



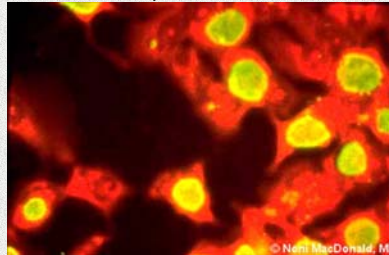
Chlamydia Positivity among American Indian/Alaska Native Women: Comparing Indian Health Service and Infertility Prevention Project Clinic Populations, Region X

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Background

Chlamydia (CT) is the most frequently reported bacterial sexually transmitted disease (STD) in the United States. For 2006, the median state-specific CT test positivity for the United States for women seen in family planning clinics aged 15-24 years was 6.7%.



Chlamydia trachomatis. Infected HeLa cells (fluorescent antibody stain). Photograph taken from Red Book® Online.

IHS Stop Chlamydia Project

For over ten years the Indian Health Service (IHS) has collected positive CT test results through facilities participating in the Stop CT program. In exchange for case report data, IHS provides participating facilities with free azithromycin. Beginning 2006, IHS facilities implementing the Stop CT program expanded data collection to include capturing CT negative test results along with positive case reports. The goal of expanding data collection is to provide more useful information to the program and participating facilities by calculating CT positivity by select demographic variables. An additional purpose of expanding data collection is to become more aligned with the Centers for Disease Control and Prevention (CDC) Infertility Prevention Project (IPP).

CDC Infertility Prevention Project

Since 1988 CDC, in collaboration with the Office of Population Affairs within the Department of Health and Human Services, has supported a national program that focuses on CT screening and treatment services of sexually active women. Partnerships with IPP include state and local STD prevention and family planning (FP) programs, family planning regional training centers and state public health laboratories. IHS has been considered a partner, but recently more collaboration between IHS and IPP has occurred.

Objective

To compare CT testing volume, positivity and screening coverage among American Indian/Alaska Native (AI/AN) women aged 15-24 years screened in IHS and IPP FP facilities in 3 Region X states.

Methods

We analyzed 4,535 IHS and 1,482 IPP CT test records from 6 IHS and Tribal facilities and 92 IPP FP facilities in Alaska (AK), Idaho (ID) and Washington (WA) for AI/AN women aged 15-24 years. CT positivity was calculated by program, facility, state and age groups.

CT screening coverage for IHS was calculated by using the count of individual women visiting the participating IHS facilities as the denominator. Screening coverage for IPP was calculated by using the total number of visits to a Title X FP facility as the denominator. CT screening coverage was calculated by program, facility and state.

Results

In 2006, IHS facilities reported 4,126 CT tests in AK, 190 tests in ID and 219 in WA. IHS CT positivity was 10.0% (AK: 10.3%; ID: 5.3%; WA: 9.1%). IPP FP facilities reported 303 CT tests in AK, 71 tests in ID and 1108 in WA for a total of 1,482 tests, which accounted for only 3.1% of total IPP records among women aged 15-24 years across all race/ethnic groups. IPP CT positivity was 8.7% (AK: 10.9%; ID: 8.5%; WA: 8.1%). For teens aged 15-19 years IHS and IPP CT positivity was 12.1% and 10.9%, respectively.

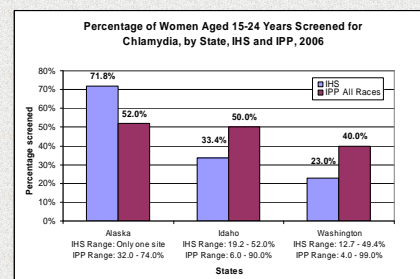
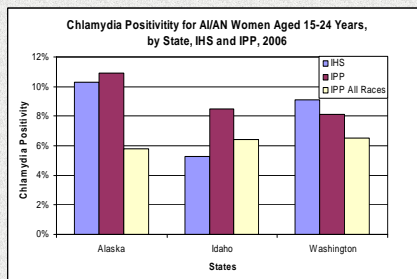
When all races/ethnicities are combined, IPP CT positivity for the AK, ID and WA was 6.2% (AK: 5.8%; ID: 6.4%; WA: 6.5%).

CT Screening coverage overall for IHS was 62.8% (AK: 71.8%; ID: 33.4%; WA: 23.0%). IPP overall screening coverage was 38.3% (AK: 60.0%; ID: 53.0%; WA: 33%).

Conclusion

CT positivity was significant for AI/AN young women seen in both IHS and IPP as compared to overall CT positivity for all races in this region. AI/AN testing volume among IPP FP facilities was surprisingly limited; IHS facility penetration is also modest within the three states. IHS participation in the Stop CT Project declined after increasing required data from facilities in 2006. For IPP, this may be due to IPP clinic locations, client access challenges, or misclassification of patient race.

CT screening coverage varied among the states with AK showing the best screening coverage for both IHS and IPP. Screening coverage for both IHS and IPP is not at a desirable percentage.



Limitations

Small numbers of tests for both IHS and IPP limit analyses that can be done. IHS data include relatively few facilities compared to the total number of facilities that are located in AK, ID and WA.

IHS facilities focus more on primary care, whereas IPP facilities focus more on family planning; thus these data might represent slightly different AI/AN populations.

IPP state CT screening coverage ranges might be skewed due to not all facilities participating in IPP CT testing. Regardless, these facilities are included in calculating the CT screening coverage range. Therefore, CT screening coverage most likely has a smaller range than currently represented, when including CT tests done outside of IPP.

Only IPP collects risk behavior data along with CT screening data, IHS does not currently collect risk behavior data making it difficult to properly evaluate related risk taking behaviors across populations and agencies.

Implications

Community screening coverage should be addressed by collecting census data for AI/AN in the community and determining the percentage of the population who received a CT screen.

Facilities should examine existing program structures and practices to promote greater accessibility, increase service utilization, and ensure culturally appropriate care for identified priority populations.

Standardized risk behavior data should be collected at IHS facilities to be able to better direct screening efforts to those at high risk for contracting CT while facilitating enhanced analysis among both AI/AN internal and external user populations.

Increased participation of IHS facilities is needed in the Stop CT Project in order to increase representative regional AI/AN prevalence data

Increased collaboration and sharing of AI/AN-specific data between IHS and IPP will more clearly define STD disparities among Native communities while increasing capacity to advocate for resources.

Acknowledgments

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