Sexually Transmitted Disease Surveillance 2003 Supplement

Chlamydia Prevalence Monitoring Project Annual Report 2003

Division of STD Prevention
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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The report is also available by Internet via the CDC home page at:

http://www.cdc.gov/std/Chlamydia2003/

Preface

Chlamydia Prevalence Monitoring Project Annual Report, 2003 presents statistics and trends for *Chlamydia trachomatis* in the United States through 2003. This annual publication is intended as a reference document for policy makers, program managers, health planners, researchers, and others who are concerned with the public health implications of this disease. The figures and tables in this edition supersede those in earlier publications of these data.

The surveillance information in this report is based on the following sources of data: (1) case reporting from all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands; and (2) prevalence data from the Regional Infertility Prevention Projects, the National Job Training Program, the Jail Prevalence Monitoring Project, and the Indian Health Service.

Chlamydia Prevalence Monitoring Project Annual Report, 2003 consists of three parts. The **National Profile** contains text and figures that provide an overview of chlamydia surveillance in sexually active women and men in the United States. It also includes the sources and limitations of the data used to produce this report. The **Regional Profiles** contain chlamydia trend data in women in all ten HHS regions. The **State Profiles** provide statistical information about chlamydia in women in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands. The **City Profiles** provide statistical information about chlamydia in women for selected cities.

Any comments and suggestions that would improve the usefulness of future publications are appreciated and should be sent to the Division of STD Prevention at **DSTD@cdc.gov**

Acknowledgments

This report would not have been possible without the contributions of the State and Territorial Health Departments, the STD Programs, the Regional Infertility Prevention Projects, the Office of Population Affairs, the Jail STD Prevalence Monitoring Project, the Adolescent Women Reproductive Health Monitoring Project, the Indian Health Service, and the U.S. Department of Labor which provided surveillance data to the Centers for Disease Control and Prevention.

This report was prepared by the following staff members of the Surveillance and Special Studies Team of the Epidemiology and Surveillance Branch and the Statistics and Data Management Branch of the Division of STD Prevention, National Center for HIV, STD, and TB Prevention, Centers for Disease Control and Prevention: Susan Bradley, Jim Braxton, Sharon Clanton, Darlene Davis, Linda Webster Dicker, LaZetta Grier, Kathleen Hutchins, Riduan Joesoef, Elvin MaGee, Garrett Mallory, Debra Mosure, Emmett Swint and Kimberly Thomas.

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To view the State and City Profiles, please use the drop down boxes on **http://www.cdc.gov/std/Chlamydia2003/**

Chlamydia Prevalence Monitoring Project Annual Report – 2003

The Centers for Disease Control and Prevention's (CDC) Chlamydia Prevalence Monitoring Project is a collaborative effort among the Regional Infertility Prevention Projects, federally-funded STD programs, state epidemiologists, public health laboratory directors, the U.S. Department of Labor, and the Indian Health Service (IHS). The purpose of the project is to monitor the prevalence of genital *Chlamydia trachomatis* infections among women screened for this infection in the United States through publicly-funded programs. The data presented on chlamydial infection in this report complement and supplement data presented in CDC's *Sexually Transmitted Disease Surveillance, 2003*.[1]

Introduction

Since 1988, CDC has supported screening programs for *Chlamydia trachomatis* infections and has monitored positivity to evaluate program impact. As documented by chlamydia case reporting (i.e., morbidity) data, case rates following initiation of chlamydia screening and treatment programs have resulted in increases in cases detected and reported. To minimize the impact of variation in chlamydia testing and reporting on the interpretation of surveillance data, CDC, states, and Regional Infertility Prevention Projects use screening positivity data to estimate chlamydia prevalence among selected populations. This report compares data on chlamydia prevalence in selected populations with data reported to CDC through the case reporting system.

Sources of Data

Regional Infertility Prevention Projects

Chlamydia screening and prevalence monitoring activities were initiated in Health and Human Services (HHS) Region X in 1988 as a CDC-supported demonstration project. In 1993, as part of the development of the National Infertility Prevention Program, chlamydia screening services for women were initiated in three additional HHS regions (III, VII, VIII) and in 1995 services were implemented in the remaining HHS regions (I, II, IV, V, VI, IX).[2,3] All regional projects, in collaboration with state STD control and family planning programs, report their chlamydia positivity data to CDC. In some of the HHS regions, federally-funded chlamydia screening supplements existing local- and state-funded testing programs. These publicly-funded programs support chlamydia screening primarily in family planning clinics, but also in some STD clinics, prenatal clinics, jails and juvenile detention centers, and other sites.

The ten Health and Human Services (HHS) regions referred to in the text and figures are as follows: Region I = Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont; Region II = New Jersey, New York, Puerto Rico, and U.S. Virgin Islands; Region III = Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia; Region IV = Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee; Region V = Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin; Region VI = Arkansas, Louisiana, New Mexico, Oklahoma, and Texas; Region VII = Iowa, Kansas, Missouri, and Nebraska; Region VIII = Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming; Region IX = Arizona, California, Hawaii, and Nevada; and Region X = Alaska, Idaho, Oregon, and Washington.

State and Local Health Departments

As of 2000, all 50 states and the District of Columbia have regulations requiring the reporting of chlamydia cases.

Corrections Facilities

In 2003, 34 states reported chlamydia screening data from corrections facilities. These data were reported as part of the Jail STD Prevalence Monitoring Project, the Adolescent Women Reproductive Health Monitoring Project, the Syphilis Elimination Initiative, the Regional Infertility Prevention Projects, or in response to CDC's request for data.

National Job Training Program

Since 1990, approximately 20,000 female National Job Training Program entrants have been screened each year for chlamydia, with all tests performed at a central laboratory using a single test type.[4] Since July 2003, all male National Job Training Program entrants have been screened for Chlamydia. Changes in laboratory and test type (EIA to DNA probe) occurred in

mid-1997. The National Job Training Program, administered by the U.S. Department of Labor, is primarily a residential job training program for urban and rural economically-disadvantaged youth aged 16 to 24 years at more than 100 sites throughout the country. The U.S. Department of Labor makes these chlamydia test results available to CDC to calculate prevalence in this population.

Indian Health Service

In 2003, approximately 8,000 women aged 15-30 years were screened at 22 facilities in two of 12 Indian Health Service (IHS) areas. The Indian Health Service provided these data to CDC.

The 12 Indian Health Service (IHS) areas referred to in the text and figures are as follows, with overlap in some states: Aberdeen Area (Iowa, North Dakota, Nebraska, and South Dakota); Alaska Area (Alaska); Albuquerque Area (Colorado and New Mexico); Bemidji Area (Illinois, Indiana, Michigan, Minnesota, and Wisconsin); Billings Area (Montana and Wyoming); California Area (California); Nashville Area (Alabama, Connecticut, Florida, Louisiana, Maine, Maryland, Massachusetts, Mississippi, New York, North Carolina, Rhode Island, South Carolina, and Tennessee); Navajo Area (Arizona, New Mexico, and Utah); Oklahoma City Area (Kansas, Oklahoma, and Texas); Phoenix Area (Arizona, Nevada and Utah); Portland Area (Idaho, Oregon, and Washington); and Tucson Area (Arizona).

Data Limitations

The interpretation of chlamydia data is complicated by several factors. First, case reports and prevalence data result from the use of several different types of diagnostic tests for chlamydial infection (e.g., direct fluorescent antibody, EIA, DNA probe assay, DNA amplification); these tests vary in their sensitivity and specificity. Second, chlamydia positivity in women attending clinics is an estimate of prevalence; it is not true prevalence. Crude positivity may include those women who are tested two or more times during a single year. Comparisons of positivity with prevalence have shown that in family planning clinics, positivity is generally similar to or slightly higher than prevalence, and in STD clinics, positivity is somewhat lower than prevalence; however, these differences are usually small, with the relative difference <10%.[5] Third, while nearly all family planning clinics perform universal screening of sexually active women <20 years of age, and most clinics do so among women <25 years of age, some selective screening is performed among women 20- to 24-years old and selective screening is frequently performed among women ≥25 years of age. Fourth, while monitoring prevalence among persons seeking care at clinics provides important information on certain segments of the population, these data cannot be generalized to the population as a whole.

The data from the National Job Training Program are an exception to the first three caveats. Most of the tests are performed using a single test type. Data are limited to entrance exam testing; therefore, no one is included twice. All persons entering the National Job Training Program are required to be tested.

As noted above, various laboratory test methods were used for all data. Except for Figures 4, 5, and 12-21, the figures presented do not include an adjustment of test positivity based on laboratory test type and sensitivity. The chlamydia test results for each test type were weighted to reflect the sensitivity of the test used.[6] These test-specific sensitivities were defined as estimates from published evaluations of chlamydia screening tests.[7,8] Limitations of this adjustment include unknown dates when laboratories changed tests, missing information on the type of test used, variation of test sensitivity within a technology type and among laboratories, and no adjustment for use of supplemental methods that could increase test sensitivity.

Chlamydia Data – 2003

Case reports

In 2003, 877,478 chlamydial infections were reported to CDC from 50 states and the District of Columbia. The reported number of cases of chlamydial infection was more than two times greater than the reported cases of gonorrhea (335,104 gonorrhea cases were reported in 2003). From 1987 through 2003, the reported rate of chlamydial infection in women increased from 78.5 cases to 466.9 cases per 100,000 population (Figure 1). These increases in the reported national chlamydia rate likely represent increased chlamydia screening, increased use of nucleic acid amplification tests which are more sensitive than other types of screening tests, and improved reporting, as well as the continuing high burden of disease.

In 2003, state- and outlying area-specific chlamydia rates among women ranged from 78.7 per 100,000 to 462.3 per 100,000 (Figure 2). This variation in rates reflects both state-specific differences in screening and reporting practices, and in true disease burden.

Chlamydia positivity in women in family planning and prenatal clinics

In 2003, the median state-specific chlamydia test positivity in 15- to 24-year-old women who were screened at selected family planning clinics in all states, the District of Columbia, Puerto Rico, and the Virgin Islands was 5.9% (range, 2.8% to 18.9%, Figure 3).

The effectiveness of large-scale screening programs in reducing chlamydia prevalence has been documented in areas where this intervention has been in place for several years.[9,10] In 2003, after adjusting trends in chlamydia positivity to account for changes in laboratory test methods and associated increases in test sensitivity, chlamydia test positivity in women aged

15-24 years screened in family planning clinics decreased in four of 10 HHS regions from 2002 to 2003, increased in five regions and remained the same in one region (Figure 4). Similar trends in positivity are seen for adolescent women aged 15-19 years screened in family planning clinics (Figure 5). Although chlamydia positivity has declined in the past year in some regions due to the effectiveness of screening and treatment of women, continued expansion of screening programs to populations with higher disease prevalence may have contributed to the increases in positivity in other regions.

In 2003, the median state-specific chlamydia test positivity among 15- to 24-year-old women screened in selected prenatal clinics in 27 states and the Virgin Islands was 7.4% (range, 2.4% to 19.7%, Figure 6).

Chlamydia prevalence in National Job Training Program entrants

In women entering the National Job Training Program in 2003, based on their place of residence before program entry, state-specific chlamydia prevalence ranged from 3.4% to 16.0% in 39 states and Puerto Rico (Figure 7). The median state-specific chlamydia prevalence was 9.9%.

In men entering the program from 38 states and Puerto Rico from July through December 2003, the median state-specific chlamydia prevalence was 7.8% (range 1.5% to 12.7%) (Figure 8)

Chlamydia positivity in women and men entering juvenile and adult corrections facilities

Data on positivity of chlamydial infection entering juvenile or adult corrections facilities were reported to CDC from 34 states (Figure 9). In adolescent women entering juvenile detention facilities, the median facility positivity for chlamydia was 15.9% (range 2.7% to 33.5%); positivity was greater than 10% in 37 of 48 facilities reporting data. In adult women entering 36 corrections facilities, the median positivity for chlamydia was 6.3% (range 1.3% to 19.2%).

The median chlamydia positivity in adolescent men entering 64 juvenile corrections facilities was 5.4% (range 1.3% to 12.9%) (Figure 10). In adult men entering 37 corrections facilities, the median positivity was 6.4% (range 1.0% to 27.1%)

Chlamydia positivity in women attending Indian Health Service clinics

In 2003, chlamydia positivity in 15- to 30- year-old women screened at clinics in two IHS areas was 11% (Figure 11).

Notes on State and City Profiles

Morbidity Surveillance: Reporting of Chlamydia Cases

Figure A. Chlamydia rate per 100,000 women, 1994 - 2003.

Crude incidence rates (new cases/population) were calculated on an annual basis per 100,000 population. In this report, the 2003 rates for all states were calculated by dividing the number of cases reported from each area in 2003 by the estimated area-specific 2000 population. Rates for 1994-2003 were calculated using postcensal population estimates based on the Bureau of the Census data (U.S. Bureau of the Census; 1991-2000 Estimates of the Population of Counties by Age, Sex and Race/Hispanic Origin: 1990 to 2000; machine-readable data files).

Prevalence Monitoring: Reporting of Chlamydia Positivity

Figure B. Chlamydia positivity among women 15 to 24 years of age, by testing site, 1994-2003

Table 1. Chlamydia positivity among women 15 to 44 years of age, by testing site, 2003

Figure C. Chlamydia positivity by age group in women attending family planning clinics, 2003

Chlamydia test positivity was calculated by dividing the number of women testing positive for chlamydia (numerator) by the total number of women tested for chlamydia (denominator includes those with valid test results only and excludes unsatisfactory and indeterminate tests) and was expressed as a percentage. The denominator may contain multiple tests from the same individual if that person was tested more than once during the period for which screening data are reported. Various chlamydia laboratory methods were used and no adjustments of test positivity were made based on laboratory test type and sensitivity. Chlamydia prevalence data on female National Job Training Program entrants are not presented when the number of persons tested from a state was fewer than 100. The number of clinics cited in Table 1 for each state or city represents family planning (FP), sexually transmitted disease (STD), prenatal, Indian Health Service (IHS), and other clinics screening 25 or more women and juvenile and adult corrections facilities screening 100 or more women.

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[9]Addiss DG, Vaugh ML, Ludka D, Pfister J, Davis JP. Decreased prevalence of Chlamydia trachomatis infection associated with a selective screening program in family planning clinics in Wisconsin. *Sex Transm Dis* 1993;20:28-35.

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Figure 1. Chlamydia — Rates by sex: United States, 1984–2003

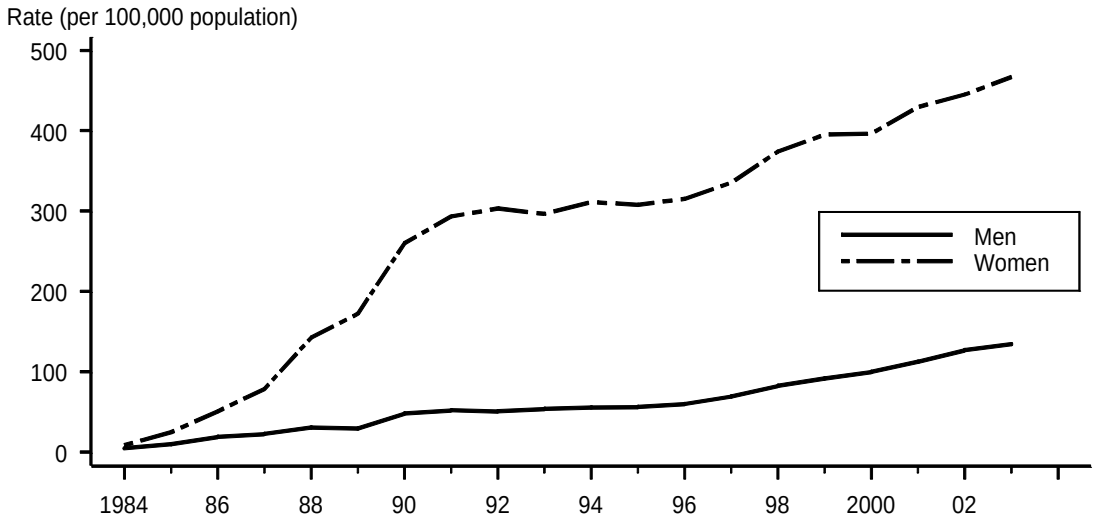
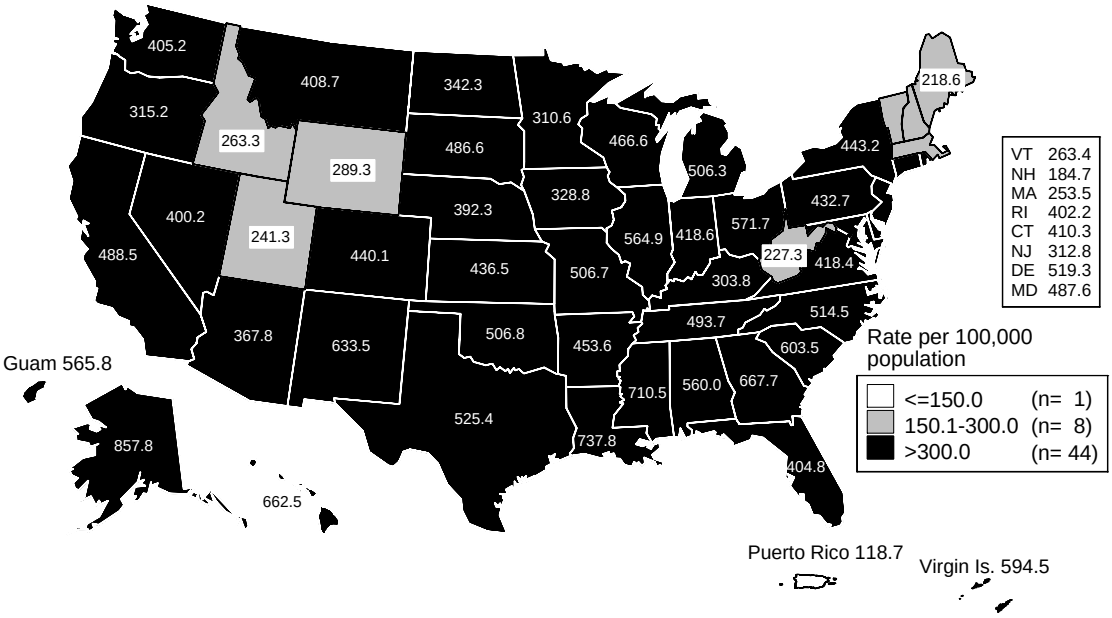
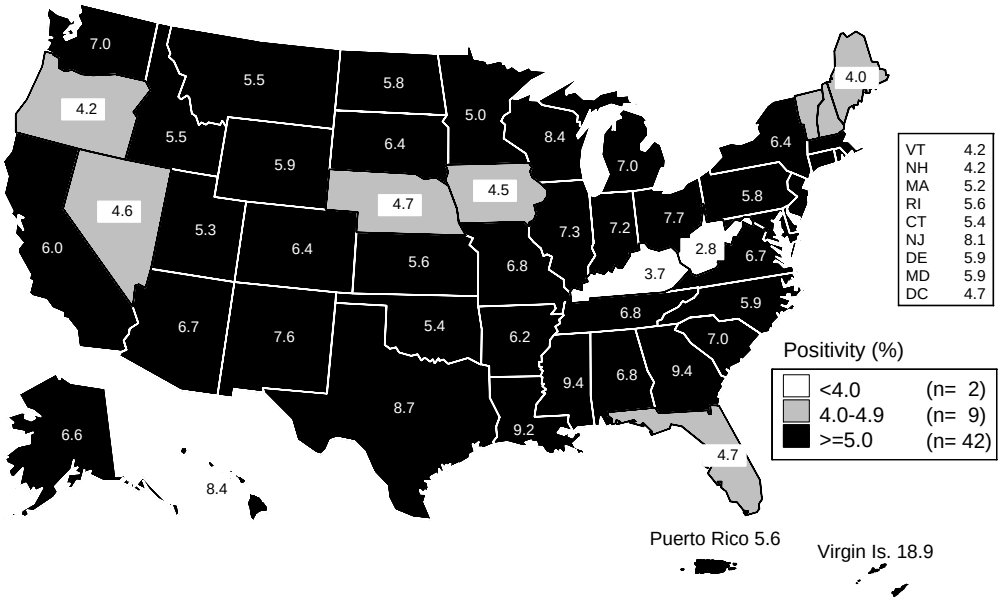


Figure 2. Chlamydia — Rates for women by state: United States and outlying areas, 2003



Note: The total rate of chlamydia for women in the United States and outlying areas (Guam, Puerto Rico and Virgin Islands) was 462.3 per 100,000 female population.

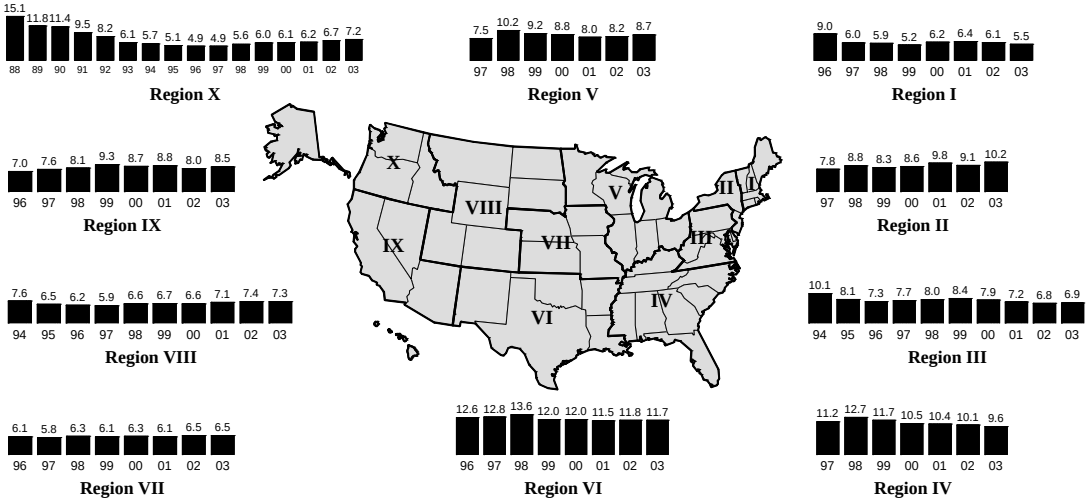
Figure 3. Chlamydia — Positivity among 15-24 year old women tested in family planning clinics by state, 2003



Note: Includes states and outlying areas that reported chlamydia positivity data on at least 500 women aged 15-24 years screened during 2003.

SOURCE: Regional Infertility Prevention Projects; Office of Population Affairs; Local and State STD Control Programs; Centers for Disease Control and Prevention

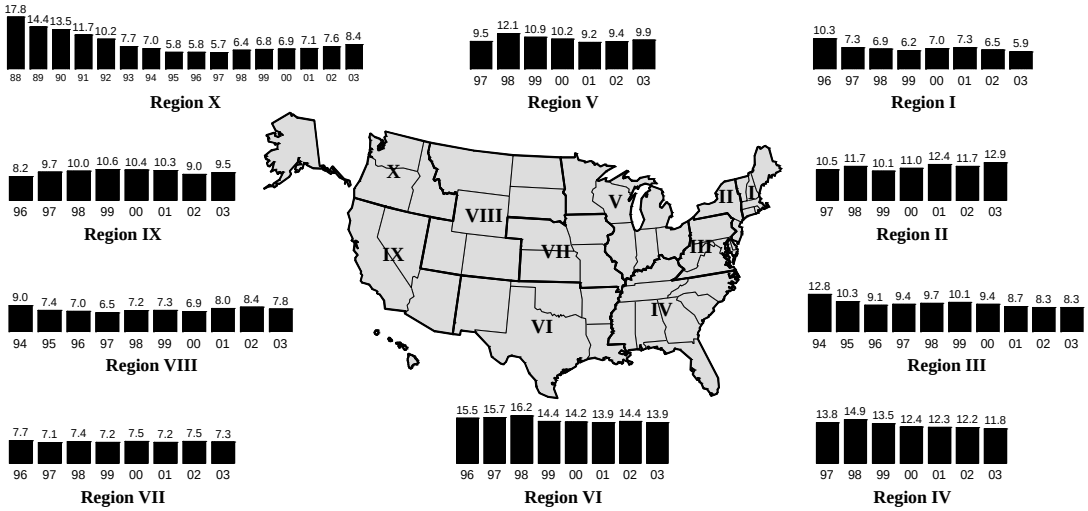
Figure 4. Chlamydia — Trends in positivity in 15- to 24-year old women tested in family planning clinics by HHS regions, 1988–2003



Note: Trends adjusted for changes in laboratory test method and associated increases in test sensitivity. No data on laboratory test method available for Region VII in 1995 and Regions IV and V in 1996.

SOURCE: Regional Infertility Prevention Projects; Office of Population Affairs; Local and State STD Control Programs; Centers for Disease Control and Prevention

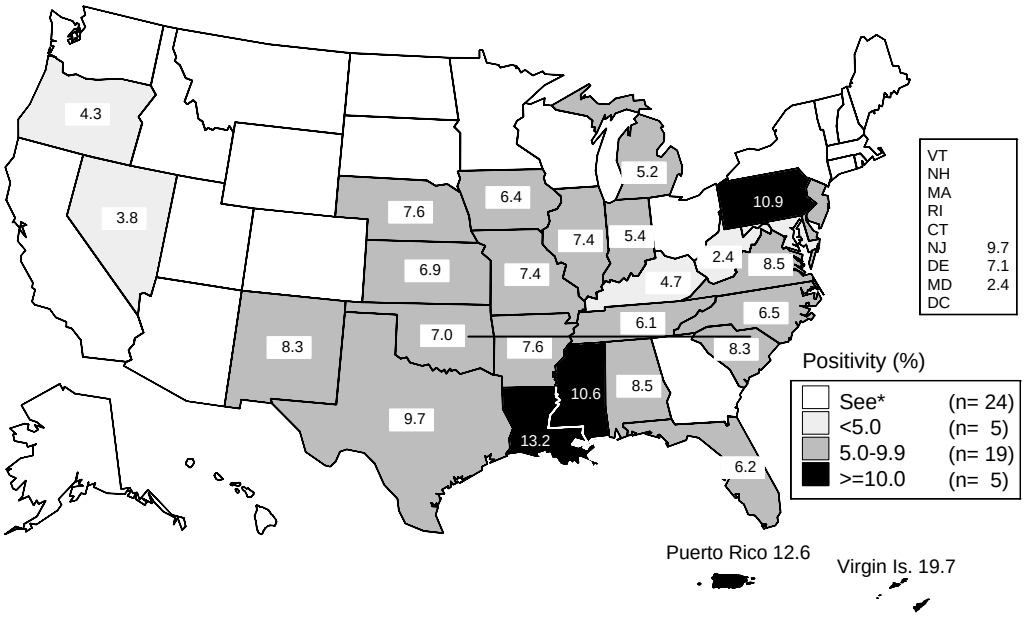
Figure 5. Chlamydia — Trends in positivity in 15- to 19-year-old women tested in family planning clinics by HHS regions, 1988-2003



Note: Trends adjusted for changes in laboratory test method and associated increases in test sensitivity. No data on laboratory test method available for Region VII in 1995 and Regions IV and V in 1996.

SOURCE: Regional Infertility Prevention Projects; Office of Population Affairs; Local and State STD Control Programs; Centers for Disease Control and Prevention

Figure 6. Chlamydia — Positivity in 15- to 24-year-old women tested in prenatal clinics by state: United States and outlying areas, 2003

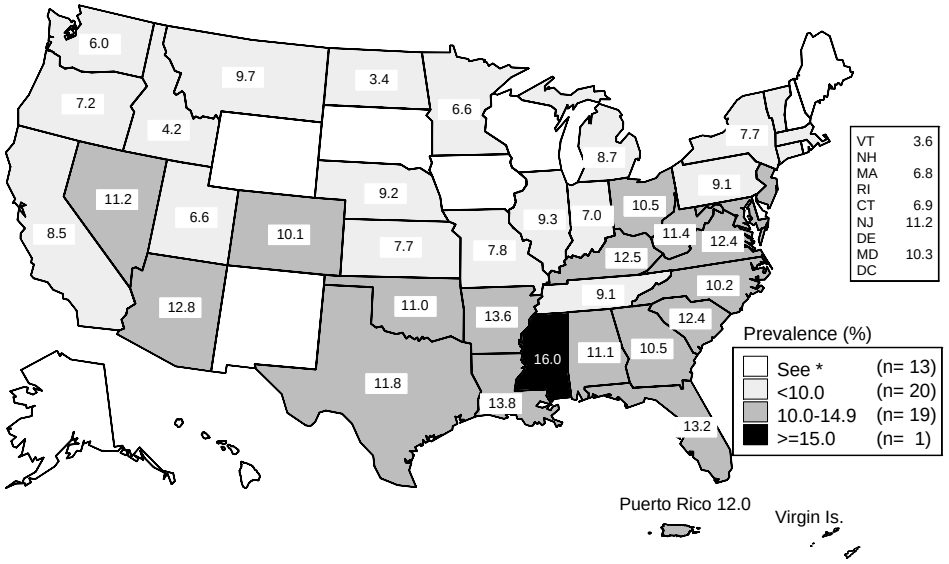


*States not reporting Chlamydia positivity data in prenatal clinics.

Note: Includes states and outlying areas that reported Chlamydia positivity data on at least 100 women aged 15-24 years during 2003.

SOURCE: Regional Infertility Prevention Projects; Office of Population Affairs; Local and State STD Control Programs; Centers for Disease Control and Prevention

Figure 7. Chlamydia — Prevalence in 16- to 24-year-old women entering the National Job Training Program by state of residence: United States and outlying areas, 2003

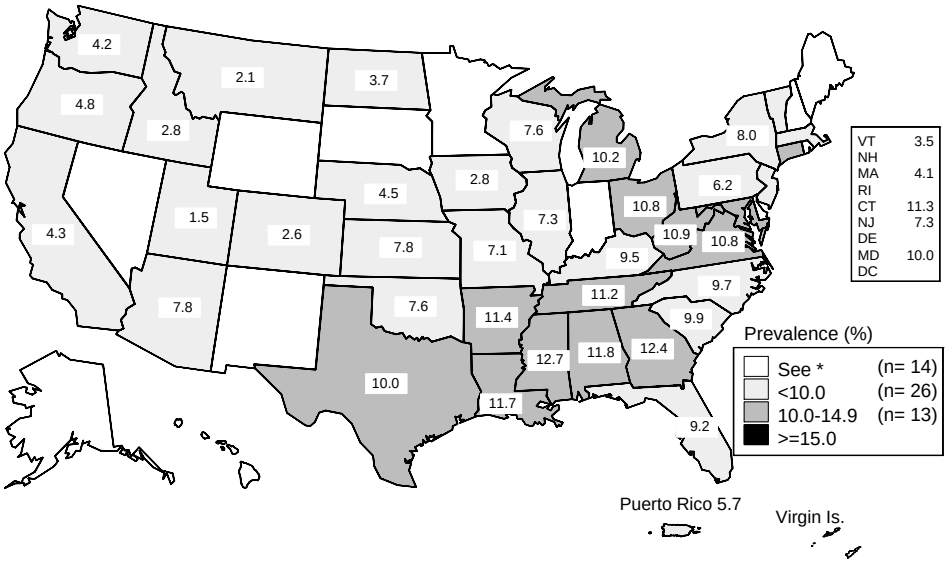


*Fewer than 100 women residing in these states and entering the National Job Training Program were screened for chlamydia in 2003.

Note: The overall Chlamydia prevalence in female students entering the National Job Training Program in 2003 was 9.9%.

SOURCE: U.S. Department of Labor

Figure 8. Chlamydia — Prevalence in 16- to 24-year-old men entering the National Job Training Program by state of residence: United States and outlying areas, 2003

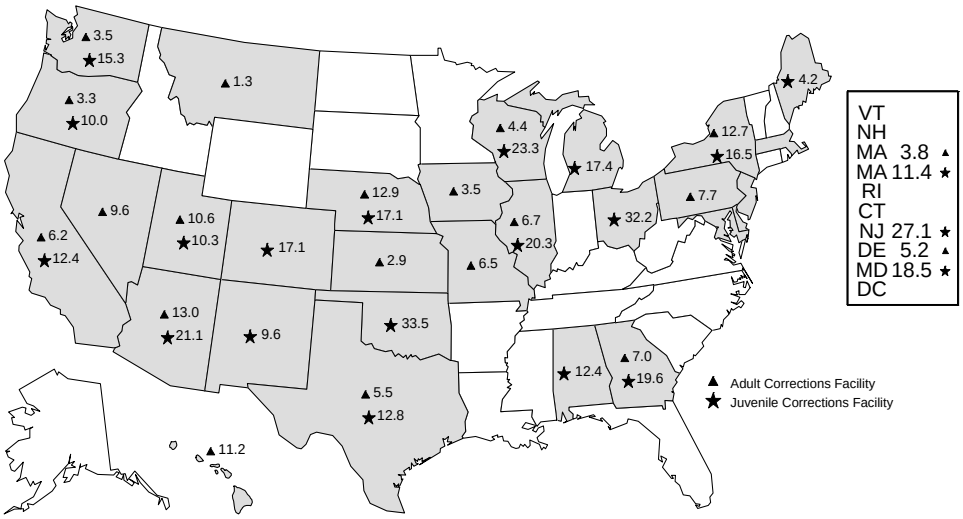


*Fewer than 100 men residing in these states and entering the National Job Training Program were screened for chlamydia in 2003.

Note: The overall chlamydia prevalence in male students entering the National Job Training Program in 2003 was 8.0%. Men were screened from July through December 2003.

SOURCE: U.S. Department of Labor

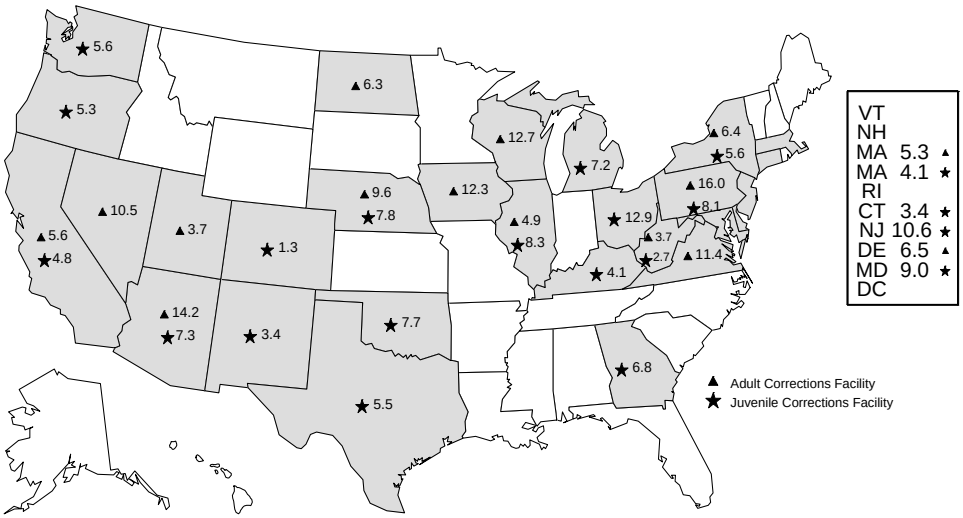
Figure 9. Chlamydia — Positivity in women entering juvenile and adult corrections facilities, 2003



Note: The median positivity is presented from facilities reporting >100 test results. Arizona, California, Hawaii, Illinois, Massachusetts, Nevada, New York, Pennsylvania, Texas, Utah, and Wisconsin submitted data from more than one adult corrections facility. Alabama, Arizona, California, Illinois, Michigan, New York, Texas and Washington submitted data from more than one juvenile corrections facility.

SOURCE: Jail STD Prevalence Monitoring Project; Adolescent Women Reproductive Health Monitoring Project; Regional Infertility Prevention Projects; Local and State STD Control Programs; Centers for Disease Control and Prevention

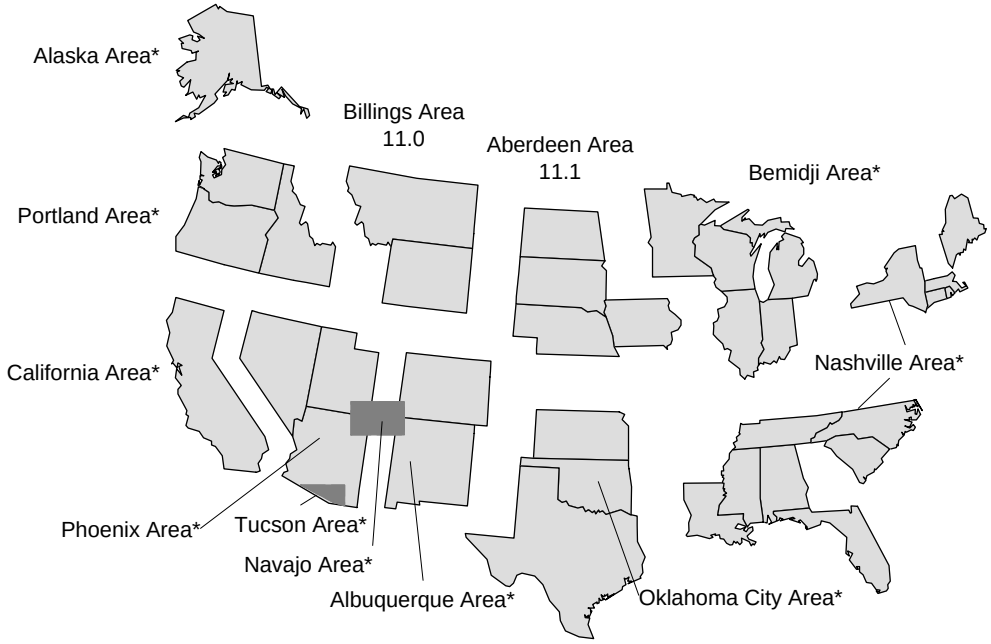
Figure 10. Chlamydia — Positivity in men entering juvenile and adult corrections facilities, 2003



Note: The median positivity is presented from facilities reporting >100 test results. Arizona, California, Massachusetts, Nebraska, Nevada, New York, Wisconsin, Pennsylvania, Utah, and West Virginia submitted data from more than one adult corrections facility. Arizona, California, Illinois, Kentucky, Maryland, Massachusetts, Michigan, New Jersey, New York, Oklahoma, Oregon, Texas, and Washington submitted data from more than one juvenile corrections facility.

SOURCE: Jail STD Prevalence Monitoring Project; Regional Infertility Prevention Projects; Local and State STD Control Programs; Centers for Disease Control and Prevention

Figure 11. Chlamydia — Positivity in 15- to 30-year-old women tested in Indian Health Service (HIS) Clinics by IHS areas, 2003

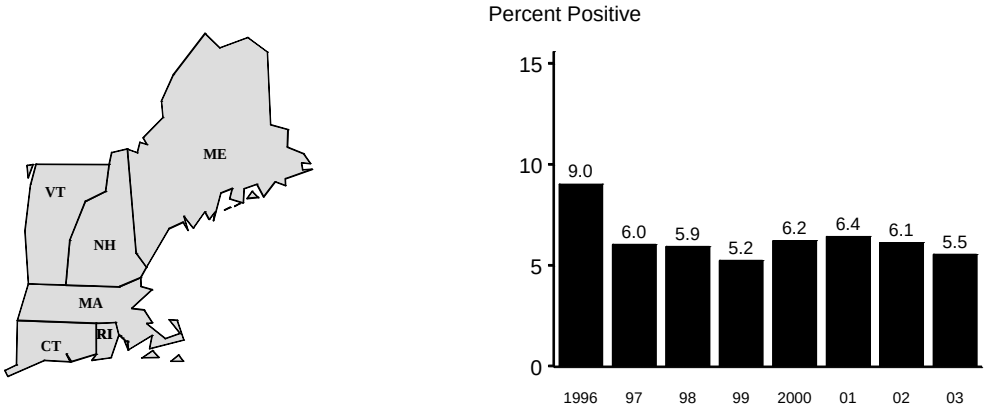


*IHS areas not reporting chlamydia positivity data during 2003.

SOURCE: Indian Health Service

Regional Profiles

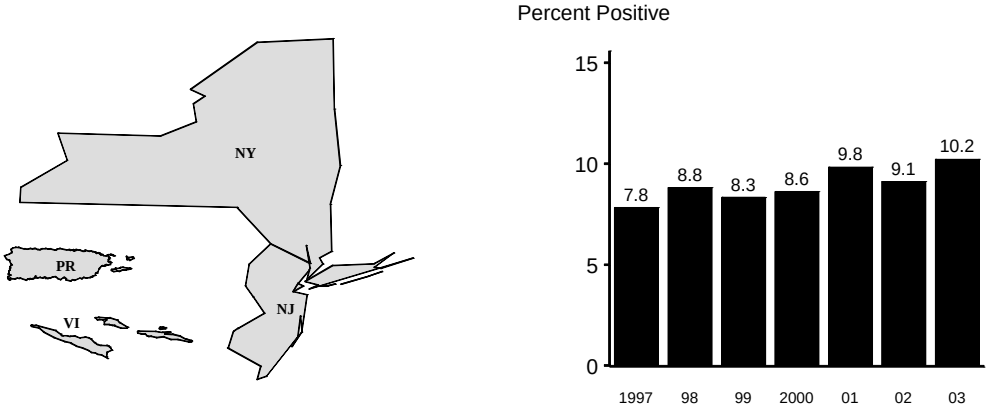
Figure 12. Chlamydia — Trends in positivity in 15- to 24-year-old women tested in family planning clinics: Region I, 1996-2003



Note: Trends adjusted for changes in laboratory test method and associated increases in test sensitivity.

SOURCE: Regional Infertility Prevention Projects; Office of Population Affairs; Local and State STD Control Programs; Centers for Disease Control and Prevention

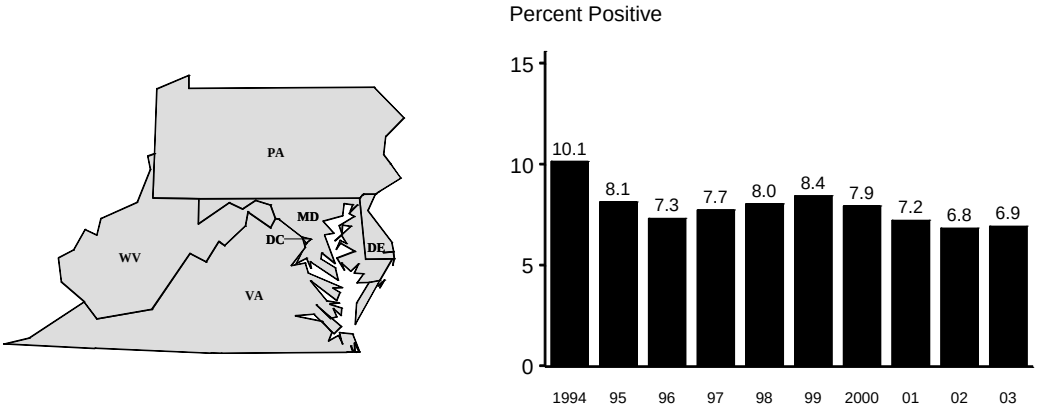
Figure 13. Chlamydia — Trends in positivity in 15- to 24-year-old women tested in family planning clinics: Region II, 1996-2003



Note: Trends adjusted for changes in laboratory test method and associated increases in test sensitivity.

SOURCE: Regional Infertility Prevention Projects; Office of Population Affairs; Local and State STD Control Programs; Centers for Disease Control and Prevention

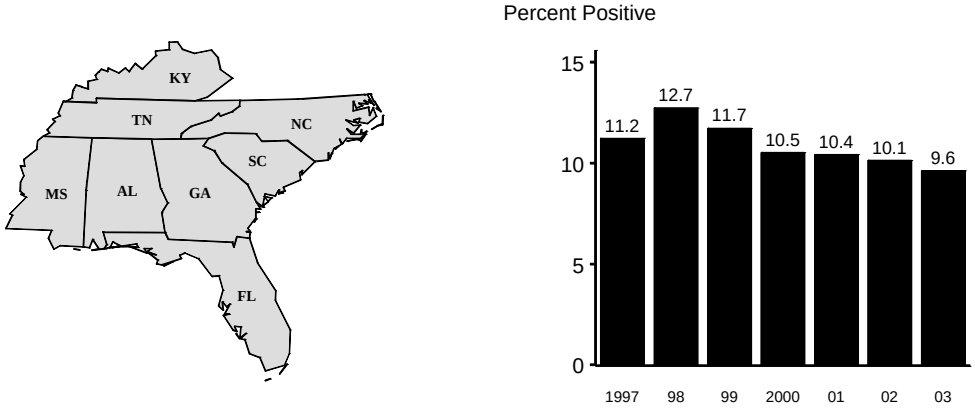
Figure 14. Chlamydia — Trends in positivity in 15- to 24-year-old women tested in family planning clinics: Region III, 1996-2003



Note: Trends adjusted for changes in laboratory test method and associated increases in test sensitivity.

SOURCE: Regional Infertility Prevention Projects; Office of Population Affairs; Local and State STD Control Programs; Centers for Disease Control and Prevention

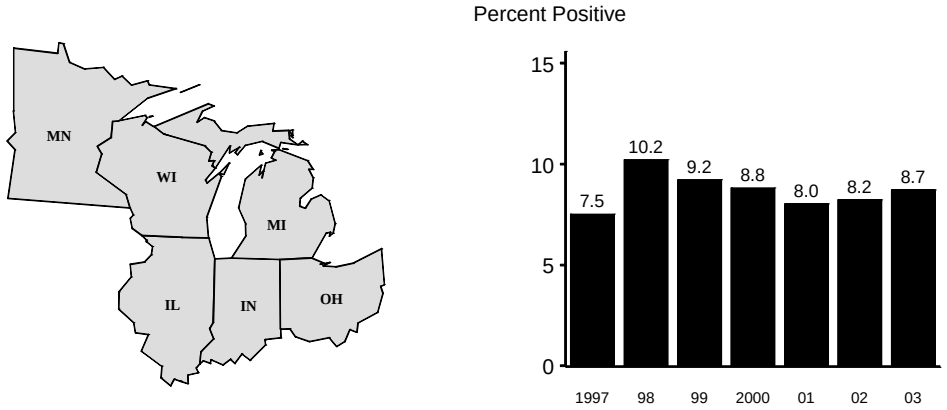
Figure 15. Chlamydia — Trends in positivity in 15- to 24-year-old women tested in family planning clinics: Region IV, 1996-2003



Note: Trends adjusted for changes in laboratory test method and associated increases in test sensitivity.

SOURCE: Regional Infertility Prevention Projects; Office of Population Affairs; Local and State STD Control Programs; Centers for Disease Control and Prevention

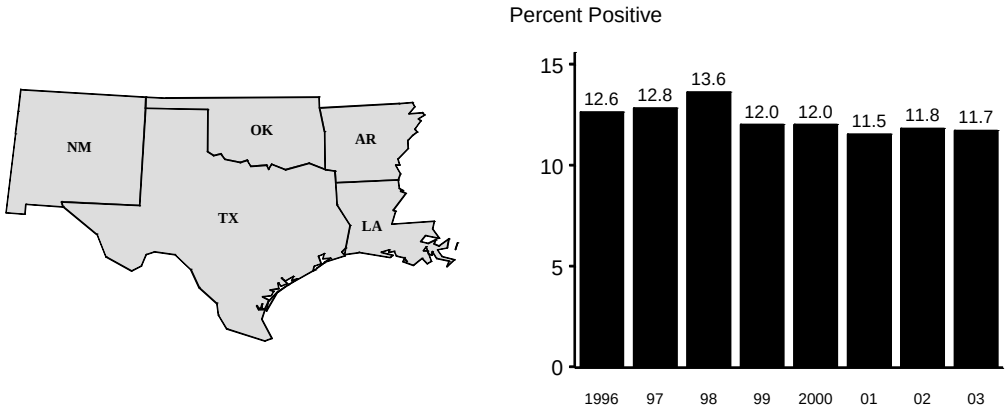
Figure 16. Chlamydia — Trends in positivity in 15- to 24-year-old women tested in family planning clinics: Region V, 1996-2003



Note: Trends adjusted for changes in laboratory test method and associated increases in test sensitivity.

SOURCE: Regional Infertility Prevention Projects; Office of Population Affairs; Local and State STD Control Programs; Centers for Disease Control and Prevention

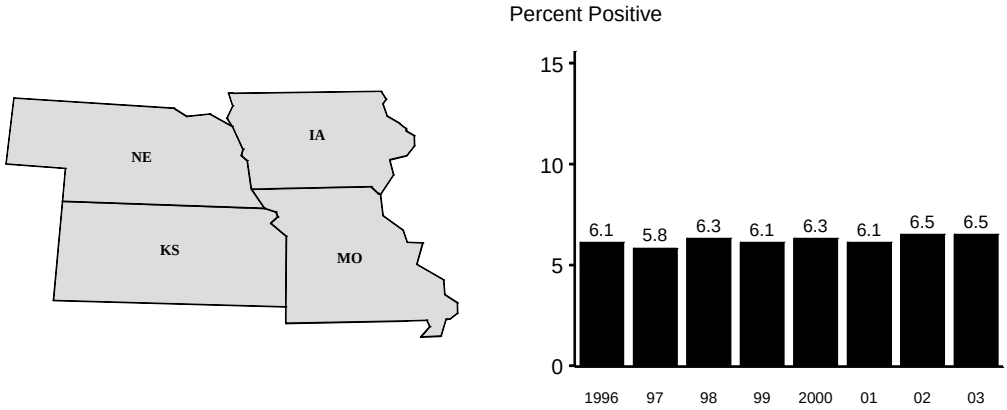
Figure 17. Chlamydia — Trends in positivity in 15- to 24-year-old women tested in family planning clinics: Region VI, 1996-2003



Note: Trends adjusted for changes in laboratory test method and associated increases in test sensitivity.

SOURCE: Regional Infertility Prevention Projects; Office of Population Affairs; Local and State STD Control Programs; Centers for Disease Control and Prevention

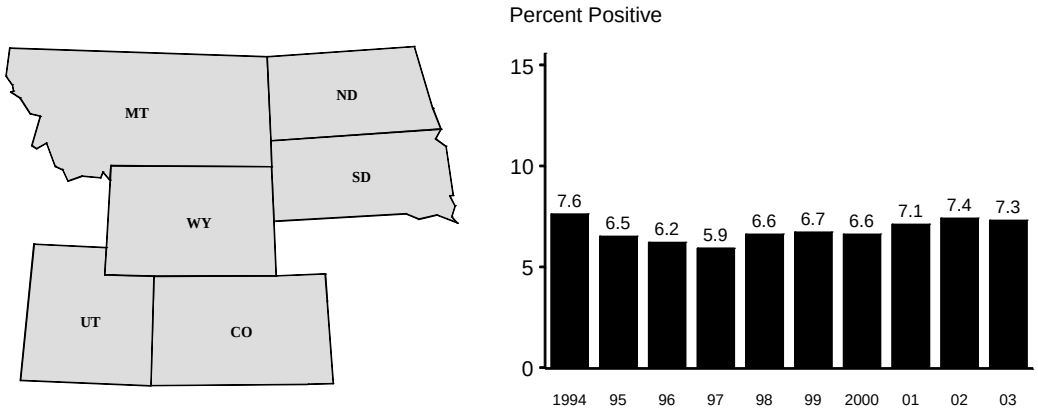
Figure 18. Chlamydia — Trends in positivity in 15- to 24-year-old women tested in family planning clinics: Region VII, 1996-2003



Note: Trends adjusted for changes in laboratory test method and associated increases in test sensitivity.

SOURCE: Regional Infertility Prevention Projects; Office of Population Affairs; Local and State STD Control Programs; Centers for Disease Control and Prevention

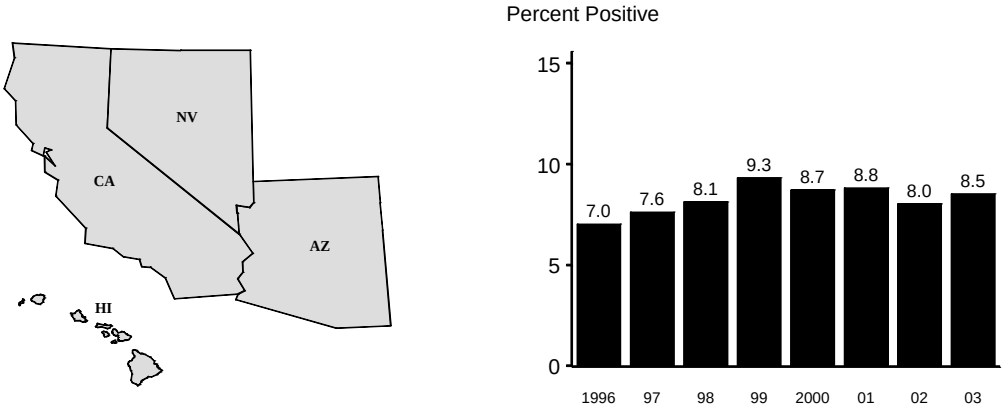
Figure 19. Chlamydia — Trends in positivity in 15- to 24-year-old women tested in family planning clinics: Region VIII, 1996-2003



Note: Trends adjusted for changes in laboratory test method and associated increases in test sensitivity.

SOURCE: Regional Infertility Prevention Projects; Office of Population Affairs; Local and State STD Control Programs; Centers for Disease Control and Prevention

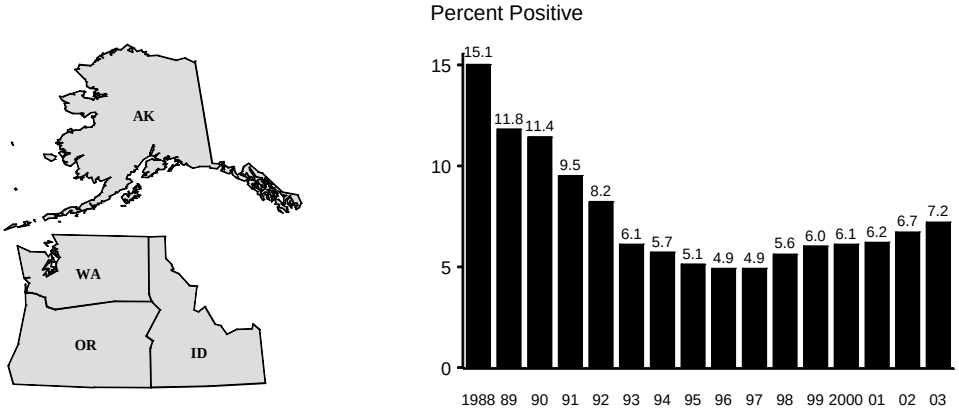
Figure 20. Chlamydia — Trends in positivity in 15- to 24-year-old women tested in family planning clinics: Region IX, 1996-2003



Note: Trends adjusted for changes in laboratory test method and associated increases in test sensitivity.

SOURCE: Regional Infertility Prevention Projects; Office of Population Affairs; Local and State STD Control Programs; Centers for Disease Control and Prevention

Figure 21. Chlamydia — Trends in positivity in 15- to 24-year-old women tested in family planning clinics: Region X, 1996-2003



Note: Trends adjusted for changes in laboratory test method and associated increases in test sensitivity.

SOURCE: Regional Infertility Prevention Projects; Office of Population Affairs; Local and State STD Control Programs; Centers for Disease Control and Prevention