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Commentary on the Benefits of In-Person Syphilis Partner Services for Priority Populations

Melinda Salmon, BA^{*}, Melissa Boyette, BA[†]

^{*}Centers for Disease Control and Prevention, Atlanta, GA

[†]National Board of Public Health Examiners, Washington, DC

There are no shortcuts, and we have to meet people where they are. Some people face tremendous barriers to STI prevention and health services. So, the most important work is often outside the clinic, whether it be reaching out to communities with testing, interviewing patients to offer services to their partners, or delivering treatment directly to someone.

- Laura Bachmann, MD, MPH, Acting Director, CDC's
Division of STD Prevention

The above is a statement from Dr. Laura Bachmann, former Acting Director of the Division of STD Prevention, Centers for Disease Control and Prevention, made upon the release of the 2022 STI Surveillance Report. The authors of this commentary agree with the call to action from Dr. Laura Bachmann and offer this commentary to build upon her directive to “meet people where they are,” and therefore provide in-person, community-based partner services for people diagnosed with syphilis. This expert opinion is based on over 50 years of combined experience in STI and HIV disease intervention. The authors suggest returning to the provision of client-centered field investigation and partner services for some priority populations as one strategy that could help to combat the recent dramatic increase in syphilis incidence. Provision of in-person partner services can improve participation, enhance timeliness of investigations, and ensure equitable access to services. Partner services is one of the key public health interventions for the prevention and control of syphilis and includes interviewing people with a sexually transmitted infection, eliciting and notifying exposed partners, and facilitating access to timely examination and treatment, as appropriate. Partner services can only have an impact on individuals if people infected with or at risk for syphilis are located so they have an opportunity to benefit from the services. Relying on telephonic methods of communication limits the reach of this important intervention to people who are willing and able to engage via telephone, which leaves behind the harder-to-reach populations who cannot be reached by telephone or are difficult to engage. Before the COVID-19 pandemic, delivery of in-person partner services and associated field-based

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Correspondence: Melinda Salmon, BA, Centers for Disease Control and Prevention, Atlanta, GA. MEH3@cdc.gov.
M.B. is a former employee of the Centers for Disease Control and Prevention.

investigational activities was standard practice for many years as recommended by the Centers for Disease Control and Prevention (CDC).¹

On January 24, 2024, the CDC released the 2022 Sexually Transmitted Infections (STI) Surveillance Report.² According to the report, syphilis cases (all stages and congenital syphilis) increased 80% in the past 5 years. More than 3700 congenital syphilis cases were reported in 2022, reflecting an alarming 937% increase in the past decade. Of the 3755 congenital syphilis cases reported, 282 were reported as congenital-syphilis-related still births and infant deaths. The case rates for congenital syphilis are staggering in some specific populations. Among American Indian and Alaska Native people, nearly 1 in 250 live births results in a baby with congenital syphilis. These figures are shocking and are a call to action for a strategic change in syphilis management, including partner services. Program data consistently illustrate that women and people who are pregnant are more receptive to partner services than other populations (A. Cope, personal communication, April 26, 2024). Because of this, state, tribal, local, and territorial (STLT) health department STI program leaders can consider prioritizing field investigation to locate clients, and face-to-face, on-site (i.e., in a clinic, correctional facility, shelter, residence, or other community settings) partner services activities, with an emphasis on contact elicitation, for people who are infected with syphilis (clients), especially pregnant people and women of childbearing age. In-person partner services activities and associated field investigation may also improve access to testing and treatment services for harder-to-reach populations. This could have significant impact on the current adult female and congenital syphilis epidemic.

The COVID-19 pandemic was the perfect storm for STLT health department STI programs that already had deteriorating infrastructure due to many years of level funding in the face of dramatically increasing syphilis morbidity. Many disease intervention specialists (DIS) and other disease intervention professionals (hereafter DIS) were reassigned to assist with COVID-19 case investigation and contact tracing, resulting in STI control program staffing shortages that impacted their ability to reach people with STIs and HIV. In addition, many DIS voluntarily left their jobs to join COVID-19 programs where they were paid comparable salaries to work in a 100% remote environment. This turnover resulted in the hiring of many new DIS at a time when federal resources for DIS training were diverted to train COVID-19 case investigation and contact tracing staff. In the absence of formal training, many STI programs developed scripts or forms for new staff to follow during the interview process. These tools are counter to the recommended client-centered techniques like asking open-ended questions and using a conversational interview style, which maximize the amount of information gathered during the interview.¹ Concurrently, partner services activities were delivered primarily via telephone, which inhibits the use of key interviewing techniques such as reading body language, picking up on nonverbal cues, and observing the client's environment for investigative clues to identify potential contacts.

What had long been a little-known intervention (contact tracing) is now widely familiar to the public through case investigation and contact tracing efforts employed during the COVID-19 pandemic, but the public's perception of contact tracing for COVID-19 could be hampering public health efforts for STIs and HIV.³ People might be cautious about engaging with public health departments following the strict isolation and quarantine

measures employed through contact tracing during the COVID-19 pandemic. The public might not understand the difference between COVID-19 contact tracing and partner services for STI and could be refusing services based on a lack of awareness of the difference between these interventions. It is unknown how COVID-19 contact tracing measures have impacted people's willingness to engage with STI partner services, but maintaining the telephonic practices employed during the pandemic might serve only to further align disease intervention work with what people came to expect from COVID-19 contact tracing.

During and following the COVID-19 pandemic, many sectors adapted their workforces to a remote environment. Often in response to staffing shortages and funding challenges, a remote workforce has been maintained in some STI control programs where DIS are conducting partner services activities remotely. However, there are insufficient data to demonstrate the effectiveness of a telephonic model of partner services. Before the COVID-19 pandemic, in-person interviews were recommended for clients unless there was no reasonable alternative.¹ No formal recommendations to conduct all partner services activities virtually or telephonically have been published. Conducting partner services interviews and notifying contacts via telephone or other virtual methods does not allow for field investigation, which is an important tool to locate people who have tested positive and their partners and ensuring their examination and treatment. Although telephonic partner services may be more efficient and cost-effective, the shift to telephonic service delivery heavily impacts harder-to-reach people who face barriers with communication, transportation, and mistrust of systems, leaving them more vulnerable to negative health outcomes and acquisition of infection. People who do not have access to technology (i.e., telephone, smartphone, computer), are un/under-housed, or have limited access to health care are unlikely to be reached by a DIS who only has telephonic and electronic tools at their disposal. This has been observed repeatedly while providing technical assistance to STI programs in response to increases in syphilis among emerging populations, such as people with substance use disorder, people with a history of incarceration, and those who are experiencing homelessness. Making the additional effort of conducting in-person activities to reach these populations could help to prevent a disproportionate burden of disease for people who already face significant disparities.

Sexual behaviors and STI diagnoses are sensitive and private topics. During the partner services interview, the client is asked to reveal extremely personal and private information about themselves and their sex partners. Building rapport is critical to gaining trust and making the person feel comfortable sharing this highly sensitive information. In-person encounters enhance the ability to read body language, make eye contact, assess for understanding, and provide a personable interaction with the client, which is essential to building rapport. Field-based investigation activities are critical for additional reasons as well. During a face-to-face encounter, a DIS can provide point-of-care testing and collect specimens for laboratory-based STI and HIV testing, which facilitates timely diagnosis and treatment. Patients referred by telephone for these services may be less likely to receive them.⁴ In addition, DIS can employ keen investigative techniques and identify trends, at-risk social networks, and venues of epidemiologic significance, and provide more timely services in a community setting than they can in a telephonic encounter. For example, if a DIS conducts a field investigation in the same location (i.e., motel, bar, housing

complex) multiple times in a short period of time, they can quickly determine that the location is epidemiologically significant and recommend additional intervention such as screenings and outreach. In addition, a DIS involved in field activities may encounter previously unidentified people at risk of infection and can provide immediate on-site services, facilitating timely access to testing, treatment, and referral to other supportive services. These types of impromptu intervention opportunities cannot occur when partner services encounters are limited to telephone calls. Field-based investigations also facilitate timelier follow-up and improved contact elicitation, which may result in increased case-finding during episodes of increased transmission.⁵ An in-person visit from a DIS conveys a level of urgency to the client and facilitates a more honest and open interview.

Amid a shortage of penicillin G benzathine, the only treatment available for preventing congenital syphilis, disease intervention activities such as the collection of symptom history and partner information are crucial to determining how long a person has been infected with syphilis. When interviews are conducted in-person, the DIS can use visual aids such as symptom picture cards to assist with accurate reporting of patient symptoms. Without this critical information, programs default to a diagnosis of “syphilis of unknown duration,” which necessitates a 3-dose regimen of penicillin G benzathine, each delivered at specific time intervals.⁶ This regimen complicates compliance and uses precious treatment resources. Disease intervention specialists collect detailed symptom histories and identify infected partners, which informs a more accurate diagnosis. As a result, cases of early syphilis are accurately identified so the treatment regimen can be a single dose of penicillin G benzathine, saving the additional doses for others who need it.

Alternative treatment regimens, testing and screening programs, and rapid test technology are welcome tools for diagnosis and treatment, but partner services are unique interventions that identify infected people and prevent disease from developing in exposed partners. Conducting partner services activities telephonically was done out of necessity during the pandemic and became the status quo in many programs despite the long-standing recommendation for conducting in-person activities.¹ Absent formal recommendations in support of virtual or telephonic service delivery, STLT health departments could collect data to measure the effectiveness of in-person versus virtual and telephonic methods of locating and providing partner services interviews. This evaluation could help identify priority populations and inform prioritization of in-person partner services activities, including field investigation, in response to the escalating syphilis epidemic. Although it might not be feasible to conduct in-person partner services for all syphilis cases due to staffing or funding constraints, STLT health departments could prioritize these activities for pregnant people and other women of childbearing age and others based on effectiveness and local surveillance data to ensure equitable access to testing, treatment, and partner services for populations most impacted. For example, STLT health departments could analyze local partner services outcomes data to identify populations with similar demographic or risk-based characteristics that are not being reached through virtual or telephonic efforts (i.e., reviewing index cases and contacts who are dispositioned as “insufficient information,” “unable to locate,” or “refused”) to identify trends. To ensure equitable access to testing and treatment services, those populations could be prioritized for in-person partner services. Transmission among these harder-to-reach communities could amplify existing inequities

if they are not located and offered partner services. In order to do this important work, DIS would benefit from training to employ field-based investigative techniques that could enhance the impact of partner services, especially those who do not have previous training and experience in field investigation.¹ The experience gained through delivery of in-person interviews and notifications could bolster DIS skills for use in telephonic or virtual encounters when in-person encounters are not feasible.

With syphilis cases dramatically increasing and disproportionately impacting populations with significant barriers to health care access, it is the appropriate time to leverage the in-person model of partner services as one strategy to ensure equitable access to vital disease intervention services to improve syphilis outcomes and help to control transmission.

Disclaimer:

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