

In Support of the Publicly Funded Sexually Transmitted Infections Specialty Clinic—ASTDA Position Statement

ASTDA Board of Directors

EXECUTIVE SUMMARY

Over the past decade, the rates of reportable sexually transmitted infections (STIs) have been steadily increasing in the United States. The diagnosis and treatment of STIs among patients and their partners is the cornerstone of STI control and prevention. Publicly funded, categorical STI clinics play a key role in the public health STI control infrastructure but availability of these services has been decreasing as funding has declined. It is the position of the American Sexually Transmitted Diseases Association (ASTDA) that publicly funded STI clinics continue to perform a critical service in the response to rising STI rates in the United States and require resource investments at all levels of government, including the development of federal funding streams.

BACKGROUND

The STI rates in the United States are rising. The number of reported chlamydia cases are the most ever reported to the US Centers for Disease Control and Prevention and the number of reported gonorrhea and syphilis cases are at their highest levels since 1991. As a result of the resurgence of syphilis among women and failing prevention efforts, the rise in congenital syphilis is especially alarming.¹

The reasons for rising STI rates are not fully understood. Men who have sex with men are particularly vulnerable to STIs and bear a disproportionate burden of the overall number of gonorrhea and syphilis cases.^{2,3} Changing perspectives on the probability of human immunodeficiency virus (HIV) transmission brought about by the use of highly effective antiretroviral therapy for HIV treatment and prevention have led to changes in attitudes toward condom use and other prevention strategies with the unfortunate and initially counterintuitive result that reducing HIV threats may be accompanied by increasing exposures to other STIs.^{4,5} Thus, the rise in STIs may be the unintended consequence of major successes in other areas of public health. On the other hand, negative developments have also contributed to rising rates of STIs. Importantly, syphilis and congenital syphilis have been associated with the current opioid and methamphetamine epidemics.⁶ Finally, a fraying public health infrastructure that has been slow to react to these emerging STI epidemics is linked to a reduction in prevention services.²

Although additional causes of the rising STI rates will continue to be elucidated, an effective public health response is urgently needed.

Disease prevention strategies can be conceptualized as *primary*, that is, preventing illness; *secondary*, treating disorders before complications ensue; and *tertiary*, management of serious outcomes. Overwhelming data and common sense support the importance of primary prevention. However, in the control of communicable diseases, secondary prevention at the individual level constitutes primary prevention in the community.

Accordingly, the diagnosis and treatment of persons with symptomatic STIs and their sex partners has long been a cornerstone of STI control and prevention. Publicly funded, categorical STI clinics have historically played a key role in the public health STI control infrastructure because they were set up to provide low-threshold access to expert clinical evaluation. Clinic procedures often required invasive diagnostic techniques to obtain samples for cervical and urethral cultures, as well as parenteral antimicrobial treatment. The development of nucleic acid amplification tests in the mid-1990s revolutionized the STI field, especially gonorrhea and chlamydia diagnosis.⁷ The superior sensitivity and specificity of these tests allowed for the use of noninvasive samples including urine and (self-obtained) vaginal, rectal, and pharyngeal swabs that made these tests readily available outside the traditional STI clinic and also allowed for the implementation of screening guidelines.⁸

From the American Sexually Transmitted Diseases Association

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These developments have facilitated the expansion of STI testing and treatment outside traditional STI clinics, including primary care, family planning, school-based health, corrections, emergency departments, HIV prevention and care settings, as well as online venues.⁹ The Patient Protection and Affordable Care Act (ACA), signed into law in 2010 and implemented in 2014, expanded access to health care for millions of Americans. With STI testing readily available in the primary care settings, and access all but guaranteed by the ACA, the continued need for publicly funded “safety net” STI clinics became less obvious. As a result, many STI clinics limited their services or closed altogether, amid questions as to their continued relevance.¹⁰

Clearly, the widened availability of STI testing is to be applauded and supported. Unfortunately, however, this development may have directly contributed to erosion of the publicly funded STI clinical care system—leading some experts to speculate that “the resurgence of syphilis, and particularly congenital syphilis, is not an arbitrary event, but rather a symptom of a deteriorating public health infrastructure.”² Historically, the dramatic resurgence of gonorrhea and syphilis and the emergence of *Chlamydia trachomatis* infections from the 1960s to the mid-1970s followed and was partly attributable to the wholesale dismantling of public health clinical and preventive services for STI prevention for three decades because of the overoptimistic estimates of the impact of penicillin and other antibiotics. The current challenge is to avoid repeating that unfortunate history.

Abundant evidence supports the continued critical importance of the publicly funded categorical STI clinic, particularly for concentrated epidemics, such as gonorrhea, syphilis, and HIV, and to ensure access to quality STI care for vulnerable and marginalized populations. First, because the US Supreme Court 2012 decision allowed states to choose whether to expand Medicaid under the ACA, large numbers of persons remain uninsured, with many residing in states with the highest STI rates. Furthermore, access to private health care does not necessarily mean that persons will use these providers for STI services. In many countries with (near) universal access to health care, STI clinics are nonetheless thriving,⁹ suggesting that other factors play a role beyond health insurance and access to care. These factors include low cost, same-day access, and confidentiality. Furthermore, clinical expertise of STI clinic staff is often cited as a key feature in the decision where to access STI services.¹¹ Finally, even when insured, patients with an STI concern often prefer the privacy of a relatively anonymous STI clinic to having to disclose to a primary care provider.^{12,13}

In this emerging landscape of STI care, what should be the future role of publicly funded STI clinics? Foremost, it should be recognized that categorical STI clinics endorse STI treatment and prevention as their primary public health mission, unlike other clinical providers who may offer STI testing and treatment in an array of other health services. Categorical STI clinics, thus, possess unparalleled capacity to function as a central hub in their local or regional STI provider network and play a role as an essential partner in the overall STI public health response in the region. Rather than being perceived solely or even primarily as “safety net clinics” ultimately destined for obsolescence once access to primary health services is assured, these clinics should be understood as *centers of excellence* that provide the delivery of expert STI clinical care through state-of-the-art diagnostic capabilities, on-site treatment, effective, compassionate follow-up care of patients, and comprehensive management of their sex partners, contributing crucially to community-wide prevention. They should be available for low-threshold referral and consultation for providers in the region, and they are a resource for management of the sex partners of patients with STIs in primary care facilities, especially when partners are not themselves established patients in those facilities.

Furthermore, they should be easily accessible as a primary clinical resource to at-risk populations who have no other care provider or choose not to access their primary care provider for reasons of confidentiality. In addition to the provision of expert care for syphilis, gonorrhea, chlamydia, trichomoniasis, and viral STIs, including genital herpes and human papillomavirus infections, as well as STI-associated syndromes, such as nongonococcal urethritis, vulvovaginal infections, and pelvic inflammatory disease, categorical STI clinics, should continue to play a critical role in HIV prevention activities through the provision of HIV testing, HIV preexposure and postexposure prophylaxis,¹⁴ and for certain populations onsite initiation of HIV treatment and follow-up care.¹⁵

Finally, STI clinics are also a critical resource for sentinel surveillance research, including gonococcal resistance,^{16,17} research in the development of new STI diagnostics and treatment, as well as for clinical training and workforce development.^{18,19} The CDC-funded 8 regional STI Prevention Training Centers are all organized around model STI clinics²⁰ and the necessary expansion of capacity in STI workforce development, especially in regions of the country with the highest STI morbidity, demand the availability of local STI specialty clinics. A recently released guidance for the delivery of quality STI clinical services by CDC will be helpful in this process.²¹

Public STI clinics are not immune to nor should be pardoned from market forces and other influences that dictate operational efficiency, cost containment, and other responsible resource allocation. With increasingly constrained resources, STI clinics have responded to the challenge by providing their services in the most cost-efficient manner. Noninvasive nucleic acid amplification testing for the diagnosis of gonorrhea and chlamydia allows the triage of patients into those that need full physical examination versus those who need only screening, so-called express visits, which has significantly increased efficiency, reduced wait times and turn-away rates, and lowered costs for STI clinics.^{22–24} In an era of cost constraints, publicly funded STI clinics should be proactive in finding ways to diversify their funding, for example, by integrating with family planning²⁵ and HIV prevention services.^{14,15} Although billing patients for services may seem to be anathema to the public health mission of STI clinics, carefully designed programs that encourage patients to use their insurance while readily allowing them access if they choose not to use insurance and have no other means of paying could still result in a sizeable source of revenue.²⁶

Notwithstanding the means by which publicly funded STI clinics may enhance their fiscal stability, none can survive without governmental support. The imperative of providing both primary and secondary prevention services justifies a substantial contribution of public resources. Traditionally, STI clinics have been funded by local and state governments, whereas the federal government has funded nonclinical STI prevention functions, such as surveillance and partner services. However, funding for STI clinics is woefully inadequate at all levels of government, leading to curtailment of services and closing of clinics.¹⁰

This must change.

CONCLUSIONS

It is the position of the American Sexually Transmitted Diseases Association that publicly funded STI clinics perform critical services for, and are central to, an effective public health response to rising STI rates in the United States and require resource investments at all levels of government, including the development of federal funding streams. The Ryan White Care Act of 1990 proved to be a critical federal investment in the successful treatment of

patients with HIV infection and ultimately led to a reduction in HIV transmissions. The current STI crisis requires a similar response.

POSTSCRIPT

This position statement was conceived, written, and vetted by the ASTDA Board of Directors before the COVID-19 pandemic became an all-consuming reality in the United States with dramatic impacts on the delivery of health services, including the provision of STI care. However, these developments do not diminish the relevance of the statement. Indeed, some STI specialty clinics are taking the lead in the development, implementation, and evaluation of practice adjustments dictated by the need for social distancing, including, in some circumstances temporarily providing telephone consultation, telemedicine visits, and syndromic management.^{27–29} The COVID-19 pandemic has sparked a discussion about the deficiencies in public health preparedness in the United States and the need for the development of a robust agenda to not only confront the current or a similar future epidemic but also to enhance the overall capabilities of the public health system at federal, state, and local levels. STI control and prevention should very much be part of that agenda.

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