

Sexually Transmitted Diseases in California

2015 Technical Notes

OVERVIEW OF THE DATA SOURCES, BY SEXUALLY TRANSMITTED DISEASE

DATA SOURCE	Sexually Transmitted Disease			
	Chlamydia	Gonorrhea	Syphilis	Other STDs
CASE-BASED SURVEILLANCE	X	X	X	X
ENHANCED CASE-BASED SURVEILLANCE		X	X	
PREVALENCE MONITORING				
Family Planning Clinics	X	X		
STD Clinics	X	X		
Managed Care Organizations	X	X		
Juvenile Detention Facilities	X	X		
ANTIMICROBIAL RESISTANCE SURVEILLANCE		X		
LABORATORY SURVEY	X	X	X	X

The sexually transmitted diseases (STD) surveillance systems operated by California state and local STD control programs are the sources of data in this publication. **Case-based surveillance** is conducted for the following reportable STDs: chlamydia, gonorrhea, syphilis, and chancroid. Case reports are submitted to local health jurisdictions (LHJ) in the form of laboratory reports and reports from health care providers. LHJs then submit the data to the California Department of Public Health (CDPH). In 2015, most health jurisdictions used the California Reportable Disease Information Exchange (CalREDIE) system, while a few entered case data into unique locally developed systems.

Rates by county and selected city health jurisdictions were calculated with the use of State of California, Department of Finance, *E-6: Population Estimates and Components of Change by County, July 1, 2010-2015*, Sacramento, California, December 2015. Rates by age, race/ethnicity, and gender were calculated with the use of State of California, Department of Finance, *Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060*, Sacramento, California, December 2014. In this report, data are presented by county and for the separate city health jurisdictions of Berkeley, Long Beach, and Pasadena. The data for these cities are displayed separately from their respective county totals and are included in the county totals.

The **race and ethnicity** information included in this report is based on the following categories: African American/black (black, non-Hispanic); Hispanic/Latino (Hispanic ethnicity, regardless of race designation); white (white, non-Hispanic); Asian/Pacific Islander (combined Asian and Native

Hawaiian/Pacific Islander, non-Hispanic); Native American/Alaskan Native (non-Hispanic); multi-race (non-Hispanic); other race (non-Hispanic); and Not Specified (no race or ethnicity information was available). The substantial amount of missing race/ethnicity data from laboratory and health care provider reports limits the interpretation of race/ethnicity data from these surveillance data. The majority of case reports originate from laboratories, a source which does not routinely collect data on race/ethnicity. Further, some managed care organizations and other health care service providers do not routinely record race/ethnicity of patients. The observed racial/ethnic disparities may reflect true differences in the infection rates, differential access to health care, and/or reporting practices of different types of providers that serve different populations.

Because the proportion of these racial/ethnic data that are missing varies substantially across LHJs, for the “Chlamydia Cases & Rates with County, Gender, Race/Ethnicity, and Age Detail” and “Gonorrhea Cases & Rates with County, Gender, Race/Ethnicity, and Age Detail” tables that show rates of chlamydia and gonorrhea by LHJ, gender, age and race/ethnicity, the cases missing race/ethnicity data in each LHJ/gender/age strata have been redistributed in accordance with cases that do have such data in the same strata. This adjustment is necessary to make meaningful comparisons of rates by race/ethnicity across LHJs. This adjustment makes the assumption that the cases without race/ethnicity data have the same distribution of race/ethnicity as cases that do have such data. While this assumption is undoubtedly not fully accurate in some LHJs and therefore these tables must be interpreted cautiously, the assumption, or some other adjustment technique, is essential for comparisons across LHJs to be made.

Rates for **congenital syphilis** were calculated with the use of State of California, Department of Finance, Demographic Research Unit, *Historical and Projected State and County Births, 1970-2023, with Actual and Projected Fertility Rates by Mother's Age and Race/Ethnicity, 2000–2023*, Sacramento, California, December 2014; and State of California, Department of Public Health, Center for Health Statistics, *Birth Statistical Master Files*.

Enhanced case-based surveillance for syphilis¹ is based on standardized interviews of syphilis cases conducted by LHJ disease intervention specialists. Enhanced surveillance for gonorrhea² is based on standardized interviews of a *sample* of gonorrhea cases and their medical providers conducted by LHJ disease intervention specialists and/or public health nurses. For these syphilis and gonorrhea cases, a range of demographic, behavioral (e.g., gender of sex partners, venues where sex partners were met), and clinical (e.g., symptoms, HIV serostatus) data are collected beyond what is available from the Confidential Morbidity Reports (CMRs) alone.

Ocular syphilis surveillance as of 2014-2015 is based on extracting suspected cases among reported syphilis cases with either clinician-observed or patient-described symptoms associated with ocular syphilis, e.g., blurry vision, vision loss, retinitis, uveitis. Lack of standardization in the reporting of ocular symptom and diagnosis data presents a challenge for interpreting the burden of and trends in ocular syphilis.

Prevalence monitoring for chlamydia and gonorrhea through 2013 was conducted primarily in family planning and STD clinics through the CDC chlamydia prevalence monitoring project which began in 1995. The chlamydia prevalence data for California came from three project areas: San Francisco; Los Angeles; and the California Project Area (CPA), which includes the remaining

¹ <http://www.cdph.ca.gov/data/statistics/Documents/STD-Data-Syphilis-Elimination-Surveillance-Data.pdf>

² <http://www.cdph.ca.gov/data/statistics/Documents/STD-Data-CGSS-Regional-Data.pdf>

health jurisdictions in California. In 2013, data were only available for the CPA, which collected chlamydia and gonorrhea testing data from 40 family planning clinics and 4 STD clinics.

Prevalence monitoring for chlamydia and gonorrhea is also conducted in managed care settings. Since 1999, Kaiser Permanente Northern California (KPNC) has participated in electronic transmissions of data to CDPH. Through a data transmission protocol that removes patient identity, KPNC has provided the chlamydia and gonorrhea testing data for all patients tested.

Prevalence monitoring data for juvenile detention facilities comes from the Chlamydia Screening Project (ClaSP), which provides chlamydia screening for adolescents at entry into juvenile detention facilities through partnerships between juvenile justice and local health department STD control programs. Data on chlamydia and gonorrhea testing comes from a standardized data collection form used in all participating sites.

California carries out surveillance for gonococcal drug resistance as part of the national **Gonococcal Isolate Surveillance Project (GISP)**. Every month, sentinel site STD clinics in Los Angeles, Orange, San Diego, and San Francisco health jurisdictions are asked to submit the first 25 gonococcal isolates from male urethral specimens. Because of decreasing rates of culture testing for gonorrhea, there may be fewer than 25 isolates per month in a given site.

The **California Clinical Laboratory Survey** is based on a list of all licensed laboratories in California, provided by the CDPH Laboratory Field Services Branch. Laboratories were eligible for survey recruitment if the state ID prefix was CLF (state licensed non-physician operated with federal CLIA certificate that can perform waived, moderate, and high complexity testing) or CPH (public health laboratory). Laboratories were excluded if the state ID prefix was CLR (clinical laboratory with state certificate of registration that can perform waived tests, i.e., has federal CLIA certificate of waiver), CLP (physician office laboratory that is performing physician performed microscopy), CLM (physician office laboratory that is not accredited and can perform waived and non-waived testing with federal CLIA certificate of accreditation), COS (non-California laboratory with a federal CLIA certificate), CNC (non-licensed/registered laboratory), or CMS (multiple sites under one license or registration). The most recent laboratory survey summary report is available at <http://www.cdph.ca.gov/data/statistics/Documents/STD-Data-LabSurvey.pdf>.

The source of **national STD data** presented is Centers for Disease Control and Prevention, *Sexually Transmitted Disease Surveillance, 2014*. Atlanta, Georgia: U.S. Department of Health and Human Services, 2015. The U.S. Year 2020 Goals are from U.S. Department of Health and Human Resources, Healthy People 2020 web site, Topic Area Sexually Transmitted Diseases (<http://www.healthypeople.gov/2020/topics-objectives/topic/sexually-transmitted-diseases/objectives>).

SMALL NUMBERS CAUTION

Readers should observe caution when interpreting rates based on few events and/or small populations. For more information, refer to *Guidelines for Statistical Analysis of Public Health Data with Attention to Small Numbers, Revised, July 2003*. This publication can be found at: <https://fhop.ucsf.edu/sites/fhop.ucsf.edu/files/wysiwyg/smallnumbers2003.pdf>.

Furthermore, because small numbers may result in potential confidentiality concerns, in our “Chlamydia Cases & Rates with County, Gender, Race/Ethnicity, and Age Detail” and “Gonorrhea Cases & Rates with County, Gender, Race/Ethnicity, and Age Detail” tables stratified by LHJ/gender/age/race/ethnicity, some cells along with “complementary” cells have been suppressed in these publicly accessible data. For these tables, any cell is suppressed if the difference between the population “denominator” and the number of cases “numerator” is less than or equal to 50; and any complementary cells are suppressed such that the numbers in the originally suppressed cell(s) cannot be recalculated.

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James P. Watt, M.D., M.P.H., Chief

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
STD CONTROL BRANCH
Heidi M. Bauer, M.D., M.S., M.P.H., Chief
Joan M. Chow, M.P.H., Dr.P.H.
Denise M. Gilson

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Inquiries regarding this report should be directed to:

Denise Gilson
California Department of Public Health
STD Control Branch
Surveillance and Data Management Unit
MS 7320
P.O. Box 997377
Sacramento, CA 95899-7377
Phone: (916) 552-9812