NCSD
National Coalition of STD Directors

Promoting Sexual Health Through STD Prevention

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B. Kaye Hayes, MPA
Acting Director, Office of Infectious Disease and HIV/AIDS Policy (OIDP)
Office of the Assistant Secretary for Health (OASH)
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 715-G
Washington, D.C. 20201

RE: Draft Sexually Transmitted Infections National Strategic Plan 2021-2025

Dear Ms. Hayes,

Thank you for the opportunity to provide comments on the draft Sexually Transmitted Infections National Strategic Plan 2021-2025 (STI Plan). The National Coalition of STD Directors (NCSD) is a national public health membership organization representing health department STD directors in all 50 states, seven large cities and counties, and five US territories. While David Harvey, in his role as executive director, provided brief comments on an earlier confidential draft of the STI Plan, these more extensive comments are the result of consultations with NCSD members, the NCSD Board of Directors, and clinical experts in the STD field.

We are glad to see this draft plan and congratulate the U.S. Department of Health & Human Services for the work completed to date. As you know, NCSD has long called for a national STI plan, and we are pleased that NCSD was able to contribute in various ways to the draft plan, including background research that we commissioned from the National Academy of Public Administration and the Treatment Action Group (TAG), our research on the impact of COVID-19 on the STD field, and recommendations that we solicited from our members and the broader field.

The draft plan has a number of significant strengths. We strongly support the vision statement and inclusion of people “regardless of age, sex, gender identify,

sexual orientations, race, ethnicity, disability, geographic location or social economic circumstance." We believe that the goals, objectives, and strategies appropriately address the STI epidemic. The draft plan is comprehensive, data driven, well organized, strongly discusses stigma and social determinants of health, and emphasizes the importance of seeing STIs through a syndemic lens. Other strengths include a clear statement that STIs have a different impact on specific populations—such as Black and Latinx people, gay men (referred to as MSM in the draft plan), and women, among other groups.

We do, however, believe the plan can be improved, and we offer the following recommendations, organized by areas of concern followed by specific wording changes or additions.

Areas of Concern

1. No federal commitment

The national STI epidemics are so pervasive and prevalent that in order to make a difference, we need substantial changes to our public health and health care systems. It is correct that this problem is beyond the federal government's ability to solve. Both the public and private sectors have an important role to play, and health care, education, and housing stakeholders—among many others—will need to step up and play a role if we are to reverse these escalating epidemics.

We had hoped that a Federal STI Action Plan—the term used to refer to the plan in a presentation to the NCSD membership during STD Engage 2019—would outline what the federal government would do to address these ever-expanding STI epidemics, and how the federal government would influence and provide leadership to other sectors. We are concerned that changing the plan from a federal STI action plan to an STI National Strategic Plan commits the federal government to nothing more than producing an implementation plan sometime in the future rather than a genuine action plan.

2. No context

While this plan includes a strong description of the current state of the various STI epidemics, it includes no context, no discussion of how we got here, and no mention of the societal and individual changes that have occurred in the last 10 years. Insurance rates have changed, and there have been significant changes in

HIV treatment and prevention, for example. In particular, syphilis rates have increased dramatically in the last decade, and there is no discussion as to why a highly publicized syphilis elimination effort failed in the 1990s.

Additionally, nowhere in this plan is vaccine hesitation discussed and its causes explored. Lessons learned from the introduction of the HPV vaccine and stigma associated with a vaccine connected to sexual activity have implications not only for increasing HPV vaccine uptake but also for the uptake of other potential STI vaccines.

3. No mention of racism
Similarly, there is no mention of how systemic racism and racist policies and practices in health care, public health, education, and housing throughout our history-- to name just a few-- have impacted current STI rates. The scourge of Tuskegee still shadows STI care and research, and nowhere is that reality mentioned in this draft plan. Racism has caused a strong distrust of our health care system among key communities and population groups called out in the indicators of this plan. Not acknowledging—and working to address—the continued effect racism has on our systems will only contribute to the expanding STI epidemics.

4. No implementation plan
While the future release of an implementation plan is generally referenced, the lack of specificity and timeline will limit its impact. We call for the release of a federal implementation plan by January 1, 2021 and the participation of non-federal stakeholders on the implementation working group.

5. No mention of the financing
This draft STI plan includes no mention of how these goals, objectives, strategies, and indicators are going to be financed, whether through public funding, private sector funding, or a combination. Additionally, potential changes to the Affordable Care Act and Medicaid coverage will surely influence STI rates. By omitting any mention of financial resources, the plan cannot succeed.

6. No acknowledgement of state differences and barriers
While this plan outlines regional STI differences, it lacks any acknowledgement of the state policies that have influenced those differences and also lacks an

acknowledgement of how these policies will negatively effect stakeholder's ability to meet the plan's indicators. Condom education and lack of electronic reporting from all providers are just two specific examples.

7. Inadequate recognition of STI specialty clinics
As was previously mentioned in David Harvey's comments to OIDP, nowhere does the plan describe the important role of STI specialty clinics and the fact that they have no federal funding stream. Additionally, although other health programs are mentioned (family planning, primary care, Maternal and Child Health, etc.) there is no description of their relative contribution to STI care, which varies dramatically by program.

8. Disease Intervention Specialists
DIS are a key workforce for the STI epidemic. NCSD calls for a greater recognition and appreciation for the DIS role contributing to the surveillance system, navigating people to testing and treatment services, and intervening through contact tracing the chain of infections. Also, support for DIS training, national certification, and the important role of DIS in the syndemic approach to lowering rates of STIs, eliminating HIV, and ending Hepatitis should be included in the plan.

9. No mention of STI impact on trans people
Beyond the mention that the vision applies to all people "regardless of gender identity," the draft STI plan fails to detail the significant burden of STIs on trans people. Stigma, discrimination, and misunderstanding at the individual, community, and institutional levels, coupled with a public health system that is often not equipped to serve trans individuals, pave the way for an increasing disease burden that is challenging to address. Transgender men and women are included as a special population in the Centers for Disease Control and Prevention's 2015 STD Treatment Guidelines and the final STI Plan must address the STI burden in this population.

Discussion of Indicators

Overall, the NCSD membership agreed that the plan's indicators addressed the STI epidemics and are related to implementing the plan's goals. However, some members acknowledged that state policies and practices would severely limit

their ability to contribute to achieving the goals described in the plan. Other members felt that the 10-year goals were not aspirational. However, we heard wide agreement about the following:

- Increased STI testing will mean, at least in the short term, that STI cases and rates will increase.
- Disparity indicators should not be separate but should be sub-sets of the core indicators.
- There should be at least one indicator related to the syndemics, such as Ryan White providers screening for other STIs and medication-assisted treatment clinics screening for syphilis.

Additional Comments

- **No language around Expedited Partner Therapy (EPT)**
  This should be added as a new Strategy 2.1.2: "Increase the use of Expedited Partner Therapy in clinical settings," and the barrier to full EPT implementation in Federal Qualified Health Centers should be addressed.

- **Confusing language regarding third-trimester congenital syphilis screening**
  Language used on page 25 regarding "vulnerability" to syphilis acquisition is unclear and allows for provider bias. NCSD encourages language that all pregnant women be screened for syphilis in their third trimester.

- **No mention of the significant, recent STI vaccine investment by National Institutes for Health (NIH)**
  This could be added on page 14.

- **Non-reportable and emerging STIs**
  Non-reportable and emerging STIs, such as trichomoniasis and mycoplasma genitalium, are not described at all, although they complicate treatment for those who have other STIs.

Again, we appreciate the opportunity to provide more detailed feedback on this draft plan. We look forward to working with the federal government in its implementation. Should you like additional information, please contact Stephanie Arnold Pang, NCSD director, policy and government relations, at sarnold@ncsddc.org.

Sincerely,

Caitlin Conrad
Chair, Board of Directors

David C. Harvey
Executive Director

National Coalition of STD Directors