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North of 60: Cross-border Partnership for Sexual Health in the Arctic

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While each Arctic community (those north of 60 degrees north latitude) is distinct, Arctic regions of North America share similar social, natural, and built environments, cultural mixes, economies, natural resources, and health care settings. They also share disproportionately high rates of sexually transmitted infections (STIs), adolescent pregnancy, sexual abuse, substance abuse, and suicide.

Arctic communities generally lack access to culturally appropriate health education resources and effective contraception. In the United States, higher rates of STIs are reported for Alaska Native and American Indian people than for whites. In Canada, STI surveillance systems rarely collect race and ethnicity; however, evidence suggests an STI disparity for indigenous populations there, as well.

The US and Canada have formed an international partnership to define and address the social and cultural determinants influencing sexual health disparities. A binational summit in Anchorage, Alaska, in 2008 helped foster an international partnership among Alaska Natives in Alaska, and Inuit, First Nations, and Métis in northern Canada.

Summit activities are summarized in the Indian Health Service report, *Sexually Transmitted Diseases among Alaska Native and Inuit, First Nation, and Métis in Canada: Discovering Opportunities for Collaboration*. It identifies opportunities for collaboration in three priority areas: clinical care, prevention interventions and research, and STI education and messaging as they relate to northern communities.

The summit identified several barriers to sexual health. At the community level, social and cultural stigma associated with STI diagnosis discourage people from seeking clinical care, while geographic isolation limit that care and contribute to perceptions that sexual networks are closed, theoretically protecting the community from outside diseases.

Lack of human resource infrastructure, including provider shortages, insufficient training, and high turnover could limit STI services. Some participants believed this to be particularly true in communities that lacked a champion to apply for funding or advocate for prioritization of STIs.

Trust was identified as a potential barrier to STI care. Cultural insensitivity of providers was identified as one of the most important barriers to seeking health care–and one of the most easily corrected. Sometimes the solution was as simple as being visible and approachable at community events. Training health care providers to take a proper sexual history and how to ask questions in a culturally appropriate manner could make STI case identification more efficient and reduce provider discomfort.

The indigenous health care provider paradox was identified as a potential barrier to providing and accessing care. Even when Alaska Native, First Nations, Inuit, and Métis health care providers were available, they may feel uncomfortable asking certain community members questions related to sexual risk because of cultural protocols, especially if the patient is older than the health care provider.

These common barriers of limited health care resources, competing health care interests, health care system and provider mistrust, and cultural insensitivity all transcended differences in American and Canadian health care systems. Overcoming them presents an opportunity for collaboration across borders and communities. Active community participation in the development and implementation of interventions is essential for success, along with support from local community leaders and influential community members.