

Notes From the Field

Acceptability and Feasibility of Urine Screening for Chlamydia and Gonorrhea in Community Organizations: Perspectives From Denver and St Louis

Persons at risk for sexually transmitted diseases (STDs) face barriers in gaining access to health services, including limited understanding of the structure of the services, lack of insurance, and distrust of providers. Novel STD-screening diagnostics, including DNA amplification techniques for screening urine for chlamydia and gonorrhea, no longer require invasive sampling procedures, so screening can be carried out in nonclinical settings. STD-screening programs in schools and community settings using these techniques have been successful; however, many such programs involve health department staff conducting infrequent or one-time screening campaigns. The long-term sustainability of STD screening outside of traditional clinical settings, including partnerships with community organizations, has not been demonstrated; however, the importance of research in this area has been recognized.

Denver, Colo (population 494 462), and St Louis, Mo (population 396 685), are 2 of the 7 sites that participated in the first phase of a multisite effort entitled the Gonorrhea Community Action Project (GCAP), whose goal was to inform the development of interventions to increase health seeking for populations at risk for STDs. GCAP was funded by the Centers for Disease Control and Prevention and the National Institute of Mental Health. Researchers in Denver and St Louis conducted pilot studies on the feasibility of involving nontraditional

public health partners—community organizations that serve at-risk populations but do not provide STD prevention services—in STD screenings. Both cities have strong STD programs at the local health department level. The results suggested 3 models for partnership between public health and community organizations.

Organizations With Clinical Capacity

The Denver GCAP, administered by the Denver Department of Public Health, has formed a partnership with a community organization serving homeless youths that provides limited health services supervised by volunteer physicians. Other partners included a state-funded juvenile detention facility and a county jail, both with in-house nurse practitioners. Medical staff in these organizations recognized the advantages of urine-based screening and had the requisite skills for taking sexual histories and counseling on STDs. They collected urine specimens from clientele, and the Department of Public Health retrieved and tested specimens. The department reported results back to each organization, which was then responsible for all education, follow-up, treatment, and notification of partners.

Organizations Without Clinical Capacity That Request STD Screening by Outside Health Providers

The St Louis GCAP, administered by the Division of Infectious Diseases of the Washington University School of Medicine, implemented regular screenings at 20 community organizations. In many cases, GCAP staff formed partnerships with local AIDS organi-

zations and the St Louis Department of Health to offer ligase chain reaction (LCR) screening and STD education in addition to HIV screening and educational efforts already ongoing in these sites. Participating organizations and establishments, which supported the goal of increased screening and education but had limited resources, ranged from drug treatment centers, shelters, and bars to a Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) clinic. Screenings were conducted on a rotating basis, with a flexible delivery style to accommodate varied organizational requirements. GCAP, in conjunction with the health department, conducted follow-up to ensure treatment and notification of partners.

Organizations Without Clinical Capacity That Request Staff Training for STD-Screening Services

A third model is one in which staff at community organizations and establishments had no clinical skills but were interested in conducting screening and becoming a resource for STD prevention. In Denver, staff at an after-hours club, a place for youth to “hang out” in a safe environment, were interested in offering regular screenings. In St Louis, a barmaid was instrumental in recruiting participants for screening at her bar and is now interested in conducting screening. In both cities, recruitment for screening in these venues was accomplished by staff at the establishments and screening was done by GCAP. Staff at the club for youth in Denver are currently receiving training in STD-prevention education and STD-screening protocol. Responsibility for screening can pass to the staff of the community establishments once staff are fully trained.

Results of Screening Efforts

The public health advantages of this approach cannot be ignored; during the pilot effort, we screened a total of 849 persons. In Denver, 572 were screened for chlamydia and 514 of these were also screened for gonorrhea. In St Louis, 277 were screened for both chlamydia and gonorrhea. Those screened were from hard-to-reach populations—for example, asymptomatic clients and youth. In Denver, 50 persons (8.7%) were positive for chlamydia and 17 (3.3%) were positive for gonorrhea; in St Louis, 22 (7.9%) were positive for chlamydia and 7 (2.5%) were positive for gonorrhea. These results indicate a disease prevalence equivalent to or higher than that seen in traditional STD clinic settings. Follow-up, treatment, and notification of partners were completed for all but 2 positive cases. Preliminary cost analyses showed a total program cost of \$19 521 in Denver and \$9223 in St Louis. Costs averaged \$33.60 per test and \$527.34 per case detected in Denver and \$37.45 per test and \$439.20 per case detected in St Louis.

Strengths and Limitations of the Process

We seek to offer nonclinical STD screening in sustainable public health–community partnerships. The first model that we described,

which was used more heavily in Denver, relied on the skills of medical professionals already working in communities to provide services that increase access to care; this approach may have been biased toward symptomatic clients. The second model, used more heavily in St Louis, was driven by the community organization's desire to collaborate with health care providers to increase screening services. Although this model was more labor intensive, quality control was maintained by health professionals and relationships were sustained across organizations. The third model required intensive training of organization staff to become involved in STD screening and greater effort in the beginning of the program to maintain quality control among nonmedical staff implementing the program. This approach, however, allowed for the development of skills within the organization; when community organization staff complete training, less health department labor will be required.

We realize that as partnerships between public health departments and community organizations are developed, each program must be tailored to the organization's needs and will therefore deviate from any fixed model. While these programs are currently sustained by federal research dollars, long-term sustainability through regular public health activities can be ensured through continued demonstration that screening in non-

traditional settings is cost-effective for the identification of STDs among high-risk persons who may be asymptomatic and/or may not otherwise seek care. □

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Contributions

S. S. Bull directed the pilot study in Denver, analyzed the data from Denver, and was the primary author for the paper. C. A. Jones directed the pilot study in St Louis, analyzed the data from St Louis, and was the secondary author for the paper. D. Granberry-Owens collected all the data in St Louis and participated in the analysis of St Louis data. B. Stoner supervised data analysis in St Louis and contributed to the writing of the paper. C. Rietmeijer supervised data analysis in Denver and contributed to the writing of the paper.