

# 10. Communicable Diseases

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Among communicable diseases, sexually transmitted infections (STI) have perhaps received the most attention in recent years. The primary STIs include chlamydia, gonorrhea and human immunodeficiency virus (HIV). Because each of these conditions can be spread by people unaware that they have acquired the disease, efforts to increase screening of asymptomatic patients have been recommended by CDC and the US Preventive Services Task Force. Current screening guidelines recommend screening all women ages 15 to 25 annually for chlamydia. For HIV, the recommendations are to screen all pregnant women and to offer HIV testing at least once to every patient between the ages of 13 and 64, regardless of any risk factors that may or may not be present

The importance of these conditions cannot be overemphasized. Chlamydia and gonorrhea are the primary causes of pelvic inflammatory disease in women which can lead to tubo-ovarian abscess and scarring of the fallopian tubes, which in turn can result in infertility and ectopic pregnancy. If left untreated, these diseases can result in unnecessary morbidity and even death. Antibiotic resistance in recent years has been a significant development complicating

the effective treatment of infections caused by gonorrhea.

HIV infection is a life-long infection which progresses to Acquired Immune Deficiency Syndrome (AIDS) if not treated. Fortunately, effective treatments for HIV have been developed and are available in the US. AI/AN are among those who qualify for reduced or free medications to treat HIV. Unfortunately, because of stigma and a lack of awareness, many AI/AN do not know their HIV status and do not receive appropriate care until they have advanced disease. Because an estimated 50% of new HIV infections are caused by approximately 20% of HIV positive individuals who are infected but unaware, there has been increased effort to screen everyone between the ages of 13 and 64 who might otherwise not be recognized by healthcare providers as potentially infected. Making HIV screening a part of routine preventive health care helps reduce the stigma and barriers to testing.

In Oregon, chlamydia diagnoses increased from 2000 to 2012, while gonorrhea diagnoses showed no significant trend. The prenatal HIV screening rate for Oregon IHS clinics increased from 2009 to 2013, and the rate of HIV diagnoses stayed similar to whites in the state.

# Chlamydia Diagnoses

AI/AN women in Oregon have consistently had higher rates of chlamydia than AI/AN men and whites of both sexes (Figure 10.1). Chlamydia diagnosis rates for AI/AN females rose sharply from 2000-2004, decreased through 2007, and steadily increased through 2012. In 2012, the chlamydia diagnosis rate for AI/AN females in Oregon was 3 times higher than the rate for AI/AN males, and twice as high as the rate for White females.

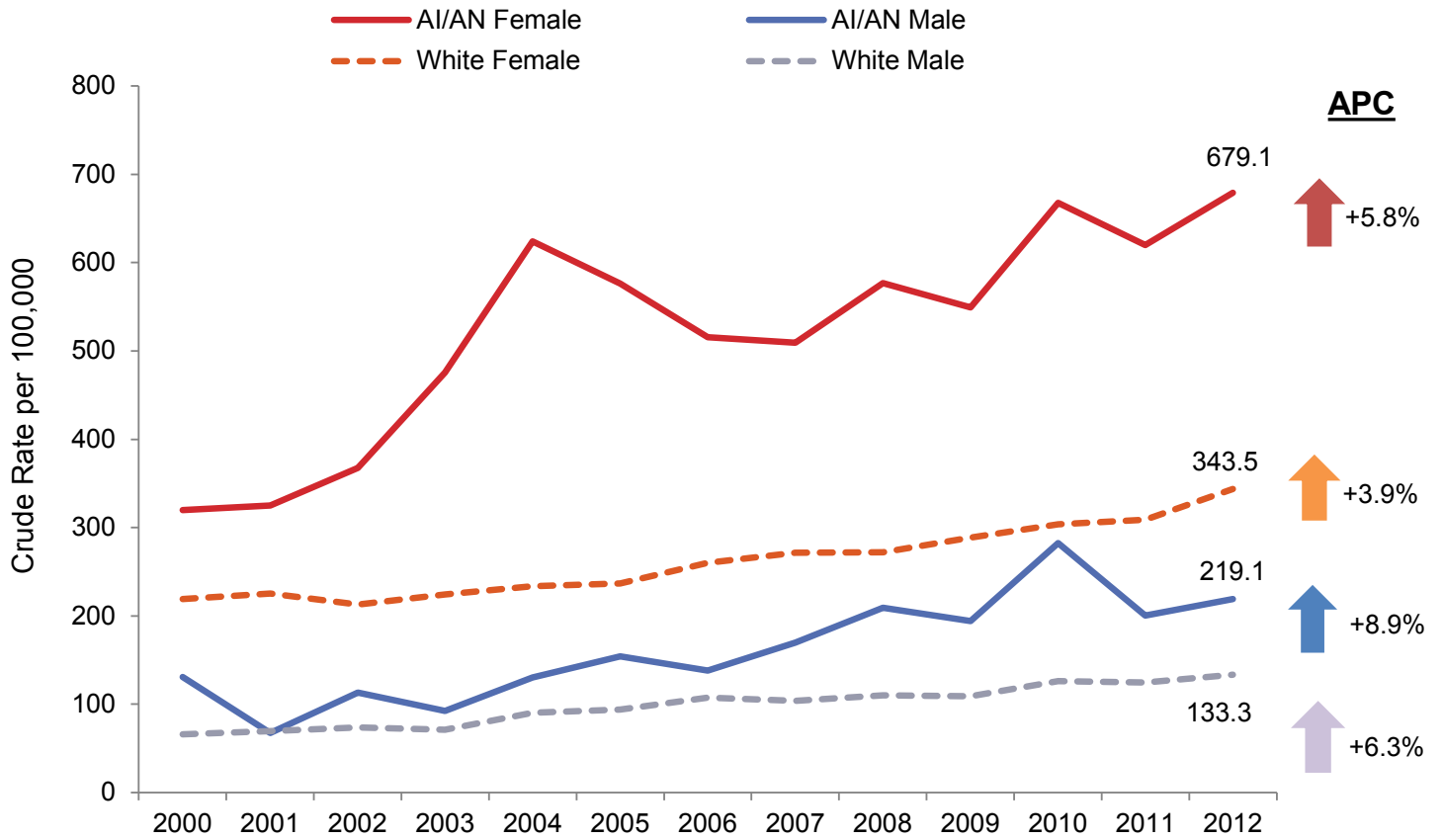
Chlamydia diagnosis rates for AI/AN males and whites of both sexes have also increased since 2000. Chlamydia diagnosis rates for males have increased more rapidly than rates for females, though the overall rates for males are still lower than rates for females. The average annual percentage change in rates from 2000 to 2012 was 8.9% for AI/AN males and 6.3% for white males.

Trends in sexually transmitted diseases (STDs) may reflect changes in diagnosis and reporting practices instead of actual changes in disease incidence rates over time, and should be interpreted with caution.

**Data Source:** Center for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas. <http://gis.cdc.gov/GRASP/NCHHSTPAtlas/main.html>.

**Data Notes:** Rates based on confirmed diagnoses during the year. Crude rates do not take into account the age differences between the AI/AN and NHW populations. AI/AN race not corrected for misclassification.

**Figure 10.1: Chlamydia diagnosis rates by race, sex, and year, Oregon, 2000-2012.**



APC = Annual Percentage Change.

# Gonorrhea Diagnoses

AI/AN females in Oregon have consistently had higher rates of gonorrhea than AI/AN males, though this gap has narrowed in recent years (Figure 10.2). The gonorrhea diagnosis rate for AI/AN women increased sharply from 2000 to 2005 before decreasing through 2008. The rate for AI/AN males showed a similar pattern, though the changes were less dramatic than those seen for AI/AN females. In 2012, the gonorrhea diagnosis rates for AI/AN females and males were 41.9 and 30.3 cases per 100,000, respectively. For whites, males have consistently had higher gonorrhea diagnosis rates than females, and have also had higher rates than AI/AN males for many of the years shown in Figure 10.2.

Trends in STDs may reflect changes in diagnosis and reporting practices instead of actual changes in disease incidence rates over time, and should be interpreted with caution.

**Data Source:** Center for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas. <http://gis.cdc.gov/GRASP/NCHHSTPAtlas/main.html>.

**Data Notes:** Rates based on confirmed diagnoses during the year. Crude rates do not take into account the age differences between the AI/AN and NHW populations. AI/AN race not corrected for misclassification.

**Figure 10.2: Gonorrhea diagnosis rates, three-year rolling averages, by race and sex, Oregon, 2000-2012.**



# HIV Screening in Pregnancy

HIV screening during pregnancy can identify women who are at risk for infecting their newborns. HIV-positive mothers who receive treatment during their pregnancy can reduce the risk that their newborns will also be infected with HIV. The U.S. Healthy People 2020 goal is 74.1% of women ages 15-44 who were pregnant in the past year to have an HIV test as part of their prenatal care. IHS tracks the percentage of pregnant AI/AN women who were tested for HIV during their pregnancy. The 2013 goal for this measure was 82.3%.

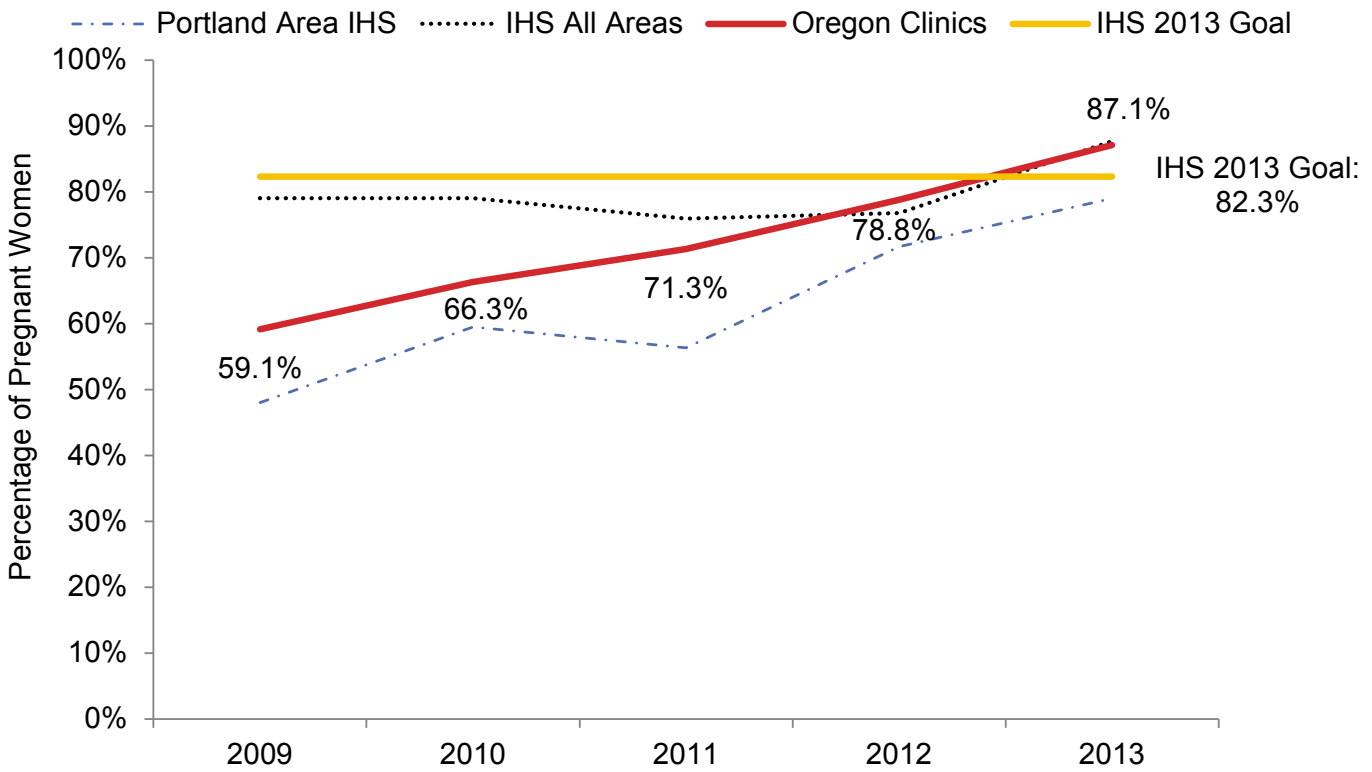
The prenatal HIV screening rate for Oregon clinics increased from 59.1% in 2009 to 87.1% in 2013. (Figure 10.3) The screening rate for Oregon clinics exceeded the Portland IHS rates for all years, and was above the national goal of 82.3% in 2013.

**Data Source:** Portland Area Indian Health Service.

**Data Notes:** Data labels only shown for Oregon clinics. Oregon clinics include non-urban federal and tribal Indian health facilities in Oregon. Portland Area IHS clinics include non-urban federal and tribal Indian health facilities in Idaho, Oregon, and Washington.



**Figure 10.3: HIV screening rates for pregnant AI/AN women seen at IHS facilities, 2009-2013.**

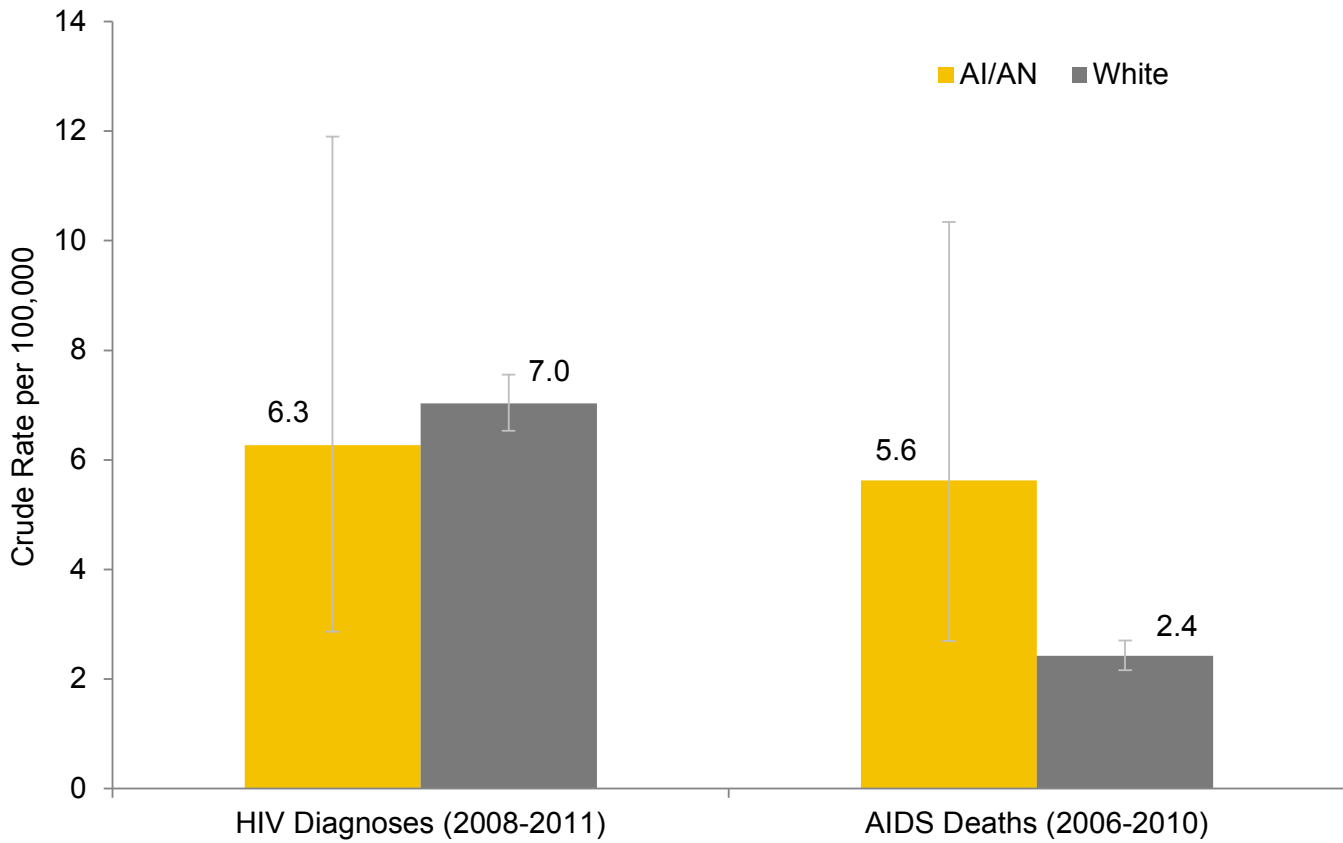


# HIV Diagnoses and AIDS Deaths

From 2008 to 2011, the estimated rate of HIV diagnoses for AI/AN in Oregon was similar to the rate for whites in the state (6.3 vs. 7.0 diagnoses per 100,000 population). From 2006-2010, the death rate for AI/AN with AIDS was 2.3 times higher than the rate for whites. Neither of these findings was statistically significant. Because of small numbers for AI/AN, there is considerable uncertainty in these estimates, as demonstrated by the wide confidence intervals around the AI/AN rates. Further, the comparisons are based on unadjusted rates and do not take into account the age differences in the AI/AN and white populations.

**Data Source:** Center for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas. <http://gis.cdc.gov/GRASP/NCHHSTPAtlas/main.html>.

**Data Notes:** Data on HIV infections likely underestimate the true number of HIV diagnoses due to underreporting to state surveillance systems and because not all infected individuals are tested. Death data include deaths of persons with diagnosed HIV/AIDS from any cause (not just AIDS-related deaths). AI/AN race not corrected for misclassification.

**Figure 10.4: Rates of HIV diagnoses (2008-2011) and AIDS deaths (2006-2010) by race, Oregon.**



## Program Spotlight: Project Red Talon

Project Red Talon (PRT) has provided training and technical assistance to tribes and tribal organizations throughout the U.S. on implementing and evaluating culturally appropriate sexual health and STD/HIV prevention programs since 1988. Project Red Talon works to delay sexual initiation, reduce sexual risk-taking, reduce STD/HIV infections and disparities, and achieve a more coordinated national and regional response to STDs and HIV. PRT's activities include:

**We R Native:** We R Native is a multimedia health resource for Native teens and young adults (<http://www.wernative.org>). Special features include monthly contests, community service grants, an "Ask Auntie" Q&A service, discussion boards, and medically accurate information reviewed by experts in public health, mental health, community engagement, and activism.

**Native VOICES:** The Native VOICES project is an initiative to develop an evidence-based sexual health video for AI/AN teens and young adults (15-24 years old) to reduce the incidence of HIV/STD and teen pregnancy. The video provides accurate risk information,

corrects misconceptions, and demonstrates culturally-specific strategies for encouraging condom use and enhancing partner communication.

**Native It's Your Game (IYG):** Native IYG is a multimedia sexual health curriculum for middle school aged youth (12-14 years). IYG teaches about healthy relationships, life skills, communication, and refusal skills. It emphasizes abstinence, but also teaches students how to protect themselves from pregnancy and sexually transmitted infections using medically accurate information.

**STD/HIV Quality Improvement:** PRT staff collaborate with the IHS STD and HIV Programs to improve STD, HIV, and Hepatitis C screening measures at Indian Health Service/Tribal/Urban (I/T/U) clinics nationwide. The project works to address organizational, cultural, and individual factors that prevent AI/AN from being screened for STDs, HIV, and Hepatitis C. The project provides training and technical assistance to assist clinics in improving screening rates and clinical sexual health measures.

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