First author; reference; country; quality;[a]	Primary focus; (screening approach); sex; age	View point	Effectiveness data sources	Cost data; year and currency	Model used	Test	Treatment	Primary outcome	Results	Comment
Adams et al. 2004,[22] **UK** **B(2) Pass**	Screening **(Selective opportunistic);** **Women; 16-24 years**	**Health care system**	**Not applicable**	**UK £ Sterling 2001**	**Not applicable**	**LCR**	**Single dose (1g) Azithromycin or Doxycycline (alternatives for pregnant women)**	**Average cost per screening invitation**	**Average cost (with partner management) £14.88 per screening offer; £21.83 per testing episode; £38.36 per positive episode**	**High quality cost study (not an economic evaluation) presenting costs of the UK opportunistic screening programme.**
Begley et al. 1989, [35] **USA** **A(1) Pass**	Screening **(Non-selective opportunistic);** **Adolescents; 12-19 years**	**Health care system**	**Own primary study**	**Own primary study** **1987 US $**	**No model**	**Not specified**	**Oral tetracycline (7 days, qds)**	**Cost per test/ screen/treatment**	**Chlamydia screening of asymptomatic patients in FP clinic cost effective**	**No model - analysis insufficient to make policy recommendations**
Blake et al. 2004,[13] **USA** **A(1)** **Pass**	Screening **(Selective opportunistic)** **Young men in detention; 14-18 years**	**Health care system**	**Primary (own study) and secondary**	**Dept of Youth Services salary data and literature** **No price year or currency specified**	**Static: decision analytic model**	**LE test strips (Chemstrips 9) LCx, or BD ProbeTec**	**Single dose (1g) Azithromycin**	**Cost per case of PID prevented**	**Three strategies: Universal screening (urine NAAT); NAAT testing LE positive urines; No screening. Universal NAAT screening most cost effective for prevalence 2.8% or higher**	**Comprehensive study, well reported. Model takes no account of re-infection and population effects so results might be misleading.**
Browning et al. 2001, [48] **UK** **B1?**	Diagnosis **Genitourinary medicine clinic** **Men and women**	**Health care system**	**Observed data**	**Local costs** **£ Sterling**	**None**	**BD ProbeTec on urine specimens vs. culture of genital swabs**	**None**	**Case detected**	**BD ProbeTec superior to culture for identifying chlamydia in genitourinary medicine clinic**	**Good analysis of cost per true case detected. Limited because does account for long term cost and effect of false negatives.**
Buhaug et al. 1989, [19] **Norway** **A(1) Pass**	Screening **(Selective opportunistic);** **FP, or routine GP gynae visit;** **Women; 15-39 years**	**Societal (implied, not stated)**	**Own primary study**	**Own costs from GP and University of Trondheim** **1987 NKr, £ Sterling**	**Static: Markov model**	**Not specified**	**7 day treatment, drug not specified**	**Sequelae avoided**	**Testing cost effective for 18-24 yearr olds only**	**Model used takes no account of re-infection and population effects and therefore results might be misleading.**
Buhaug et al. 1990, [18] **Norway** **A(1) Pass**	Screening **(Selective opportunistic);** **FP, or routine GP gynae visit;** **Women; 15-35**	**Societal (implied, not stated)**	**Own primary study**	**Own costs from GP and University of Trondheim** **1987 NKr, £ Sterling**	**Simulation model, details unspecified**	**Not specified**	**Lymecycline (7 days)**	**Sequelae avoided**	**Testing cost effective for 18-24 yr olds only**	**Limited information provided on simulation model approach.**

First author; reference; country; quality;[a]	Primary focus; (screening approach); sex; age	View point	Effectiveness data sources	Cost data; year and currency	Model used	Test	Treatment	Primary outcome	Results	Comment
	yrs									
Dryden et al. 1994, [49] **UK** **A(1) ?**	Diagnosis **(Selective opportunistic);** **Men and women; 16-65 years**	**Health care system**	**Observed data**	**Local costs, £ Sterling**	**None**	**EIA, DFA** **Urine specimens**	**Doxycycline (7 days)**	**Chlamydia cases detected**	**Cost per case cured £245.** **The authors state that the cost of missing a diagnosis of chlamydia was not included because there were too many variables to consider.**	**Correct result for this approach. Partial study reporting cost of detecting chlamydia. Did not incorporate long term outcomes.**
Estany et al. 1989, [56] **A(1) Pass**	Diagnosis **(Non-selective screening);** **Non-pregnant women;**	**Societal**	**Literature**	**Literature and national publication, observational data (from hospital charts)** **Canadian $ 1987**	**Static: decision analytic model**	**EIA, DFA**	**Tetracycline, (7 days)**	**Cost per PID prevented** **(analogous to major outcome averted)**	**Early detection with DFA and EIA cost-effective if prevalence exceeded 6% and 7% respectively.**	**The study compares dated diagnostic techniques. Model takes no account of population effects.**
Genc et al. 1993, [34] **Uppsala, Sweden** **A(1) ?**	Screening **(Non-selective opportunistic);** **Routine health check,** **Adolecent men;**	**Health care system**	**Literature**	**Own primary costs** **US $, no year (1SKr =7$)**	**Static: decision analytic model**	**LE-EIA, EIA**	**Azithromycin (1g single dose)**	**Cure for men, including contact tracing and costs associated with PID, ectopic pregnancy, infertility**	**Compared with no screening, screening adult men reduced overall costs when chlamydia prevalence was above 2% for LE-EIA and 10% for EIA alone.**	**Model used takes no account of re-infection and population effects and therefore results might be misleading.**
Genc et al. 1996, [32] **Uppsala, Sweden** **A(1) ?**	Screening **(Non- selective opportunistic);** **Youth clinic, GP, FP;** **Women and male partners;** **Age not specified**	**Health care system**	**Literature**	**Own costs** **US $, no year**	**Static: decision analytic model**	**Culture, EIA, NAAT**	**Azithromycin (1g single dose)**	**Cost per case identified and treated**	**Screening with NAAT combined with aazithromycin for positive patients was the most cost effective strategy when the prevalence is 6%.**	**Outcome is right for this model but study is trying to suggests that individuals will be cured and does not take into account re-infection**
Genc et al. 1997, [59] **Sweden** **A1 ?**	**Treatment (Gonorrhoea with chlamydia co-infection);** **Women and men**	**Societal**	**Literature**	**Average Swedish salaries and medical care costs, US $ no year**	**Static: decision analytic model**	**Not specified**	**Doxycyline (7 days 100mg bd), Azithromycin (1g single dose)**	**Cost per cured patient**	**Doxycycline more cost-effective than Azithromycin when compliance > 80%. Azithromycin more cost effective if compliance low.**	**Model takes no account of population effects.**
Gift et al. 2004, [64] **USA** **A(1) Pass**	Treatment **(Gonorrhoea with chlamydia co-infection);** **Women;** **Age not specified**	**Health care system**	**Literature**	**US $ 2000**	**Static: decision analytic model**	**Nucleic acid hybridization test (PACE 2);** **LCR** **Endocervical specimens**	**Doxycycline + Azithromycin**	**PID cases prevented**	**Dual treatment alone not cost effective replacement for chlamydia testing but increases cases treated when combined with testing. Dual treatment results in more over**	**Comprehensive study. Model adequate for objective**

First author; reference; country; quality;[a]	Primary focus; (screening approach); sex; age	View point	Effectiveness data sources	Cost data; year and currency	Model used	Test	Treatment	Primary outcome	Results	Comment
									treatment.	
Ginocchio et al. 2003,[26] USA) A(1) Pass	Screening **(Non-selective opportunistic); Adolescent men**	**Health care system**	**Literature**	**US $ 2000**	**Static: decision analytic model**	**LE-LCR vs LCR Urine specimens**	**Not specified**	**PID cases prevented**	**LCR alone prevented 104 more cases of PID than LE-LCR but cost $22.62 more per male screened. For this to be more efficient than LE-LCR, the LCR cost needs to decline to <$18**	**Comprehensive study, well reported. However, model used takes no account of re-infection and population effects and therefore results might be misleading.**
Goeree et al. 2001,[37] Canada A(1) Pass	Screening **(Selective opportunistic); Women; 15-24 years**	**Health care system**	**Literature**	**Various sources in Ontario Canadian $ 1999**	**Markov model**	**Seven combinations of test and samples performed on symptomatic, asymptomatic and high risk women .**	**Not specified**	**Prevention of chlamydia cases over 10 years (including sequelae)**	**Screening all women 15-24 years considerably more costly and only moderately more effective than screening only high risk women**	**Outcome unclear. Probabilities of long term sequelae not presented explicitly. Distinguished diagnostic testing in this study (symptomatic) and screening (asymptomatic). Model takes no account of re-infection and population effects and might be misleading.**
Gunn et al. 1998, [23] US A(2) Pass	Screening **(Selective opportunistic); Outreach clinic; High risk adolescent males; teenage**	**Health care system**	**n/a**	**Own primary study 1996 US $**	**No model**	**LCR**	**Single dose (1g) Azithromycin**	**Cost per specimen obtained and cost per case identified**	**Cost per specimen obtained $103; cost per case identified was $1677**	**Correct approach for the objective of evaluating an intermediate outcome.**
Haddix et al. 1995, [60] USA A1 ?	Treatment **Women**	**Healthcare perspective publicly funded clinic perspective**	**Literature**	**Consumer Price Index US $**	**Static: decision analytic model**	**Lab-confirmed diagnosis (test not specified), presumptive diagnosis**	**Azithromycin (1g single dose), doxycycline (7 days 100mg bd**	**PID case prevented**	**Azithromycin is a cost effective alternative to Doxycycline. However, the cost of Azithromycin must decrease markedly for it to be less costly to the publicly funded clinic.**	**Model takes no account of population effects.**
Howell et al.	Partner notification	**Health**	**Literature**	**US $ 1994**	**Static:**	**Not stated**	**Single dose**	**Locating and**	**Contact tracing of female**	**Inadequate modelling**

First author; reference; country; quality;[a]	Primary focus; (screening approach); sex; age	View point	Effectiveness data sources	Cost data; year and currency	Model used	Test	Treatment	Primary outcome	Results	Comment
1997, [44] **USA** **A1 Pass**	**Women and men**	**care system**			**decision analytic model**		**azithromycin**	**treating partners**	**partners of male cases with chlamydia more cost effective than contacting male partners of women to prevent re-infection.**	**approach given attempt to look at population effects of chlamydia spread as a result of partner notification.**
Howell et al. 1998, [55] **USA** **A1 Pass**	Diagnosis **(Selective opportunistic screening);** **FP clinics;** **Women;** **<30 years**	**Health care system**	**Literature, direct observation, expert opinion**	**Local standard costs, literature** **US $ 1995**	**Static: decision analytic model**	**Cell culture, EIA, non-amplified probe assay, PCR (cervical specimens), PCR (urine), LCR (cervical specimens)**	**Doxycycline (7 days)**	**Additional case of PID prevented** **(analogous to major outcome averted)**	**LCR on cervical specimens on women receiving pelvic examinations most cost-effective. LCR on cervical specimens without pelvic examination would also prevent more disease than EIA.**	**Model takes no account of population effects and therefore results might be misleading.**
Howell et al. 1998, [30] **USA** **A(1) Pass**	Screening **(Non selective opportunistic);** **FP;** **Women;** **11-68 years (Median 25 years, focus age<30 years)**	**Health care system**	**Own primary study**	**Baltimore City hospital and literature** **US $ 1995**	**Static: decision analytic model**	**PCR tests on cervical swab, and or urine**	**Doxycycline**	**Sequelae prevented in men, women and infants but considers consequences of longer term sequelae**	**Age based screening provides the greatest cost saving of the three strategies examined. Universal screening is cost effective at a prevalence greater than 10.2%**	**Model used takes no account of re-infection and population effects and therefore results might be misleading.**
Howell et al. 1999, [40] **USA** **A(1) Pass**	Screening **(Selective population);** **Female army recruits;** **17-39 years**	**Military (modified payer)**	**Own primary study**	**TRADOC and own costs** **US $ 1995**	**Static: decision analytic model** **implied (but not presented or made explicit)**	**LCR**	**Single dose (1g) Azithromycin**	**PID avoided**	**Screening by age provided a cost saving to the Army over a 1 year period**	**Model used takes no account of re-infection and population effects and therefore results might be misleading.**
Howell et al. 2000, [39] **USA** **A(1) Pass**	Screening **Selective population screening;** **Female US army recruits;** **All recruits – age**	**Military and civilian**	**Own primary study**	**TRADOC & Own costs** **US $ 1998**	**Static Decision analytic model**	**LCR**	**Single dose (1g) Azithromycin**	**Sequelae avoided**	**Screening army recruits is cost effective. From military perspective screening under 25 years provides greatest cost saving**	**Model used takes no account of re-infection and population effects and therefore results might be misleading.**

First author; reference; country; quality;[a]	Primary focus; (screening approach); sex; age	View point	Effectiveness data sources	Cost data; year and currency	Model used	Test	Treatment	Primary outcome	Results	Comment
	focus <25 years									
Hu et al. 2004 [24] **USA** **A(1) Pass**	Screening **(Selective opportunistic);** **Women only;** **15-29 years**	**Modified societal**	**Literature**	**US $ 2000**	**State transition simulation model**	**NAAT (unspecified)** **Urine specimens**	**Azithromycin (1g single dose)**	**Cost per quality adjusted life year**	**Four alternative screening strategies. Annual screening followed by semi -annual screening for those with a history of infection was the most effective and cost effective strategy. It consistently had an ICER less than $25,000 per quality adjusted life year.**	**State-transition model with cycle time 6 months. Attempts to incorporate issues that require a dynamic model by using population averages. This does not reflect reality. No mention of partner notification. QALY outcome not described.** **Results should be viewed with caution**
Hueston et al. 1997, [67] **USA** **A(1) Pass**	Treatment **Pregnant women**	**Health care provider**	**Literature**	**Local charges** **$ 1996**	**Static: decision analytic model**	**Not applicable**	**Amoxicillin (7 days 500g tds), Erythromycin (7 days qds), Clindamycin (14 days qds), Azithromycin (1g single dose)**	**Cost per case cured**	**Amoxicillin,500mg 3 times a day for 7 days followed by a single dose of azithromycin for non-responders is the most cost-effective strategy for treatment.**	**Partial study. Does not include re-infection or long term outcomes (including of neonates)** **Model takes no account of population effects.**
Kacena et al. 1998, [54] **USA** **B(1) ?**	Diagnosis **(Selective population screening);** **Women; army recruits**	**Health care system**	**Observational data**	**Local costs US$**	**None**	**LCR** **Pooled urine specimens**	**Not applicable**	**Cost per specimen tested**	**At 8% prevalence, pooling by four would reduce costs by 39%. At 2% prevalence pooling by eight samples would reduce costs by 59%**	**Cost study only – but only paper identified on the subject of pooling specimens**
Katz et al . 1988, [43] **USA** **A(1) ?**	Partner notification **(Field follow up or two self-referral strategies);** **Men with non-**	**Health care system**	**Own study**	**US $ 1985**	**None**	**Culture**	**Not specified**	**Locating partners**	**Field follow up by trained investigators proved to be the most cost effective method of locating patients with CT.**	**The data are old but the methods for partner referral similar to current patient referral. The model used is not an issue in this evaluation because**

First author; reference; country; quality;[a]	Primary focus; (screening approach); sex; age	View point	Effectiveness data sources	Cost data; year and currency	Model used	Test	Treatment	Primary outcome	Results	Comment
	gonococcal urethritis									**the objective to look at the methods of locating partners and not the population effects of the consequences.**
Knight. 2000, [57] **UK** **A(1) Pass**	Diagnosis **(Non -selective opportunistic screening);** **Women (men through partner notification);** **16-25 years**	**Health care system**	**Observational data, literature**	**Local costs** **1997 £ Sterling**	**Dynamic: simulation approach**	**ELISA, PCR/LCR** **Type of specimen not stated**	**Included but not specified**	**No outcome measure used – costing study only**	**Testing with LCR would reduce the cost of testing and treating by around the second year of implementation. Cost savings due to the increased sensitivity of the test. Global screening not cost effective**	**Acceptable basic dynamic structure, but monthly cycle is a potentially serious defect. Some dubious assumptions, e.g. all partners are positive. The absence of an effectiveness measure means that conclusions about the cost-effectiveness of screening should not be drawn from this study.**
Magid et al. 1996, [61] **USA** **A(1) Pass**	Treatment **Women; non pregnant, child bearing age**	**Payer perspectiv e**	**Expert, literature and assumptions**	**National charges and prices (Blue Cross and Blue Shield) average wholesale drug prices** **US $ 1993**	**Static: decision analytic model**	**Not applicable**	**Azithromycin (1g single dose), doxycycline (7 days 100mg bd)**	**Major complication averted**	**Azithromycin strategy more cost effective than doxycycline.**	**Model takes no account of population effects. Paper did incorporate different levels of compliance.**
Marra et al. 1997, [62] **USA** **A(1) ?**	Treatment **Women; Hypothetical cohort of 5000**	**Third party payer**	**Literature , expert opinion**	**Hospital costing departments** **US $ currency year not stated**	**Static: decision analytic model**	**Lab confirmed diagnosis (test not specified) and presumptive diagnosis**	**Azithromycin (1g single dose) doxycycline (7 days 100mg bd)**	**Cost per cure**	**Concluded that azithromycin should be used to treat laboratory cases. Azithromycin for presumptive cases if probabilities of chlamydia and PID >19%, doxycycline effectiveness <78%, or cost of azithromycin <$19.**	**Model takes no account of population effects and therefore results might be misleading. (based model on Haddix et al. [221).**
Marrazzo et al. 1997, [33] **USA** **A(1) Pass**	Screening **(Non-selective opportunistic);** **FP, STD clinics;** **Women;**	**Societal**	**Own primary study**	**Own costs from region office of family planning** **US$ 1993**	**Static Decision analytic model**	**DFA/culture/EIA/ DNA probe**	**Doxycycline (compliance estimated at 70-100%, see Washington '87**	**Sequelae avoided**	**At the given prevalence it would be cost saving to screen universally in FP clinics and selectively in STD clinics**	**Model used takes no account of re-infection and population effects and therefore results might be misleading.**

First author; reference; country; quality;[a]	Primary focus; (screening approach); sex; age	View point	Effectiveness data sources	Cost data; year and currency	Model used	Test	Treatment	Primary outcome	Results	Comment
	Mean age 22 - 25 years						)			
Mehta et al. 2002,[25] **USA** **A(1) Pass**	Screening **(Non-selective opportunistic);** **Emergency department (gonorrhoea and chlamydia);** **Men and women; 18-31 years**	**Health care system**	**Literature**	**US $ 1999**	**Static: Decision analytic model**	**LCR** **Urine specimens**	**Azithromycin (1g single dose) + ciprofloxacin (500mg single dose)**	**Cost to prevent case**	**Five strategies: Standard, enhanced, mass treatment. Mass treatment most cost effective strategy among men and women.**	**Comprehensive study which was well reported. However model used takes no account of re-infection and population effects and therefore results might be misleading.**
Moriarty et al. [63], 2001 **New Zealand** **A(1) ?**	Treatment **Women**	**Health care system**	**Literature, medical records, experts, arbitrary**	**National pricing schedules**	**Extended mathematical model**	**EIA confirmed by DFA, LCR**	**Doxycyline (7 days 100mg bd), azithromycin (1g single dose)**	**Cost per patient cured**	**Azithromycin regimens more cost effective. Single dose azithromycin ensured both compliance and minimised side effects.**	**Main aim was to discuss the modelling approach. Needs more detail of model to assess properly.**
Mrus et al. 2003, [45] **USA** **A(1) ?**	Diagnosis **Adolescents in juvenille detention** **13-18yrs**	**Societal**	**Cohort study and literature**	**US $ 1998**	**Static Decision analytic model**	**Urine; LE test and LCR; Additional sample& swab test to all testing positives on urine**	**Azithromycin (1g single dose)**	**Cost per case treated; cost minimisation comparing estimated total cost of diagnosing and treating chlamydia as well as associated with complications.**	**Urine LE results produced the lowest incremental cost effectiveness ratio. In the extended time horizon treating males on the basis of urine LE results least expensive strategy**	**Inappropriate use of longer time horizon cost minimisation analysis, which implies treatin. Takes no account of the different sensitivities of tests. The valuation of these outcomes has not been included, leading to potential bias. Model takes no account of population effects.**
Nettleman et al. 1991, [17] **USA** **A(1) ?**	Screening **Selective opportunistic screening;** **Pregnant;** **Women;**	**Health care system**	**Literature**	**Literature** **Currency and year not stated**	**Static: decision analytic model**	**Culture, DFA**	**Erythromycin (7 days)**	**Cost per complication (salpingitis. neonatal pneumonia)**	**Screening all pregnant women was not cost effective although depended on the test.**	**Model used takes no account of re-infection and population effects and therefore results might be misleading.**

First author; reference; country; quality;[a]	Primary focus; (screening approach); sex; age	View point	Effectiveness data sources	Cost data; year and currency	Model used	Test	Treatment	Primary outcome	Results	Comment
	Not specified but pregnant									
Nettleman et al, 1988, [51] USA A(1) Pass	Diagnosis **(Non-selective opportunistic); Student health clinic**	**Health care system**	**Observed data, literature**	**Local standard cost US $**	**Static: decision analytic model**	**Culture, ELISA, IFA, MIF**	**Not applicable**	**Cost per case detected**	**Screening with DFA more cost-effective than no screening. Culture alone or as confirmation less cost-effective. l**	**The study compares dated diagnostic techniques Model takes no account of population effects.**
Nyari et al. 2001, [53] Hungary A(1) ?	Diagnosis **(Non-selective opportunistic) Women; 15-19 years**	**Health care system**	**Observational data, literature**	**Not stated presume local costs US $ year not stated**	**Static: decision analytic model**	**ELISA, Gen-Probe Type of specimen collection not stated**	**Doxycyline**	**Cost per case prevented (analogous to MOA)**	**Screening by amplified Gen-Probe assays (followed by treatment of positive patients) is the preferred screening strategy for young women in Hungary**	**Model takes no account of population effects and therefore results might be misleading.**
Paavonen et al. 1998, [31] (Finland) A(1) ?	Screening **(Non selective opportunistic); Women; Age not specified**	**Health care system**	**Literature and expert opinion**	**National Research and development Centre for Welfare and Health Finland US $ (year & exchange rate not specified)**	**Static: decision analytic model**	**PCR on urine; EIA on swabs**	**Azithromycin (1g single dose)**	**Cure; cost per case detected; looks at longer term outcomes**	**Population screening using PCR is cost effective even in low prevalence populations. Net saving for pop screening in Finland $3.5 m**	**Model used takes no account of re-infection and population effects and therefore results might be misleading.**
Peeling et al. 1998, [47] Canada A(1) ?	Diagnosis **(Selective) Chlamydia and gonorrhoea; Men; 15-68 years;**	**Health care system**	**Observed data**	**Local costs Canadian $**	**None**	**PCR or LE for urine specimens, culture for urethral specimens**	**Not stated**	**Cost per case detected**	**Targeted screening using risk assessment recommended in the Canadian STD guidelines would detect the same number of cases as universal screening, but with reduced costs.**	**Partial evaluation. No discussion or analysis of re-infection or infection to others and of issue of false negatives.**
Petitta et al. 1999, [58] USA A(1) Pass	Treatment **Men and women**	**Health care system**	**Literature, arbitrary, own primary study, expert opinion**	**Hospital charges, literature US$ implied**	**Static: decision analytic model**	**Not applicable**	**Azithromycin (1g single dose), prescription for doxycycline (7 days 100mg bd), pre-packed doxycycline**	**Assume cost per case cured**	**Pre-packed doxycycline and azithromycin decreased re-infection and overall costs compared with prescription doxycycline. Azithromycin decreased relapse compared with pre-packed doxycycline but incremental impact on cost was inconclusive.**	**Model takes no account of population effects and therefore results might be misleading. The paper compared prescription vs complete package for doxycycline**
Philips et al. 1987, [36]	Screening **(Non selective**	**Health care**	**Literature**	**Local Charges US $ 1984**	**Static: decision**	**DFA or EIA Endocervical**	**Tetracycline (7 days qds)**	**Cervicitis**	**Testing women for cervical chlamydia is cost effective**	**Model used takes no account of re-infection**

First author; reference; country; quality;[a]	Primary focus; (screening approach); sex; age	View point	Effectiveness data sources	Cost data; year and currency	Model used	Test	Treatment	Primary outcome	Results	Comment
USA **A(1) Pass**	**opportunistic); Gynae visit;** **Women;** **Age not specified**	**system**			**analytic model**	**specimens**				**and population effects and therefore results might be misleading.**
Postma et al. 2000, [27] **Netherlands** **A(1) Pass**	Screening **(Non selective opportunistic);** **General Practice;** **Women; 15-34 years**	**Societal**	**Own Study: this is the Amsterdam Pilot study**	**Short term costs from primary study. Long term costs from the published literature-** **US $ 1996**	**Static decision analytic model**	**LCR**	**Single dose (1g) Azithromycin**	**Major outcome averted**	**Screening sexually active women under 30 is cost effective**	**Model used takes no account of re-infection and population effects and therefore results might be misleading.**
Postma et al. 2001, [14] **Netherlands** **A(1) Pass**	Screening/Partner notification **(Selective opportunistic)** **Women and male partners in GP;** **15-29 years**	**Societal**	**Amsterdam Pilot study**	**Dutch sources and published** **Literature** **Euros 1996**	**Static decision analytic model**	**LCR**	**Single dose (1g) Azithromycin**	**Net cost per Major Outcome Averted**	**Partner pharmocotherpay reduces net costs per major outcome averted of the screening program by 50%. Thus partner notification significantly improves cost effectiveness**	**Inadequate inclusion of population effects. But authors argue that this is a justifiable first step and do not attempt to make policy recommendations.**
Sahin-Hodoglugil. 2003, [52] **USA** **A(1) Pass**	Diagnosis **Gonorrhoea and chlamydia;** **Women in sub Saharan Africa**	**Health care system**	**Literature (based on Sub Saharan Africa where possible)**	**US $ 2002**	**Static: decision analytic model**	**Syndromic management vs mass treatment**	**Doxycycline or Azithromycin for chlamydia, ciproflaxin for gonorrhoea, vs. mass treatment with doxycycline**	**Cost per cure**	**Mass treatment with doxycycline for chlamydia most cost effective strategy.**	**Comprehensive paper focusing on African women. Syndromic management rather than aetiological diagnosis. Model used appropriate for objective of this paper.**
Schiotz et al. 1992, [65] **Norway** **A(1) ?**	Treatment **Women;**	**Health service**	**Literature**	**Norwegian medical charges and published studies using Norwegian prices** **US $ (NKr)**	**Static: decision analytic model**	**Culture**	**Lymecycline (10 days 300mg bd)**	**PID case prevented**	**Routine test of cure of asymptomatic chlamydia after treatment not cost beneficial.**	**Model takes no account of population effects and therefore results might be misleading.**
Scoular et al. 2001, [46] **UK** **B1 Pass**	Diagnosis **Laboratory receiving tests from all settings;** **Women and men;** **All ages**	**Health care system**	**Observational data**	**Local costs** **£ Sterling 2000**	**None**	**LCR, EIA** **Urine and urethral swabs**	**None**	**Cost per case detected**	**Substantial health gains are likely to be achieved at both an individual and public health level as a result of introduction of LCR testing.**	**Authors acknowledge that this is a partial evaluation. Costs and effects of false positive and false negative tests not considered.**
Sellors et al. [16] 1992 (USA)	Screening **Selective opportunistic;**	**Health care system**	**Own primary study**	**Own costs** **Can $ 1989**	**No model**	**EIA and/or culture**	**Not specified**	**CT infection**	**Selective versus population screening in low prevalence settings is efficient**	Explorative study. Correct conclusion reached.

First author; reference; country; quality;[a]	Primary focus; (screening approach); sex; age	View point	Effectiveness data sources	Cost data; year and currency	Model used	Test	Treatment	Primary outcome	Results	Comment
A(1) Pass	**Women; Mean 21.5 years**			**(1CAN$=US$0.85)**						
Sellors et al. 1993, [50] Canada A1 Pass	Diagnosis **(Non-selective opportunistic); Men; 16-35 years**	**Health care system**	**Observed data**	**Local costs Canadian $ 1992**	**None**	**LE, EIA and PCR urine specimens in the first instance positives were re-called for further collection using both urine and urethral specimen collection.**	**Not applicable**	**Cost per case detected**	**LE urine strip accurate screening test. Used to pre-select urine specimens for chlamydia testing would be less costly per case detected than testing all specimens.**	**Partial evaluation. No discussion or analysis of re-infection or infection to others and of issue of false negatives.**
Shafer et al. 1999, [15] USA A(1) Pass	Screening **(Selective opportunistic); Adolescent female; 15-19 years**	**Health care system**	**Literature**	**Government charges deflated to reflect cost 1995 US $**	**Decision analysis**	**LCR & PCR**	**Single dose (1g) Azithromycin & I/m Ceftriaxone 1g**	**PID prevented**	**1283 cases of PID would be prevented at a mean cost of $5093**	**Model used takes no account of re-infection and population effects and therefore results might be misleading.**
Skjeldestad et al. 1988,[20] Norway A(1) Pass	Screening **(Selective opportunistic); Women seeking abortion; Age not specified**	**Health Care System**	**Own primary study**	**Local cost data 1985 US$ & NOK**	**No Model**	**Culturing - but not specified**	**Lymecycline (7 days)**	**Salpingitis**	**Abortion seeking women should be screened and treated for chlamydia.**	**No model and no attempt to make policy decisions. Acceptable conclusion**
Townshend et al. 2000, [29] UK A1?	Screening **(Non-selective opportunistic) Men and women; 12-40 years**	**NHS**	**Literature**	**Literature UK Sterling £ No year stated**	**Dynamic: System dynamics model**	**Not specified**	**Not specified**	**PID and related sequelae for men, women and neonates**	**Suggests that proposed screening programme would prevent significant numbers of infertility cases annually. Additionally it could be paying for itself after about 4 years and re-couping the initial outlay after about 12.**	**Appropriate transmission dynamic model. Paper highlights use of model and suggesting some conclusions. Economic quality of this paper was dubious.**
Trachtenberg et al. 1988, [21] USA A(1) Pass	Screening **Selective opportunistic screening; Family Planning clinic; Women; Not specified**	**Health Care System**	**Based on study by Handsfield JAMA 86 - 2 Seattle FP clinics**	**Based on data used by Washington (ref) Not stated in this study - but cites Washington**	**Static: decision analytic model**	**DFA**	**Doxycycline (7 days)**	**Sequelae avoided**	**Screening asymptomatic women is cost effective**	**Model used takes no account of re-infection and population effects and therefore results might be misleading.**

First author; reference; country; quality;[a]	Primary focus; (screening approach); sex; age	View point	Effectiveness data sources	Cost data; year and currency	Model used	Test	Treatment	Primary outcome	Results	Comment
Van Valkengoed et al. 2001, [42] **Netherlands** **A(1) Pass**	Screening **(Non selective population)** **Women only;** **15-40 year olds**	**Societal**	**Amsterdam Pilot study & own primary data**	**Cites Postma et al {671}** **1996 US $**	**Static: decision analytic model**	**LCR**	**Single dose (1g) Azithromycin (or Erythromycin for pregnant women for 5 days)**	**Woman cured and Major outcome averted**	**Estimated cost of curing one woman is US $1,210. The net cost of preventing one major outcome is $15,800. Population screening of 15-40 yrs is not cost effective**	**Model used takes no account of re-infection and population effects and therefore results maybe misleading.**
Wang et al. 2002, [41] **USA** **A(1) Pass**	Screening **(Non-selective population)** **School pupils; Chlamydia and gonorrhoea,** **Men and women**	**Health care sector**	**Own primary study and literature**	**US $ 1997**	**Static: decision analytic model**	**Urine -LCR for school based testing. For non school based testing the test could vary**	**Single dose (1g) Azithromycin**	**Cost per case of PID prevented**	**The school based screening program prevented an estimated 38 cases of PID as well as $119,866 in treatment costs. For PID and it sequelae it resulted in savings of $1524 per case of PID prevented.**	**Model used takes no account of re-infection and population effects and therefore results might be misleading.**
Washington et al. 1987, [66] **USA** **A(1) ?**	Treatment **(Combined treatment for gonorrhoea and co-infection with chlamydia)**	**Health care system**	**Observational date, literature,**	**Wholesale prices, hospital charges, literature, arbitrary** **US $**	**Static: decision analytic model**	**Not applicable**	**Three regimens: Ampicillin (3.5g + probenecid, single dose); Tetracycline (7 days 500mg qds); combined treatment, same dosage and regimen**	**Cost per case treated**	**Combination treatment more than twice as cost-effective as tetracycline and seven times as cost-effective as ampicillin when the medical cost of managing PID is considered. When the costs of treating ectopic pregnancy and infertility are considered the cost-effectiveness increases further.**	**Model takes no account of population effects and therefore results might be misleading..** **Old paper pre 1987, also combined treatment for chlamydia and gonorrhea**
Welte et al. 2000, [28] **Netherlands** **A(1) Pass**	Screening **(Non selective opportunistic); General Practice;** **Men and women**	**Societal**	**Amsterdam Pilot study & literature**	**Short term costs from Postma et al. Long term costs estimated from resource use.** **US $ 1997**	**Dynamic: discrete event simulation**	**LCR**	**Azithromycin (1g single dose)**	**Major outcome averted**	**Screening may save costs in the long, but not short run.**	**Appropriate transmission dynamic model. High estimate of progression to PID. 50-75% effective screening**

First author; reference; country; quality;[a]	Primary focus; (screening approach); sex; age	View point	Effectiveness data sources	Cost data; year and currency	Model used	Test	Treatment	Primary outcome	Results	Comment
	15-65 years									**rate.**

Legend:

Abbreviations: bd – twice daily; BD ProbeTec – strand displacement amplification test (Becton Dickinson, Franklin Lakes, NJ); Chemstrips 9 LE – leucocyte esterase test (Roche Diagnostics, Basel); DFA – direct fluorescent antibody test; EIA – enzyme immunoassay; FP – family planning clinic; GP – general practice; ICER – incremental cost-effectiveness ratio; LCR – ligase chain reaction (Abbott Diagnostics, Chicago, IL); MOA – major outcome averted; NAAT – nucleic acid amplification test; PCR – polymerase chain reaction (Roche Diagnostics, Basel); PID – pelvic inflammatory disease; QALY – quality adjusted life year; qds – four times daily; tds – three times daily;