

Section I: Region X Infertility Prevention Project

History

The Region X Chlamydia Project has served as a national model for widespread screening and treatment of women for Chlamydia trachomatis infection. Since 1988, uniform selective screening criteria have been implemented at Title X family planning (FP) clinics in Public Health Service Region X (states of Washington, Idaho, Oregon and Alaska). Beginning in 1993, the Project expanded beyond selective screening in FP clinics to publicly funded STD clinics throughout the four states in the region. In these STD clinics, universal screening of male and female patients has been implemented. In 1994, the Project expanded to other community agencies serving adolescents and women of reproductive age. These agencies included community and migrant health centers, prenatal programs, school-based adolescent centers, non-Title X FP clinics, and juvenile and adult detention.

Due in large part to the success of the Region X Project, the CDC was able to obtain funds from Congress to launch a National Infertility Prevention Program. In 1992, the CDC, through the Office of Population Affairs (OPA), funded regional demonstration projects in Regions III, VII, and VIII. In 1994, Regions IV, V, and IX received development funds. In 1995, the remaining three PHS regions, I, II and VI received development funds. These demonstration projects funded through the Infertility Prevention Projects legislation, aim to reduce the costly and destructive sequelae of chlamydia and other sexually transmitted diseases which are responsible for unintended infertility in women.

Overview

The Region X Infertility Prevention Project (IPP) goal is to control chlamydia through the collaborative efforts of STD and Family Planning providers and Public Health Laboratories. Representatives in each state from these program areas comprise a Regional Chlamydia Executive Committee, which oversees and approves project activities. The Executive Committee meets together at least two times a year and conducts teleconference calls on a quarterly basis. There are three standing subcommittees – Clinical Services, Laboratory, and Data. These subcommittees explore issues, keep abreast of new information related to chlamydia, develop guidelines and standards, and provide recommendations to the full Executive Committee. These committees meet face-to-face before each Executive Committee meeting and as needed by teleconference.

Each state has a designated person from the State STD program responsible for overseeing the Chlamydia project in that state. The Project Coordinator from the Center for Health Training administers regional aspects of the project in Region

X, and provides coordination and support to the Executive Committee and Project. The Regional Data Analyst, also from CHT, provides for the cleaning and analysis of the data and subsequent presentation of that data to CDC and other interested stakeholders. The Centers for Disease Control and Prevention (CDC) provides on-going technical assistance, with current information on testing technology, surveillance, advances in treatment and national morbidity trends.

The CDC provides twice yearly meetings for all ten regional Infertility Prevention Project Coordinators to enhance networking, sharing implementation strategies and to efficiently provide technical assistance and communication to project staff. In addition to coordinator meetings, the CDC facilitates a funding workgroup, comprised of representatives from all ten federal regions. This group meets 1-2 times per year to discuss and provide input to CDC staff on regional needs, distribution of funds and other fiscal/administrative details. Another participant at the national level is a representative from the Association of Public Health Labs (APHL) in the position of National Chlamydia Lab Coordinator.

Magnitude of the Chlamydia Problem (from 1998 CDC Update: Some Facts About Chlamydia and 1998 Surveillance Supplement)

Chlamydia is the most frequently reported infectious disease in the United States. Though 607,602 cases were reported in 1998, an estimated 3 million cases occur annually. Severe under reporting is largely a result of substantial numbers of asymptomatic persons whose infections are not identified because screening is not available. Highlights of reported data are as follows:

From 1984 through 1997, reported rates¹ of chlamydia increased from 3.2 to 207.0 cases per 100,000 population. This trend primarily reflects increased screening, recognition of asymptomatic infection (mainly in women), and improved reporting capacity rather than a true increase in disease incidence.

In 1997, the reported rate of chlamydia for women (335.8) substantially exceeded the rate for men (70.4), due mainly to increased detection of asymptomatic infection in women through screening. Low rates of reported chlamydia among men suggest that many of the partners of women with chlamydia are not screened or treated. As in previous years, 1997 rates of chlamydia were highest in the West and the Midwest, where substantial resources have been committed for organized screening programs.

➤ ***How are adolescents and young women affected?***

As many as 1 in 10 adolescent girls tested for chlamydia is infected. Based on reports to CDC provided by states that collect age-specific data, teenage girls

¹Rates are per 100,000 population.

have the highest rates of chlamydial infection. In these states, 15- to 19-year-old girls represent 46% of infections and 20- to 24-year-old women represent another 33%. These high percentages are consistent with high rates of other STDs among teenagers.

Among women entering the Job Corps in 1998, chlamydia rates ranged from 4.6 – 20.3% by state (20,000 entrants are screened annually). Chlamydial infection is widespread geographically and highly prevalent among these economically disadvantaged young women between 16 and 24 years old.

➤ **What does chlamydia cost?**

The annual cost of chlamydia and its consequences in the United States is more than \$2 billion. The CDC estimates screening and treatment programs can be conducted at an annual cost of \$175 million. Every dollar spent on screening and treatment saves \$12 in complications that result from untreated chlamydia.

Untreated chlamydia can cause severe and costly reproductive health problems. Up to 40% of untreated chlamydia infections will develop into PID. Of those with PID, 20% will become infertile, 18% will suffer from debilitating chronic pelvic pain, and 9% will have a life-threatening ectopic pregnancy. In young men, untreated chlamydia typically causes urethral infection, but may also result in complications such as swollen and tender testicles.

Evidence suggests that a comprehensive screening, treatment, partner referral and education program can significantly reduce the prevalence of chlamydia. Using relatively low cost screening and treatment methods available, the Region X Chlamydia project seeks to reduce the prevalence of the disease, thereby controlling any further escalation in cost, both human and financial, from the serious sequelae of untreated Chlamydia infection.

Several studies have demonstrated that targeting screening efforts to those clients of highest risk detects the majority of chlamydia while limiting the costs associated with universal screening of sexually active individuals. Since 1988, the Region X Chlamydia project has successfully used a selective screening approach in Title X family planning clinics. Information derived over 9 years from our own family planning clinics, combined with recommendations for screening criteria published by the CDC in the MMWR, 1993, and 1998 (Vol. 47, No. RR-1) has guided the Region X Chlamydia project in determining screening criteria used in other community-based organizations.

Region X Chlamydia Project: Goals and Objectives

Goal: To assess and reduce the prevalence of chlamydia and chlamydia-related complications in populations at risk for the disease. The collaborative efforts of STD, family planning providers, expansion sites, and the public health laboratories, a program of consistent screening, treatment, education, partner management, and data collection, provides the framework for reducing the prevalence.

Objectives: Specific objectives for each state vary each year. The primary infrastructure objectives include:

1. Maintain current screening and treatment activities in FP and STD clinics and Expansion sites in WA, OR, AK and ID. The following is a general summary of CT testing and treatment that occurs at clinics within Region X. Figures are approximate and based on 1998 test records.

Sex:	Measure	Tests
	Female	134,000
	Male	22,000

WA	OR	ID	AK
75,000	50,000	20,000	11,000

Clinic Type:	Tests	
	Female	Male
Family Planning (Title X)	74,000	1,500
STD	13,000	15,000
Other expansion sites	47,500	5,500

The major types of clinics covered under "expansion sites" include the following testing levels for **female** clients:

Community Health	19,000
Non-Title X	14,000
Migrant Health	4,500
H.S./College Health	6,000
Teen/Women's Clinics	2,500
Corrections	2,000

Treatment was provided directly to 5,500 female and 2,500 male patients screened at participating sites. It is estimated that about 12,000 partner contacts were also treated.

➤ **Family Planning**

Provide selective screening of approximately 74,000 female clients annually in 196 Title X Family Planning clinics:

WA	OR	ID	AK
32,000	25,000	15,000	2,000

➤ **STD Clinics**

Continue universal screening of approximately 13,000 female STD clients in 126 STD/Health Districts:

WA	OR	ID	AK
5,500	5,500	1,500	500

Male screening in STD clinics is provided with other STD funds.

➤ **Expansion Sites**

Continue selective screening of approximately 47,500 females in 189 agency sites serving women at risk:

Community Health:	WA	11,000	OR	1,500
	ID	500	AK	6,000
Non-Title X	WA	7,000	OR	5,500
			AK	1,500
Migrant Health:	WA	3,000	OR	1,500
H.S./College Health:	WA	2,000	OR	3,000
	ID	1,000		
Teen/Women's Clinics:	WA	2,500		
Corrections	WA	1,000	OR	500
			AK	500

➤ **Provide Treatment**

Provide treatment to almost 25,500 CT positive clients and partner contacts:

WA	OR	ID	AK
13,500	7,800	2,000	2,200

Objectives (cont.):

2. Maximize cooperation and collaboration among the 4 STD project areas, 7 regional FP grantees, 4 participating public health laboratories, STD/chlamydia research sites, and other regional collaborators through advisory board meetings and conference calls.
 - Monitor project success in serving the intended population, quality of services, efficient and appropriate use of funds, and adherence to regional standards.
 - Conduct needs assessments in the areas of training, quality assurance efforts, customized data analysis, etc.
 - Participate in national meetings with other Regional Project staff, CDC, special workgroups and researchers to further the national project goals.
 - Provide public and professional education and training regarding the prevention, nature, and consequences of chlamydia infection.
 - Provide technical assistance and act as a resource for the three Region X subcommittees (laboratory, data, and clinical services) on chlamydia-related issues.
 - Monitor the components of data collection system including the data entry process, data cleaning, and data report generation; Send summary data to each project area and the CDC on a quarterly basis.
3. Maintain and expand quality assurance plan to evaluate medical, laboratory, treatment and education services.
 - Through project areas conduct uniform training in all sites regarding protocols for specimen and data collection; distribute specimen collection video to all sites.
 - Assist project areas in efforts to monitor selective screening criteria and clinical protocols via selected chart review.
 - Continue established system for assessing laboratory quality assurance for automated tests.
 - Continue protocols for confirmatory testing and revise when indicated.

CT Project Executive Committee

Voting Members

	Alaska	Idaho	Oregon	Washington
STD	Susan Jones	Anne Williamson	Doug Harger	Larry Klopfenstein
Family Planning	Cathy Feaster	Susan Ault	Carol Elliott	Sandee Knuttgen
LAB	Rose Tanaka	Roy Moulton Sadika Kobic (alt)	Ed Schulmerich	Romesh Gautom
Other	Tony Bell	Ella Gordon	Chris Biggs	Katherine Gudgel

Non-Voting Members

REGION X INFRASTRUCTURE	
Elizabeth Patrick:	Project Coordinator
Scott LaMontagne:	Data Analyst
Wendy Lewis:	Project Assistant

COMMITTEE CHAIRS	
Karen Crouse:	Lab
Doug Harger:	Data
Chris Knutson:	Clinical Services

CDC PROGRAM STAFF	
Mac McCraw:	Program Consultant
Dorothy Gunter:	National IPP Coordinator
Rick Steece:	National Lab Consultant

CT Project Subcommittee Membership

	LAB	DATA	CLINICAL SERVICES
	Karen Crouse, Chair - Spokane Lab	Doug Harger, Chair - OR	Chris Knutson, Chair - WA
AK:	Rose Tanaka	Susan Jones	Tony Bell Cathy Feaster
ID:	Roy Moulton Sadika Kobic	Anne Williamson	Susan Ault Clare Howland Ella Gordon
OR:	Ed Schulmerich Christianne Biggs	Doug Harger	Carol Elliott Dr. Mark Nichols - Consultant
WA:	Jay Lewis Romesch Gautom	Larry Klopfenstein Katherine Gudgel	Sandee Knuttgen Vivien Hanson, MD
UW Research:	Linda Cles	Debra Cibene Barbara Krekeler	Jeanne Marrazzo, MD
P.H. Region Office / Other		Karen Cormier – FP Data Manager Scott LaMontagne Research Analyst CHT	Kelly Culbert – Seattle STD Prevention Training Center