**Policy for Syphilis, Chlamydia, Gonorrhea, and HIV Screening and
Patient and Partner Management Within**

**IHS, Tribal and urban Indian Healthcare Facilities**

# Implementation Date:       Review Interval: Yearly

# Point of Contact:       Clinical Site:

## Purpose

To expand opportunities for confidential STI screening and treatment among AI/AN populations.

## background

Sexually transmitted infections (STIs) including chlamydia, gonorrhea, syphilis, and HIV continue to impose a significant health burden on American Indian and Alaska Native (AI/AN) people as compared to other racial/ethnic groups. In 2013, among all races and ethnicities, AI/AN had the second highest rates of chlamydia and gonorrhea and the third highest rates of primary and secondary (P&S) syphilis. In 2013, reported case rates of chlamydia and gonorrhea among AI/AN were nearly 4 times higher than comparable rates for whites. Early diagnosis, treatment, and partner management can reduce STI transmission and manifestations of untreated infections [1].

High rates of STIs in AI/AN communities mainly affect adolescents. Adolescents are at higher risk for STIs due to a number of factors including involvement in higher risk sexual partnerships, multiple sex partners, and challenges in gaining access to sensitive and comprehensive sexual and reproductive health care. Moreover, unprotected sexual practices among adolescents can also lead to increased risk of unintended pregnancy and HIV infection. High STI rates can also be indicators of limited knowledge; unclear perception of risk; and lack of, inconsistent, or incorrect use of prevention methods, such as condoms. These challenges support the need for increased efforts to improve access, quality, and delivery of STI testing and partner management and to encourage safer sex practices, including condom use, among populations at risk within AI/AN communities.

Because there are standard recommendations for chlamydia, gonorrhea, syphilis and HIV screening and treatment, the provision of these confidential services can be incorporated into standard protocols to ensure that patients and their sex partners receive care that follows national guidelines. Standard protocols of this type may expand and facilitate STI screening and treatment opportunities for AI/AN communities. 

The Indian Health Service provides medical services to diverse populations. Many of these communities are small and located in rural areas. STI screening, diagnosis and treatment should be managed using strict confidentiality. AI/AN community members may be concerned about the confidentiality of their STI testing information and sexual orientation. These concerns should be addressed with each patient, with assurance that information regarding this medical information is not shared with staff, family members, or sexual partners. These concerns may be especially important to recognize and address in smaller communities where friends, associates, or family members may be employed by local medical facilities.

## Resources

National guidelines support the following recommendations. Each recommendation is referenced to an online resource.

## STI/HIV SCREENING AND TESTING IN PREGNANCY

* Syphilis screening should be performed on all pregnant women at the first prenatal visit. During periods of and in areas of high syphilis morbidity, an additional syphilis test should be performed during the third trimester (between 28-32 weeks gestation) and again at delivery. [2]
* HIV testing should be provided to all pregnant women, with re-testing in the third trimester (preferably before 36 weeks’ gestation) for high-risk women (e.g., women who use illicit drugs, have STIs during pregnancy, have multiple sex partners or have HIV-infected partners).
* Testing for chlamydia and gonorrhea should be performed at the first prenatal visit and repeated during pregnancy based on sexual risk. This testing should utilize nucleic acid amplification test (NAAT) on vaginal or cervical swabs or urine.
* Testing for hepatitis B surface antigen (HBsAg) should be performed at the first prenatal visit.
* Consider testing for Hepatitis C virus (HCV) for those pregnant women at risk (e.g., current or former drug users, persons with known exposure to HCV and persons with HIV).
* Papanicolaou (Pap) smear testing should be performed at the first prenatal visit if none has been documented in the previous 12 months.
* Evaluation for bacterial vaginosis (BV) should occur only in those pregnant women who are symptomatic with vaginal discharge.

STI SCREENING AND TESTING IN GENERAL POPULATIONS

* HIV testing should be offered to all persons ages 13-64 entering healthcare facilities with no documented prior testing [3].
* Chlamydia and gonorrhea screening should be provided annually to all sexually active women under the age of 25 [2] and to women 25 years or older with risk factors
* Screening of young males should be considered in clinical settings with high prevalence of chlamydia (STI clinics, adolescent clinics, corrections).
* Men who have sex with men (MSM) should be screened for HIV, Hepatitis C, syphilis, chlamydia, and gonorrhea at least annually and more frequently based on sexual risk [2].
* Specimens collected for gonorrhea and chlamydia in MSM should be obtained from the urethral (penile), rectal, and/or oral regions based on sexual behavior [2].
* Persons diagnosed with chlamydia or gonorrhea should be re-tested 3 months after treatment to identify and treat re-infection [2]. Pregnant patients should be re-tested 3-4 weeks after treatment.
* Due to similar behavioral risk factors and the risk of STI/HIV co-transmission, persons diagnosed with a bacterial STI or HIV should receive testing for other STIs (e.g., HIV, chlamydia, gonorrhea, and syphilis) [2].
* Sexual risk assessments should be included in provider-collected medical intakes. STI screening among persons not mentioned above should be based on sexual risk behaviors including, but not limited to, unprotected sex, sex with multiple partners, anonymous sex, same-sex activity, drug use, prior history of an STI, and knowledge of partners engaging in high-risk sexual activity [2].

## Treatment and Referral of Patients and Partners

* Patients with STIs should be treated according to CDC STI treatment guidelines [2].
* Persons with STI symptoms should receive presumptive antibiotic therapy on the day of exam [2] prior to receiving laboratory results.
* Known contacts of cases of syphilis, chlamydia, and gonorrhea should be offered presumptive treatment at the time of visit, prior to receiving laboratory results [2].
* Depending on regional practices, untreated sexual contacts of STI cases should be referred and reported to public health nursing, designated tribal health programs, or the local health department for partner services.
* Providers should seek to elicit partners and refer them for testing and presumptive treatment [2].
* People who are HIV-negative, but at substantial risk for HIV infection, should be offered access to pre-exposure prophylaxis, or PrEP, a way for people to prevent HIV infection by taking a pill every day [10].
* Expedited Partner Therapy (EPT) or Patient Delivered Partner Therapy (PDPT) should be available to heterosexual men and women diagnosed with chlamydia and/or gonorrhea, according to state and national guidelines [3]. EPT is the clinical practice of treating the sex partners of patients diagnosed with chlamydia or gonorrhea by providing prescriptions or medications to the patient to take to his/her partner without the health care provider first examining the partner.
	+ For chlamydia, provide medication or prescription (with accompanying instructions) of azithromycin 1gm PO x 1 dose for patient to give to partner(s).
	+ For gonorrhea, provide medication or prescription of cefixime 400mg PO x 1 dose PLUS azithromycin 1 gm PO x 1,with accompanying instructions, for patient to give to partner(s).

## Reporting

* Health providers in <<insert region>> are required to report cases of chlamydia, gonorrhea, syphilis, genital herpes and chancroid to the local health department.
* STI reporting forms are available at: <<insert website and phone number, as appropriate>>.

## Vaccinations

* Hepatitis B vaccination should be offered to all unvaccinated, uninfected persons being evaluated for an STI [2].
* HPV vaccination is recommended for all women (including immunocompromised) between the ages of 9-26 regardless of prior sexual activity, HPV infection, or abnormal PAP results [4].
* HPV vaccination is recommended for males between the ages of 9-21 regardless of prior sexual activity or HPV infection [4].
* HPV vaccination is recommended for men who have sex with men and immunocompromised men (including those with HIV-infection) through age 26 [4].
* HPV4 or HPV9 vaccines are acceptable for men or women.

## Questions and Resources

* This sample policy and protocol can be adapted for local use. These documents and accompanying information sheets can be found on the IHS STI Program website [5].
* Questions regarding STI diagnosis, treatment, patient and partner follow-up, and reporting should be directed to the appropriate local tribal health department or to the respective state STI program.
* STI educational resources for providers and tribal health departments are available from the IHS National STI Program [5], the CDC [6], Project Red Talon [7], and I Know Mine [8]. HIV educational resources are available from the IHS National HIV Program [9]. HCV educational resources are available from the IHS Division of Epidemiology and Disease Prevention and the IHS Office of Clinical and Preventive Services. [11]
* More or less frequent screening should be considered based on local STI morbidity patterns. Gonorrhea screening should be considered in regions and populations with high or increasing morbidity.

## Contact Information for Local Health Department:

<<insert address for reporting>>

<<insert phone number>>

<<insert fax number>>

## Online References:

1. <http://www.cdc.gov/std/stats13/default.htm>
2. <http://www.cdc.gov/std/treatment/>
3. <http://www.cdc.gov/std/ept>
4. <http://www.cdc.gov/std/hpv/default.htm>
5. <http://www.ihs.gov/epi/index.cfm?module=epi_std_resources>
6. <http://www.cdc.gov/std>
7. <http://www.npaihb.org/epicenter/project/project_red_talon/>
8. <http://www.iknowmine.org>
9. <http://www.ihs.gov/medicalprograms/hivaids/>
10. <http://www.cdc.gov/hiv/risk/prep/index.html>

11. <https://www.ihs.gov/epi/index.cfm?module=epi_hepatitis_mai>n