

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 public health efforts surrounding sexual health. Specifically, this funding should be used to address healthcare billing and insurance, surveillance, screening, prevention, treatment, and other key areas.

It is critical that both state and local health departments collaborate with community partners, healthcare providers, clinical staff, policy makers, and other workforce members to take the following actions:

STI Screening, Prevention and Treatment

- Conduct sexually transmitted infections (STI) testing and treatment in accordance with the U.S. Preventive Services Task Force (USPSTF) [Recommendations for STI Screening and Treatment](#), as well as the Centers for Disease Control and Prevention (CDC) STI 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;
- 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;
- Provide access to treatment and prevention services via innovative and evidence-based models, such as by rebranding STI clinics as sexual health clinics, offering express visits, using self-collected samples and technology, including telemedicine to contact, counsel, and treat patients, and partnering with pharmacies and retail health outlets.

Healthcare Billing and Insurance

- Protect young people's confidentiality concerns in healthcare billing and insurance claims;
- Pursue innovative billing mechanisms; leverage 340B drug pricing; use "top-of-license" strategies to increase clinic capacity; offer insurance navigation for clients where possible;
- Advocate for insurance coverage of HIV pre-exposure prophylaxis (PrEP) STI-related vaccines (hepatitis A/B, human papillomavirus, and mpox) and associated laboratory and clinical services to ensure equitable access to free, no cost services.



Surveillance

- Use local, regional, and national STI surveillance data to monitor STI trends, identify outbreaks, track emerging threats such as antibiotic-resistant gonorrhea and congenital syphilis, and guide planning efforts;
- Prioritize use of secondary STI surveillance data (i.e., data that was collected from sources beyond STI programs, etc.), and practice triangulation of STI data with hepatitis, HIV, opioid overdose, and other data describing social determinants of health to better describe the STI syndemic and understand appropriate use of public health interventions to address it.

HIV Screening, Prevention, and Treatment

- Increase access to HIV screening, linkage to care and treatment, and HIV prevention methods, including PrEP;
- Incorporate PrEP education across the primary care and sexual health services continuum, as well as raise awareness of PrEP among providers;
- Endorse HIV prevention and management strategies, including post-exposure prophylaxis (PEP), especially for people at an elevated risk for exposure.

Additional Considerations

- Address social determinants of health (SDOH) and barriers to care, including transportation, food, housing, employment, education, etc. as SDOH are often competing priorities that interfere with people accessing STI prevention and treatment services that they need;
- Ensure that STI clinics are designed to be safe and supportive environments for all, including being youth-friendly and welcoming to BIPOC (Black, Indigenous, and people of color) and people who identify as LGBTQIA+ (lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual, and more) by creating systems and training providers in support of cultural humility and trauma-informed care;
- Address divergence/deployment of public health staff/workforce, specifically DIS, that have assisted with the COVID-19 pandemic;
- Utilize marketing campaigns across radio, tv, and social media to reach marginalized populations and to increase public awareness surrounding STI testing, education, resources, etc.;
- Provide or support primary prevention interventions such as health education and condom distribution, immunizations, 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;
- Support policies that improve access to STI services for those groups at high-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;
- 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;
- Leverage community relationships & contact tracing capacity developed during COVID-19 to support ongoing STI work; and

- Support the integration of STI services in healthcare settings, such as prenatal, adolescent, and overall primary care, as well as harm reduction settings by educating providers and partners about properly screening for and treating STIs.

Justification

According to the Centers for Disease Control and Prevention (CDC) *2020 Sexually Transmitted Disease Surveillance Report*, there were 2.4 million cases of chlamydia, gonorrhea, and syphilis reported in 2020.¹ Although cases have historically risen from year to year, the number of STI cases reported in 2020 was 13% less than reported in 2019. According to CDC, this decline in cases was likely due to decreased STI screening during the COVID-19 pandemic, resulting in underreporting of cases.² The total number of STI cases in 2020 included more than one million cases of chlamydia. Adolescents and young adults represent the majority of chlamydia cases in 2020, with 61% of reported cases among people aged 15-24 years.²

In 2020, a total of 677,769 gonorrhea cases were reported to the CDC.² Since 2009, gonorrhea cases have more than doubled and during 2019-2020, gonorrhea cases increased by 5.7%.² Reported gonorrhea cases have been the most prevalent amongst both males and females across three regions of the country: the Midwest, Northeast, and South.² The largest increase in gonorrhea cases were observed among non-Hispanic Black/African American people and non-Hispanic people of mixed races.²

In 2020, 133,945 syphilis cases were reported to the CDC, including 41,655 cases of primary and secondary (P&S) syphilis.² According to the *2020 Sexually Transmitted Disease Surveillance Report*, the rate of P&S syphilis increased by 6.8% during 2019-2020.² Both males and females make up reported cases, and rates of P&S syphilis increased amongst non-Hispanic American Indian/Alaska Native people, as well as non-Hispanic people of mixed races.² Congenital syphilis rates also increased by 15% from 2019 to 2020. In 2020, 2,148 cases of congenital syphilis were reported, including 149 congenital syphilis-related stillbirths and infant deaths.²

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. Furthermore, an increased risk of contracting human immunodeficiency virus (HIV), and prevalence of various cancers, have been associated with STI infection. It can be difficult for individuals to navigate and afford the expenses associated with these health issues and complications, and more importantly, these health issues can be debilitating and can affect an individual's quality of life.

It is critical that individuals have access to STI testing and treatment services that are current and evidence based. Testing and treatment services should be based on recommendations and guidelines outlined in the U.S. Preventive Services Task Force (USPSTF) *2021 Recommendations for STI Screening and Treatment* and the CDC's *2021 STI Treatment Guidelines*. Both documents are the most up to date versions and are a great source of clinical guidance to provide screening and treatment services to individuals with a higher risk for STIs. Additionally, both resources place an emphasis on the utilization of telemedicine to address the barriers and challenges that individuals face in accessing STI services. For example,

telemedicine can be a great tool for ensuring that individuals have access to self-testing, and can be used to reach marginalized groups, including rural communities. Beyond telemedicine, it is also important to provide testing and treatment services in both clinical and non-clinical settings to broaden the reach to marginalized groups including in jails, schools, juvenile detention facilities, and other settings that individuals at high-risk for STIs may access. For instance, according to CDC, multiple studies have shown that people entering correctional facilities have a high prevalence of STIs, HIV, and viral hepatitis which emphasizes that screening in jails is important to reach substantially more people at high-risk for STIs.²³ Similarly, both males and females in detention centers have been reported to have high rates of chlamydia and gonorrhea in comparison to nonincarcerated people within the community.²⁴

Local health departments can increase access to and uptake of STI testing and treatment, as well as PrEP services, by conducting provider education, including through public health detailing, to promote the integration of STI screening into primary care and specialized healthcare, including obstetrics, which is particularly important for addressing congenital syphilis. Efforts may include educating healthcare providers about best practices for diagnosing and treating STIs or sharing STI clinical guidelines.²⁶ 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.²⁷ Because urine- only screening misses 70 to 88% of chlamydia and gonorrhea infections in men who have sex with men (MSM), local health departments should encourage providers in the community to incorporate extragenital testing into screening practices for MSM.²⁸ Local health departments can also conduct provider education to ensure private healthcare providers are aware of CDC's current treatment guidelines for gonorrhea as well as 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 recommended treatment.²⁹

There has been a sharp increase in STI cases among pregnant people in the U.S., highlighting the ongoing need for STI screening. Increases have been particularly notable for congenital syphilis, which can lead to premature births, stillbirths, and even death if left untreated. The CDC recommends that pregnant people be tested for syphilis and other STIs during the first prenatal visit and in the third trimester of pregnancy.²⁴

Adolescents and young adults represent two hard to reach populations that are greatly impacted by STIs. According to the *2020 Sexually Transmitted Disease Surveillance Report*, 53% of reported STI cases were amongst adolescents and young adults aged 15-24 years and reported cases are steadily on the rise.² There are a significant number of barriers and challenges that adolescents and young adults face when accessing STI services, including confidentiality issues. According to a 2013-2015 National Survey of Family Growth, 12.7% of sexually experienced youth decided to not seek sexual and reproductive health services due to concerns that their parents might find out during or after the visit.³ It is critical that public health efforts, policies, and procedures are adopted to ensure that adolescents and young adults' confidentiality is protected. Policies and procedures should be established that address healthcare billing and insurance claims that often impede the ability of providers to deliver STI services on a confidential basis to adolescents and young adults.⁴

Youth and adolescents' experiences with shame and stigma have also served as barriers to seeking care.²¹ Within today's society, the prevailing cultural norms related to adolescent sexuality can be harmful as it is a common belief that youth should not be sexually active or use STI services.²¹ A sex positive approach can be a useful tool for providers and sexual health educators to implement within STI clinics and school settings to change cultural norms surrounding sexually active youth. Through various studies, effective ways to implement this approach include (but are not limited to) ensuring that youth have access to a safe and open environment, recruiting professionals that are comfortable and skilled in engaging young people, as well as adopting a peer engagement approach.²²

Hard to reach and marginalized populations can also benefit from marketing and promotion of STI services, resources, and education including via radio, tv, and social media. According to many studies, using channels such as digital and social media has proved to be successful way to eliminate barriers of access, stigma, distance, and time.²⁵ Additionally, marketing through these channels can have a profound impact on STI-related behaviors and help to support evidence that greater exposure to marketing materials and campaigns is associated with greater behavior change.⁵ Given the successes associated with these methods, more resources and funding should be provided to local health departments to support this work.

It is also important that billing issues are addressed to ensure that individuals have access to STI services. Historically, cost and privacy barriers have been mitigated by providing access to public STI clinics that offer services at no or minimal costs to the patient.¹⁰ However, a significant decline in public health funds and a rise in healthcare costs have required many clinics to bill insurance for services, contributing to new challenges for patients.¹⁰ Many patients have been faced with costly out of pocket expenses, including copays, coinsurance, and deductibles when attempting to engage in the healthcare system.¹⁰ Insurance companies and healthcare systems must work together to reduce these expenses. One potential tool is the 340B program, which enables certain healthcare providers – including, but not limited to, health centers and STD clinics – that serve low-income and uninsured patients to purchase drugs at lower costs.¹⁶ To participate in the program, covered entities must recertify eligibility every year, prepare for program audits, keep 340B Office of Pharmacy Affairs Information System (OPAIS) information up to date, accurately report how billing for Medicaid fee-for-service drugs is completed, and not resell or transfer 340B drugs to ineligible patients.¹⁷

Ongoing STI surveillance efforts must be improved to actively monitor and analyze data for STIs, including chlamydia, gonorrhea, and syphilis. Surveillance efforts help health departments respond in a timely manner and to develop prevention and intervention strategies, as well as help to inform policy. Due to a number of competing priorities, including the recent COVID-19 pandemic, many jurisdictions were unable to focus on STI surveillance activities and timely data collection from 2020 to 2022. In fact, according to CDC, the number of reported STIs declined during the beginning of the COVID-19 pandemic in March and April of 2020.⁵ Additionally, around that same time period, there was an impact on sentinel surveillance activities which monitor trends in patient demographics, the provision of STI services, the proportion of patients testing positive for an STI, and gonorrhea surveillance.⁵ As a result, many jurisdictions were unable to collect sufficient data to understand the STI epidemic and the public health resources needed to address it. To best address the STI epidemic and to make further advancements in the

future, it is important that STI surveillance is prioritized. It is also important to consider prioritizing secondary STI data and triangulating that data from multiple sources – hepatitis, HIV, opioid overdose, and other data describing social determinants of health – to inform public health efforts. Secondary data could be obtained from existing data on reportable diseases beyond data that is available from STI programs. The prioritization of secondary STI data is a helpful adjunct to surveillance, formal public health research, as well as monitoring and evaluation efforts.⁶ This process also contributes to an integrated approach which can have a profound impact on addressing the STI epidemic. To best adopt this approach, local health departments must have access to timely data collection and reporting across all programs as this information is critical to health department’s work.

Addressing the ongoing STI epidemic must also include tackling social determinants of health and barriers to care. Through research, it is evident that social conditions and factors contribute to high rates of STIs amongst racial or ethnic minority groups.⁷ Some of these social factors – including lack of transportation, poverty, unstable housing, unemployment, and lack of education – can serve as barriers to care. If an individual has competing priorities and challenges, it is difficult for that individual to focus on their health and wellbeing. Therefore, it is critical that programs and interventions focus on addressing the root causes of these inequities, developing strategic partnerships, leveraging resources, and focusing on sustainability.⁸

In addition to social determinants of health, programs and interventions should focus on ensuring that providers demonstrate cultural humility towards their patients as cultural barriers between patients and providers can further contribute to health disparities. According to CDC, cultural humility is defined as an attitude through which an individual learns about other cultures in conjunction with becoming more aware of one’s own beliefs and identities, intended to result in greater mutual understanding, equity, honesty, and trustworthy relationships.¹³ At the local, state, and federal level, cultural humility can be improved through strategies like provider training, diversity in staffing, and ensuring that research efforts are representative of diverse groups of people.¹⁴ If cultural humility is not at the center of this work, it will be difficult to address the STI epidemic as culturally diverse populations make up the majority of this epidemic and should be provided with access to STI services that meet their needs.

Trauma informed care should also be integrated into STI clinics as many of the populations served have experienced some form of violence or trauma in their lifetime. Research has shown that traumatic effects of violence may contribute to sexual risk behaviors and STIs, especially for vulnerable populations including women.¹⁵ To address the violence that is prevalent amongst this population and others, it is recommended that screenings are completed for multiple forms of violence, interdisciplinary STI clinic services, and additional trauma informed sexual risk reduction interventions.¹⁵

Beyond ensuring that patients have access to culturally competent and trauma-informed care, there are other ways in which both providers and non-providers can strive to provide safe and supportive environments for all patients. According to the CDC, a welcoming clinical environment should include establishing a patient’s name and preferred pronouns, as well as the patient’s sexual orientation and gender identity.²⁰ Additionally, providers and non-providers (when necessary) should obtain information from patients regarding their sexual history as this is

an important part of routine care and ensuring that patients are appropriately assessed and screened for sexual health concerns.²⁰

Aside from the primary provider's role, local health department disease intervention/investigation specialists (DIS) play a critical role in addressing the STI epidemic as they 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, as they play 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.

During the COVID-19 pandemic, a significant portion of the STI workforce, specifically DIS was deployed to assist with the COVID-19 response. In fact, according to CDC, 30% of STD/HIV DIS assisted with conducting COVID-19 contact tracing.⁹ Prior to the pandemic, more than 2,200 local, state, and federal DIS were working across the country to protect their community's health.⁹ Since 2020, the transmission of the COVID-19 virus has declined, and it is important that efforts are made to allow for the DIS workforce and other public health staff to focus on their STD/HIV program priorities. If those deployment efforts are unable to be addressed, the country should attempt to focus on building greater capacity through hiring and training additional staff. This is important as local health departments were not adequately prepared to respond to the COVID-19 pandemic, as well as the ongoing STI epidemic due to limited staff and resources. In fact, many local health departments reported an influx in patients and clients during the pandemic but were not prepared to handle additional patients due to staff shortages. In the future, it is important that local health departments are equipped with the tools and resources that are necessary to respond to a public health emergency, as well as to continuously support their regular program and clinical activities that help to address the STI epidemic.

Beyond the STI epidemic, the country must also focus its efforts on addressing the HIV epidemic. HIV intersects with other health conditions, including STIs, to form syndemics and in turn, this contributes to ongoing health disparities and inequities.¹¹ Through the country's Ending the HIV Epidemic (EHE) initiative, HIV prevention services must be scaled up to reach vulnerable and marginalized populations and this can be achieved by prioritizing those populations in STI clinics. For instance, as encouraged by CDC, STI clinics could further increase patient access to HIV prevention and treatment services by implementing self-collected STI testing, conducting express visits, offering pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP), assisting patients with linkage to care and treatment, as well as facilitating partnerships with community-based organizations, community HIV clinical providers, and health departments.¹² To date, these strategies have been implemented at some STI clinics across the country, but more efforts must be made to continue to make further advancements. Additional strategies to address both the STI and HIV epidemics, includes adopting an Expedited Partner Therapy (EPT) approach to provide timely treatment to the sex partner(s) of the person diagnosed with a STI. This strategy does not require an examination or evaluation of the partner(s) and helps to prevent reinfection and further STI transmission. It also

helps to address the stigma that is often associated with STIs and in many cases, this strategy has contributed to an increase in partner communication.

It is also critical for local health departments to practice integrating services to address the syndemic of STIs, HIV, substance use, and viral hepatitis. This is important as HIV, substance use, and viral hepatitis often affects similar populations as STIs and each of these health concerns directly affects the other.³⁰ In fact, according to CDC, the use of opioids and other substances has been linked to increasing STIs and outbreaks of infectious diseases.³⁰ Additionally, CDC states that 4 in 10 acute hepatitis B cases in the United States are estimated to result from sexual transmission.³⁰ Given these statistics, programs should consider integrating existing programs, including syringe services, substance use disorder treatment programs, and HIV testing and PrEP programs in STD clinics.³⁰ The integration of these services and programs will help to contribute to holistic, coordinated care which is necessary to address the STI epidemic, as well as other epidemics that affect marginalized groups.

Local health departments play a critical role in the prevention and treatment of STIs, but additional actions are important to consider. Local health departments need additional funding and investment to support each jurisdiction's public health infrastructure to continue to contribute to this important work. 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 according to CDC, there has been a 40% reduction in federal funds to support STI programs since 2003 and these cuts have impacted the local public health workforce.¹⁸ 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. According to a 2020 cross-sectional survey of individuals working in public health during the ongoing COVID-19 pandemic response, the public health workforce has decreased by 20%, and 62% of local health departments reported budgets that were drastically reduced over time.¹⁹ It is evident that these cuts have significantly impacted the local public health workforce, which has decreased by 23% since 2008.³¹ After years of budget cuts and a decreasing public health workforce, 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. This will ensure that health departments have the capacity to continue to address the STI epidemic through the implementation of current and evidence-based approaches to effectively prevent and treat STIs across the country.

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Record of Action

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