

Sexually Transmitted Disease Prevention

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Dr. Gail Bolan

Director, Division of STD Prevention

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention



Overview of Discussion

- STDs: a Public Sector Responsibility
 - STD prevention is HIV prevention
- Deteriorating Public Health Infrastructure for STD Prevention and Control
- Continued Need for Publicly Funded STD Services
- Resurgence of syphilis and congenital syphilis in the U.S.

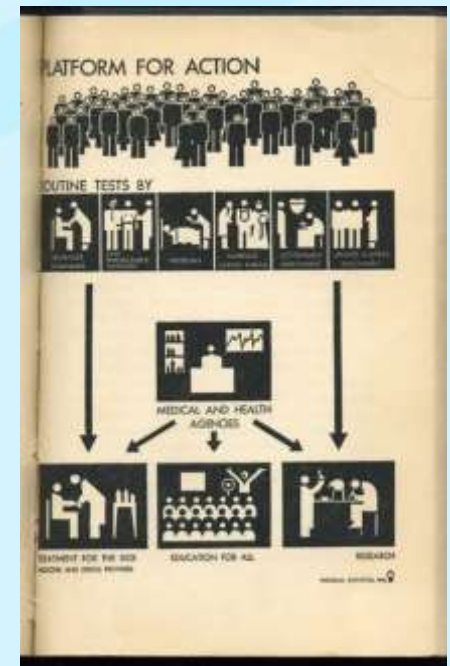


**SEXUALLY TRANSMITTED DISEASE
PREVENTION AND CONTROL:
A JOINT RESPONSIBILITY BETWEEN FEDERAL,
STATE AND LOCAL GOVERNMENTS**



United States STD Control: The Approach from 1937 through Today

- Public sector responsibility to prevent and control the spread of STDs
- Health education, promotion and behavior change
- Identify and treat infected people through:
 - Screening of asymptomatic individuals and linking them to care
 - STD clinics (funded by states and localities) - mainly for symptomatic care
 - HD sexual partner notification and treatment
- Individually-based interventions
- Specialty clinics and disease intervention specialist (DIS) focus



STD Prevention is HIV Prevention

- STDs can increase susceptibility to and transmission of HIV
- STD treatment may reduce a person's ability to transmit HIV
- HIV testing in STD clinics is a cost-effective HIV prevention strategy
- STDs are the most consistent risk factor for testing HIV positive among MSM
- STDs in MSM without HIV are important risk markers for HIV acquisition, and can help identify MSM who may benefit from PrEP



State and Local STD Prevention Funding

STD prevention in the U.S. is funded by federal, state, and local governments

Federal Funds Support: Some State and Local Health

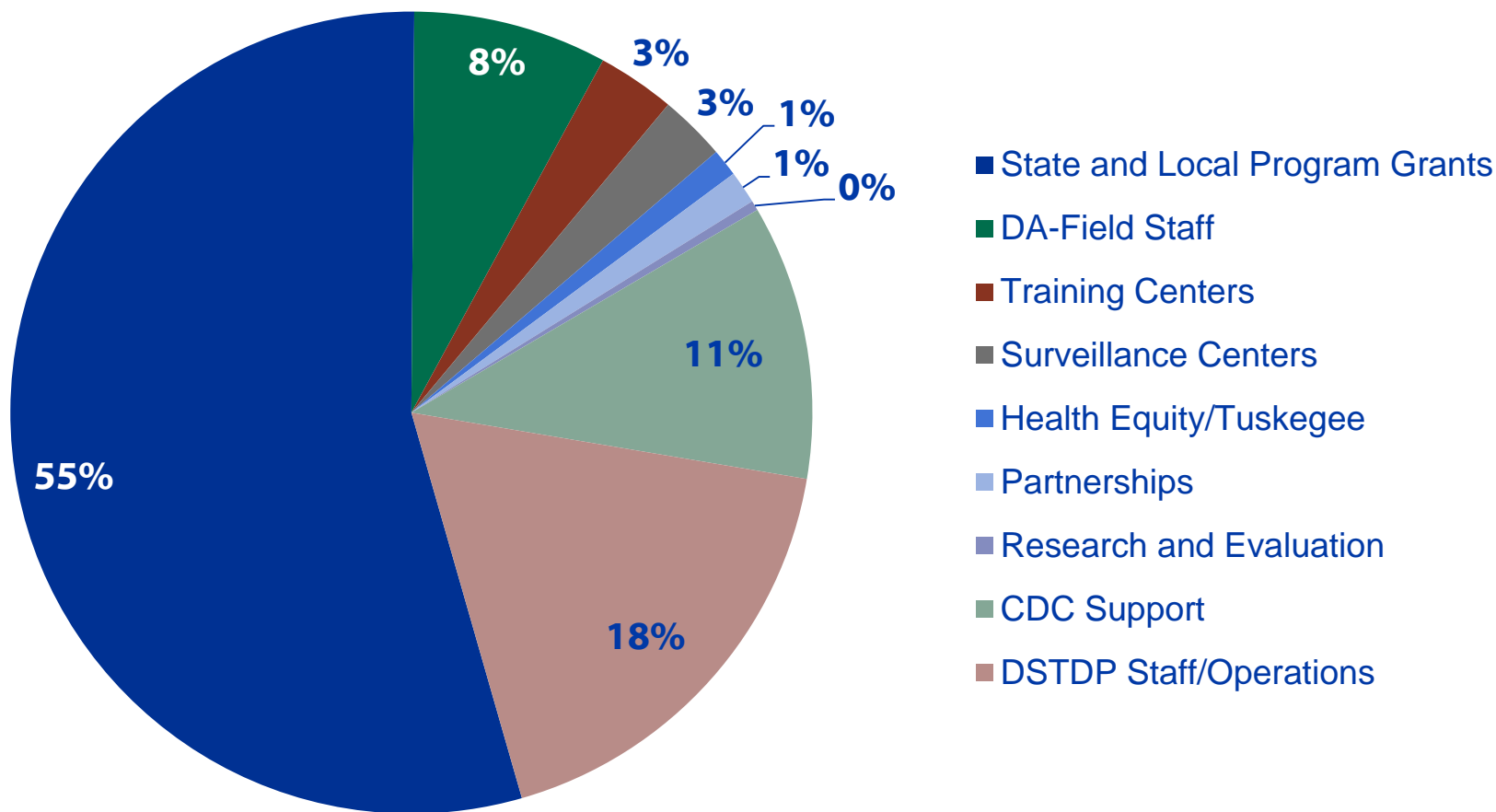
- Surveillance
- Provider training
- Contact tracing and linkage to care
- Health promotion/ education and outreach
- Limited support for clinical preventive services

Departments Provide Additional Funding to Enhance or Support:

- Surveillance
- Contact tracing and linkage to care
- Health education
- STD clinical preventive services
- STD clinics or other clinical settings to provide specialized, confidential, same-day STD services.
 - Support includes STD specialized clinicians, on site lab tests and STD medications



FY 2015 CDC STI Funding (\$157.3M)†



† Amount does not include \$10.1M HIV funding provided to state and local STD programs

* Includes Working Capital Fund, PHS, and other support

State and Local STD Prevention Programs Provide Vital STD and HIV Public Health Services

Local STD Programs (FY12)	State STD Programs (FY12)
81% provided contact tracing	85% provided contact tracing
71% provided STD screening in non-clinical settings <ul style="list-style-type: none">• 25% provided HIV field testing for STD contacts	57% provided STD screening in non-clinical settings <ul style="list-style-type: none">• 38% provided HIV field testing for STD contacts
65% directly linked HIV+ identified in the field to care	92% directly linked HIV+ identified in the field to care



STD Prevention Programs Provide Vital STD and HIV Public Health Services

- **Each year, state and locally funded STD clinics identify**
 - HIV
 - 20% of all new cases in the U.S. (8,400 cases)
 - Syphilis
 - 25% of all U.S. reported cases in males; 19% in females
 - Gonorrhea
 - 20% of all U.S. reported cases in males; 9% in females
 - Chlamydia
 - 17% of all U.S. reported cases in males; 6% in females



DETERIORATING STD PUBLIC HEALTH INFRASTRUCTURE



Impacts of State and Local Budget Cuts to STD Prevention Programs

52% of STD programs experienced budget cuts in FY2012:

Impact	% of programs with budget cuts reporting each impact*
Reduced clinic hours	43%
Reduced oddslot screening	40%
Reduced contact tracing for chlamydia, gonorrhea and other non-syphilis infections	40%
Increased or initiated fees or copays	34%
STD clinic closures	7%

*An estimated 21 local health department
STD clinics closed in FY 2012*



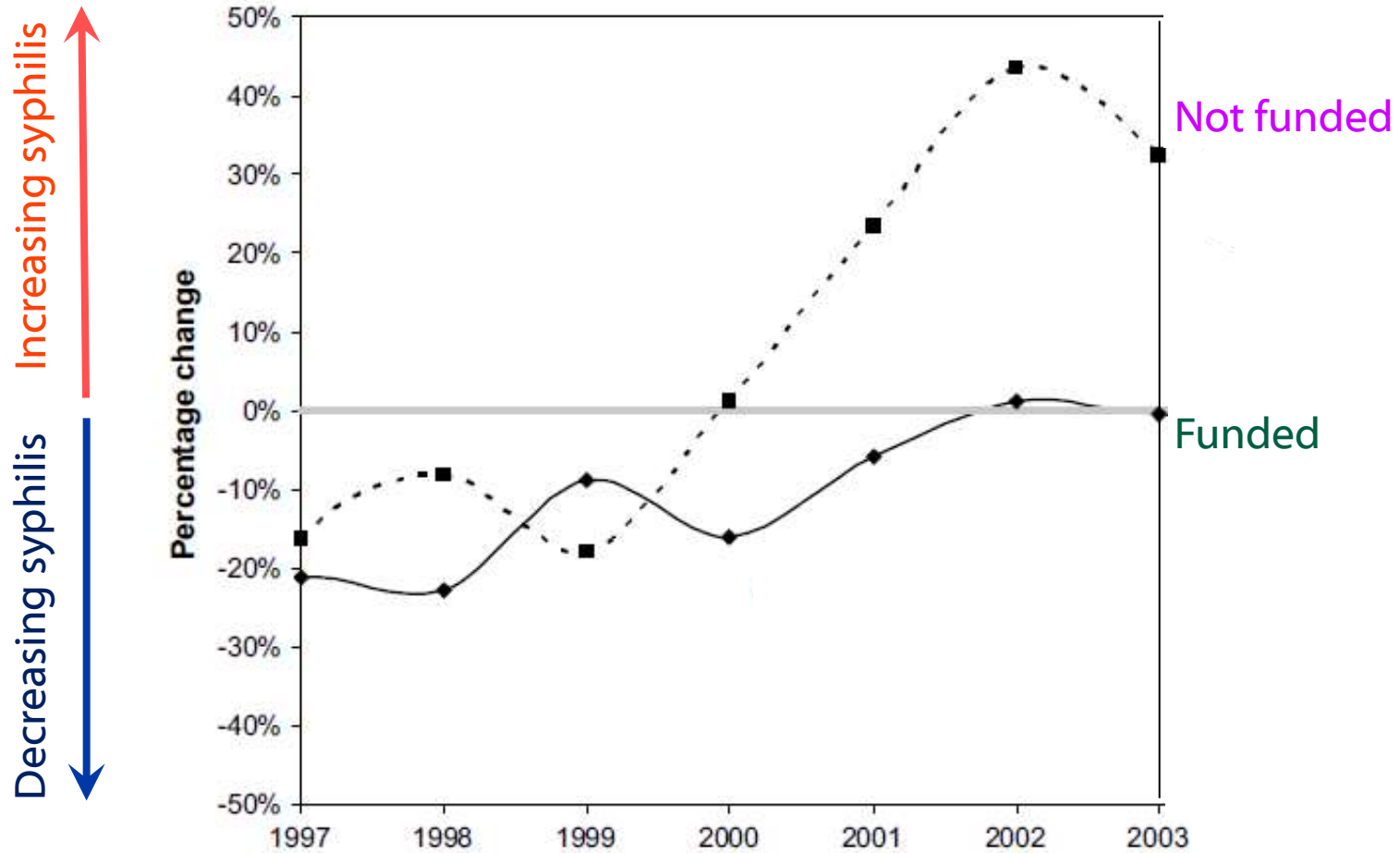
*Programs that had cuts could identify more than one impact; shown are the percentages of programs with cuts that identified at least one impact

Impact of State and Local Budget Cuts on STD Prevention Programs

Local STD Program Impact	% reporting
Decrease in STD staffing (FY12)	18%
Decrease in disease intervention specialists (DIS)	48%
Decrease in clinicians	65%
STD staff detailed to other (non-STD) public health emergencies	36%
Reported this as a <i>major</i> impact on activities	22%
Decrease in staffing from FY06-FY11 (mean of 3 staff)*	34%

* Preliminary data by Cuffe KM, Leichliter JS, Gift TL

Change in syphilis rates in states funded vs. not funded for increased syphilis prevention*



* Increased funding initially provided in 1998/1999

Source: H. Chesson, K. Owusu-Edusei Jr. / *Social Science & Medicine* 67 (2008) 2059–2062

CONTINUED NEED FOR PUBLICLY FUNDED STD SERVICES AFTER THE AFFORDABLE CARE ACT



#STDMONTH16 **talk.test.treat.** **#TalkTestTreat**

Testing is the only way to know if you have an STD.

Continuing Need for Publicly Funded STD Clinical Preventive Services

- In 2016, 4.6 million people (2.6 million women and 2 million men) ages 15 to 44 are both uninsured and in need of STD services
- In 2016, chlamydia-related services alone for this group will cost \$150 million
 - This does not include other STD screening, testing, and treatment, such as for syphilis, gonorrhea, or HIV.
- The Affordable Care Act has reduced the number of uninsured people who need publicly funded STD services, but 4.6-4.7 million uninsured people are expected to need STD services annually through at least 2023

Gift TL, Haderxhanaj LT, Torroni EA, Behl AS, et al. Estimating the size and cost of the STD prevention services safety net. *Public Health Reports*. 2015;130:602-609.



Continuing Need for State and Locally Funded STD Clinics After the Affordable Care Act

- An assessment of more than 4,300 patients of 21 state and locally funded STD clinics in the U.S. found:
 - Half of STD clinic patients were uninsured, and one-fifth were on Medicaid or Medicare
 - Half of the patients reported using the STD clinic primarily because they could walk-in or get a same-day appointment, and one quarter reported that low or no cost was the primary factor
 - If the STD clinic was not available, 1 out of 5 uninsured patients, and 1 out of 5 patients with Medicaid or Medicare, reported they would have gone to the hospital ER
 - The cost of STD testing in emergency departments is 15-80% higher than in other non-hospital settings

Hoover KW, Parsell BW, Leichter JS, Habel MA, et al. Continuing need for sexually transmitted disease clinics after the Affordable Care Act. *American Journal of Public Health*. 2015;105(S5):S690-S695.

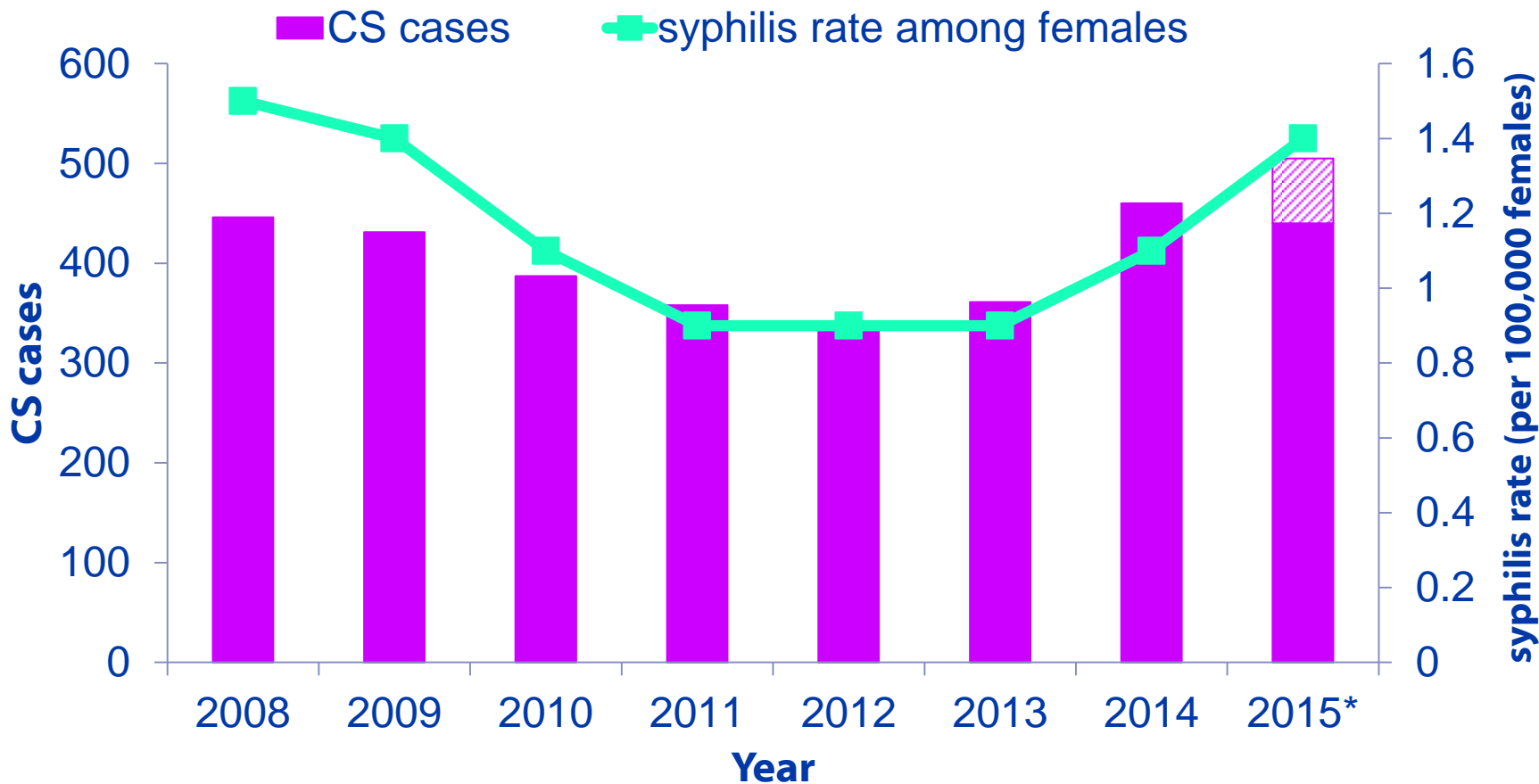


RESURGENCE OF SYPHILIS IN THE U.S.

- Congenital syphilis
- Women
- Men
- Ocular syphilis



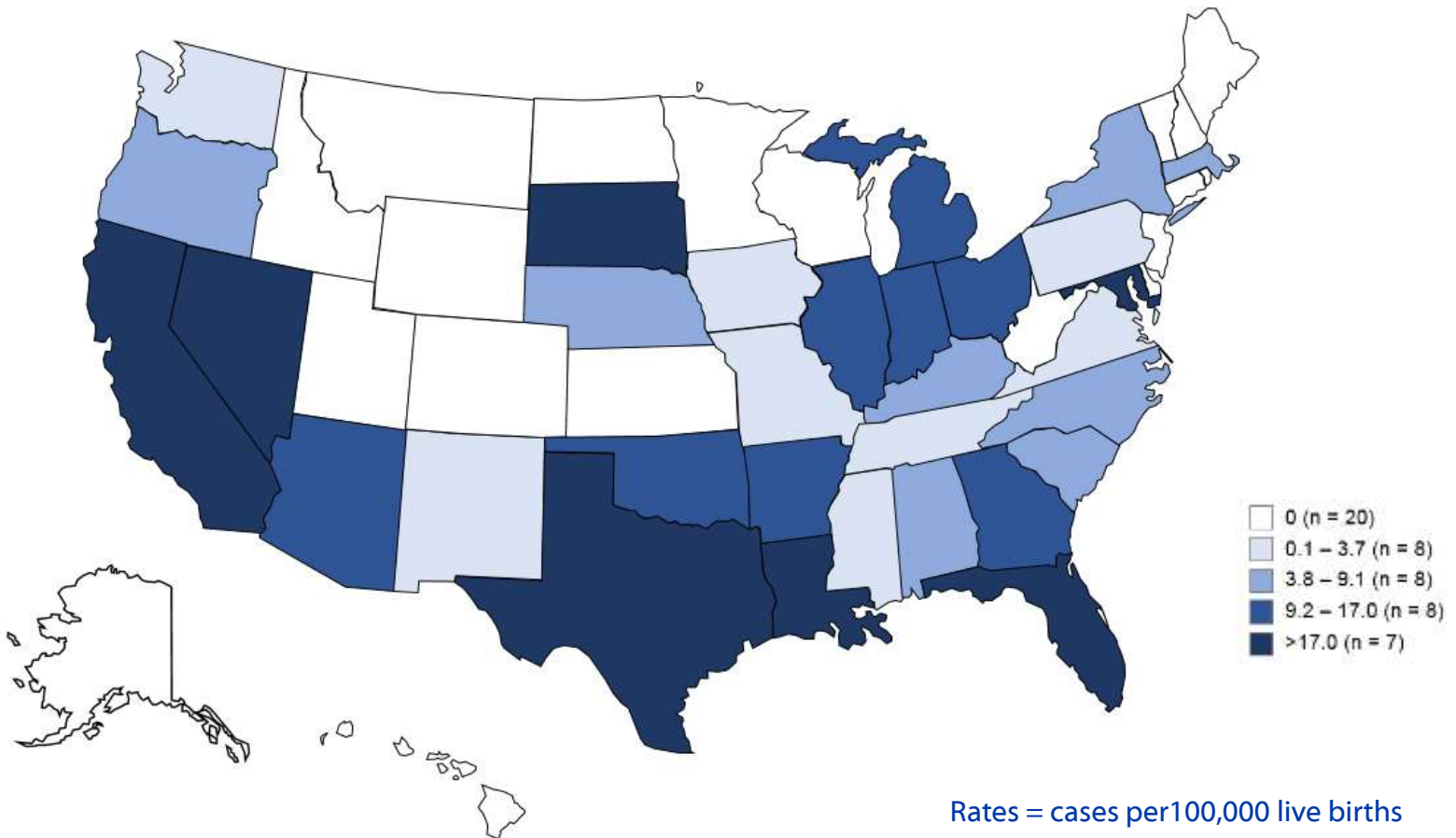
Congenital Syphilis (CS) Cases and Rate of Syphilis[†] Among Females, U.S., 2008–2015*



*2015 data are preliminary, as of March 31, 2016

[†] Primary and Secondary Syphilis

Congenital Syphilis — Rates of Reported Cases by State, U.S., 2014



- 31 states reported cases in 2014 (vs. 25 states + DC in 2013)
- 20 states with increased cases/rates during 2013–2014

Characteristics of Mothers Who Gave Birth to Infants with Congenital Syphilis in the U.S., 2014

	Number (N=458)	Percent
Did not receive prenatal care	100	21.8%
Received prenatal care (N=314, 68.6%)		
No treatment	135	29.5%
Treated <30 days prior to delivery	78	17.0%
Non-penicillin therapy	3	0.7%
Inadequate regimen for stage	13	2.8%
Adequate treatment	43	9.4%
Unknown treatment status	42	9.2%
Unknown prenatal care status	44	9.6%

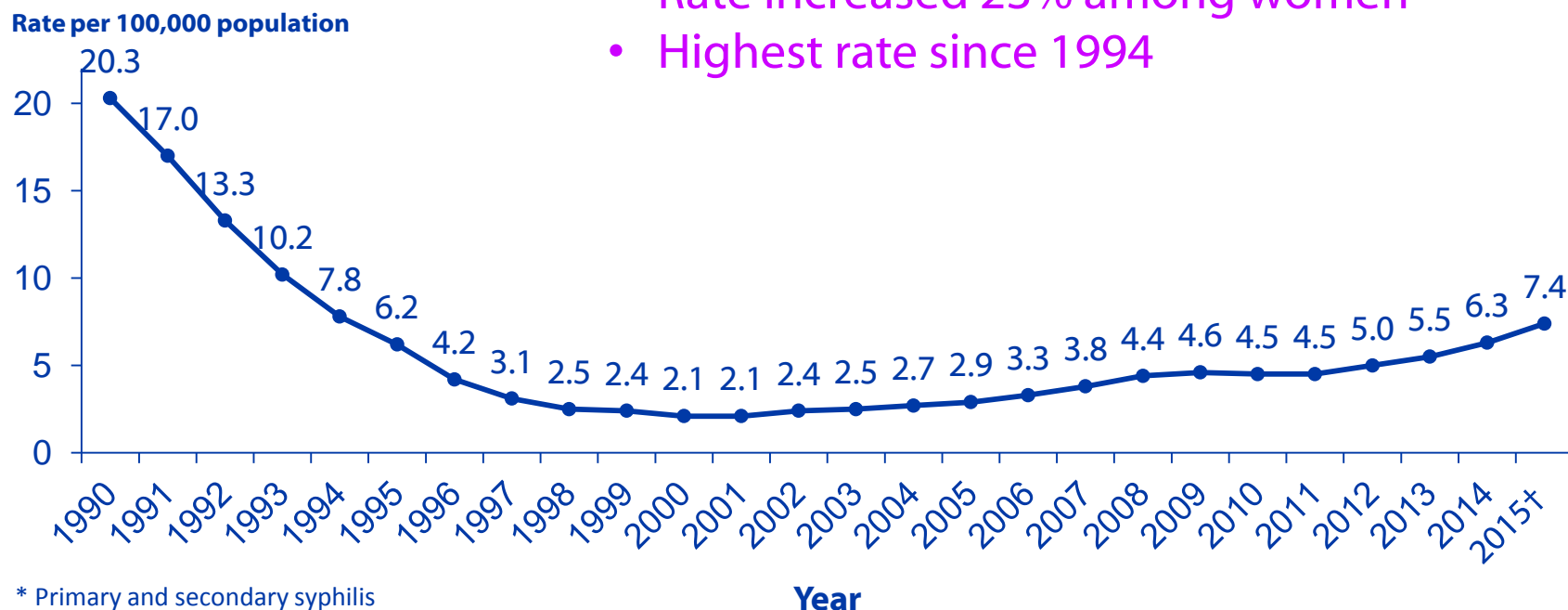
Vital Status of Reported Congenital Syphilis Cases in the U.S., 2010–2014

	<u>2010</u>	<u>2011</u>	<u>2012</u>	<u>2013</u>	<u>2014</u>
Vital status of infant	N (%)	N (%)	N (%)	N (%)	N (%)
Alive	357 (92%)	338 (95%)	314 (94%)	332 (93%)	420 (92%)
Infant death	7 (2%)	4 (1%)	3 (1%)	4 (1%)	8 (2%)
Stillborn	23 (6%)	13 (4%)	15 (5%)	22 (6%)	25 (6%)
Unknown	1 (0.2%)	3 (1%)	2 (1%)	1 (0.3%)	5 (1%)
Total	387 (100%)	358 (100%)	334 (100%)	359 (100%)	458 (100%)

Syphilis* — Rate of Reported Cases, United States, 1990–2015[†]

2015[†]:

- 23,529 cases
- Rate increased 17% among men
- Rate increased 23% among women
- Highest rate since 1994



* Primary and secondary syphilis

[†]2015 data are preliminary, as of March 31, 2016

Syphilis Rates* by Region and Sex

	2011	2012	2013	2014	2015 [†]	% change 2014–2015 [†]
West total	4.9	5.7	6.7	7.8	9.4	21%
Females	0.4	0.5	0.8	1.2	1.6	34%
Males	9.3	10.9	12.6	14.4	17.2	20%
Midwest total	3.2	3.3	4.0	4.4	4.7	7%
Females	0.7	0.7	0.7	0.9	1.0	10%
Males	5.8	6.0	7.4	7.9	8.4	7%
South total	5.3	5.8	5.9	6.8	8.1	19%
Females	1.7	1.5	1.4	1.5	1.8	23%
Males	9.1	10.2	10.6	12.3	14.6	19%
Northeast total	3.8	4.3	4.8	5.5	6.4	18%
Females	0.4	0.4	0.4	0.5	0.6	21%
Males	7.4	8.4	9.3	10.7	12.5	17%

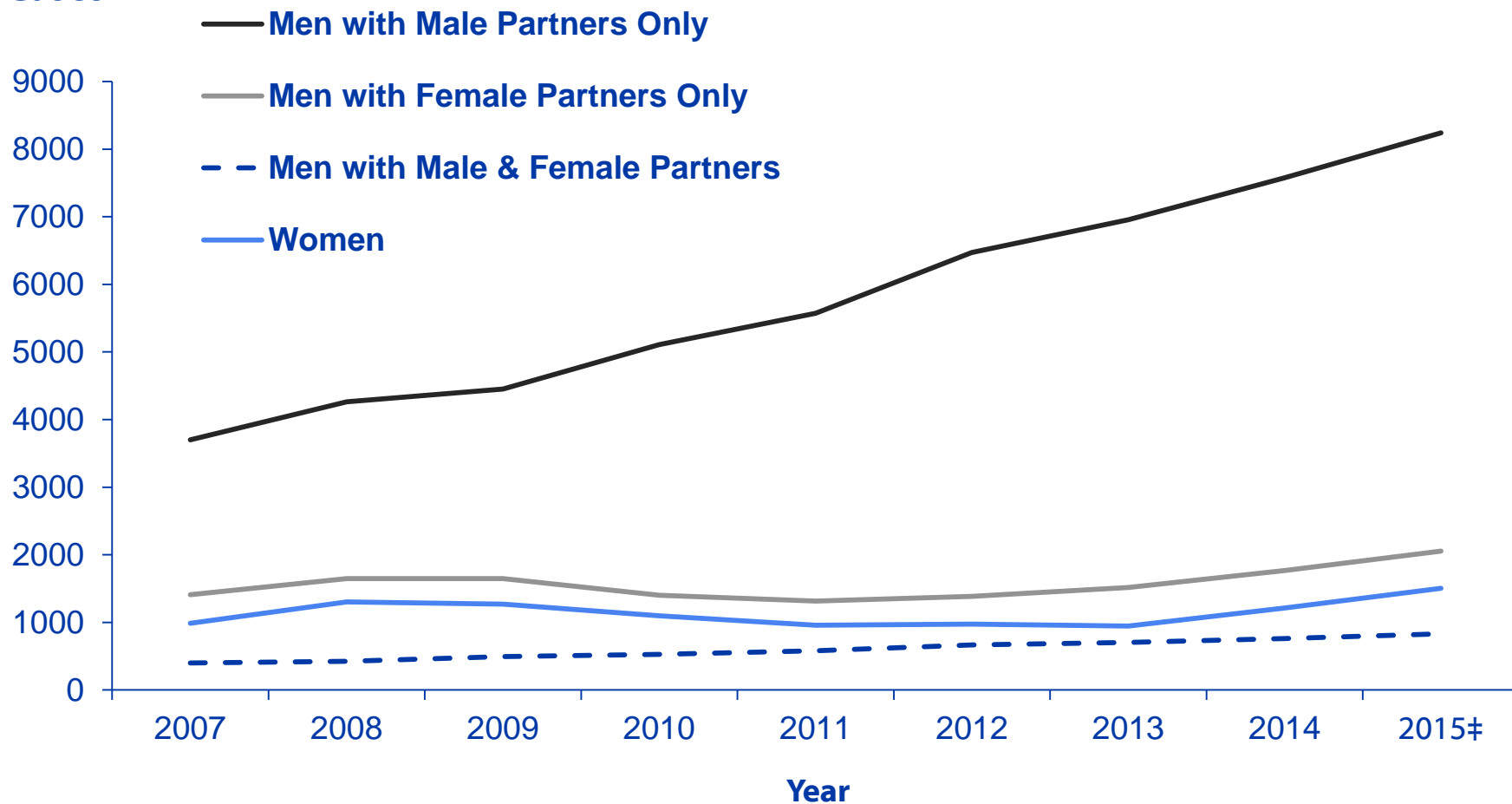
* Primary and secondary syphilis rates per 100,000 population.

[†]2015 data are preliminary, as of March 31, 2016.

NOTE: % change calculated using precise (not rounded) rate.

Cases of Syphilis[†], by Sex and Sex Partner, 27 states*, 2007–2015[‡]

Cases



[†] Primary and Secondary Syphilis

* 27 states reported sex of sex partner data for ≥70% of reported cases of primary and secondary syphilis for each year during 2007–2014.

[‡]2015 data are preliminary, as of March 31, 2016.

Ocular Syphilis Increase

Ocular syphilis: a manifestation of neurosyphilis affecting the eyes, which can occur at any stage of syphilis

- CDC issued a clinical advisory for ocular syphilis on 4/3/2015
- Majority of cases are among HIV-infected MSM
- 8 jurisdictions have reviewed their surveillance data, and have identified 382 cases from 2014 and 2015
- Several cases have resulted in significant outcomes including blindness



For more information: <http://www.cdc.gov/std/syphilis/clinicaladvisoryos2015.htm>



Preliminary Epi Aid Results: Ocular Syphilis Cases North Carolina, 2014–2015

- 63 cases identified
- 94% male
 - 71% reported male sex partners
- 56% HIV-infected
- Patients identified throughout the state
- All of the cases were efficiently identified by disease investigation specialists (DIS), STD program “boots on the ground”
- Of the cases identified, 1 in 3 had reported or documented vision loss



Summary

- The congenital syphilis increase from 2013 to 2014 was 28%
- Syphilis among MSM equals the levels of infections seen prior to the HIV epidemic
- Erosion of STD public health infrastructure is impacting STD, HIV and other public health prevention responses
 - Reduction of DIS staff and closure of STD clinics is especially harmful
- There is a continuing need for publicly funded STD services post-ACA implementation





Thank you Questions?

gyb2@cdc.gov

For more information please contact Centers for Disease Control and Prevention

1600 Clifton Road NE, Atlanta, GA 30333
Telephone, 1-800-CDC-INFO (232-4636)/TTY: 1-888-232-6348
E-mail: cdcinfo@cdc.gov Web: www.cdc.gov

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