NACCHO
National Association of County & City Health Officials
The National Connection for Local Public Health

09-10

STATEMENT OF POLICY

Prevention and Control of Sexually Transmitted Infections

Policy

To support and advance the essential role of local health departments (LHDs) in the prevention and control of sexually transmitted infections (STIs),[1] including HIV, the National Association of County and City Health Officials (NACCHO) encourages:

- Increased funding from federal and state governments to support local STI prevention and control programs, activities, and services. Though implementation of the Patient Protection and Affordable Care Act (ACA) will expand health insurance coverage for many people who are currently uninsured or underinsured and require that private insurers cover certain preventive services, including STI counseling and screening, the need for publicly-funded STI prevention and control programs provided through LHDs will remain essential.
- Increased flexibility in the use of federal and state funds to improve LHDs' ability to provide and support locally-relevant and appropriate STI prevention and control efforts, including the ability to integrate STI activities, programs, and services with other disease-specific activities, programs, and services to best meet the needs of individuals and communities.
- The Centers for Disease Control and Prevention (CDC) to increase support and funding for workforce development through scholarships/fellowships, continuing education, and ongoing technical assistance to LHDs and their partners to ensure that the skills and expertise needed to prevent and control STIs at the local level (including clinical, epidemiologic, laboratory, and case/contact finding and care) are maintained and enhanced.

Justification

STIs pose a significant disease burden in the United States. The CDC estimates that there are approximately 19 million new STI infections each year, almost half of which occur among young people 15 to 19 years of age.[2] However, many cases of STIs go undiagnosed and some are not reported to the CDC, so reported cases of chlamydia, gonorrhea, and syphilis (the three nationally notifiable STIs) represent only a fraction of the true burden of STIs in the U.S.[3] In 2010, a total of 1,307,893 cases of sexually transmitted chlamydia infection were reported to the CDC, representing the largest number of cases ever reported to the CDC for any condition.[4] In the same year, a total of 309,341 cases of gonorrhea and 13,774 cases of primary and secondary syphilis were reported,[5] and there are an estimated 50,000 new HIV infections in the U.S. annually.[6]

The American public has an important stake in the prevention and control of STIs because all communities are impacted and all individuals directly or indirectly pay for the costs of these diseases.[7] Most STIs are easily treated or cured, however many cases go undetected and/or

untreated, resulting in long-term and more costly complications, such as pelvic inflammatory disease, infertility, sterility, chronic pain, ectopic pregnancy, and even death. Furthermore, an association between STIs and the risk of HIV infection at both individual and population levels has been demonstrated in studies and meta-analyses.[8] In addition to the potential for serious health consequences, STIs have a substantial economic impact. The CDC estimates that STIs cost the U.S. health care system as much as $15.9 billion annually.[9] To reduce the health and economic consequences of STIs, expanded prevention and early intervention efforts, including screening, are needed.

LHDs have traditionally played a critical role in STI prevention and control by operating programs and providing services supported by government funding dedicated to communicable disease prevention. While there are a number of non-governmental organizations that conduct STI prevention and control activities in communities, health departments conduct the bulk of these activities. Sixty-four percent of the nation's LHDs report that they provide screenings for STIs and 61 percent report that they provide screenings for HIV.[10] Treatment for STIs and HIV/AIDS is provided by 59 percent and 21 percent of all LHDs, respectively.[11] Additionally, the likelihood that LHDs provided screening and treatment services increases with increasing population size of the jurisdiction served. For example, 85 percent and 43 percent of LHDs serving populations greater than 500,000 persons report that they provide treatment for STIs and HIV/AIDS, respectively.[12]

In addition to operating clinics for the diagnosis and treatment of STIs and linkage to care for HIV/AIDS patients, LHDs also conduct case investigations to identify, evaluate, and treat the sexual partners of persons diagnosed with an STI. These activities, referred to as disease intervention and partner services, are a primary means to break the chain of transmission. Health departments are also heavily involved in surveillance activities to monitor and track STIs in the community to prioritize and plan prevention and control efforts.

Since many STIs are often asymptomatic, LHD STI clinics and other health care providers ultimately only serve a small portion of those infected, illustrating the need for increased efforts and resources to ensure effective STI screening.[13] The U.S. Preventive Services Task Force (USPSTF) and the CDC provide clinical recommendations for screening and treatment.[14,15] Another important strategy for expanding STI screening, especially to high-risk populations, is to offer STI and HIV testing in non-traditional or out-of-clinic settings, such as schools, correctional facilities, bathhouses, and other community settings.[16] LHDs are integral to the development and operation of programs and initiatives offering screening and testing in such settings.

However, funding to support in-clinic and out-of-clinic services is dwindling. In 2011, 57 percent of all LHDs reduced or eliminated at least one program as a result of budget cuts. Twenty-three percent of all LHDs reported a reduction to clinical health services and 10 percent reported a reduction to their communicable disease testing and/or treatment programs.[17] Furthermore, increased health insurance coverage resulting from ACA implementation will not fully address the STI prevention and control needs of all individuals and communities, meaning that strong LHD prevention and control programs remain essential and must be adequately funded and supported.

The ACA does play a very important role in STI prevention and screening though, as it helps make prevention more affordable and accessible by requiring health plans to cover preventive services and eliminate cost sharing. Under the ACA, private health plans must provide coverage for a range of preventive services, including evidence-based screenings and counseling. The screening and counseling services that insurers must provide are those with a rating of "A" or "B" in the recommendations of the USPSTF, which includes screening for STIs, including HIV.[18] (Note: Screening for chlamydia and gonorrhea in women, but not men, is given a rating of "A" or "B.") In regard to coverage for preventive services under Medicaid, the ACA includes opportunities for increased federal matching rates if plans cover the preventive services rated "A" or "B" by the USPSTF without charging cost-sharing for these services.[19]

Medicaid, private health insurers, and LHD STI programs will need to formalize collaborative arrangements and capitalize on the strengths of each organization in order to have a population-level impact on reducing STI transmission. The CDC and state and local health departments must also work together to implement performance measures, require collaborative activities, promote education of and outreach to clinicians, and produce improvements in reporting and surveillance.

Record of Action

Proposed by NACCHO HIV/STI Workgroup
Approved by NACCHO Board of Directors
November 2009
Updated September 2012

References

[1] Sexually transmitted infections refer to any infection that is transmitted primarily through person-to-person sexual contact including, but not limited to, HIV, syphilis, gonorrhea, chlamydia, trichomoniasis, genital herpes, genital human papillomavirus, and hepatitis B. There are more than 30 different sexually transmissible bacteria, viruses, and parasites.

[2] Centers for Disease Control and Prevention. (2009). Sexually Transmitted Disease Surveillance, 2008. Atlanta, GA: U.S. Department of Health and Human Services.

[3] *Ibid.*

[4] Centers for Disease Control and Prevention. (2011). *Sexually Transmitted Disease Surveillance, 2010*. Atlanta, GA: U.S. Department of Health and Human Services.

[5] Centers for Disease Control and Prevention. (2011). *Sexually Transmitted Disease Surveillance, 2010*. Atlanta, GA: U.S. Department of Health and Human Services.

[6] Prejean, J., Song, R., Hernandez, A., Ziebell, R., Green, T., et al. (2011). Estimated HIV Incidence in the United States, 2006-2009. PLoS ONE 6(8): e17502. doi:10.1371/journal.pone.0017502.

[7] Centers for Disease Control and Prevention. (2011). *Sexually Transmitted Disease Surveillance, 2010*. Atlanta, GA: U.S. Department of Health and Human Services.

[8] Ward, H. & Ronn, M. (2010). The contribution of STIs to the sexual transmission of HIV. Current Opinion in HIV/AIDS. 2010 July; 5(4): 305–310. doi:10.1097/COH.0b013e32833a8844.

[9] Centers for Disease Control and Prevention. (2009). *Trends in Reportable Sexually Transmitted Diseases in the United States, 2007*. Atlanta, GA: U.S. Department of Health and Human Services.

[10] National Association of County and City Health Officials (2011). *2010 National Profile of Local Health Departments*. Washington, D.C.

[11] *Ibid.*

[12] *Ibid.*

[13] Farley, T., Cohen, D., & Elkins, W. (2003). Asymptomatic sexually transmitted diseases: the case for screening. *Preventive Medicine*. 36(4): 502-509.

[14] Meyers, D., Wolff, T., Gregory, K., et al. USPSTF. (2008). Recommendations for STI Screening. *American Family Physician*. 77:819-824
[15] Centers for Disease Control and Prevention. (2010). Sexually Transmitted Diseases Treatment Guidelines, 2010. MMWR 59(No. RR-12):1-110.
[16] Auerswald, C., Sugano, E., Ellen, J., & Klausner, J. (2006). Street-based STD testing and treatment of homeless youth are feasible, acceptable and effective. *Journal of Adolescent Health*, 38: 208-212.
[17] National Association of County and City Health Officials. (2012). Local health department job losses and program cuts: Findings from January 2012 survey. Washington, D.C.
[18] Kaiser Family Foundation. (2011). Preventive Services Covered by Private Health Plans under the Affordable Care Act. Retrieved on September 28, 2012 from http://www.kff.org/healthreform/upload/8219.pdf.
[19] Kaiser Family Foundation. (2012). Coverage of Preventive Services for Adults in Medicaid. Retrieved on September 28, 2012 from http://www.kff.org/medicaid/upload/8359.pdf.