

09-10

STATEMENT OF POLICY

Sexually Transmitted Infections

Policy

The National Association of County and City Health Officials (NACCHO) calls for increased local, state and federal funding to support and strengthen the public health infrastructure for a comprehensive sexual health approach to sexually transmitted infections (STI) prevention and treatment.

In support of a comprehensive high-impact approach to STI prevention and treatment, NACCHO recommends that local health departments work with their community and state partners to take the following actions:

- Assure testing and treatment is conducted in accordance with the U.S. Preventive Services Task Force (USPSTF) Recommendations for STI Screening and the Centers for Disease Control and Prevention (CDC) STD Treatment Guidelines;
- Support the use of extra-genital (all site or three-site) STI testing by educating healthcare providers and patients about the need to test for STIs in the pharynx and rectum as well as the urethra and vagina;
- Use surveillance data to monitor trends, identify outbreaks, track emerging threats such as antibiotic-resistant gonorrhea, and guide planning efforts;
- Improve coordination and data sharing between STI and HIV programs to increase screening, improve access to linkage to care and treatment, and scale-up pre-exposure prophylaxis (PrEP) for HIV prevention;
- Provide or support primary prevention interventions including health education and condom distribution,¹ testing, and treatment in clinical and non-clinical settings, including in schools, jails, juvenile detention facilities, and other settings that allow access to individuals at high-risk for STIs;
- Implement targeted disease investigation and intervention, including use of internet partner services, to identify persons with STIs and their partners and link them to care and treatment;
- Support policies that improve access to STI services for those most at-risk for infection, including expedited partner therapy (EPT), minor consent laws for confidential STI services, and syphilis testing for pregnant people in both the first and third trimester;
- Support the integration of STI services in healthcare settings, such as prenatal, adolescent, and overall primary care, by educating healthcare providers about properly screening for and treating STIs;
- Ensure that STI clinics and services are designed to be safe and supportive environments for all, including being youth-friendly and welcoming to people of color and people who identify as LGBTQ;
- Ensure an accurate and non-judgmental sexual history is taken for all patients in the health department and educate non-health department providers to do the same; and
- Explore novel and innovative approaches to expanding the availability and acceptability of STI services, such as by rebranding STI clinics as sexual health clinics, offering express visits,² using self-collected samples and technology to contact patients with their test results, and establishing standing orders for



STI services in health department clinical settings so that it is standard practice to include a sexual health panel of laboratory tests for all clients, especially for men who have sex with men (MSM).

To ensure locally relevant and appropriate STI prevention efforts, federal STI funding must be flexible and allow local health departments to integrate STI activities and services with other health department efforts. Additionally, increased collaboration between federal partners and state and local health departments is necessary to ensure STI priorities and program requirements are in alignment with local circumstances and responsive to emerging threats.

Local health departments must work with and on behalf of their communities to ensure that populations most impacted by STIs are appropriately and effectively served. STIs disproportionately impact young people, communities of color, and LGBTQ individuals, due to social conditions that differ among the groups including poverty, education levels, and access to healthcare. Recognizing these inequities and working to minimize them is critical and local health departments must support policies that improve access to STI services for those most impacted by STI-related morbidity, including young people, MSM, and pregnant people.

Lastly, NACCHO urges increased funding for and attention to STI-related research, including expanded prevention strategies; development of biomedical interventions to prevent, detect, and treat STIs (e.g., vaccines, point-of-care diagnostics, new treatments); and increased understanding of the progression and manifestation of STIs, including drug resistance and transmission networks.

Justification

Sexually transmitted infections, specifically chlamydia, gonorrhea, and syphilis, have reached crisis levels in the United States. Local health departments are on the frontlines of the response to these increases and publicly-funded STI programs are an essential component of our nation's response to this crisis. According to the CDC's *2017 STD Surveillance Report*, in 2017, more than 2 million cases of chlamydia, gonorrhea, and syphilis (the three nationally reportable STIs) were reported to the CDC, the highest number on record.³ Between 2016 and 2017 alone, reported chlamydia cases increased 6.9% to 1,708,569; gonorrhea cases increased 18.6% to 555,608; and primary and secondary syphilis cases increased 10.5% to 30,644.³ Further, 918 cases of congenital syphilis—syphilis transmitted from mother to child during pregnancy—were reported in 2017, a 43.8% increase since 2016 and a 153.3% increase since 2013.³ In 2017, congenital syphilis also resulted in at least 64 stillbirths and 13 infant deaths.³ Many STI cases are not reported to the CDC and even more remain undiagnosed, meaning these numbers do not reflect the true burden of STIs in the United States. The CDC estimates that there are approximately 20 million new STI infections each year, almost half of which occur among young people 15 to 24 years of age, and that there are more than 110 million STI cases in the United States at any given time.⁴

While chlamydia, gonorrhea, and syphilis are historically easily treated or cured when diagnosed and treated properly, many infections are asymptomatic and consequently remain undetected and untreated, which can result in long-term and costly complications, such as pelvic inflammatory disease, infertility, sterility, chronic pain, ectopic pregnancy, and even death. Each year, untreated STIs result in infertility in at least 20,000 women across the United States, and untreated syphilis among pregnant women causes infant death in up to 40% of cases.⁵ An association between STIs and the risk of HIV infection has also been demonstrated in studies and meta-analyses.⁶ In addition to the potential for serious health consequences, STIs have a substantial economic impact. The CDC estimates that STIs cost the U.S. healthcare system nearly \$16 billion annually.⁴

Tools and strategies to effectively prevent and treat STIs exist, but funding cuts have hampered local health departments' ability to sufficiently provide them within their communities. Local public health funding comes from a variety of sources and the mix from one local health department to another varies significantly. The sources can generally be lumped into the following categories: federal and state funding, county or city appropriations, and fees from services offered. For nearly a decade, local health departments have faced

declining and stagnant budgets and, in 2017, one-third reported anticipating funding cuts for the next fiscal year.⁷ Federal funding for STI prevention has decreased significantly in recent years and in few cases have state and local jurisdictions been able to make up the difference. These cuts have significantly impacted the local public health workforce, which has decreased by 23% since 2008.⁸ According to a nationally representative survey conducted in 2013, nearly two-thirds of local health department STI programs had experienced budget cuts in the previous year, resulting in reductions in staffing, clinic hours, and STI prevention efforts.⁹ After years of budget cuts, local health departments need increased federal, state, and local funding to strengthen and sustain STI services and implement promising and proven strategies to close the gaps in prevention, diagnosis, and care. Local health departments also need increased flexibility in their use of STI funding so that they can be more responsive to local STI patterns and trends, including outbreaks or clusters. Flexible funding also allows local health departments to modernize surveillance and optimize use of local data to target prevention efforts.

Local health departments play a critical role in providing and/or assuring STI prevention and treatment services by operating programs, providing services, and working with local healthcare providers and other community partners. While there are non-governmental organizations that conduct STI prevention and control activities in communities across the United States and many STIs are diagnosed in primary or specialty healthcare settings, health departments play a significant and distinctive role. Local health department disease intervention/investigation specialists (DIS) conduct almost all disease intervention activities or case investigations to identify, evaluate, and treat the sexual partners of persons diagnosed with STIs. These activities are a primary and essential means to break the chain of STI transmission. While DIS have long been critical to local health department STI programs, their unique skillset can benefit local public health in several ways, and they are playing an increasing role in the prevention and control of other communicable diseases, as well as in emergency preparedness and the response to the opioid epidemic. Another unique role for health departments is conducting surveillance to monitor and track STIs to prioritize and plan prevention and control efforts. Local health departments also directly provide STI services. Sixty-five percent of the nation's local health departments report that they provide STI testing and 62% report that they provide HIV testing.⁸ Treatment for HIV and other STIs is provided by 35% and 63% of local health departments, respectively, and these figures are higher for health departments serving larger populations.⁸

While STIs are contracted by people in every age, sex, and racial demographic, they also disproportionately impact certain groups. Young women face heightened risk for chlamydia: In 2017, the rate of chlamydia among women was twice that of men and an estimated 9.6% of 15 to 24-year-old women in the United States have chlamydia.³ Both gonorrhea and syphilis disproportionately impact MSM: In 2017, men accounted for 87.7% of syphilis cases, and of those for whom the sexual partner(s) of the patient was reported, 79.6% were MSM.³ In 2017, the rate of gonorrhea among men was 43% higher than that of women, and the disparity is only rising—between 2013 and 2017, the rate increased 39.4% for women and 86.3% for men.³ While information about sexual partner(s) of patients with gonorrhea is not often collected and/or reported to CDC, data from the STD Surveillance Network suggests that between 2010 and 2015, gonorrhea incidence increased among MSM by 151%, compared to 40% for women and 32% for men who have sex with women.¹⁰

People of color are also disproportionately impacted by STIs due in part to inequities in wealth, income, and educational attainment—all of which inhibit access to, and affordability of, quality STI prevention and treatment services—and historical and persistent racism, which exacerbates medical mistrust among communities of color and can result in implicit provider bias or discrimination.³ The rate of chlamydia among blacks was 5.6 times the rate among whites in 2017, and for American Indians/Alaskan Natives, Native Hawaiians/Other Pacific Islanders, and Hispanics, the rates were 3.7, 3.4, and 1.9 times that of whites, respectively.³ For gonorrhea, rates among blacks, American Indians/Alaskan Natives, Native Hawaiians/Other Pacific Islanders, and Hispanics, were 8.3, 4.5, 2.8, and 1.7 times higher than whites, respectively.³ And for syphilis, blacks, Native Hawaiians/Other Pacific Islanders, Hispanics, and American Indians/Alaskan Natives experienced rates 4.5, 2.6, 2.2, and 2.1 times that of whites.³

Local health departments should collaborate with community partners and healthcare providers to develop strategic, high-impact STI prevention plans for addressing rising rates of STIs including developing comprehensive approaches to sexual health promotion that meet individuals where they are and support the informed decision-making about sexual health. High impact prevention is the approach to disease prevention in which proven, cost-effective, and scalable interventions are used to target the right populations in the right geographic areas. Given the limited resources of STI programs at this time and the array of important strategies for addressing STIs, it is essential that this targeted approach is used. An effective response to the STI crisis requires expanded prevention and early intervention efforts. Since STIs are often asymptomatic, local health department STI clinics and other healthcare providers ultimately serve only a small portion of those infected. While USPSTF and CDC provide clinical recommendations for screening and treatment, reaching all people recommended for STI screening will require a multi-pronged approach, as the barriers that impact access to STI services and the preferences and needs that influence health seeking behavior are distinct among different populations.

Many cases of STIs are diagnosed outside of local health department STI clinics by a provider in their community but a significant proportion remain undiagnosed. Local health departments can increase access to and uptake of STI testing and treatment by conducting provider education, including through public health detailing, to promote the integration of STI screening into primary care as well as specialized healthcare, including obstetrics, which is particularly important considering increases in congenital syphilis. This may include educating healthcare providers about best practices for diagnosing and treating STIs or sharing STI clinical guidelines.¹¹ In a recent study, less than half of sexually active, non-partnered respondents reported annual STI testing, despite medical guidelines that recommend annual screening for this population.¹² As urine-only screening misses 70 to 88% of chlamydia and gonorrhea infections in MSM, local health departments should encourage providers in the community to incorporate extragenital testing into screening practices for MSM.¹³ Local health departments can also conduct provider education to ensure private healthcare providers are aware of CDC's current treatment guidelines for gonorrhea and other STIs and promote antibiotic stewardship. This is critical as patients diagnosed with gonorrhea outside of STI, family planning, or reproductive health clinics are two to three times less likely to receive the recommend treatment.¹⁴

The stigma associated with STIs may inhibit patients from seeking STI services from their regular provider or at a location where they may see people they know, and/or they may want to avoid billing notifications from their insurance company (i.e., an explanation of benefits). At the same time, many people prefer obtaining STI services from public STI clinics, as they often offer walk-in, same-day appointments at a low cost and high quality of care.¹⁵ STI clinics are often preferred by populations at disproportionate risk for STIs and/or those who may face heightened barriers in accessing STI services: 59% of STI clinic patients are young people under the age of 30, 73% are people of color, and 50% are uninsured.¹⁵ Sixty percent of STI clinic patients could access healthcare at another facility and half of insured patients choose to self-pay, rather than use their insurance, which demonstrates the ongoing need for publicly funded STI clinics, despite increases in insurance coverage.¹⁵

Privacy concerns may have a disproportionate impact on the health seeking behavior of young people: 22.6% of adolescents aged 15-17 report that they would not seek sexual and reproductive health services because their parents could find out.¹⁶ Young people aged 15-17 years old who had seen a healthcare provider privately, without a parent in the room, were nearly twice as likely to receive a sexual risk assessment (71.1 vs. 36.6%) and more than twice as likely to be screened for chlamydia (34.0 vs. 14.9%).¹⁶ In a separate study, less than one-third (32.6%) of STI clinic patients covered by their parents' insurance were willing to use it, demonstrating the critical need for confidential and affordable STI services for young people.¹⁷ As half of all new STI infections in the United States occur among young people aged 15-24 years old, expanded minor

consent laws, which dictate the services that minors can obtain without parental permission and/or notification, can mitigate the privacy concerns that often inhibit young people from accessing sexual health services.

Eliminating disparities and addressing the gaps in STI prevention and care will require adapting programs and services to mitigate the barriers faced by populations most impacted by STIs. Implementing standing orders in STI and other public health clinics, particularly those serving MSM, for a comprehensive panel of STI tests into all clinical care provided, could help identify asymptomatic infections.¹⁸ Expanding access to PrEP for HIV prevention presents an important opportunity for local health departments to engage and increase STI testing rates among MSM and other populations at high-risk for HIV (as indicated by CDC guidelines). The CDC recommends STI testing every six months for people using PrEP and a recent study suggests that STIs among MSM would decrease drastically if PrEP use were to increase among MSM, even if condom use were to decrease as well.¹⁹ Another way to expand treatment access and uptake—especially for people with asymptomatic infections or in cases in which the individual with the infection is unlikely to seek care—is through Expedited Partner Therapy (EPT), or Patient Delivered Partner Therapy (PDPT), the practice of prescribing treatment to the partners of patients diagnosed with chlamydia and/or gonorrhea, without examination by a healthcare provider.²⁰ This allows people at particularly high-risk for STIs (i.e., the partner(s) of patients recently diagnosed with an STI) to obtain treatment regardless of their symptoms and without seeing a healthcare provider. EPT for chlamydia and gonorrhea significantly reduces re-infection among patients and is more cost-effective than standard partner referral.²⁰

Additionally, the use of self-collected samples, at-home testing, express visits, and mobile testing centers are promising strategies to make STI screening more private and acceptable, not to mention more accessible and convenient—an important consideration as more than a quarter of non-partnered, sexually active people cite a lack of time as an impediment to regular STI testing.¹² Express visits, in which a patient undergoes STI testing without a physical examination, has been shown to improve efficiency and reduce waiting time for patients.²¹ In a recent study, more than 40% of sexually active respondents reported that they would prefer an online solution for STI testing, such as one in which a self-collected sample would be shipped to and analyzed by a lab, and the results reviewed by a physician and delivered to the patient digitally.¹²

Another important strategy to increase uptake of STI services, particularly among people who might not be reached otherwise, is to offer STI testing in non-traditional and/or non-clinical settings. By offering STI services in locations where people at high-risk already spend their time, local health departments can reduce barriers to seeking STI testing and treatment, including cost, transportation, limited ability to take time off work or school, privacy concerns, or stigma. These barriers may be particularly strong deterrents for young people, however, through partnerships with schools and school districts, local health departments can offer sexual health services either on-site at schools or through school-based referral systems. These partnerships, especially when utilized to implement or strengthen sexual health education, can increase students' knowledge and skills and promote healthy behaviors, reducing STI risk.^{22,23} Local health departments should also consider partnering with local jails and juvenile detention facilities to offer STI services. As STI prevalence may be higher among people who are currently or were formerly incarcerated, and as communities of color are disproportionately impacted by both STIs and mass incarceration, offering STI testing and treatment in correctional facilities enables local health departments to prevent long-term complications from undiagnosed STIs and limit the overall spread of STIs, recognizing that most people who are currently incarcerated will soon be released and return to their communities.^{24,25}

Infection surveillance to monitor disease trends and burden are an essential role of the health department and assists in the appropriate planning of high-impact STI prevention. Investments in laboratory and surveillance infrastructure and workforce development could have a profound effect on local health department STI programs, enabling them to utilize surveillance data to target programs and services and to respond quickly to STI outbreaks and drug resistance, ultimately maximizing program impact. The emergence of multidrug-

resistant gonorrhea calls for enhanced local health department surveillance and laboratory capacity. Nearly one-third of gonorrhea strains in the United States are resistant to at least one antibiotic and CDC has named gonorrhea a top-three drug-resistant threat.²⁶ As recently as 2006, there were five CDC-recommended treatment options for gonorrhea and now there is just one remaining.²⁶ Currently, few labs and healthcare settings can test or access laboratory tests for drug-resistance in gonorrhea. Addressing this emerging public health crisis will require expanding access to these tests and improving surveillance systems to rapidly detect, appropriately treat, and prevent the spread of drug-resistant strains of gonorrhea.²⁶ CDC recommends that all state and local health departments develop the laboratory infrastructure to test gonorrhea cultures for drug resistance or establish partnerships with laboratories that can do so.²⁶ While building the infrastructure may seem daunting, the cost of inaction is undoubtedly greater. In 2013, CDC estimated that if drug-resistant gonorrhea becomes widespread, the additional direct medical costs alone could total \$235 million over 10 years.²⁷ Robust funding from federal, state, and local policymakers to equip local health departments with modern laboratory infrastructure and to support workforce development so that local health departments can leverage novel surveillance techniques is critical to addressing the increasing threat of drug-resistant gonorrhea.

Recognizing the prevalence of asymptomatic STI infections, vaccines and rapid diagnostics could transform prevention, diagnosis, and treatment. A long-term STI research strategy should also include basic research on STIs—a necessary precursor for the development of vaccines, diagnostics, and drugs.²⁸ To mitigate the impact of drug-resistant gonorrhea, the development and evaluation of new treatments, both novel medicines and new drug regimens, is necessary. While drug-resistant strains of syphilis and chlamydia remain uncommon, particularly in the United States, a proactive approach to drug development for STIs can prevent future threats.²⁹ The resurgence of syphilis has highlighted the need for further research into distinct manifestations of the infection, including neurosyphilis and ocular syphilis, and the development of new treatments, including options for pregnant people, infants, and people with penicillin allergies (approximately 10% of patients).³⁰ More effective oral medications for syphilis could make treatment more accessible, including through EPT.

Local health departments play a critical role in the prevention and treatment of STIs, and robust funding for local health department STI programs is paramount as STI rates are at record highs and climbing.³¹ An effective response to our nation's STI crisis requires a comprehensive and targeted approach to reach all people impacted by STIs, with particular attention to those disproportionately impacted and other priority populations, including young people, MSM, people of color, and pregnant people. Funding and evidence-based policies are essential for ensuring that local health departments have the capacity to implement proven and innovative STI prevention strategies. Increased funding and investments in the STI workforce and local health department surveillance and laboratory capacity are necessary for responding to emerging threats and new challenges. Many of the tools and techniques to effectively prevent and treat STIs already exist but are insufficient without additional and sustained investment in governmental public health infrastructure and services.

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