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Contrasting Policies and Administration of Sexually Transmitted Infection Programs in Saskatchewan First Nations and Alaska Native Communities

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Introduction

The Copper River (Ahtna) Native Association

The Copper River Native Association (CRNA or Association) has a venerable history dating to the early days of Alaska statehood. The CRNA was formed in 1964 by the Alaska Native Brotherhood and Sisterhood “to provide better education for children, solve water, land, and subsistence problems, find jobs, and secure human rights” (Copper River Native Association 2007). Alaska Native (AN) residents of the Copper River region are primarily Ahtna Indians—an Athabascan tribe. CRNA provides medical, dental, behavioural, and social support services to six Alaskan Native villages extending from approximately 140 kilometres north of Valdez to immediately south of Denali National Park; covering an area of approximately 120,000 square kilometres. The 2000 census reports an area population of 6,000 with Alaska Natives comprising approximately 20% of the total (Copper River Native Association 2007). CRNA is funded primarily by federal and state grants, the U.S. Indian Health Service (IHS), Bureau of Indian Affairs (BIA), and in-kind associations with regional AN health facilities and programs. High turnover of management personnel, coupled with the challenges of recruiting and retaining qualified health-care professionals, have precluded CRNA’s participation in third-party health insurance networks including Medicaid, Medicare, and private insurance products.

Funding is typically limited to services for AN beneficiaries, although there are occasions where services can be provided to non-Native residents. For example, dental services are available to all Native and non-Native residents.

Community services extending beyond CRNA are provided by:

- The Copper River Emergency Medical Services Council (local non-profit)
- State agencies, including the local magistrate’s office, the Alaska State

Troopers, and the Itinerant Public Health Nurse

- Federal agencies, including the Wrangell-St. Elias National Park and the Bureau of Land Management
- Private agencies, including SEND International, a non-denominational religious mission that operates the Cross Roads Medical Center (Copper River Native Association 2007)

CRNA is located on the road system though inclement weather and cost of transportation often preclude the four- to six-hour drive to medical facilities in Anchorage. The area lacks public transportation. Emergency medical, fixed-wing air travel is weather-dependent and can exceed US\$7,500 for a single transport. (Personal communication 2008a; Aeromed International, <www.aeromed.com/4.cfm>, September 2008.)

Ahtna Incorporated is one of twelve AN corporations established as a result of the 1971 Alaska Native Claims Settlement Act (ANCSA). Ahtna is a for-profit corporation with extensive real estate holdings (approximately 62,000 square kilometres) and business interests ranging from construction to government services contracting (Ahtna Incorporated 2008).

Five of the six communities supported by CRNA are located within the geographic boundaries of Ahtna Incorporated. However, as is common with other AN corporations, Ahtna does not financially participate with CRNA services. As a rule, AN health regions do not geographically superimpose the lands held by their communities' AN corporations.

Southern Saskatchewan First Nations

The Regina Qu'Appelle Health Region (RQHR) is funded by the Province of Saskatchewan to provide a full continuum of health services (public, acute, long-term, rehabilitation, home care, and mental) in an integrated manner to the urban and rural population of 243,767 living in a vast 26,663 square kilometre area of southern Saskatchewan (Regina Qu'Appelle Health Region 2008). The region's boundaries include the city of Regina, population 176,915, one hundred towns and villages, and seventeen First Nation reserves. About 24% of the RQHR population resides in rural municipalities or on First Nations. The region's service area extends beyond its actual boundaries, because it also provides specialized or tertiary health care for 465,000 residents living in southern Saskatchewan, through the two designated provincial hospitals in Regina (Aboriginal Health Initiative Report 2000). The entire geographic area has an extensive highway system of all-season roads that supports good year-round ground transportation (Aboriginal Health Initiative Report 2000).

There are seventeen First Nations or reserves located within the boundaries of the RQHR. By culture, language, and tribal lineage, there are many distinct cultural identities, including Plains Cree, Anishinabe (or Ojibwe/Saulteaux), Assiniboine, and Dakota (or Sioux) peoples. These culturally diverse Indigenous peoples share an ancient and intertwined heritage and history on the Prairies.

First Nations people are increasingly urban dwellers, as many families are relocating to urban and rural centres to seek better employment, housing, education, and health-care opportunities. The 2006 census shows a smaller proportion of First Nations people lived on-reserve than off-reserve across Canada. In 2006, an estimated 40% lived on-reserve, while the remaining 60% lived off-reserve. The off-reserve proportion was up slightly from 58% in 1996. Censuses in both 1996 and 2006 found that about three out of every four people (76%) in the off-reserve First Nations population lived in urban areas (Statistics Canada 2006).

Though culturally diverse, First Nations communities face similar economic, social, and health difficulties and challenges. Due to many risk factors, there is serious concern about Registered Indian vulnerability to epidemics. Using a determinant of health lens, it is generally acknowledged that Registered Indians have poorer health status compared to other Canadians due to inequities in education, income, physical environments, social status and coping skills, early childhood health, etc. Moreover, it is thought that Aboriginal people may be biologically or genetically predisposed to chronic diseases like diabetes. The highest-risk First Nations population's vulnerability to disease can be seen as rooted in a complex social reality characterized by poverty, substandard housing, underemployment, addictions, family violence and gender disparity, the lack of knowledge of healthy living, racism, and marginalization (Public Health Agency of Canada Surveillance and Risk Assessment Division 2007).

Saskatchewan Health Care

Health care is provided without fees or charges to all residents who present a Saskatchewan Health Services Card, including First Nations citizens through a universal health-care system. So-called Medicare is a national health-care program designed to ensure that all residents of Canada have reasonable access to medically necessary hospital and physician services on a prepaid basis, and on uniform terms and conditions. Guided by the provisions of the *Canada Health Act*, provinces and territories are responsible for delivering health-care services. These services include insured hospital care and primary health care. First Nations and Inuit peoples access these insured services through provincial and territorial governments. There are, however, a number of health-related goods and services that are not insured by provinces and territories or other private insurance plans.

First Nations On-Reserve Health Care and Health Benefits

First Nations persons who live on-reserve may choose to access health care in two main ways: Either through federally-funded on-reserve health centres and non-insured health benefits, or by accessing provincially funded health care provided by physicians or by the RQHR in the towns and city. The two main health-care options are the result of significant developments in the history of Saskatchewan health; first, the Treaty Four signing of 1874 that established an enduring relationship with the Crown and federal government, and a fiduciary responsibility

for Indian health care; and second, the emergence in the province of universal Medicare in the 1950s and nationally in the 1960s. Another important historical development is “health transfer” in the 1990s, whereby many First Nation communities negotiated more autonomy and responsibility over health care as a feature of First Nation self-governance.

Registered Indian health care as a negotiated treaty right, or as enhanced programming, is funded federally by a branch of Health Canada called First Nations Inuit Health (FNIH). Under health transfer, FNIH disburses funds to First Nation band councils to operate staffed health centres or nursing stations. However, many chiefs and on-reserve health directors say that the health centre program operating funds are limited, and therefore health-care services are limited to specific programs like home care, chronic disease management, or elder care. Health centre staff usually includes a health director, community health nurses (CHN), community health workers (CHW), home-care nurses, home-care aides, and clericals.

The Non-Insured Health Benefits (NIHB) Program funds claims for a specified range of needs-based, non-insured benefits. Qualifying Registered Indians are eligible for the NIHB Program, which offers a limited range of medically necessary health-related goods and services when they are not insured elsewhere. These benefits include:

- Pharmacy (including prescription and over-the-counter drugs and medical supplies/equipment)
- Dental services
- Transportation to access medically required services
- Glasses and other vision-care aids and services
- Other health-care services, including short-term crisis intervention mental health counselling (Health Canada 2008)

First Nations health directors report that persons with concerns about a possible STI would likely choose to go to a physician for treatment and care (Personal communication 2008b).

Primary health-care centres are an emerging format of health care in Saskatchewan. Several have recently opened in urban and rural locations. A primary health-care centre offers coordinated health by using teams of care providers that may include physicians, nurse practitioners or licensed practical nurses (LPN), nurses, nutritionists, pharmacists, social workers, etc. Currently, a primary health-care physician and LPN team visit six communities (including three First Nation communities) to provide weekly care in the eastern part of the region.

Table 3.1: Incidence of Sexually Transmitted Infections in Alaska and in the Alaska Native Population

Population Group	Male	%	Female	%	Total	%	Rate per 100,000
Alaska Native	4	22.2	2	28.6	6	24.0	5.1
State	18	100.0	7	100.0	25	100.0	3.8

National Coalition of STD Directors, STDs in Alaska Natives <www.ncsddc.org/upload/wysiwyg/documents/ALASKA.pdf>

Epidemiology of Sexually Transmitted Infections

Copper River Native Association

Alaskans suffer one of the highest rates of STIs in the United States (National Alliance of State and Territorial AIDS Directors 2008; see **Table 3.1**). Kaufman and colleagues (2007) claim that “American Indian adolescents have two to four times the rate of sexually transmitted diseases (STDs) compared to whites nationally, they shoulder twice the proportion of AIDS compared to their national counterparts, and they have a 25% higher level of teen births.”

According to the US Centers for Disease Control and Prevention (2006), Alaska (Native and non-Native) ranks highest in the United States for chlamydia at 682 per 100,000 and relatively low for gonorrhea and syphilis infections (94.9 and 3.8 per 100,000, respectively). Mississippi ranks highest for gonorrhea infections at 257.1 per 100,000, while Louisiana ranks highest for syphilis at 30.7 per 100,000. The rates of infection for chlamydia and gonorrhea are 420% and 300% higher, respectively, for AN when compared to Alaskan non-Native populations. The difference in the rate between the two groups for syphilis infections is nominal. It is disturbing that the rates for chlamydia and gonorrhea infection for AN women are between 250% and 300% the rate for AN men.

Hepatitis A infections have diminished from 772 to 2 reported cases between the years 1993 and 2006, while reported hepatitis B infections have decreased 50%, from 15 to 8 during the same period. In contrast, cases of hepatitis C have almost quintupled between 1996 (the first year reported) and 2006, from 246 to 1,181 reported cases. This data does not delineate between Native and non-Native residents. However, the State of Alaska Health and Social Services (State of Alaska—Department of Health and Human Services 2008) reports that the rate of hepatitis in AN communities is about 134% of that in all Alaskan communities.

The HIV/AIDS infection rate for the Native American/AN males is nominally higher than for non-Natives, though Native American/AN females are infected at a rate of about double that for non-Native females, 7.5 vs. 3.0 per 100,000, respectively (National Coalition of STD Directors 2007). The summary is provided in **Table 3.2** on page 36.

Table 3.2: Cases and Rates of HIV/AIDS in the United States

	Adults or Adolescents						Children (<13 yrs)		Total ^a	
	Males		Females		Total ^a					
Race/ethnicity	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate
White, not Hispanic	9,848	18.2	1,682	3.0	11,531	10.4	28	0.1	11,559	8.8
Black, not Hispanic	11,624	124.8	6,389	60.2	18,013	90.4	107	2.0	18,121	71.3
Hispanic	5,352	56.2	1,405	15.8	6,757	36.7	25	0.4	6,782	27.8
Asian/Pacific Islander	324	14.5	89	3.8	413	9.0	5	0.4	417	7.4
American Indian/Alaska Native	138	19.1	57	7.5	195	13.2	0	0.0	195	10.4
Total^b	27,455	36.2	9,708	12.2	37,163	23.9	168	0.5	37,331^c	19.8

Estimated numbers of cases and rates (per 100,000 population) of HIV/AIDS, by race/ethnicity, age category, and sex, 2005—thirty-three states with confidential name-based HIV-infection reporting (Revised June 2007). <www.cdc.gov/hiv/topics/surveillance/resources/reports/2005report/table5b.htm>

The not-for-profit organization Advocates for Youth argues that disproportionate HIV rates in Native American (AI) and AN women are multi-faceted:

The majority of HIV-positive AI/AN women (66%) contract HIV through heterosexual intercourse, while a significant number (33%) are infected through injection drug use.

A lack of access to health care and/or a lack of trust in health-care providers and systems may keep AI/AN young women from receiving adequate medical care, including HIV testing and treatment.

Intimate partner violence against young AI/AN women is all too common, and, since condom negotiation is difficult for women in violent relationships, they are at risk for HIV. Drugs and alcohol are often factors in cases of sexual violence, thereby increasing risks.

A lack of education about the disease may lead AI/AN young women to still believe it is a “gay white man’s disease,” suggesting that they are not at risk.

Table 3.3: Provincial Incidence and Incidence Rate for STIs—Saskatchewan

Sexually Transmitted Infections	2000	2001	2002	2003	2004	2005	2006
Chlamydia - genital	2942	3169	3615	3749	3609	3795	4256
Gonorrhea - genital	467	528	558	544	628	718	954
Syphilis - primary, secondary		2	1	5	1	1	14
Syphilis - early latent	1	1		1	1	1	3
Provincial rate per 100,000	333.7	361.1	407.3	426.6	416.4	442.2	521.0

Source: Population Health Branch, SK Ministry of Health. Unpublished data.

Tribal members gather regularly from distant locations for large ceremonies; some young people engage in unprotected sexual contact with acquaintances at these ceremonies,¹ greatly increasing their risk of HIV (Advocates for Youth, HIV and young American Indian/Alaska Native women 2008).

Southern Saskatchewan First Nations

Statistically profiling STI epidemics amongst the First Nations population is challenging because ethnic identifiers are not collected in health data for the general population and there is no record or analysis by patient ethnicity. This can make it difficult to appreciate First Nations health issues, the impact of epidemics, and health-care effectiveness in communities. However, HIV/AIDS cases are “notifiable” to health officials, and by legislation, Aboriginal ethnicity data may be collected for HIV/AIDS. This provision has provided a clearer picture of the HIV pandemic amongst Aboriginal peoples. Furthermore, Saskatchewan Health Population Health Branch says that there are difficulties getting complete STI reporting from all physicians and other care agencies across the province. The epidemiology statistics presented here may not provide a complete profile. These reporting problems have led to delays and to the following being currently deemed “unpublished data.”

Recent unpublished STI statistics from the Saskatchewan Ministry of Health, Population Health Branch show provincial population incidence and incidence rates per 100,000 for chlamydia, gonorrhea, and syphilis have been steadily increasing from 2000 to 2006 (see **Tables 3.3, 3.4, and 3.5** on pages 37–39).

Saskatchewan 2006 male and female genital chlamydia rates by age group show totals of 2,678 female cases and 1,579 male cases, with rates per 100,000

Table 3.4: 2006 Male and Female* Genital Chlamydia Rates, Age Group, Saskatchewan

	10–14			15–19		
	Cases	Pop.	Rate	Cases	Pop.	Rate
Females	58	34,304	169	1,092	37,867	2,884
Males	-	-	-	391	39,849	981
TOTAL	58	70,278	83	1,483	77,716	1,908
	20–24			25–29		
	Cases	Pop.	Rate	Cases	Pop.	Rate
Females	937	36,931	2,537	354	32,181	1,100
Males	583	38,431	1,517	276	33,341	828
TOTAL	1,520	75,362	2,017	630	65,522	962
	30–39			40–59		
	Cases	Pop.	Rate	Cases	Pop.	Rate
Females	198	60,236	329	36	139,524	26
Males	234	60,203	389	84	141,111	60
TOTAL	432	120,439	359	120	280,635	43
	60+			Total		
	Cases	Pop.	Rate	Cases	Pop.	Rate
Females	2	105,085	2	2,678	505,857	529
Males	11	86,107	13	1,579	497,374	317
TOTAL	13	191,192	7	4,257	1,003,231	424

Source: Population Health Branch SK Ministry of Health, Unpublished data.

*Rates are shown by gender for chlamydia because of the story it tells about the burden of illness among young females

of 529.4 and 317.5, respectively, for all age groups (see **Table 3.4**). However, the data also shows a much higher incidence of infection amongst youth aged fifteen to nineteen and twenty to twenty-four years, with young female rates of 2,883.8 and 2,537.2 for the two age groups, compared to young male rates of 981.2 and 1,571. This should signal the increasing vulnerability of youth. It also indicates the disproportionate burden of illness placed on young females, compared to males within the population and/or likely reflects the fact that women are more likely to present for doctor's care and, consequently, diagnosis and treatment. Anecdotally, RQHR health-care providers say that they encounter many Aboriginal women with STI care needs and health consequences. However, these general population figures do not indicate the impact on Registered Indian and Métis persons.

Table 3.5: 2006 Genital Gonorrhea Rates, Age Group, Saskatchewan

RHA NAME	10–14			15–19		
	Cases	Pop.	Rate	Cases	Pop.	Rate
TOTAL	19	70,278	27	358	77,716	461
RHA NAME	20–24			25–29		
	Cases	Pop.	Rate	Cases	Pop.	Rate
TOTAL	277	75,362	368	135	65,522	206
RHA NAME	30–39			40–59		
	Cases	Pop.	Rate	Cases	Pop.	Rate
TOTAL	96	120,439	80	58	280,635	21
RHA NAME	60+			Total		
	Cases	Pop.	Rate	Cases	Pop.	Rate
TOTAL	11	191,192	6	954	1,003,230	95

Source: Population Health Branch, SK Ministry of Health, Unpublished data.

The gender profile is quite similar for gonorrhea, but the rates are much lower

The male and female genital gonorrhea rates by age group (**Table 3.5**) show a similar gender profile, but the rates are much lower.

Saskatchewan and Canada HIV/AIDS statistics and analysis do identify Aboriginal ethnicity but some of these do not discern Registered Indian, Métis, and Inuit populations, instead using the encompassing term “Aboriginal” people.

A recent study shows that more than 75% of HIV infections are the result of intravenous drug use, but even though less than half of infections are sexually transmitted (counting MSM and heterosexual relations), this data can nonetheless provide some insight into STI epidemics.

Aboriginal people are over-represented among HIV/AIDS cases in Canada. In 2005, there were an estimated 2,300 to 4,500 new HIV infections in Canada, of which an estimated 200 to 400 (9%) were in Aboriginal people; whereas the Aboriginal population in Canada is about 3% of the country’s population. Aboriginal people represented about 7.5% of all persons living with HIV in Canada in 2005 (an estimated 3,600 to 5,100 Aboriginal persons). Overall, the HIV infection rate among Aboriginal people is nearly three times higher than among non-Aboriginal people (Hennink, M. et al. 2006).

In Saskatchewan, 124 laboratory-confirmed HIV cases were reported during 2007 compared to 100 cases in 2006, 78 in 2005, 54 in 2004, and 40 in 2003. There was a total of 553 HIV-infected individuals identified in the ten years from 1998 to 2007, an increase of approximately 25 new diagnosed cases in each of the past four years. Close to three-quarters (72%) of total HIV cases in 2007

were residents in the health regions containing the urban centres of Saskatoon and Regina.

Injection drug use (IDU) remains one of the major risk exposures reported by HIV-infected cases. In Saskatchewan, injection drug use accounts for 68% of total 2007 cases, whereas 23% of total cases nationally self-disclosed injection drug use. The incidence of eighty-four cases reporting injection drug use in 2007 is almost a 25% increase over the sixty-seven cases reported in 2006. Forty-one males and forty-three females reported this risk exposure. Sixty-three of the eighty-four cases self-disclosing injection drug use also self-identified as Aboriginal. Thirty-one of the sixty-three cases were female. Over half (52%) of HIV-infected injection drug users in 2007 were between fifteen and nineteen years of age with another one-quarter in the thirty to thirty-nine year age group. Thirteen of eighty-four cases (16%) were fifteen to nineteen years (eleven females), thirty of eighty-four cases (36%) were twenty to twenty-nine years (nineteen females), and twenty of eighty-four cases were thirty to thirty-nine years (nine females).

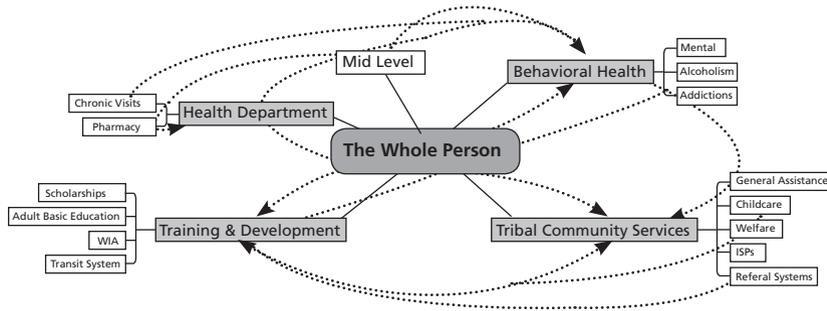
In 2004, the number of female cases began to increase, surpassing the number of male cases in 2005 and 2006. In 2007, the trend reversed slightly, but female cases still exceeded male cases in the younger age group of fifteen to nineteen years (eleven female versus two male cases), and twenty to twenty-nine years (twenty-five females versus sixteen male cases). Of note is the steady upward trend in the percentage of youth between fifteen and nineteen years beginning in 2001.

Ethnicity data characterizes Saskatchewan populations to support targeted program planning and resource allocation. In 2007, HIV cases of Aboriginal origin accounted for 49% (61 of 124 cases) and 51% (63 cases) were of non-Aboriginal ethnicity (22 Caucasian, 3 Black, and 1 Asian). Ethnicity was not recorded for 33 (27%) of 2007 HIV cases. This compares to increases in Aboriginal cases of 60% in 2006 and 68% in 1999.

In 2006, 60% of females (thirty-six of sixty cases) were Aboriginal compared to 39% of males (twenty-five of sixty-four cases). The Caucasian group comprised twenty-two of the sixty-three non-Aboriginal cases in 2007, including four females.

Eleven of the thirteen HIV cases in the fifteen to nineteen year age group were Aboriginal females diagnosed in 2007. Sixty-six percent (twenty-seven of forty-one cases) in the twenty to twenty-nine age group were of Aboriginal ethnicity. Sixteen of the twenty-seven cases in this age group were female. Nationally, the largest rise in this proportion is seen among the fifteen to twenty-nine year age group in which females represented 17% of reports between 1985 and 1999 and 36% in 2007.

The number of male cases whose primary risk exposure for HIV infections was engaging in sex with other men declined. In 2006, only four cases (9%) self-identified this risk. In 2007, eleven men (9%) reported this risk. Four of these also

Figure 3.1: The Whole Person Service Delivery Model, Copper River Native Association

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reported injecting drugs. Men having sex with men represented 43% of total cases nationally compared to 9% of total cases in Saskatchewan in 2007.

Heterosexual exposure is acquired through sexual relations with a known HIV-positive partner or where the case has had heterosexual relations and no other identifiable risk exposure for HIV. The fourteen cases (11% of all cases) reported in 2007 are in keeping with this trend (Government of Saskatchewan 2008).

A study of risk behaviours of intravenous drug users in Regina, 87.2% of whom self-identified as Aboriginal, raises concerns about the lack of condom use. The study noted that the majority of respondents (68% of males and 70% of females) reported never using condoms with regular sex partners. Particularly vulnerable Aboriginal populations, such as people who inject drugs and are involved in sex work, indicate that condom use with regular, casual, and client partners is inconsistent, contributing to the vulnerability of this population to HIV (Government of Saskatchewan 2008).

Services Available for Beneficiaries Presenting with STIs

Copper River Native Association

CRNA's Whole Person model (Figure 3.1) demonstrates the holistic approach intended by the association. It is an ambitious cadre of often underfunded services available to CRNA's beneficiaries. Structured interviews were conducted with various managers and providers at the CRNA and Mt. Sanford Tribal Consortium (MSTC).² The following are consensus statements factored from the series of structured interviews.³

There are various points of entry for individuals presenting with suspicion of an STI or related ailment. Each community within the CRNA region has a health clinic. Health clinics are staffed, with some exceptions, by community health aids

(CHAs). CHAs are trained through the Alaska Tribal Health System, acquiring skills to comply with certain protocol standards. Protocols are presented in coherent fashion in a series of community health aid manuals. The manuals offer guidance for providing clinical care and patient education (example provided in **Appendix A**).

The Department of Social Services, another service provided by CRNA, is not a typical point of entry for patients seeking care for STIs.

Behavioural health offers the most comprehensive intake mechanism for patients with STIs. Initial visits are routinely one-and-one-half to two hours in length, often providing adequate time for the patient to feel at ease. The behavioural health intake visit often provides the opportunity to discuss the full array of services available to the STI patient (refer to **Figure 3.1** on page 41).

In most cases, the CHA, the local non-Native health facility, or the regional Alaska Native facility in Anchorage is the first point of contact. Patients with concerns of confidentiality may choose the non-Native or Anchorage facility. Seeking services outside CRNA contributes to additional challenges for subsequent medical care and with engaging patients with the remaining non-medical services available through the association.

Initial visits to medical providers includes diagnostic testing to determine the presence of an STI, with antibiotics as the first course of treatment. Patient visits for STIs are reportable to the State of Alaska Health and Human Services Office of Epidemiology. Patients may be referred to the regional Alaska Native hospital in Anchorage. On occasion, patients diagnosed with STIs are referred to behavioural health for their broader array of services.

Southern Saskatchewan First Nations

Interviews were conducted with on-reserve First Nations health-care providers, RQHR health-care providers and administrators, and community-based organization staff to gather information about the care continuum for sexually transmitted infections.

There are various points of entry for a Registered Indian presenting with suspicion of an STI or related ailment. A Registered Indian who resides on-reserve would most likely seek care from a physician in a town near to their First Nation or in the city, rather than go to the on-reserve health centre. Health directors and First Nations citizens alike say privacy concerns or fears about confidentiality breaches in small communities keep patients from seeking STI care on-reserve. The NIHB transportation benefit by medical van is available to those with a verifiable medical appointment, as is necessary medication.

Off-reserve, there are a variety of other health-care points of entry, including general practitioners in walk-in clinics, resident doctors in hospitals/emergency rooms, the nurse practitioners at Four Directions Community Health Centre, or any of five emerging primary health-care centres in urban and rural settings.

The Communicable Disease/Sexual Health Program (STD Clinic) of RQHR Population and Public Health Services located in downtown Regina receives walk-in patients. The clinic is nurse-driven, and offers free and confidential testing and treatment for STDs. Immunizations are also available for high-risk persons. The clinic provides single-dose, observed treatment. In addition, the nurses provide bicillin injections for the treatment of syphilis, and may provide a physician-signed prescription or longer course of antibiotic treatment if indicated (i.e., allergic to single-dose). Appropriate follow-up/testing, contact tracing, and notification are done by the clinic. Counselling is done at every visit, both pre-test and post-results, and includes information on STDs, risk reduction (condoms, safer drug use), negotiating safer situations, etc. Clinic staff persons are confident that clinic services are well-known in the community and attest that clients learn about the service from partners in the community, other health-care providers, friends, through health fairs, poster campaigns, etc.

Furthermore, the collection of STI health data is supported by health legislation and centrally managed through the Provincial Disease Control Laboratory.

The clinic is also home base for the street project that provides a van and outreach staff who provide education, sterile needle exchange, condoms, counselling, and referral to drug-involved inner-city residents and sex trade workers.

Community-based organizations and community health programs offer significant STI-related counselling, referral, and support through on-site outreach staff, providing programs and projects that emphasize relationship-building with clients. The following organizations operating in Regina have mandates to address HIV/AIDS, hepatitis C, and other communicable diseases:

AIDS Programs South Saskatchewan Inc. was incorporated in 1986, with a mandate to support community health and well-being through the sharing of HIV/AIDS information and resources.

Carmichael Outreach Services Inc. and other core community associations delivers a hepatitis C project and needle exchange amongst other services.

All Nations Hope AIDS Network was incorporated in 1986, with a mandate to promote the health of Aboriginal communities by working together to provide support and share HIV/AIDS and hepatitis C knowledge and resources. It refers clients to Aboriginal service organizations that work with the identified at-risk population, and fosters awareness, contact with Aboriginal elders and traditional healers, and participation in ceremonies.

Planned Parenthood Regina was incorporated in 1986, with a mandate to promote sexual health and well-being by providing education, resources, services, and referrals for the community. The organization promotes sexual health, provides peer education, and supports youth-driven projects in the community.

Barriers to Access

Copper River Native Association

The majority of patients will seek care for STI and concomitant medical, behavioural, and lifestyle-related issues during multiple visits. However, this does not imply that all barriers to access have been eliminated.

STIs continue to carry a social stigma contributing to fear of ridicule or isolation as a significant barrier. It is common for patients to be related to or within the same social network as CHAs. Travel costs can be prohibitive, especially in cases where treatment is sought in Anchorage. Co-morbidities, including substance abuse and depression, are both drivers and resisters to seeking care. Transience often disrupts continuity of care. The extensive familial and community social networks throughout the region encourage frequent relocation for those individuals lacking permanent homes.

South Saskatchewan First Nations

Barriers to access may be economic, social, or cultural in nature. Moreover, there are a limited number of physicians or general practitioners who carry very demanding caseloads. Not everyone has a family doctor. Many Registered Indians tend to use walk-in clinics for physician care, but this can be complicated by full waiting rooms or clinics offering less client-centred personal care.

Economically, people who live in poverty can lack the means to gain access to transportation, even if that is just money for a bus ride into the city. Child-care needs can impede participation in programs. Efforts are being made to offer accessible primary health care and public health services in select high-need neighbourhoods.

Socially, some First Nations people may not feel comfortable and competent in the mixed company of persons of other social and cultural backgrounds. Culturally appropriate services and “more Aboriginal health-care providers who understand” are common requests arising out of community consultations on health needs and services.

Culturally, some community spokespersons advocate returning to traditional beliefs, ceremonial practices, and life ways as a community health necessity. Traditional Aboriginal persons say some form of spiritual strengthening is an essential part of health. Most claim that holistic health care is necessary, yet health systems seem to struggle to provide coordinated and integrated mental-physical-emotional-spiritual care that is well-suited to First Nations and Métis people. A Regina STD clinic staff person was unsure whether or not culturally sensitive care was required for STI treatment, and whether or not client wanted more cultural sensitivity in the clinic service than is currently offered, suggest that a survey is perhaps warranted. Health-care providers say that some people do not seek available health care because of the fear, distrust, and apathy that are somewhat

Table 3.6: Total HIV/AIDS Federal Funding, United States Fiscal Year 2007

Department/Organization	Alaska	United States
Centers for Disease Control and Prevention HIV/AIDS Funding	\$2,047,499	\$531,101,751
Housing Opportunities for Persons with AIDS Funding	\$0	\$256,162,000
Substance Abuse and Mental Health Services Administration HIV/AIDS Funding	\$0	\$107,503,426
Office of Minority Health HIV/AIDS Funding	\$0	\$11,322,893
Ryan White Program Funding	\$1,996,612	\$2,050,220,880
Total	\$4,044,111	\$2,956,310,950

characteristic of so-called “hard to-reach” and marginalized populations. Persons who suffer active addictions or engage in other illicit activities can tend to avoid health care. Exceptional efforts are being made to reduce barriers and engage with marginalized populations, particularly amongst young women of child-bearing age, and sole parents of young children.

Funding for STI Services

Copper River Native Association

According to the Kaiser Family Foundation (2008), funding for STI services in Alaska amounts to US\$4 million (**Table 3.6**), or 0.13% of total U.S. funding. The population of Alaska comprises 0.02% of total U.S. population making the per capita STI funding 650% higher for Alaska residents than for U.S. residents as a whole.

CRNA relies primarily on IHS funding, and federal and state grants for provision of medical services. Payment from other sources is available, though CRNA suffers from the irony that precludes payment from Medicaid, Medicare, and private health plans (also known as “third-party payment”). CRNA lacks the resources to recruit highly skilled medical professionals, and CRNA is not eligible to generate revenue via third-party payment until the association recruits highly skilled medical professionals.

CRNA’s behavioural service relies on U.S. Bureau of Indian Affairs funding in addition to federal and state grants. This service is staffed by a credentialed psychotherapist and, therefore, qualifies for Medicaid payment.

Mt. Sanford Tribal Consortium is staffed by an itinerant mid-level provider (e.g., nurse practitioner); qualifying the consortium’s health clinics for third-party payment. MSTC estimates their non-grant revenue proportions as 70% Indian Health Service, 20% Medicaid, 5% Medicare, and 5% private health plans.

Southern Saskatchewan First Nations

Regional health authorities are funded by Saskatchewan Health. Efforts to analyze specific costs of STI health care are somewhat confounded because there is no clear dollar-trail for specific treatments and care for Medicare-insured services. Data collection systems do not collect specific or individualized cost information. Health-care funding is often generalized within health organization and department budgets without specific STI breakouts. STI care is seen as a very small part of the overall array of health concerns. In the universal-health-care environment, the cost of care itself seems like a remote consideration for frontline workers, or anyone below the mid-level budget managers. Federal and provincial funding is global, and health systems departmental budgets tend to be large, making it difficult to ascribe dollar values to STI treatment and care. In addition, the cost of physician care can be obscured by sheer numbers, and data collection offers no readily available tally of STI visits and costs. Dollar figures of FNIH funding on a national and regional level can be obtained, while health transfer agreements with First Nations are posted on the Internet as an accountability measure. These documents could be mined for broad dollar allocations, but there is no detail on STI care, or any indication of such services being offered. Likewise, RQHR funding is broad, and upon further inquiry some costs, such as the operation of the STD clinic, may be available; however, there is no breakdown on costs per client.

Summary

The funding mechanisms are clearly divergent for the administration of STI programs in the RQHR and CRNA health delivery systems. In contrast, this paper implies that social and cultural attitudes, scope of services, and administrative challenges are similar for the two populations.

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Appendix A

Alaska Community Health Aide/Practitioner Manual

Patient Care Visit

Example of “Patient Education” protocol

Female 2E

Patient Education

Safer Sex

1. Sexually Transmitted Infections (STIs) can be passed by oral, vaginal, and anal sex.
 - Infections can be passed by sex between men and women, between men, or rarely between women.
 - Use condoms, from start to finish every time you have sex.
 - Anal sex, even with a condom, is very risky.
2. If you have more than one sex partner, you are at higher risk of getting or spreading infections.
 - It is safer to have only one sex partner.
 - Your partner should NOT have other sex partners.
 - Know your sex partner well.
 - Ask sex partner(s) about their behaviour. If they have other partners or use IV street drugs, you will be at risk for infections.
3. If you drink alcohol, use it responsibly.
 - If you get drunk, you may not be able to say no to someone who wants to have sex with you.
 - During a blackout, you may not know with whom you have had sex.

(4th edition, 2006, 523.)

Endnotes

- 1 Editor's note: The authors wanted to make the point that these are gatherings, not necessarily ceremonies.
- 2 MSTC was established in 1992 to address the health care, educational, and social service needs for their beneficiaries in two of the six Native communities also served by CRNA. CRNA provides support to MSTC in the form of funding (Bureau of Indian Affairs) and staffing for behavioural health services.
- 3 Interviewees are acknowledged at the conclusion of this paper.

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