Sexually Transmitted Infections
Adopting a Sexual Health Paradigm

The STI Workforce Needs Support and Expansion To Meet the Needs of the Nation

The health care system and federal agencies should incentivize sexual health promotion as a focus area of practice for both the clinical workforce and important segments of the nonclinical public health and social services professions.

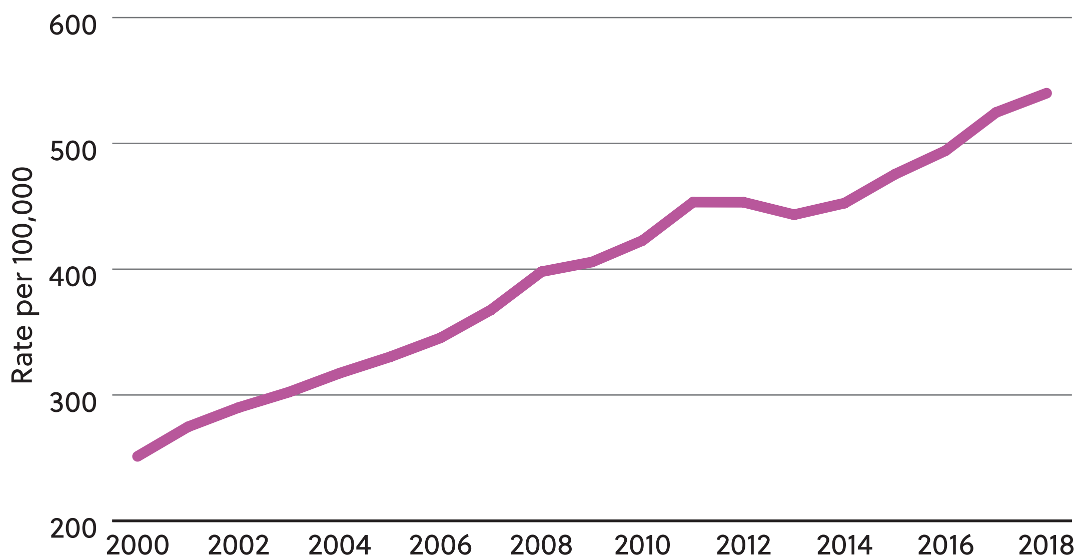
Sexually transmitted infection (STI) rates are persistently high, increasing, and at record levels in the United States. The lack of progress in STI prevention and control represents longstanding underinvestment in the broader public health system and its workforce, as highlighted during the COVID-19 pandemic. The report *Sexually Transmitted Infections: Adopting a Sexual Health Paradigm* provides recommendations on how the STI and sexual health workforce can accelerate national progress in reducing STIs.

Strengthening the sexual health workforce requires:

1. **Broadening ownership and accountability** for STI prevention and management to professionals not traditionally considered part of the sexual health workforce;
2. **Redefining STI specialists** from a public health perspective; and
3. **Creating opportunities for sexual health specialty training** and careers across the public health system.

A guiding paradigm for STI prevention and control is to adopt a holistic, health-centered perspective on sexual health as a key dimension of healthy living, moving away from the disease-focused framing of STIs that can lead to stigma. This paradigm shift requires an expanded sexual health workforce equipped to address STIs. It also creates opportunities to leverage additional resources and partnerships (e.g., in education, family services, community health) to supplement STI funding, infrastructure, and workforce.

Chlamydia Infections 2000–2018



One in 5 people in the United States had an STI on any given day in 2018, totaling nearly 68 million estimated infections.

A Persistent Problem

Since 2000, the overall case rate of **chlamydia has doubled, gonorrhea has increased nearly 1.4-fold**, and **primary and secondary syphilis is up 5-fold.**

Long-term effects of STIs include **chronic pelvic pain, infertility, miscarriage or newborn death,** and **increased risk of HIV infection, genital and oral cancers, neurological and rheumatological consequences, and possible death** in individuals not screened or with poorly managed care.

STIs imposed an estimated **$16 billion in lifetime direct medical costs** in the United States in 2018.

Who Should the Sexual Health Workforce Include?

The sexual health workforce should include expanded roles for primary care providers (i.e., primary care physicians, nurse practitioners, and physician assistants), nurses, pharmacists, disease intervention specialists, and community stakeholders (such as parents, health educators, community health workers, and civic and religious leaders).

- **Primary care providers** (i.e., primary care physicians, nurse practitioners, and physician assistants), nurses, and many clinical behavioral health professionals are well positioned to deliver or facilitate sexual histories, STI vaccination, routine testing, and treatment; however, clinical health care generalists often insufficiently prioritize sexual health services.
- **Nurses,** as first-line providers trained to deliver most aspects of sexual health promotion, should have a broader scope of practice related to sexual health.
- Given that about 90 percent of the U.S. population lives within two miles of a community pharmacy, **pharmacists** can serve convenient entry points into the healthcare system, including for sexual health services.
- Research demonstrates that **parents, health educators, community health workers, and civic and religious leaders** can be influential in family- and community-based sexual health education and promotion and are an important segment of the sexual health workforce who need additional support.
- **Disease intervention specialists** reduce the transmission of STIs by providing ground-level STI education and partner services including counseling, testing, and referrals.

"Institutionalized racism, especially in the clinical field, is definitely a barrier for me with the medical professionals not always listening to people of color, not always listening to queer people… they don't necessarily have all the language and noninvasive manners of asking questions… My recommendation would be to be more personable, supportive, and nonjudgmental and to have spaces for non-heteronormative people."

– Participant, lived experience panel

SPOTLIGHT ON

BROADENING OWNERSHIP AND ACCOUNTABILITY

The existing clinical health care workforce includes a large subset of practitioners and stakeholders who are traditionally not involved directly in sexual health service delivery. This places responsibility for sexual health promotion and STI services narrowly on STI clinics or among a relatively small number of STI and sexual and reproductive health specialists. However, additional practitioners across clinical health care and public health, most notably primary care providers, can participate.

Recommended Action

Incentivize and facilitate sexual health promotion as a focus area of practice for both the clinical workforce and important segments of the nonclinical public health and social services professions.

- Clinical practice guidelines and training curricula for health care generalists should define a minimum set of sexual health competencies, emphasizing the importance of consistent delivery of recommended sexual health services such as sexual histories, STI screening, and vaccination.
- The CDC and state and local health departments, in collaboration with STI/HIV expert providers and regional STI prevention training centers, should serve as a resource of clinical expertise for primary care providers and nonclinical health and social services professionals and paraprofessionals.
- CDC should identify federal and state policy actions that would most effectively expand the available workforce to address STI prevention, screening, and treatment.
- Federal partners should explore public-private partnerships to address logistical and regulatory barriers to workforce expansion.

SPOTLIGHT ON

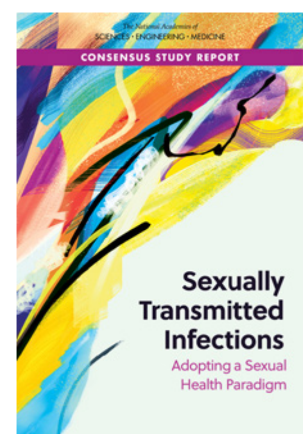
BIAS, HEALTH CARE, AND STIs

- Bias in health care both reflects and reinforces pre-existing societal inequities, and unconscious stereotypes can override objective health assessments.
- Implicit bias among health care providers has been linked to an unwitting attitude of discomfort with taking a sexual history for lesbian, gay, bisexual, transgender, and queer clients.
- Unconscious stereotypes and attitudes (1) distort perceptions of the patient, (2) influence patient-provider interactions, (3) affect clinical decision making (such as testing, diagnosis, and treatment), and (4) ultimately fuel disparities in health outcomes.
- Racial, ethnic, sexual, and gender minorities typically report that they experience microaggressions and provide lower ratings of satisfaction with health care interaction and lower levels of trust in their providers, which can affect treatment compliance and future care seeking.

Conclusion

There are approximately 600,000 prescribers in primary care, more than 3.5 million nurses, and hundreds of thousands of behavioral health professionals in the United States. The health care workforce can reinforce national efforts to address increasing STI rates in the United States by delivering STI testing, treatment, and clinical prevention. This diverse workforce with distinctive competencies is well positioned to deliver comprehensive and effective STI services.

To learn more about how to support and expand the sexual health workforce, see Chapter 11 of the report.



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