

Time to Address Inequities in Chlamydia Screening Among Adolescents

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 See also Wood et al., p. 135.

In the United States, chlamydia rates have reached an all-time high, with Black and indigenous people of color disproportionately affected.¹ According to 2019 data from the Centers for Disease Control and Prevention (CDC), rates of all sexually transmitted infections were one to two times higher among Hispanic or Latino people; three to five times higher among American Indian/Alaska Native, Native Hawaiian, and other Pacific Islander people; and five to eight times higher among Black or African Americans than among non-Hispanic Whites.¹ Specifically, the reported chlamydia rate among Black adolescents 15 to 19 years of age was more than six times the rate reported among White adolescents of the same age.¹

Differential access to and provision of health care services can lead to worse health outcomes, perpetuate bias and stigma, and oppress marginalized populations. This is why one of the overarching goals of Healthy People 2030 is to eliminate health disparities and

attain health equity for all.² The most recent Youth Risk Behavior Survey did not reveal racial/ethnic differences in the proportion of students reporting sexual activity.³ The CDC recommends annual screening for chlamydia among all sexually active females younger than 25 years.⁴ Thus, sexually transmitted infection screening rates should be relatively similar among Black and White female adolescents.

Yet, in this issue of *AJPH*, Wood et al. (p. 135) found that chlamydia screening rates were higher among Black females than White females and that individual clinicians were more likely to screen Black patients than non-Black patients. Wood et al. surmised that implicit bias among clinicians may be driving such differential practices but did not directly explore the role of implicit bias in physician behavior. Nevertheless, data from this retrospective cohort study of 15- to 19-year-old females across 31 pediatric primary care clinics prompted us to further explore what factors may be driving these disparate

rates, implicit bias being one of many. Quite simply, the more screening is done, the more infection will be found. If clinicians are inherently screening Black adolescents more, there will likely be more infection found.

An argument could be made that clinicians may screen more Black females because they deem them more “at risk” given epidemiological data demonstrating greater rates in that population. But which came first? Are sexually transmitted infection rates higher in Black populations because of a multitude of socioeconomic reasons, or is it clinician bias (which has been well reported⁵) that has led to increased testing that subsequently reveals higher rates among Black people, further perpetuating the disparity? In all likelihood, it is a combination of both.

As growing data reveal differential treatment of patients according to their race and ethnicity, many of us are working to develop interventions to achieve health equity. One such method is a standardized or automated approach to screening, such as universal screening for all sexually active adolescents. If universal screening is to be successful, however, patients must identify themselves as sexually active and agree to be screened. Literature has shown that sexual history is often not documented during pediatric primary care visits.⁶ Thus, universal screening of the sexually active population is moot if clinicians do not document a sexual history in the first place.

A standardized method to collect sexual history data that does not rely on physician inquiry is a useful, nonjudgmental, and efficient process for obtaining such information from adolescent patients. If successfully operationalized, a method of this nature, such as self-reported sexual histories

collected via electronic questionnaires with automatic screening for sexually active individuals, regardless of race or ethnicity, could help lessen disparities.

One way to increase screening efforts is to expand screening venues. Many adolescents do not see their primary care physician annually, and Black and indigenous people of color have less access than White people to primary care and preventive services.⁷ Expanding annual screening beyond the primary care office and bringing screening to areas frequented by adolescents can help reach high-risk groups and mitigate disparities. School-⁸ or sport-based screening, at-home screening, and mobile neighborhood screening are nontraditional venues that may increase screening access for marginalized adolescents. Emergency departments, in particular, serve as a source of health care access for Black and indigenous people of color and marginalized groups⁹ and thus may be a strategic venue to offer screening for sexually transmitted infections. These expanded screening opportunities should be offered at no cost to eliminate another barrier.

Although the suggestions offered here may increase screening, they fail to fully address an underlying problem: Black patients' mistrust of the health care system.¹⁰ This mistrust is present because of many historical and current issues facing our country, not only in health care but politically and socially, including but not limited to slavery, past laws banning interracial marriage based on biological concerns regarding racial mixing, the Tuskegee syphilis trial, and police brutality. Especially with respect to sexual health, patients need to feel safe and comfortable in discussing highly personal information. Although there are actions we as health care

providers and public health educators can engage in (e.g., undergoing implicit bias training as suggested by Wood et al.), there are deeper rooted systemic issues outside of medicine that, either intentionally or not, hurt people of color and continue to perpetuate disparities, adding to mistrust of the system.

Even if health care systems mandate training to reduce bias, stigma, and microaggression among providers, medicine is not practiced in a silo. There needs to be meaningful change in society if we want to eliminate disparities. Practices such as redlining, poor funding for schools in Black neighborhoods, and voter suppression laws are all intended to oppress Black and indigenous people of color. These factors, along with historic medical experimentation among Black people without consent, led to mistrust of the system, including health care. Even recent laws such as the Texas abortion restriction law will disproportionately hurt women of color because they are less likely than White women to have the means to travel outside of the state for a safe, legal abortion.¹¹ To decrease health care disparities, including those demonstrated by Wood et al., we must advocate for our patients and use our votes to support policies that lead to racial equity in health care and beyond.

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CONFLICTS OF INTEREST

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