductions in stress | 78.9 |
| Felt they experienced reductions in alcohol consumption | 67.9 |
| Felt they experienced reductions in drug use | 74.4 |
| Felt they experienced reductions in sadness | 83.1 |
| Felt they received assistance when dealing with families | 73.1 |
| Felt they received assistance in finding a home | 60.5 |
| Felt they received assistance making appointments | 82.3 |
| Felt they received assistance in getting medications | 79.1 |
| Liked the AI/AN/NH affiliation of these projects | 92.3 |
| Thought the programs were better by Native affiliation | 83.1 |
| Liked having access to traditional healers | 65.9 |
| Liked having access to support groups | 76.4 |
| Learned about prevention strategies | 86.9 |
| Expressed an interest in learning more about prevention strategies | 61.5 |
| GENERAL RESPONSE CATEGORIES | PERCENTAGE RESPONDING |
| Were glad to have received these services | 93.2 |
| Had been helped by these programs | 92.2 |
| Believed the Ahalaya Program made their lives better | 87.7 |

¹Bouey, P.D., & Duran, B.E. (2000). The Ahalaya Case-Management Program for HIV-Infected American Indians, Alaska Natives and Native Hawaiians: Quantitative Evaluation of Impacts. *American Indian Alaska Native Mental Health Research*, 9(2): 36-52.

Web-based At-Home STD Testing in Alaska: Providing Viable Alternatives to Remote Communities

Brenna Simons, PhD, and Cornelia Jessen, MA, both with the Alaska Native Tribal Health Consortium, Anchorage, Alaska

Background

Chlamydia trachomatis (CT) and *Neisseria gonorrhoea* (GC) are the two most commonly reported sexually transmitted diseases (STDs) in the US.¹ In 2010, approximately 1.3 million cases of CT and 309,000 cases of GC were reported in the US.¹ Women represent more than double the rate of CT reported in men and also demonstrate elevated rates of GC.¹ In 2010, rates of GC and CT among Alaska Native and American Indian persons were four times higher than that of whites in the U.S.¹

In 2010, Alaska had the highest rate of CT in the US (861.7 per 100,000), which is over two times the overall U.S. rate.¹ Alaska also had the third highest rate of GC in the US (182.3 per 100,000), almost twice the national average and reflecting over a 70% increase since 2008.¹ In Alaska, women, youth (15 - 24 years), and Alaska Native people are disproportionately affected by CT and GC; over 50% of total reported CT cases and 70% of total reported GC cases occurred in Alaska Native and/or American Indian persons in 2009 and 2010, respectively.^{2,3} Between 2008 and 2009, GC cases among Alaska Native women increased by 89%.^{3,4}

Alaska Native health organizations have jurisdiction over large geographic areas, containing small isolated communities where a perceived lack of confidentiality and privacy is an identified barrier to accessing health care.⁵ The Alaska Native Tribal Health Consortium (ANTHC) partnered with the “I Want the Kit” program (IWTK) at Johns Hopkins University (JHU) to provide a discrete and reliable STD testing alternative to all Alaskans. Although there are several participating IWTK sites across the country, ANTHC is the first tribal health entity to partner with IWTK. The project launched August 2011 and is made possible through funding from the IHS National STD Program and the CDC Division of STD Prevention.

Methods

How it works. Alaska’s “I Want the Kit” project (“IWTK Alaska”) is available at no cost to all Alaskan residents 14 years of age and older. (The age restriction is a national mandate by the Food and Drug Administration [FDA] and Clinical Laboratory Improvement Amendments [CLIA]

regulations concerning testing validation.) A no-cost testing kit can be requested online at www.iwantthekit.org or through the ANTHC STD Program’s website designed for youth, www.iknowmine.org.

The online interface asks the requestor for a mailing address, name, and gender. The testing kit is mailed to the requestor from JHU via US Postal Service (USPS). The kit includes:

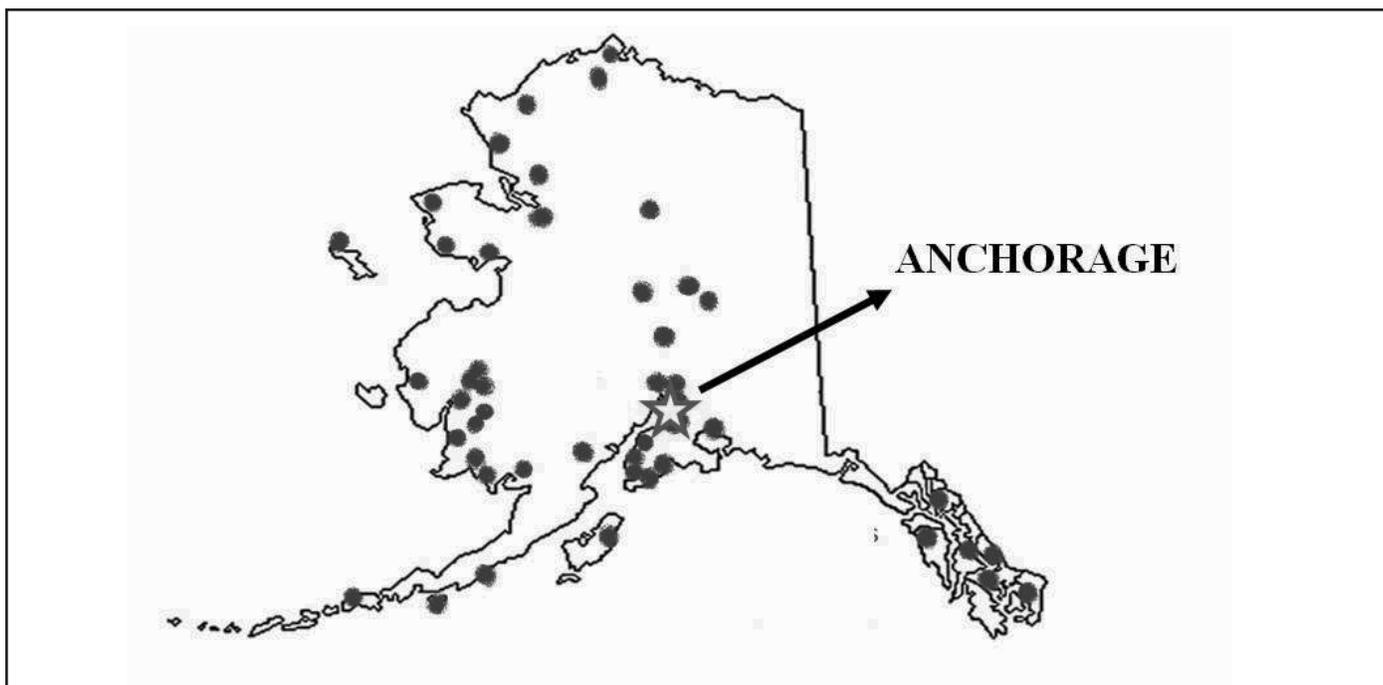
1. - Sex appropriate collection kits
2. - Instructions for collection
3. - Alaska-specific information that includes contact information and detailed description of what the participant can expect to happen after returning the test kit
4. - Contact sheet with CLIA-required personal identifiers and a preferred method of contact for results by phone, e-mail, or USPS
5. - A pre-paid envelope to return the specimens

The specimens are returned to JHU in the pre-paid envelope and JHU’s CLIA-licensed laboratory conducts testing for CT, GC, and trichomoniasis (also called “trich”—another very common STD that is not reportable to CDC). Test results for Alaska residents are reported to ANTHC by JHU directly. All test result notifications and referrals are done by the IWTK Alaska team at ANTHC, which includes trained clinical staff. To-date, program staff has followed up with every test result and referred participants for treatment to the provider of their choice. While the test is free of charge to the requestor, the treatment is not.

Promotional Activities. Previous data from other participating IWTK sites indicate a correlation between promotion/advertisements and the number of kit requests.⁶ To ensure that all regions of Alaska were aware of this testing service, IWTK Alaska implemented the following promotional activities:

1. - Flyer and postcard mail out to all village clinics, other service providers, middle and high schools statewide
2. - Facebook and www.iknowmine.org announcements
3. - TV ads on local cable stations
4. - Press releases

Figure 1. IWTK Alaska Requests Statewide



5. Ad in Alaska Newspapers, Inc.
6. Local TV news interviews
7. Public radio interviews
8. Ads on www.craigslist.org

Communication with Public Health Partners. Prior to IWTK Alaska being implemented, we disseminated information about the program throughout the Alaska Tribal Health System as well as non-tribal partners, and solicited contact information for key personnel in each region in the event of a positive result.

Results

Return Rates. Since August 2011, IWTK Alaska has received kit requests from all regions of Alaska (Figure 1).

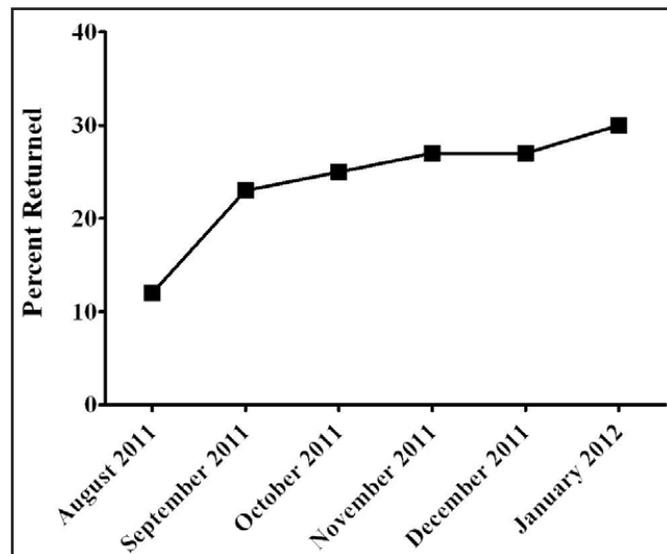
In August 2011, we recorded the highest number of kit requests (153), but the lowest return rate (12%). This could be a result of many people requesting a kit to investigate kit contents with no intention of being tested.

In the first 6 months of IWTK Alaska, a total of 389 vaginal and penile swab kits were requested of which 115 were returned. The overall return rate has continued to rise since August; in January 2012, the return rate was 30% (Figure 2).

Positivity. Among returned kits, 10 (9%) participants tested positive for at least one STD: 3 CT, 1 GC-CT co-infection, and 6 trich.

Demographics of participants returning kits. Testing kits have been received from rural and urban communities and from all regions in Alaska. Alaska Native and American Indian persons represented 27% of kits returned, while Whites represented the largest proportion of test kits returned at 58%. Other minority groups comprised the remaining 15% of returned kits (Hispanic, Black, Multiracial, and Asian/Pacific

Figure 2. IWTK Alaska Kit Return Rates



Islander). The majority (75%) of returned testing kits came from urban areas (population >20,000); however positive test results were identified from both urban and rural communities. The age of the requestors returning kits ranged from 16 to 75 years (median age 29 years); individuals age 24 and older (72%) returned testing kits at a higher rate than any other age group.

Discussion

In the first six months, IWTK Alaska received 115 genital test results from 107 participants statewide. (Some participants have used IWTK multiple times.) Individuals who request either a vaginal or penile swab kit also have the option of requesting rectal swabs. However, information regarding rectal swabs is not included here.

Return rates continue to rise and our goal is a 40% return rate (a similar rate to other IWTK sites across the country).⁶ Several persons returning kits self-identified as high risk and said they would not have gone in for testing if IWTK had not been available.

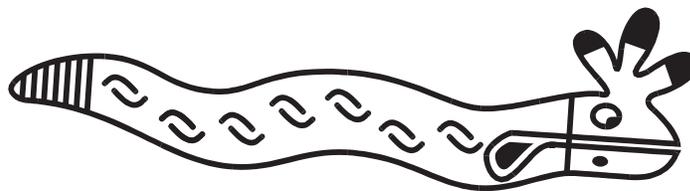
As previously reported, promotion of the service is critical to the IWTK projects,⁶ but in Alaska, the type of advertising that is most effective can vary considerably between regions. For example, advertisement on city buses and other public venues only targets those living in urban areas, whereas approximately half of Alaska's population lives in rural areas. Radio plays a big role in communication across Alaska, and television is available even in the most remote communities. IWTK Alaska has been allowed some free air time on the local cable network, and we also purchased three months of promotion on major statewide television channels including MTV, ESPN, and the Discovery Channel. During that time, we noted that kit return rates continued to rise.

In conclusion, programs such as these require a sustainable budget for local promotion and advertisement efforts as well as utilization of local and free social media

resources as much as possible. In the future, we expect that regional data will guide IWTK Alaska in targeting regions with low request numbers and return rates, with a particular focus on regions with larger proportions of AN/AI residents. The adaptation of IWTK in Alaska may be a model for other areas of the country interested in targeting at-risk and less-accessible populations for STD screening.

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WE R NATIVE: A Multimedia Health Resource for Native Teens and Young Adults

Jessica Leston, MPH, and Stephanie Craig Rushing, PhD, MPH, both of the Northwest Portland Area Indian Health Board's Project Red Talon, Portland, Oregon

WE R NATIVE is a new multimedia resource for American Indian and Alaska Native (AI/AN) teens and young adults, created by the Northwest Portland Area Indian Health Board (NPAIHB). The service includes a weekly text messaging service (with over 580 subscribers), a FaceBook page (with over 530 Friends), a YouTube channel (with over 1,000 channel views), a Twitter feed, and print marketing materials. The project will unveil an interactive website, www.WERNATIVE.org, in late spring 2012.

The goals of the service are to provide holistic adolescent health information, promote positive youth development, share youth-friendly health media and current events, encourage healthy behaviors, reinforce positive messages, increase cultural identity and pride, and create a safe place where Native youth feel comfortable, empowered, and connected to other Native youth.

WERNATIVE.org will be a comprehensive resource — for Native youth, by Native youth — providing content and stories about the topics that matter most to them. The site will empower Native youth to get actively involved in their communities, health, and well being using contests, mini-grant opportunities, quizzes, polls, discussion boards, an “Ask Auntie” Q&A, skill-building tools, and links to medically accurate information.

To join the text messaging service, text NATIVE to 24587 (standard text messaging rates apply). Weekly messages include teachings from Native leaders, tips for wellness and life balance, updates on health observances, ideas for taking action in your local community, and links to more information.

The idea of WE R NATIVE began in 2009, when Project Red Talon (a STD/HIV prevention project housed at the NPAIHB) surveyed more than 400 Native teens and young adults (ages 13 - 21 years) on their use of media technologies like the Internet and cell phones, and how they access health information. Results found technology use to be exceptionally common and diverse among survey respondents, mirroring patterns reported by teens in the general US population. Most AI/AN youth reported searching online for health information, including for diet, nutrition, exercise, or fitness; a specific illness or medical condition; drugs or alcohol; sexual health, STDs, or HIV; and depression, anxiety, stress, or suicide. In

addition, almost half reported having accessed sexual health information online.

This formative work led to the creation of WE R NATIVE (funded by the President’s National HIV/AIDS Strategy and IHS’s National HIV/AIDS and STD programs). At the core of WE R NATIVE are its values, which drove its creation:

- *We Are Native.* We are members of diverse and vibrant communities. Learn more about your culture, history, and current events.
- *I Am Strong in mind and spirit.* By sharing with one another, we can teach each other lessons about self-confidence, self-respect, pride, courage, and spirituality.
- *I Control My Body.* My body is mine and mine alone. I have control over my physical and sexual health.
- *We Are Not Alone.* Regardless of the issue, there are other Native teens and young adults going through the same life challenges . . . hear their stories and share your own. Together we can support one another through tough times and come out stronger in the end.
- *We Can Change our World.* Community involvement is something that can start small and make a big impact. We have the tools you need to get started shaping your community in positive ways.

These values shaped WE R NATIVE from a concept to a program that will directly impact youth in local communities. For more information, please contact Jessica Leston, Project Coordinator, Northwest Portland Area Indian Health Board, at jleston@npaihb.org or (907) 244-3888.



The Native Healthy and Empowered Youth (HEY) Project

*Nichole Hildebrandt (Shoshone-Bannock Tribal Member),
Project Manager, Oregon Health and Science University,
Portland, Oregon*

Overview

The Healthy and Empowered Youth (HEY) Project is a three-year demonstration grant funded by the Department of Health and Human Services' Office of Minority Health. The project is located on the Fort Hall Indian Reservation in southeastern Idaho and is administered by the Oregon Health and Science University's Department of Public Health and Preventive Medicine. The HEY Project serves youth in grades 6 through 12 who live on or near the Fort Hall Indian Reservation and includes students who attend the Shoshone-Bannock Junior/Senior High School. The project supports students in the areas of academic enrichment, life skills development, personal development and wellness, cultural awareness, and career development.

The HEY Project uses the curriculum Native STAND (Native Students Together Against Negative Decisions) and filmmaking to reach the youth who live on the Fort Hall Indian Reservation. Native STAND is a prevention curriculum for Native youth that addresses issues such as responsible behavior, healthy relationships, and prevention of sexually transmitted diseases (STD) and teen pregnancy. In addition to Native STAND content, the project partners with professional filmmakers to train HEY educators and youth on the fundamentals of media literacy and filmmaking. The skills

learned by the youth are quickly put to work as they transform information from Native STAND lessons into short films or public service announcements (PSAs) that communicate key health messages to peers and community members.

Early tribal engagement and buy-in was crucial to the success of the HEY Project. Before beginning any work on the project, HEY approached the Tribal Business Council (TBC) for their input on identifying potential youth to participate in the project and any concerns the TBC might have; it was the TBC that advised the HEY Project to work with students at the Shoshone-Bannock Junior/Senior High School. In addition, the TBC set guidelines for HEY to follow, such as restricting certain areas of the reservation from being filmed and ensuring that the Tribes' Culture Committee reviewed the films before sharing them (including through social networks).

Broad community support has also been key to the project's efforts. Important partnerships were forged with the TBC, Tribal Health and Human Services (THHS), and the Shoshone-Bannock School Board. Some of these same partnerships contributed to the formation of the HEY Advisory Committee, which includes the tribal health director and school superintendent, as well as representatives from the TBC, Indian Health Service, local newspaper, Tribal Youth Employment Program, school board, and tribal health education. The advisory committee meets at least quarterly.

Implementation

In the last semester of the 2009 - 2010 school year, the



school began offering Native STAND as an elective for students in grades 8 through 12; the first full year of implementation was the 2010 - 2011 school year. At the beginning of each trimester, pre-tests are administered to new HEY Project participants to characterize their baseline knowledge, attitudes, and behaviors related to topics covered in the Native STAND curriculum. The Northwest Portland Area Indian Health Board's Epicenter maintains a database of pre- and post-test survey data and is responsible for data analysis and evaluation reports.

Evaluation

The most recent pre-post survey data are from the 2010 - 2011 school year. At the beginning of the school year there was a total of 120 students enrolled in the junior and senior high schools; of these, 66 students (55%) completed both a pre- and post-test.

Some key findings from the evaluation:

- High school students felt that they'd learned worthwhile information from the sexual health unit. They enjoyed watching pregnancy videos, learning about birth control, STD prevention, condoms, and HIV/AIDS.
- Students felt the sexual health unit helped them become more self-aware of their bodies and allowed them to understand safe sex, pregnancy, and STDs. Some students felt that it improved their ability to gauge their level of risk for STDs/HIV and teen pregnancy, and were therefore motivated to take precautions.
- Teachers thought the reproductive health unit was both the most rewarding and the most challenging to teach. Smaller groups, separated by gender, helped the students feel more comfortable asking questions and discussing sensitive topics. The use of games, quizzes, hands-on activities, guest speakers, and videos helped make it more comfortable for the students.
- Condom use and STD testing increased for both males and females.

The project's evaluation data will be used to assess the impact of participation in the project on academic success and health outcomes related to STDs/HIV, substance abuse, and violence. The data provide the tribes with additional information to better understand and address the specific health needs of the AI/AN youth in the community. These data have been presented to the TBC, THHS, and the school superintendent; new data will be shared with these key partners as it becomes available. The tribes' feedback has been positive and has demonstrated their overall support for the HEY Project while expressing a desire to see it continue in the future. Tribal leaders, the Fort Hall community, and IHS have shown outstanding support for the HEY Project, and although the project's initial funding ends August 31, 2012, there are encouraging signs that the tribes wish to continue the project. For example, the school hired one of the HEY educators to



teach Native STAND for its health classes.

Fostering Youth Leadership

The students involved in the HEY Project have benefitted in many ways beyond gaining knowledge of the health topics addressed in Native STAND. They have become leaders in their community, have expanded their skills, and have been recognized for their achievements.

Tribal Council Presentations. Students have gone before the TBC to discuss their experience with Native STAND, including presenting the project's first five films. The TBC members were complimentary and supportive of the students; several councilmen told the students to "keep up the good work." When students were asked how they felt after presenting to the TBC, some said "it made me feel proud that they liked what we did," and others said "at first I was scared, but then it was okay by the end." Prior to the HEY Project presentation, none of the students had ever been into the Tribal Council chambers or had ever stood before the TBC. The HEY Project continuously seeks opportunities for youth to present in public forums and to be recognized for their accomplishments.

Community Contributions. The TBC determined that the HEY Project should post youth prevention messages every other month on one of the prominently placed billboards owned by the Fort Hall Casino. Since the messages are changed every other month, the billboard concept and design becomes a contest for youth to work toward having his/her work on a billboard.

New Skills Development. HEY Project's media literacy

and filmmaking components introduce new ideas and skills to youth and serves to emphasize key health messages from the Native STAND curriculum. As the students are required to produce short films and PSAs from each Native STAND class, they must learn to identify the key health message from the Native STAND session, determine the most effective way to deliver the message to a certain audience, and plan their strategy using a storyboard. From the storyboard concepts, the youth create the actual film, billboard design, or other media. There are many skills and roles for youth to learn and take responsibility for throughout the lessons in media literacy, photography, and filmmaking. There is a job for every type of personality, such as director, producer, actor, singer, dancer, playing music, selecting background music, artistic director, microphone boom holder, interviewer, interviewee, set-up, and editing.

Recognition. The HEY Project students have submitted films to festivals and contests, and have a FaceBook page and YouTube channel. Most recently, the HEY Project was recognized at the 2011 Native Youth Teen Film Festival sponsored by National Geographic; the 2011 THRIVE Conference in Portland, Oregon; the Fort Hall Wellness Conference; the 2011 NW Native Youth Conference; and during the 2011 Shoshone-Bannock Wellness Conference.

Challenges

Students have been primarily interested in the filmmaking and photography aspects of the HEY Project; unfortunately, the topic of STD and HIV prevention has been an area of struggle for the youth. The reservation is a small and close-knit

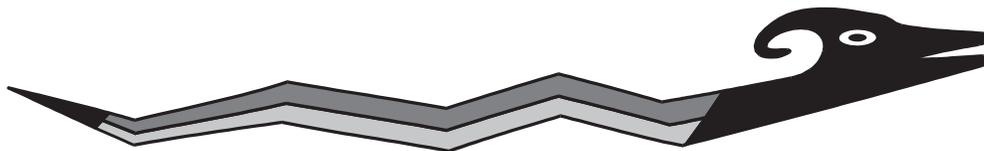
community, and none of the youth want to personally be associated with the topic of sex, STDs and HIV — even if only as an actor in a skit. The project requires the youth to produce at least one media message about the prevention of STD/HIV or teen pregnancy, so there will be at least a few completed projects for this specific topic by the time the project ends. The HEY educators are working with the students to explore other ways the STD/HIV films could be created without using live actors, such as animation and voiceovers.

Reaching Beyond the Project's Scope

Although the HEY Project is only required to follow a cohort of at least 40 males and females in grades 8-12, the project strives to reach as many youth in the community as possible. This includes special three-week summer programming (during recreation/cultural activities) and once a month Saturday filmmaking clinics; both are open to all Native youth in the community.

The summer programs and Saturday clinics are focused on overall positive youth development and do not use the Native STAND curriculum. The clinics provide the HEY educators with the opportunity to build rapport with youth who are not familiar with the project. Although a key health message is emphasized during each clinic and program, the youth have the flexibility to choose a non-health related topic.

To find out more about the HEY Project, contact Nichole Hildebrandt, Program Manager, at hildebrn@ohsu.edu or visit our FaceBook page or YouTube to view short films made by HEY Project participants. (Type *healthy empowered youth 1* in your search engine.)



This is a page for sharing “what works” as seen in the published literature, as well as what is being done at sites that care for American Indian/Alaskan Native children. If you have any suggestions, comments, or questions, please contact Steve Holve, MD, Chief Clinical Consultant in Pediatrics at sholve@tcimc.ihs.gov.

IHS Child Health Notes

Quote of the month

“The world requires at least ten years to understand a new idea, however important or simple it may be.”

Sir Ronald Ross

Article of Interest

Human Papillomavirus Vaccination Practices Among Providers in Indian Health Service, Tribal and Indian Urban Health Facilities. *Journal of Women’s Health*, Volume 21, Number 4; 2012.

The human papillomavirus (HPV) vaccine is of particular importance in American Indian/Alaska Native women because of the higher rate of cervical cancer incidence compared to non-Hispanic white women. To better understand HPV vaccine knowledge among providers working with American Indian/Alaska Native populations, the authors conducted a provider survey in Indian Health Service, Tribal and Urban Indian (I/T/U) facilities in 2009 and 2010.

Providers were more likely to administer vaccine to 13 - 18-year-olds (96%) than to other recommended age groups (89% to 11 - 12-year-olds and 64% to 19 - 26-year-olds). Perceived barriers to HPV vaccination for 9 - 18-year-olds included parental safety and moral/religious concerns. Funding was the main barrier for 19 - 26-year-olds. Overall, providers

were very knowledgeable about HPV, although nearly half of all providers and most obstetricians/gynecologists thought that a pregnancy test should precede vaccination.

This study shows that recommendations for HPV vaccination have been broadly implemented in I/T/U settings. Vaccination barriers for I/T/U providers are similar to those reported in other provider surveys. Provider education efforts should stress that pregnancy testing is not needed before vaccination.

Editorial Comment

Rates of sexually transmitted diseases and cervical cancer are higher in all IHS areas compared to the overall US rates. The HPV vaccine gives us the potential to prevent one of these sexually transmitted illnesses and cervical cancer. I/T/U sites have an advantage in that this expensive vaccine is available at no cost to our patients up to age 19 years through the Vaccine for Children’s program. Clinics should make every effort to use the RPMS immunization package to forecast when this vaccine is indicated. In addition, note that the HPV vaccine is now recommended for boys and also available through the VFC program at no cost to our clinics and patients up to 19 years of age.



MEETINGS OF INTEREST

Editor's note: As a service to our readers, The IHS Provider will publish notices of clinical positions available. Indian health program employers should send brief announcements as attachments by e-mail to john.saari@ihs.gov. Please include an e-mail address in the item so that there is a contact for the announcement. If there is more than one position, please combine them into one announcement per location. Submissions will be run for four months and then will be dropped, without notification, but may be renewed as many times as necessary. Tribal organizations that have taken their tribal "shares" of the CSC budget will need to reimburse CSC for the expense of this service (\$100 for four months). The Indian Health Service assumes no responsibility for the accuracy of the information in such announcements.

Advancements in Diabetes Seminars Monthly; WebEx

Join us monthly for a series of one-hour WebEx seminars for health care program professionals who work with patients who have diabetes or are at risk for diabetes. Presented by experts in the field, these seminars will discuss what's new, update your knowledge and skills, and describe practical tools you can use to improve the care for people with diabetes. No registration is necessary. The accredited sponsors are the IHS Clinical Support Center and IHS Nutrition and Dietetics Training Program.

For information on upcoming seminars and/or previous seminars, including the recordings and handouts, click on this link and see Diabetes Seminar Resources: [http://www.](http://www.diabetes.ihs.gov/index.cfm?module=trainingSeminars)

[diabetes.ihs.gov/index.cfm?module=trainingSeminars](http://www.diabetes.ihs.gov/index.cfm?module=trainingSeminars)

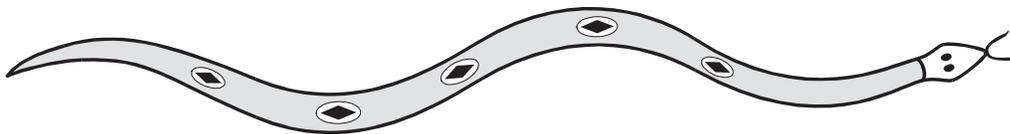
Available EHR Courses

EHR is the Indian Health Service's Electronic Health Record software that is based on the Resource and Patient Management System (RPMS) clinical information system. For more information about any of these courses described below, please visit the EHR website at http://www.ihs.gov/CIO/EHR/index.cfm?module=rpms_ehr_training. To see registration information for any of these courses, go to <http://www.ihs.gov/Cio/RPMS/index.cfm?module=Training&option=index>.

15th International Congress on Circumpolar Health August 5 – 10; Fairbanks, Alaska

The International Congress on Circumpolar Health (ICCH) is a primary source of information exchange and scholarly communication relating to circumpolar health. Through the ICCH, the International Union for Circumpolar Health (IUCH) creates a forum for circumpolar health professionals (medical scientists, policy and decision makers, Native peoples, and community leaders) to share the research findings and program successes that are unique to northern regions.

From August 5 - 10, 2012, the IUCH will reassemble for the 15th time in Fairbanks, Alaska, United States. Registration is now open for the Congress; you need not be an IUCH member to attend. To register and learn more about the Congress and IUCH, please visit <http://icch15.com/>.



POSITION VACANCIES

Editor's note: As a service to our readers, The IHS Provider will publish notices of clinical positions available. Indian health program employers should send brief announcements as attachments by e-mail to john.saari@ihs.gov. Please include an e-mail address in the item so that there is a contact for the announcement. If there is more than one position, please combine them into one announcement per location. Submissions will be run for four months and then will be dropped, without notification, but may be renewed as many times as necessary. Tribal organizations that have taken their tribal "shares" of the CSC budget will need to reimburse CSC for the expense of this service (\$100 for four months). The Indian Health Service assumes no responsibility for the accuracy of the information in such announcements.

Hospitalist

Gallup Indian Medical Center; Gallup, New Mexico

Gallup Indian Medical Center (GIMC) is currently seeking energetic and collegial internists for our new hospitalist program. The hospitalists care for all adult inpatients previously taken care of by family medicine and internal medicine physicians, and provide consultation services. We have seven FTEs for hospitalists, and while we are still growing, we enjoy further inpatient staffing support from internal medicine and family medicine.

GIMC is a 99-bed hospital in Gallup, New Mexico, on the border of the Navajo Reservation. Clinical specialties at GIMC include internal medicine, family medicine, critical care, cardiology, neurology, orthopedics, ENT, radiology, OB/GYN, general surgery, ophthalmology, pathology, pediatrics, emergency medicine, and anesthesiology. The hospitalists' daily census is approximately 25 - 30. There is a six bed ICU. Our patient population includes Navajos, Zunis, and others living nearby, as well referrals from smaller clinics and hospitals.

Gallup has a diverse community and is very livable, offering a thriving art scene, excellent outdoor activities (biking, hiking, rock climbing, cross-country skiing), safe neighborhoods, diverse restaurants, national chains and local shops, and multiple public and parochial school options. The medical community is highly collegial, is committed to continuing education, has an on-going collaboration with Brigham and Women's Hospital, and has a high retention rate.

For more information, contact Eileen Barrett, MD, at (505) 722-1577 or e-mail eileen.barrett@ihs.gov. Or please consider faxing your CV to (505) 726-8557. (4/12)

Family Practice Physician

Physician Assistant or Family Nurse Practitioner

United Indian Health Services, Inc. (UIHS), Howonquet Clinic; Smith River, California

The UIHS Howonquet Clinic is a premier health care facility located in beautiful northern California along the Pacific coast near the majestic redwoods. The organization is a unique non-profit made up of a consortium of nine tribes, with a mission "To work together with our clients and community to achieve wellness through health services that reflect the traditional values of our American Indian Community." UIHS provides wrap-around services that include medical, dental, behavioral health, and community services. Our focus is to empower our clients to become active participants in their care. If you value outdoor adventures, such as backpacking, kayaking, biking, fishing, and surfing, and you envision yourself providing services to an under-served but deserving community in a caring and holistic manner, come join our team. Please visit our website at www.uihs.org or contact Trudy Adams for more information at (707) 825-4036 or e-mail Trudy.adams@carih.net. (2/12)

Wellness Center Director

Nurse Practitioner

Chehalis Tribal Wellness Center; Oakville, Washington

The Chehalis Tribal Wellness Center provides health services to tribal and community members living on or near the reservation. The Chehalis Tribal Wellness Center is located on the 4,849 acre Chehalis Reservation in southwest Washington State. The Chehalis Reservation is situated approximately 26 miles southwest of Olympia and six miles northwest of Centralia. Services include ambulatory medical services, dental services, women's health, diabetes prevention and treatment, and contract health services. The facility has 12 exam rooms, a triage and trauma area, digital radiology, laboratory services, and a large dental clinic. The Chehalis Tribal Wellness Center is a full-service family practice clinic that has been serving Chehalis tribal members since 1979. If you would like further information about current clinical job opportunities with us, please contact Sylvia Cayenne at (360) 273-5911 or visit our website at chehalis-tribe.org. (2/12)

Physician

Nimkee Memorial Clinic; Mount Pleasant, Michigan

The Saginaw Chippewa Indian Tribe is seeking a full time physician. The Saginaw Chippewa Indian Tribe (SCIT) is a band of Chippewa Indians located in central Michigan. The tribal government offices are located on the Isabella Indian

Reservation, near the city of Mount Pleasant. The tribe owns and operates Soaring Eagle Casino in Mount Pleasant. SCIT also holds land on the Saganing reservation near Standish, with a community center in addition to the recently completed Eagle's Landing Casino on the Saganing reservation.

Besides its gaming enterprises, the tribe owns other businesses and community operations, including the Sagamok Shell Station, the Ziibiwing Cultural Society (a tribal museum), a substance abuse facility, a community clinic, and health facilities. Educational programs include the Saginaw Chippewa Academy (an elementary school), as well as a presence in the local public schools through Native American advocates and tutors. Saginaw Chippewa Tribal College is an accredited two-year college that operates with funding from the tribe.

Nimkee Memorial Clinic is open Monday through Friday from 8 am to 5 pm and is located on the Isabella Reservation. Local hospital services are provided through McLaren Central Hospital. The Nimkee Medical Clinic employs five providers, including two family practice physicians, one internist, a family nurse practitioner and a physician assistant. Nimkee Clinic also includes an on-site pharmacy.

The clients served are members and direct descendants of the SCIT and members of other US federally recognized Indian tribes residing in a five county service area including Isabella, Clare, Midland, Missaukee and Arenac counties. The tribal physician plays an essential part in the comprehensive, quality health care delivered in a holistic approach, to prevent disease and to promote wellness in the Native American community served. Ambulatory care services are provided to people of all ages and include general clinic visits of various levels of care, health promotion and disease prevention, immunization clinics, men's health clinics, women's health clinics, diabetes management, and pharmacy.

Interested applicants may apply for the position and upload a resume and credentials using the website at www.sagchip.org. The full job description will be available to view on the website as well. Any questions in regards to this position, please contact Kassy Heard at (989) 775-5605 or kheard@sagchip.org. (2/12)

Urgent Care Family Medicine Physician Northern Navajo Medical Center; Shiprock, New Mexico

The Urgent Care Clinic at Northern Navajo Medical Center in Shiprock, New Mexico has an opening for a BE/BC family medicine physician. Shiprock is located just south of Colorado with close proximity to the Four Corners area and the Rocky Mountains. This is a fast-paced urgent care clinic with over 35,000 patient visits per year. Work with a team of six physicians and nine physicians assistants caring for the Navajo people. The schedule is flexible, there is no call, and the salary is competitive with the addition of IHS Physician Market Pay. Loan repayment is available through IHS and NHSC. If you

are interested in learning more about this excellent opportunity please e-mail nancy.kitson@ihs.gov and attach your CV. (2/12)

Primary Care Physician Zuni Comprehensive Community Health Center; Zuni, New Mexico

The Zuni Comprehensive Community Health Center (Zuni-Ramah Service Unit) has openings for full-time primary care physicians starting in fall 2012. This is a family medicine model hospital and clinic providing the full range of primary care, including outpatient continuity clinics, urgent care, emergency care, inpatient (pediatrics and adults) and obstetrics, with community outreach, in a highly collaborative atmosphere. For a small community hospital, we care for a surprisingly broad range of medical issues. Our professional staff includes 17 physicians, two NPs, one CNM, a podiatrist, dentists, a psychiatrist, a psychologist, optometrists, physical therapists, and pharmacists. Our patient population consists of Zunis, Navajos, and others living in the surrounding area.

Zuni Pueblo is one of the oldest continuously inhabited American Indian villages in the US, estimated to be at least 800 - 900 years old. It is located in the northwestern region of New Mexico, along the Arizona border. It is high desert, ranging from 6000 - 7000 feet in elevation, and is surrounded by beautiful sandstone mesas and canyons with scattered sage, juniper, and pinon pine trees. Many of our medical staff have been with us for several years, reflecting the high job and lifestyle satisfaction we enjoy in this community.

For more information, contact John Bettler, MD at (505) 782-7453 (voice mail), (505) 782-4431 (to page) or by e-mail at john.bettler@ihs.gov. CVs can be faxed to (505) 782-7405, attn. John Bettler. (1/12)

Family Practice Physician (3) Family Nurse Practitioner (2) Emergency Medicine Physician (4) San Carlos Service Unit; San Carlos, Arizona

San Carlos Service Unit is recruiting for board certified/eligible emergency room and family practice physicians to join our experienced medical staff team. Additionally, we are recruiting for family nurse practitioners. We are located approximately 90 miles east of Phoenix.

The San Carlos Service Unit is the primary source of health care for approximately 13,000 people of the San Carlos Apache Nation. The service unit is a Joint Commission fully accredited eight-bed hospital and outpatient services facility with a satellite clinic. Clinical services include family medicine, pediatrics, internal medicine, prenatal and women's health, dental, optometry, physical therapy, nutrition and dietetics, social work services, and diabetes management education.

Currently there is a new hospital under construction that is scheduled for completion in the later part of 2013 or early

2014. We offer competitive salary, relocation/recruitment /retention allowance, federal employment benefits package, and loan repayment. For more information, please contact Richard Palmer, MD, SCSU Clinical Director at (928) 475-7201 or by e-mail at richard.palmer@ihs.gov. (1/12)

Family Practice Physician

Family Nurse Practitioner

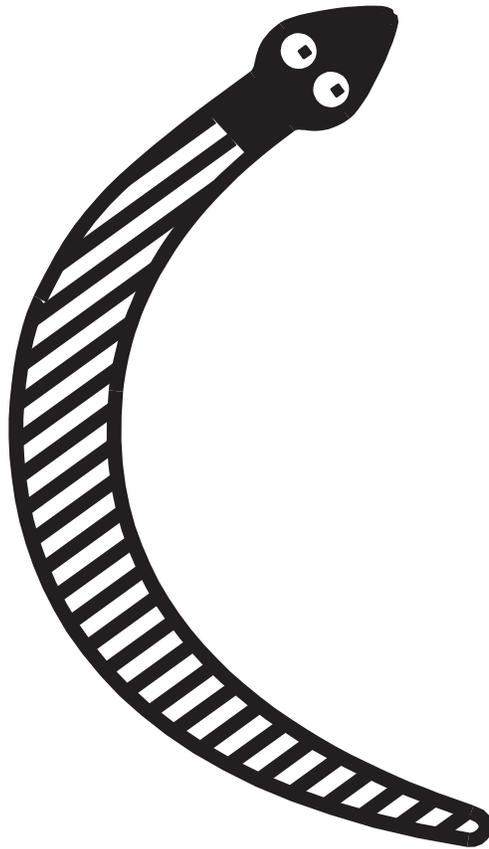
Physician Assistant

Registered Dietician (Renal)

Toiyabe Indian Health Project, Inc.; Bishop, California

Toiyabe Indian Health Project is seeking qualified applicants to fill provider vacancies within the organization. We are looking for highly motivated candidates who are

California licensed/Board certified and ready to join our team of providers. We offer competitive pay, an excellent benefits package including health insurance, life insurance, long-term disability insurance, 401k, CME, vacation and sick leave, paid holidays, and relocation assistance. Toiyabe is located in the Eastern Sierra Region of California, with abundant outdoor recreational activities such as hiking, biking, skiing, rock climbing, fishing, camping, etc. There are small communities, safe neighborhoods, and great schools/day care facilities. If interested in applying, please contact Sara M. Vance, Personnel Officer, at (760) 873-8464, ext. 224; e-mail sara.vance@toiyabe.us; or visit our website at www.toiyabe.us for complete job descriptions and applications. (12/11)



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THE IHS PRIMARY CARE PROVIDER

A journal for health professionals working with American Indians and Alaska Natives



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