

# Native Youth: Reproductive Health Disparities



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# Objectives

- Define issues related to reproductive health disparities among American Indians in North Dakota.
- Identify barriers to care for American Indian Youth in North Dakota.
- Explain systems of care for American Indian Youth in North Dakota.
- Discuss strategies to eliminate health disparities affecting American Indians in North Dakota.

# Health Disparities

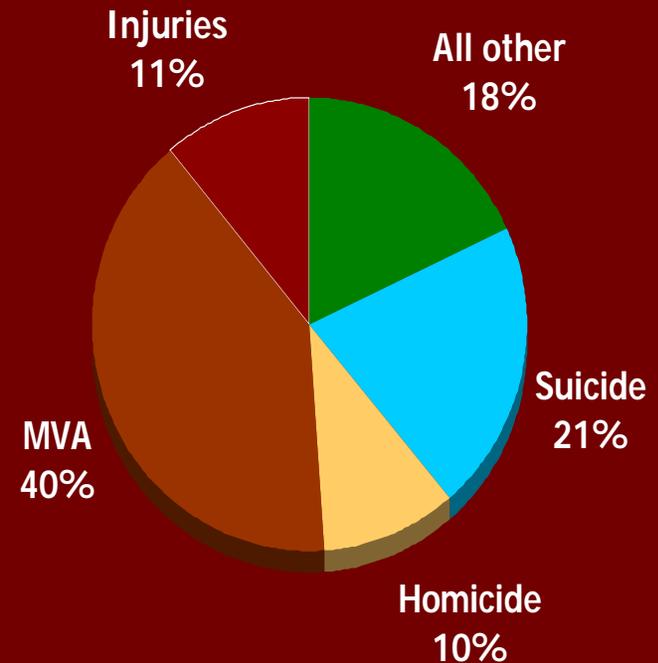
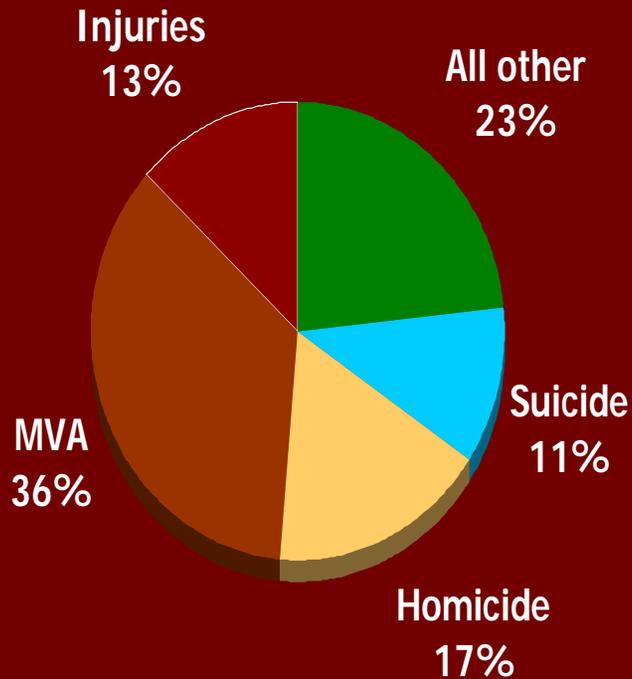
- “Inequalities in health status, utilization, or access due to structural, financial, personal, or cultural barriers. Population categories affected include, but are not limited to, those identified by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation.” ND DOH

# Mortality Ages 15 – 19

(2006, WISQARS)

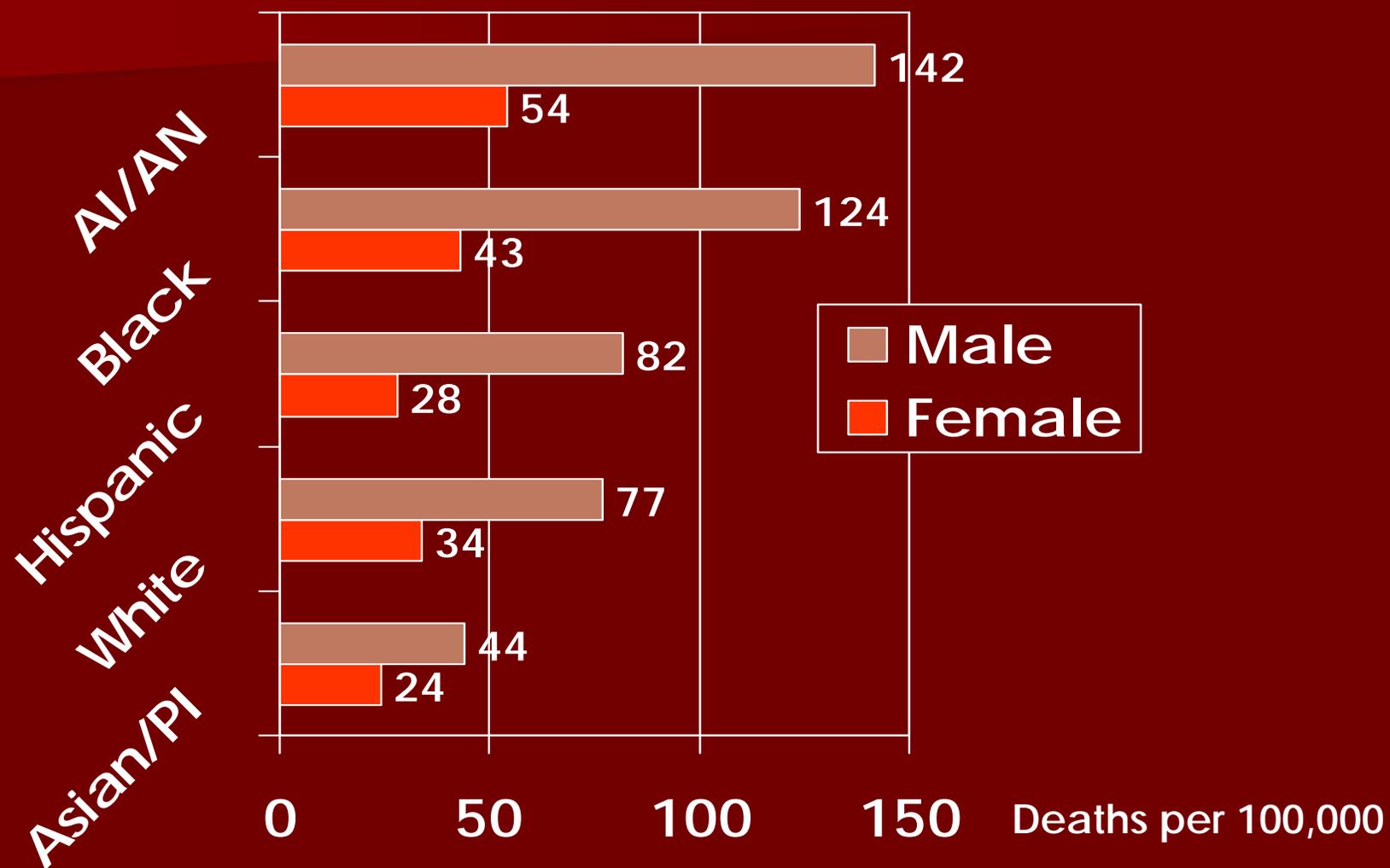
U.S. All Races

Native Americans



**Native youth death rate is 2 times as high as other youth.**

# Mortality Rates by Race and Gender, 10-24 yo; 2003



■ National Center for Injury Prevention and Control

# Office of Minority Health and Health Disparities

- “For too many racial and ethnic minorities in the United States, good health is elusive, since appropriate care is often associated with an individual's economic status, race, and gender. While Americans as a group are healthier and living longer, the nation's health status will never be as good as it can be as long as there are segments of the population with poor health status.”

# Perspective

- Treaties/eradication/genocide
- Biologic warfare (e.g. smallpox, forced sterilization)
- Illegalization of ceremonies
- Forced assimilation/boarding schools
- Relocation/Social Services/ICWA
- Food distribution programs
- Policies reinforce poverty
- Chronically Under-funded IHS



# Native American Demographics

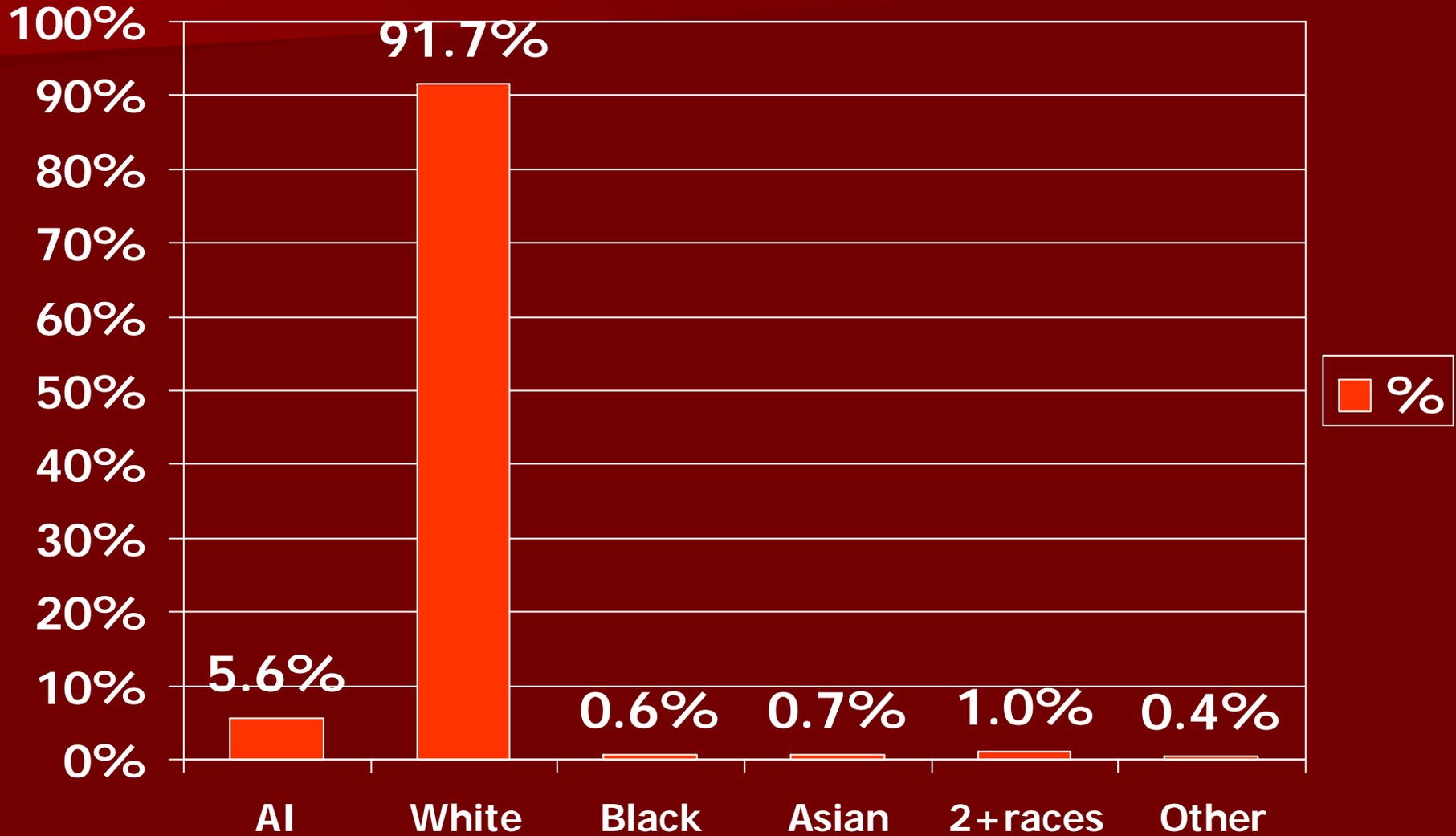
- We have a small population which is widely dispersed.
- Many different tribes, cultures and languages.
- Our population has become more urban.
- Younger population, especially on reservations.
- More unemployment and poverty in our communities.
- Less of our youth are obtaining high school diplomas or secondary education degrees.
- Our youth live in bigger households and more likely to live in different family types.

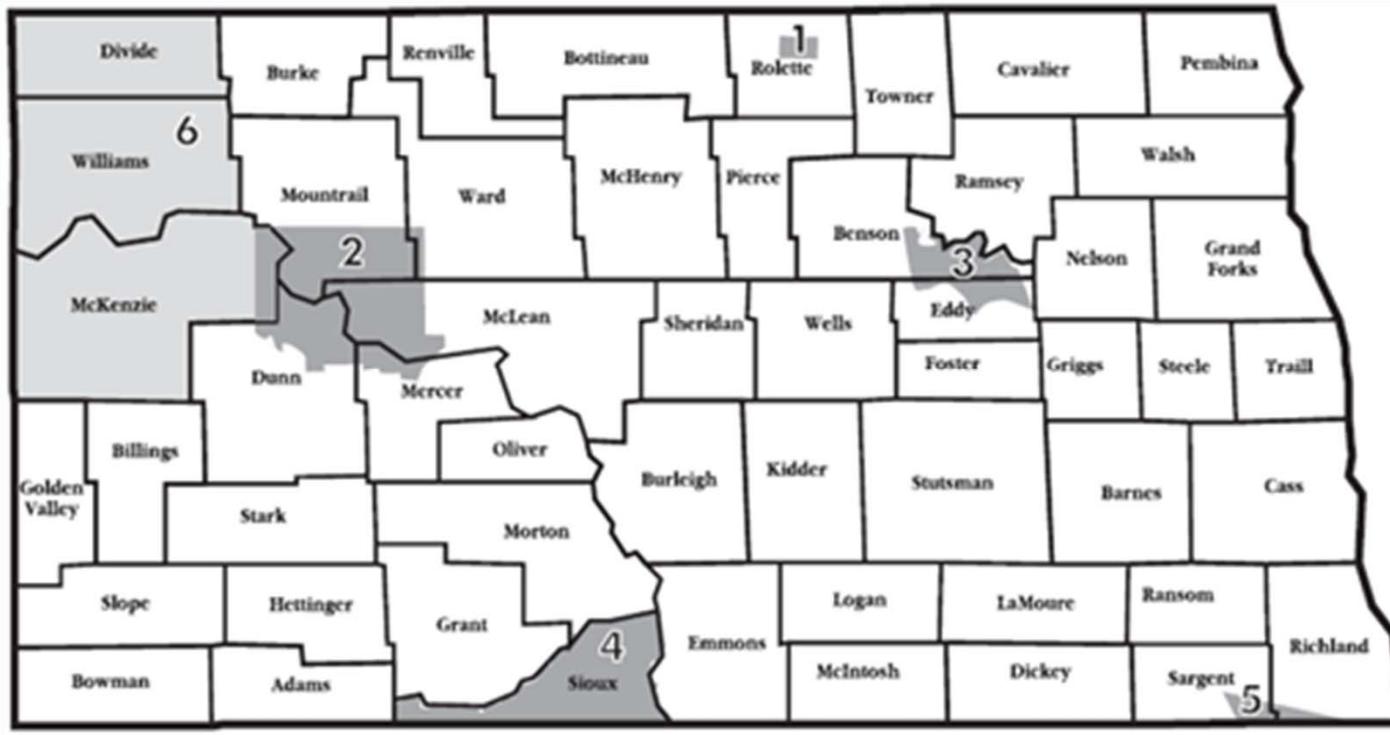
# Health Care Among Natives

- 20-60% served by Indian Health Service (IHS)
- Urban Indian health programs: 1% IHS budget
- 49% have private insurance (vs 83% whites) (Kaiser 2004and Zuckerman, Roubideaux et al 2004)
- 17% covered by Medicaid (vs 5% whites)
- 1/3 are uninsured (vs. 12% whites)
- >1/3 of uninsured do not have healthcare source
- 4 /12 IHS areas do not have child or adolescent mental health professionals

# ND Population by Race

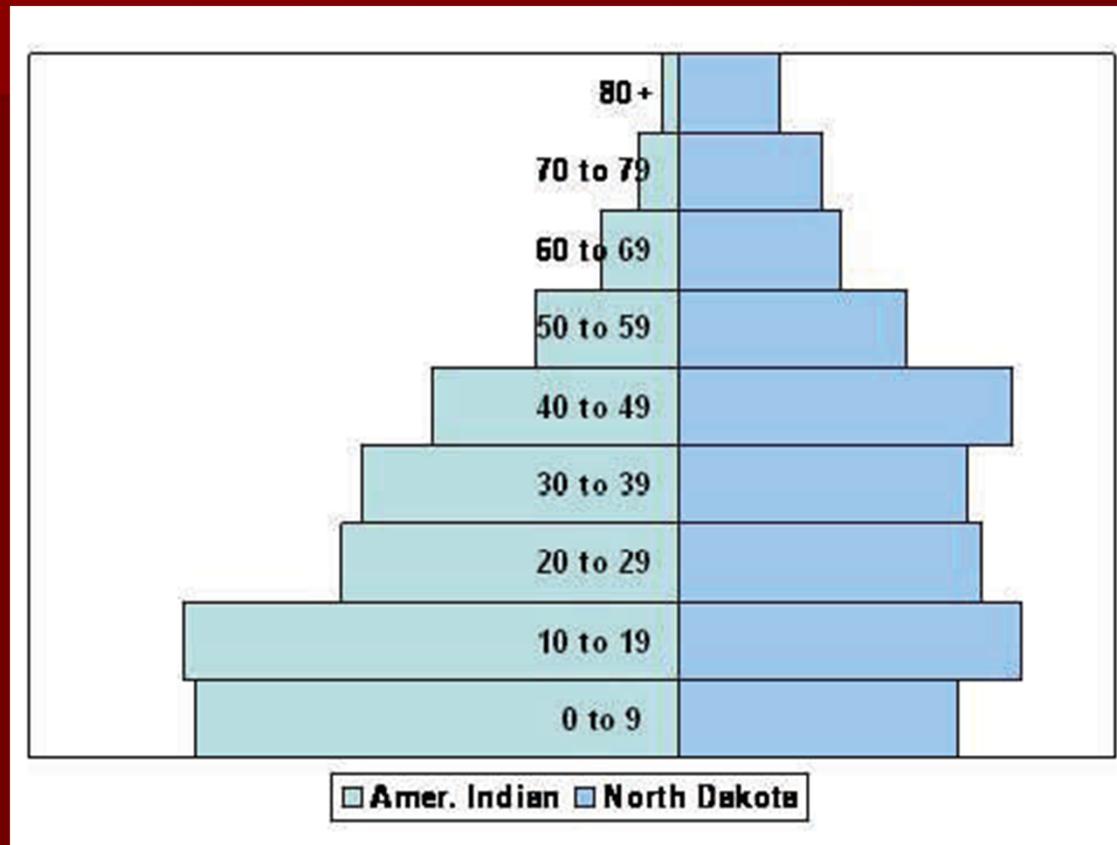
2004 US Census Community Survey





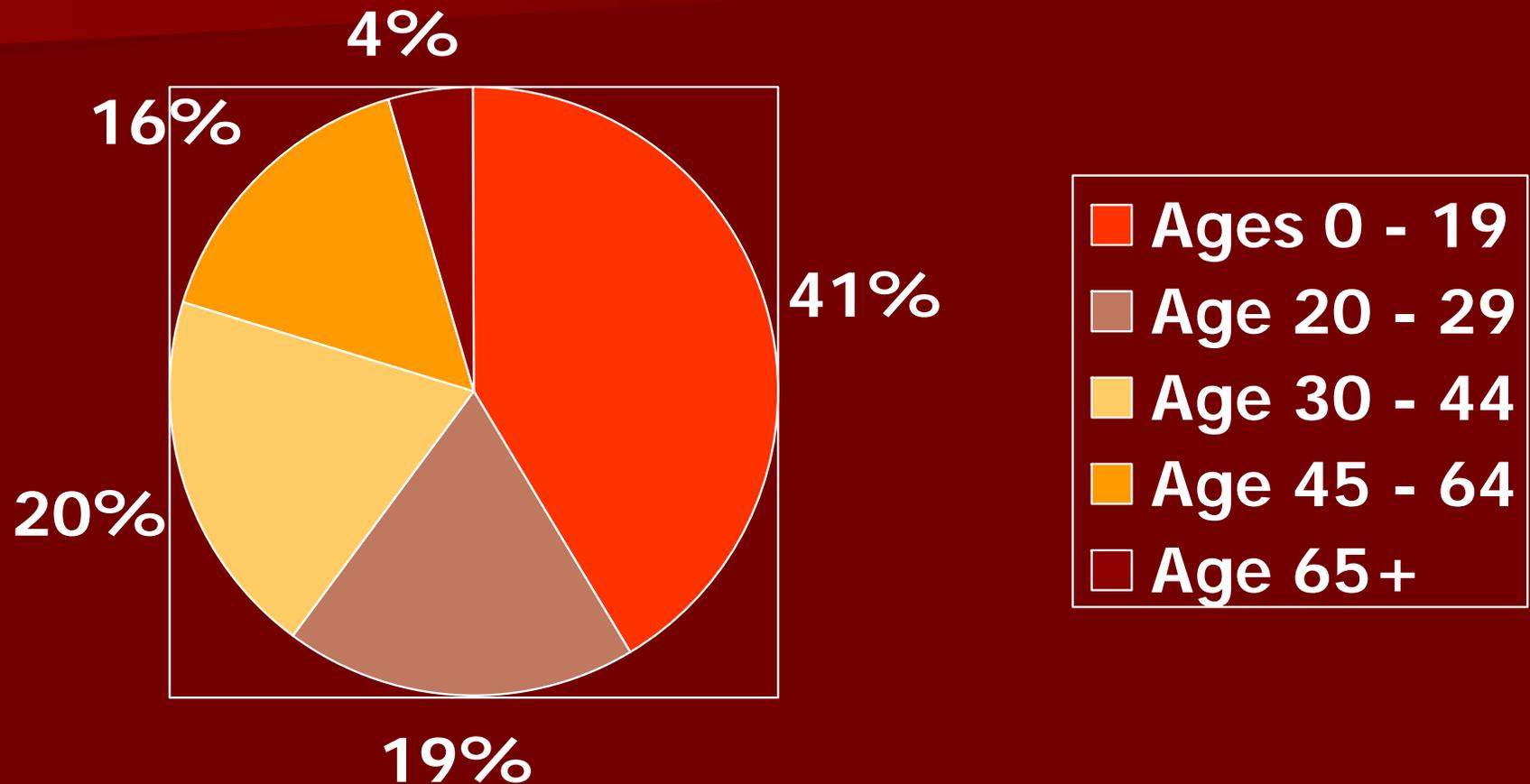
- 1. Turtle Mountain (includes Belcourt; Turtle Mountain Band of Chippewa) = 8,050 American Indians
- 2. Fort Berthold (includes New Town; Three Affiliated Tribes - Mandan, Hidatsa, Arikara) = 4,250 American Indians
- 3. Spirit Lake (includes Fort Totten; Spirit Lake Dakota Sioux Nation) = 3,371
- 4. Standing Rock (includes Fort Yates; Standing Rock Sioux Tribe, members of Dakota/Lakota nations; other half of reservation in SD) = 3,457
- 5. Lake Traverse (Sisseton and Wahpeton Sioux; most of reservation in SD)
- 6. Trenton Indian Service Area

# ND American Indian Population: Age



ND AI population is much younger than non-AI population.  
AI median age is 23 vs. non-AI median age is 36

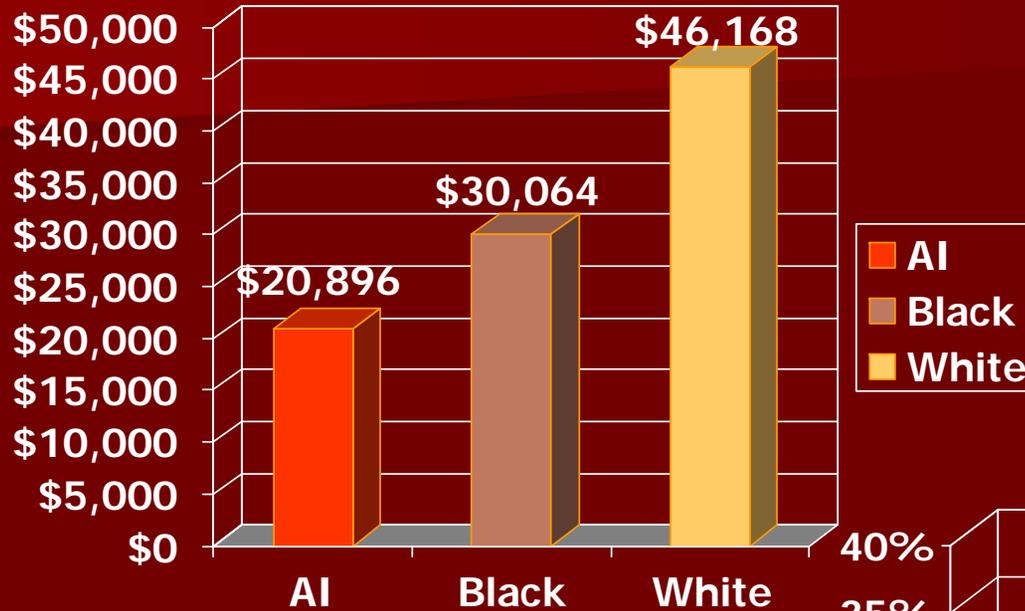
# ND AI population: Young



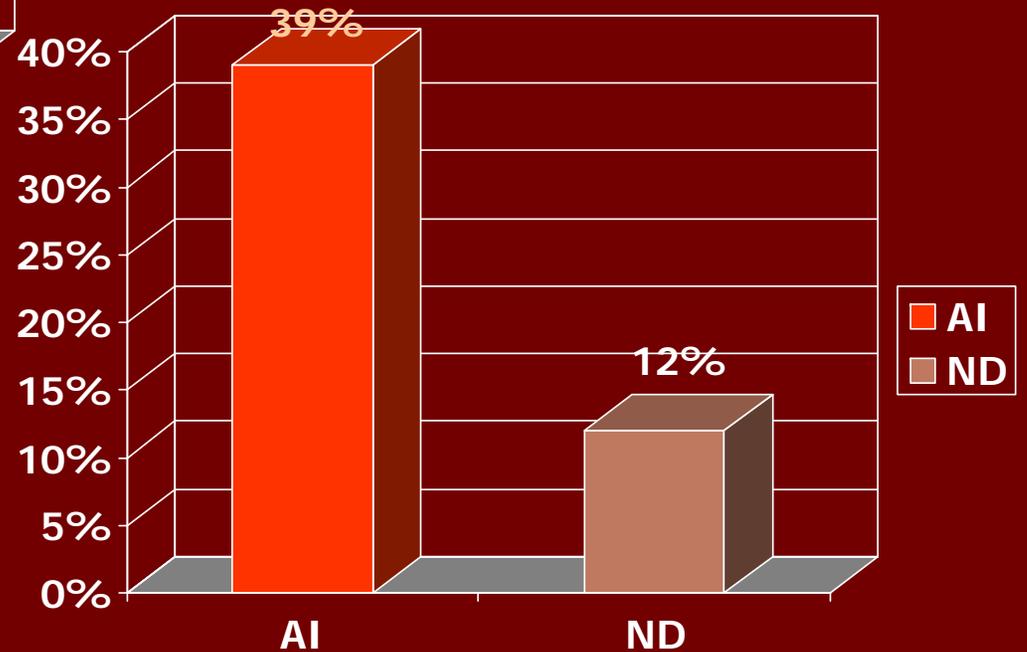
# ND AI Income

## Median Household Income, 2000

ND Kids Count, 2006

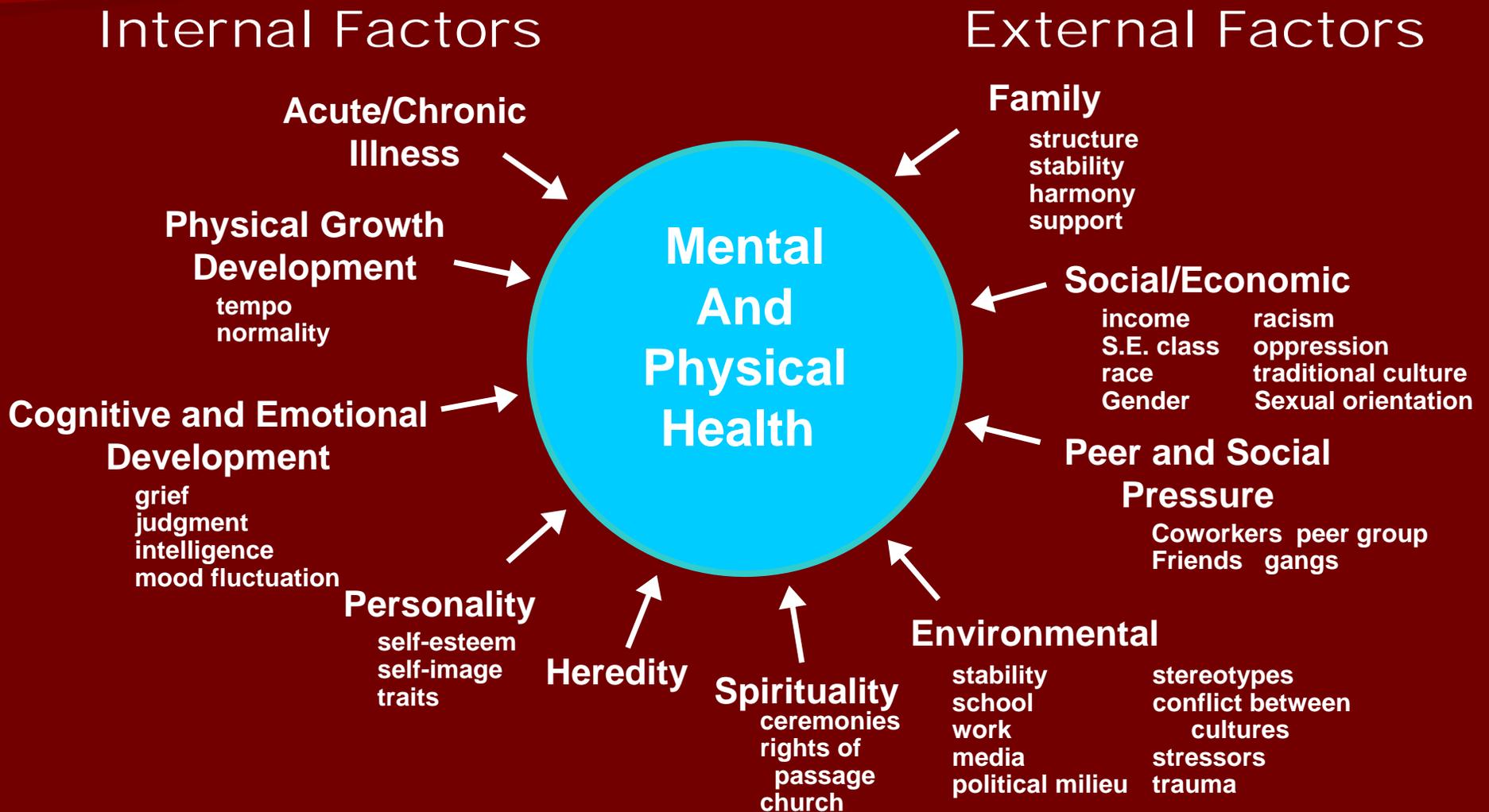


## Income Below Poverty Level



US Census Bureau,  
2004 Community Survey

# Factors Associated with Mental and Physical Health





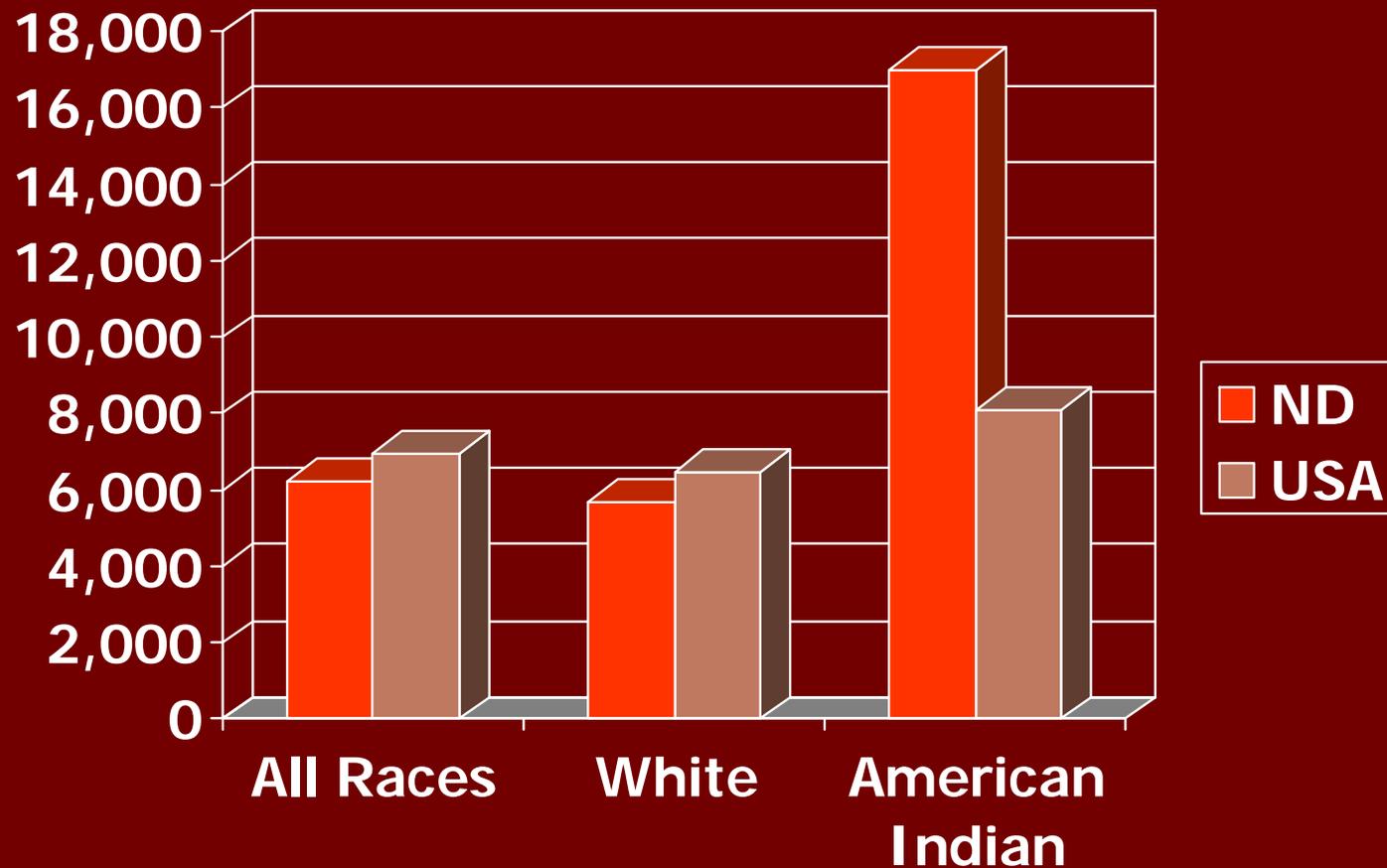
# Behaviors → Major Health Problems

- Unintentional and intentional injuries
- Alcohol and drug abuse
- Sexual behaviors that cause:
  - STDs including HIV
  - Pregnancies
- Tobacco use
- Inadequate physical activity
- Poor diet/over-eating

**Native youth are at high risk  
for all of these behaviors.**

# Years of Potential Life Lost before age 75 years, ND and USA

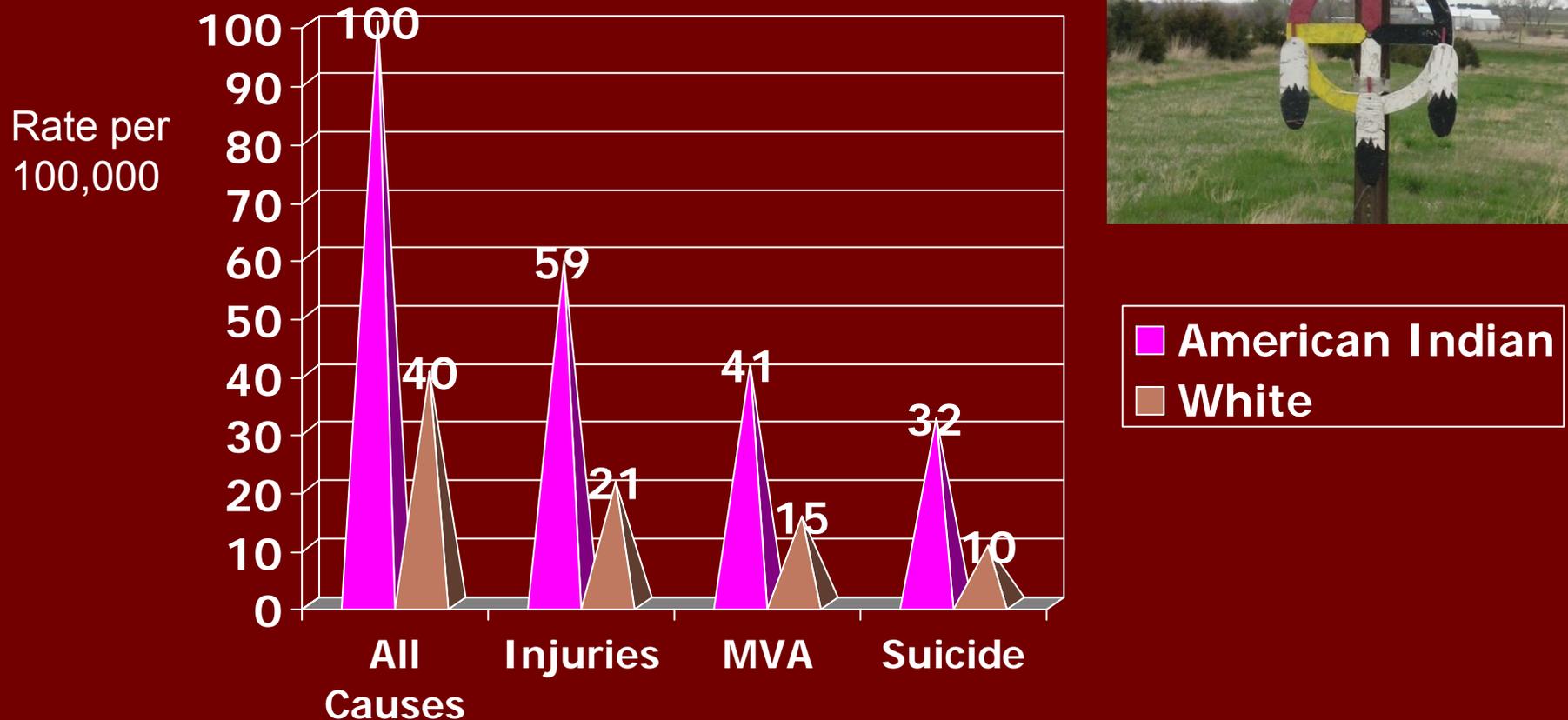
(Age-adjusted YPLL < 75 yo per 100,000 population)



CDC, WISQARS, 2007

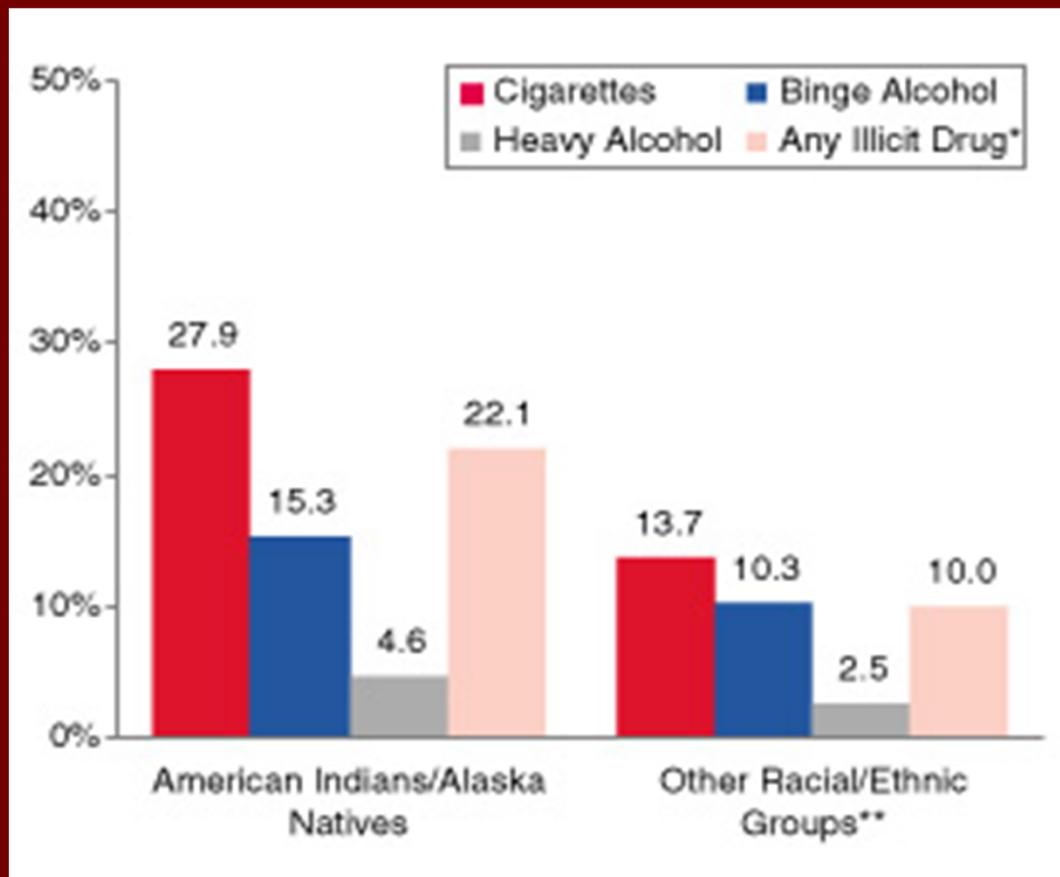
# Adolescent Mortality (Age 10-19)

by Cause and Race, North Dakota, 1990 - 1998



Unintentional injuries, MVA, and suicide rates for AI teens was 2 – 3 times higher vs. white teens.

# Substance Use



Binge > 5  
drinks  
one time

Heavy >  
5 drinks  
at one  
time, > 5  
x/mo

Survey: 2300 AI/AN's;  
Subst Abuse and  
Mental Health  
Services Admin.

Percentages of Youths aged 12-17 reporting  
substance use, by race/ethnicity: NHSDA 99-01

# Depression and Suicide

## ■ Associations with teen suicide:

- **Substance use**
- **Victim of violence/sexual abuse**
- **Gay/lesbian/questioning**
- **Depression**
- **Perceived discrimination**
- **Family/friend death or suicide**

## Depression:

- **Mood changes**
- **Difficulty concentrating**
- **Anhedonia – don't care**
- **Persistent sadness**
- **Irritability**
- **Can't sleep or sleeps a lot**
- **Change in appetite (too much or too little)**
- **Drop in grades**

# Sexuality/Teen Pregnancy

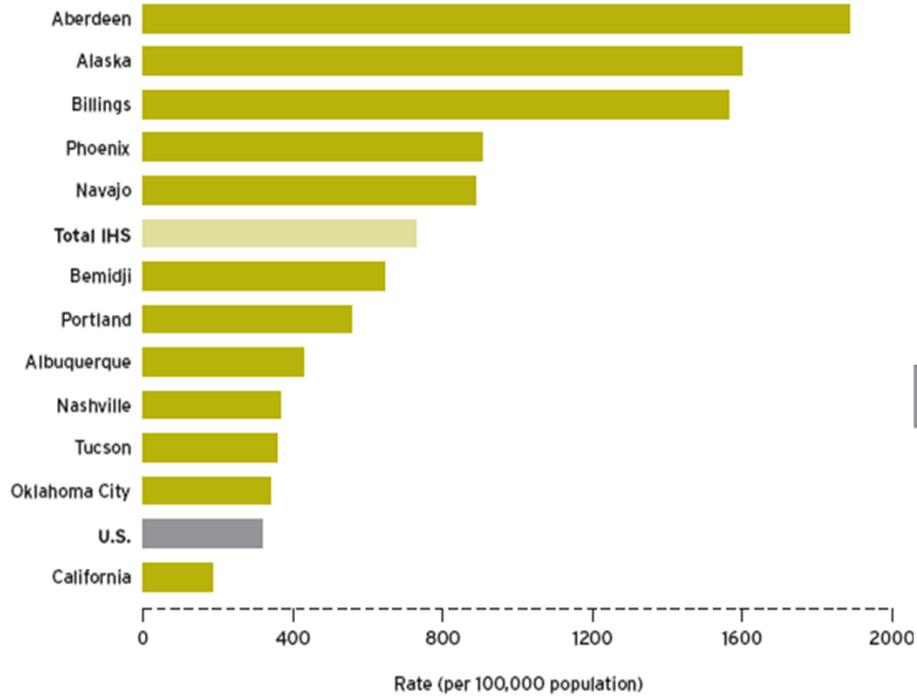
- Average age first intercourse:
  - 13-14 yo NA
  - 15-16 yo U.S.
- Intercourse by 12<sup>th</sup> grade: 61% NAs vs. 65% U.S.
- 1 out of 3 sexually active teens never use birth control or condoms.
- Birth rate 15-19 yo: (CDC 2002)
  - ✦ NA - 54 per 1000
  - ✦ U.S. - 43 per 1000

# Sexually Transmitted Diseases (STDs)

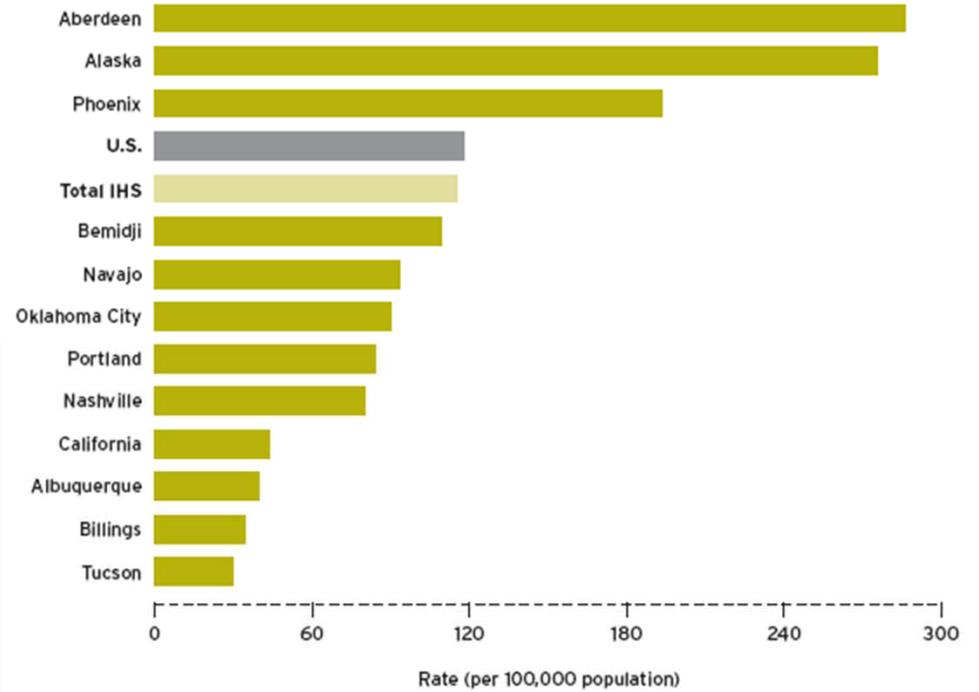
- Chlamydia
- Gonorrhea
- Syphilis
- Trichomoniasis
- Herpes Simplex Virus
- Hepatitis B
- Human Papillomavirus
- Human Immunodeficiency Virus
- Chancroid
- Lice
- Scabies



### Chlamydia Rates by IHS Area, 2004



### Gonorrhea Rates by IHS Area, 2004

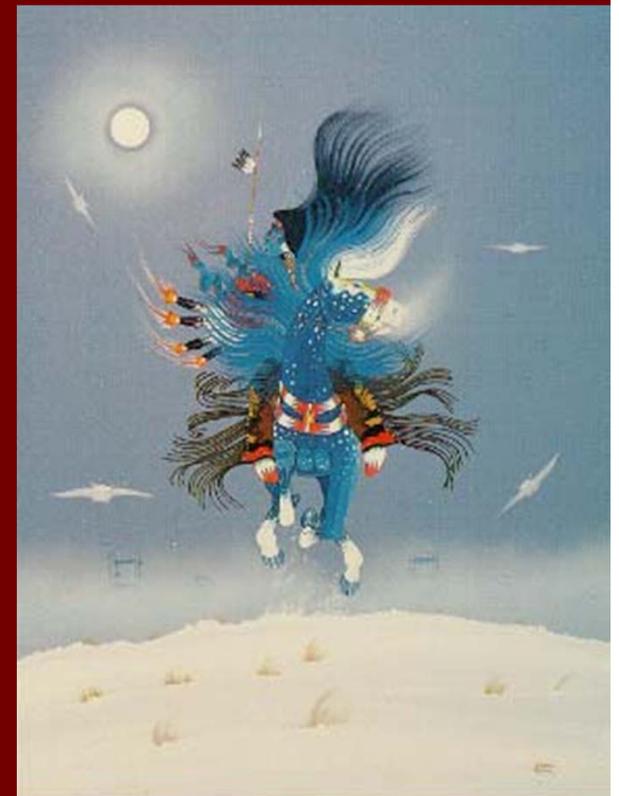


# Why are STDs concerning?

- ❑ Can have NO symptoms
- ❑ Half of seniors in high school have been sexually active, 1/4 acquire STD
- ❑ 3 million teens/ year acquire STD
- ❑ STDs may help HIV spread to other people

# Consequences of "Sex too Soon"

- Sexually Transmitted Infections
  - Unwanted or Unplanned Pregnancy
  - Miscarriages
  - Sterility
  - Lack of Prenatal Care
  - Emotional
  - Spiritual
  - Educational
  - Economical
- \* Important not to use scare tactics



# Complications of STDs

- Pelvic Inflammatory Disease
- Ectopic Pregnancy
- Infertility – difficulty having children
- Disseminated Gonorrhea Infection
- Hepatitis
- Acquired Immunodeficiency Syndrome - AIDS
- Premature Births
- Miscarriages
- Cancer
- Pain



# AI Teen Pregnancy

- Missed opportunities
- Family Support
- Grandparents raising grandchildren
- Child abuse/child neglect
- Cycle of Poverty
- Largely unknown physical health effects: osteopenia?
- Teen – fatalistic beliefs
- Is it seen as way out?

# Why are Teens at more Risk?

## ■ Psychosocial Issues

- Concrete thinking
- Denial; personal fable
- Lack of self-efficacy
- Substance use
- Serial monogamy; multiple partners
- Shorter duration relationships
- Inconsistent condom use
- Female adolescents choosing older partners

## ■ Health Care Access

- Lack of insurance
- Lack of transportation

# Why are Teens at more Risk?

## ■ Confidentiality

- Teen unaware of confidential services
- Providers unaware or resistant to confidential services

## ■ Ethnic and Racial Differences

- African-Americans, Hispanics and Native Americans have higher rates of disease (especially chlamydia, gonorrhea, and syphilis) (CDC 2000)
- Race may be marker for socioeconomic status, health care access, sexual networks with higher STD rates, or reporting/screening bias



# Why are Teens at more Risk?

## ■ Biologic Factors

- Lack of immunity to STDs
- Ectropion – squamocolumnar junction exposed on cervical surface
- Cervical mucus-thin
- Smaller vaginal introitus more susceptible to trauma



# Healthy Teens

- Physical exam/ check-up once per year
- If you've ever had sex, then should have genital exam once per year, including STD testing
- Sexually active teens – STD testing when new partner, every 6 months, or with symptoms (if no symptoms can do urine testing)
- Sexually active teens – use protection and birth control
- Plan B
- Pap smear at age 21

# Barriers to Care

- Fatalistic – “It’s going to happen anyway.”
- Cognitive level- invincible, personal fable, self-conscious (on stage), concrete thinking
- Hidden agenda.
- Teens unreliable – 50% no show rates.

# Barriers to Care

- Small communities/large extended families (relatives/acquaintances in clinic).
- Greater distances to facilities, less school based clinics.
- Busy clinics, time constraints.
- Providers discomfort with teens/ teen issues.
- Clinic not “teen friendly”.
- Long waits. Walk in only.
- Appointments difficult to make.
- Confidentiality issues.

Sara Jumping Eagle, MD

# Barriers to Culturally Competent Care

Barriers among patients, providers, and the U.S. health care system in general that might affect quality and contribute to racial/ethnic disparities in care include:

- Lack of diversity in health care's leadership and workforce.
- Systems of care poorly designed to meet the needs of diverse patient populations.
- Poor communication between providers and patients of different racial, ethnic, or cultural backgrounds.

# Risk

- For teens in general, studies show several factors associated with increased STD risk:
  - Younger age
  - Growing up in poverty or high unemployment areas
  - Teenage pregnancy
- NA youth have higher incidence of all of these.
- Risk-taking behaviors tend to cluster together. NA youth more often engage in multiple risk behaviors. (substance use, drop-out, sex) (14,31,17,32)
- Risk factors for sexual risk-taking in NA youth: substance abuse, trauma, and emotional stress.(46-47)
- Important to identify risk/protective factors specific to NA youth.

# Cultural Interplays

- What is the role of culture?
- Lakota values: courage, honesty, wisdom, generosity
- Lakota traditions hold chastity, modesty, and independence in high regard
- Historical trauma
- Changes in family roles (extended family, "hunka" relatives)
- Loss of ceremonies (rights of passage) and traditions
- Contemporary influences may conflict with traditional values/beliefs: gangs, hip-hop, MTV, BET

## DDX: Why is a sexually active teen not using contraception? (Stevens-Simon, Ped Rev Dec 98)

- **Lack of Knowledge** (something wrong, can't get pg; didn't know how to get bc, withdrawal works, too young to get pg)
- **Denial of sexual behavior** (only had sex once, not planning to have sex)
- **Fear** (side effects, afraid of poc, pelvic)
- **Personal Fable**
- **Pregnancy not undesirable** (if it happens it happens; friends w/ babies, moc wants gchild, want own place/someone to love)
- **Lack of control over reproductive behavior** (bf wants baby, bf forces sex, bf won't use bc)

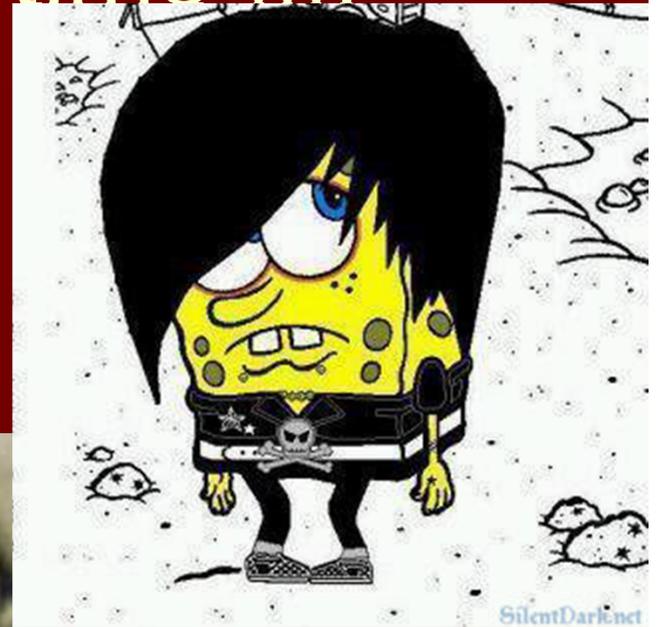
# Prevention/Risk-reduction :

- abstinence, wait until later, “born again virgin”
- condoms (unclear protection vs. HPV/HSV),
- self-efficacy
- Less partners
- Partner treatment
- Hepatitis B vaccine
- Human Papillomavirus vaccine
- visiting a health care provider

# Confidential Care

- Teens should have access to confidential services for sensitive issues.
- Parental participation should be encouraged when appropriate
- Clinician's assurance of ***confidentiality*** is ***conditional***.
  - Consensus policy of AAP, AAFP, NMA, SAM, AM

Some of you might be feeling a bit overwhelmed at this time .....



<http://go.funpic.hu>

# Indian Health Service

- Treaty obligations
- Not Entitlement, budget approved
- Not fully funded
- Shortage of Health Care Providers
- Local Units submit budget priorities to Local Area Offices, which then submit funding priorities to main IHS
- Budget priorities also include tribal consultation, yet tribes don't have direct involvement in budget formulation

# IHS Eligibility

- Is of Indian and/or Alaska Native descent as evidenced by one or more of the factors:
  - **Indian descent** and belong to the Indian community which may be verified by tribal descendancy or census number.
  - An individual must be a member, enrolled or otherwise, of an Indian or Alaska Native Tribe or Group under Federal supervision; Any other reasonable factor indicative of Indian descent; or
- Is an **Indian of Canadian or Mexican origin** recognized by any Indian tribe or group as a member of an Indian community served by the Indian Health program; or
- Is a **non-Indian woman pregnant with an eligible Indian's child** for the duration of her pregnancy through post partum (usually 6 weeks); or
- Is a **non-Indian member of an eligible Indian's household** and the medical officer in charge services are necessary to control a public health hazard or an acute infectious disease which constitutes a public health hazard.

# Indian Health Service

- Direct Care:
  - Medical/Dental/Mental health services provided at local IHS or tribal health facility
  - Varied services at different facilities
- Contract Health Services
  - Care provided at non-IHS or non-tribal facility
  - Not entitlement, not guaranteed payment
  - Must meet certain requirements for payment of services.



**Indian Health Service**

The Federal Health Program for American Indians and Alaska Natives

# IHS Direct Services

**Ft. Yates IHS:** (2 clinics- potentially 4)

- Two full time providers (pediatrician, family practice),
- Contract mid-levels for walk in clinic,
- Contract coverage for Emergency Room,
- 2 UND FP once per week,
- Ob/Gyn 1-2 times per week
- IM/Nephrologist twice per month;
- Dermatology twice per month
- Contracted Medcenter One Dialysis Unit
- Mental Health – psychologist, counselor
- Minimal In-Patient Unit

# IHS Direct Health Services

## Minne-Tohe Health Center: (3 clinics)

- Optometry
- Community Health Nurses
- 3 Family Practice Doctors
- 4 Nurse Practitioners
- Nephrology once per month
- Foot Clinic once per week
- Diabetes Care
- Wellness Center
- Dental Clinic
- New health center being built

# IHS Direct Services

## Turtle Mountain – Quentin Burdick Health Center (3 clinics)

- Dental Clinic
- 29 bed hospital
- Mental Health
- Family Practice
- Nurse Practitioners
- Community Health
- CAT Scan

## Spirit Lake Nation – 1 clinic

- 2 Family Practice Doctors
- Podiatry
- Diabetes Clinic
- Dental Clinic
- Community Health
- Mental Health

# IHS Contract Health

- Indian descendants residing off the reservation may be eligible if they meet certain conditions.
- If not residing on the reservation such individuals must live within the CHSDA and (1) be members of the tribe(s) located on the associated reservation or (2) "maintain close economic and social ties with that tribe or tribes." (e.g. Ft. Yates vs. Mandan vs. Bismarck)
- Students and foster children placed off the reservation are eligible.

# Contract Health Services

All AI/AN should be aware of the following requirements each time he/she is referred or requests IHS to pay for medical care away from an IHS or tribal health care facility.

- Patient responsibility to comply with CHS requirements
- Contract Health Service is not an entitlement program
- CHS Eligibility Requirements
- CHS Notification Requirements (72 hrs, 30 days)
- CHS Patient Process for Authorization for Payment
- Medical/Dental Priority of Care
- Use of Alternate Resource (**Payer of Last Resort**)  
(Medicare, Medicaid, VA, Private Insurance, charity, etc.)
- Appeal Process for Denial of CHS care
- Patient Rights & Responsibilities
- Directory for an IHS or tribal health care facility near your location

# IHS Contract Health

- If a student/transient is covered under CHS, then their dependents also may be covered for CHS up to 180 days if they were eligible for CHS at their original (home) CHSDA. Continued CHS eligibility is not a requirement after 180 days.
- The 180-day rule applies until the client establishes residency and becomes eligible in another CHSDA.

# IHS Medical Priorities Levels

- I. Emergent/Acutely Urgent Care Services (loss of life or limb)
- II. Acute Primary and Preventive Care Services (PNC, mammogram)
- III. Chronic Primary and Secondary Care Services (elective referral, specialty care)
- IV. Chronic Tertiary Care Services (rehab, restorative orthopedics, traditional medicine)
- V. Excluded Services (cosmetic, experimental, abortions, naturopaths)

# Tribal Health Programs

## Standing Rock Tribal Health Administration

- Community Health Representatives
- Oniyapi Program – Suicide Prevention
- Psychology Intern Program
- Youth Wellness
- Chemical Prevention
- Health Education/Healthy Start
- Ambulance Service
- WIC/Food Distribution Program
- Social Services
- Early Childhood Tracking/Head Start

# Tribal Health Programs

- Tribal Health Programs funded via tribal funds or grants obtained by tribes, they exist separate from IHS, yet may work in conjunction with IHS.
- Some lack of coordination between tribal programs and IHS, occasional duplication of services.
- Some tribal health programs do case management and follow-up services: Oniyapi Program, Anpetu Luta Otipi, and similar programs.
- Lack of coordination common between police, health programs, mental health, IHS, social services, and justice system (e.g. silos of care).

# Tribal Health Programs

- IHS not allowed to apply for federal funds, may not compete with tribes for funds, yet there are provisions for applying for grants through and with tribes or through Aberdeen Area Tribal Chairman's Health Board.
- IHS may and does bill for 3<sup>rd</sup> party reimbursement, yet billing efficiency and knowledge is very specific to each local clinic, the unit director, or billing office.
- Patients will not lose benefits through IHS by signing up for Medicaid.

# Medicaid Funding

Reasons AIs don't sign up for Medicaid:

- Process is complicated.
- Usually process has to take place far from home.
- Requires specific and detailed information that may not be available.
- Mobile families.
- Extended Families caring for children/teens.
- Concern at a tribal level that as more people use Medicaid/Medicare, the US government will gradually stop funding IHS.

# Culture: Strength of our Nations

- Resurgence of ceremonies (rights of passage) and traditions
- Mentors and use of time in traditional activities
- Teaching traditional values and ideas re: **health** (power of women, family planning, sacred body, avoid substances)
- Prevention as part of tradition
- Community roles: responsibility for elders, children
- Family roles (extended family, "hunika" relatives)

# Eliminating Health Disparities

- Prevention programs which focus on community strengths to target healthy behaviors: e.g. traditional activities, dance, avoidance of substances (etoh, tob), establish mentor relationships
- Incorporation of traditional health practices/referrals within IHS guidelines and recommendations
- Tribal Governments may enact laws to benefit community health:
  - Allowance/establishment of school based health centers to improve access (decrease teen pregnancy, decrease suicide rate, and improve mental health care access)
  - Required training regarding HIPPA and confidentiality for health care providers/staff and for tribal health staff

# Eliminating Health Disparities

- Development of community health programs to target improved health care access ( e.g. mobile health units; outreach programs to JDC or alternative school, school based clinics)
- Involvement of Tribal communities in promotion of cultural competence for health care provider trainees (e.g. medical students, nursing students, etc..)
- Establishment of cultural competence programs within IHS to ensure that new providers have such training and understanding.
- Men's Health Initiatives



# Eliminating Health Disparities

- Improvement of health care provider training in order to ensure most up to date screening practices and recommendations are being provided/followed (e.g. pap smears, STD screening, HPV vaccine).
- Patient navigator programs
- Vary scheduling practices in order to find best fit for community members
- Offer evening and weekend clinics
- Community outreach – e.g. wacipis, rodeo, fair
- Improve programs and develop media campaign which promote healthy living (e.g. safe sex, avoidance of dangerous situations, abstinence from alcohol/drugs, waiting to have sex, healthy relationships)

# YOU CAN DO IT!!!!



# Minors and Consent

(Guttmacher, 2004)

	Contraceptive Services	Prenatal Care	STD/HIV Services	ETOH/Drug Abuse Treatment	Abortion Services
<b>South Dakota</b>	No law found	No law found	Minor consent	Minor consent	Parental notice required
<b>North Dakota</b>	No law found	No law found	Minor consent > 14yo (PN if HIV test)	Minor consent >14 yo	Parental consent (both)
<b>Minnesota</b>	Minor consent (PN doc discretion)	Minor consent (PN doc discretion)	Minor consent (PN doc discretion)	Minor consent (PN doc discretion)	Parental notice (both)
<b>Nebraska</b>	No law found	No law found	Minor consent	No law found	Parental notice