



# Current Legal and Policy Environment for STI Testing in Pregnancy

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**Objectives:** To analyze the current law regulating practice with regard to testing and case reporting of STIs during pregnancy.

**Problem:** STIs during pregnancy are associated with multiple and serious adverse sequelae. Pathogens designated as sexually acquired can influence processes of implantation, contribute to infertility and cause maternal and neonatal infections and death. Adverse pregnancy and birth outcomes reported include: ectopic pregnancy, spontaneous abortion, low birth weight, prematurity, small for gestational age, stillbirth, puerperal infection, sepsis, obstructed birth canal. Additionally, neonates may experience congenital infections of the eyes, pneumonia, bone and teeth deformities, encephalitis and central nervous system involvement, with permanent neurologic impairment, recurrent respiratory papillomatosis.

**Background:** The national regulatory environment has long contained provisions relating to direct testing for sexually transmitted infections (STIs) during pregnancy. Over time, changes have been made to requirements pertaining to specific organisms, provider reporting responsibilities, and timing of testing during pregnancy. Emphasis recently has focused on screening for HIV, with very limited attention to other STIs also associated with adverse pregnancy outcomes. Subsequently, in 2005-2006 Florida ratified state laws and regulations to modernize testing practices during pregnancy with a subsequent 58% increase in case identification during pregnancy by 2009.

**Methods:** We searched LEXIS/NEXIS to identify state statutes and regulations in effect at the end of 2012 related to testing for STIs during pregnancy for the fifty states and the District of Columbia. For our survey we defined prenatal testing as categorized under the following parameters: 1) required, opt-in and opt-out; 2) women of what age; 3) designated pathogen required; 4) who was required to order testing; 5) who was required to report positives; 6) when in the pregnancy testing was required; 7) whether the provider was required to inform the woman of her test results; and finally 8) requirements for reporting positive test results.

**Limitations:** Legislation is an active process, therefore information included may have changed since gathered.

**Results:** While all states have requirements for reporting of one or more sexually transmitted infections, great variability is noted in requirements for testing during pregnancy, if at all, when, who should order testing, timing, frequency, a woman's right to refuse testing and on what basis. Notable jurisdiction differences include:

#### What to test for?

- 5 jurisdictions have no testing requirements (DC, MN, NH, ND, WI)
- 3 require consent to test (KS, ME, MO)
- 6 states require that women receive notification of their test results, with HIV results only required for IN & TN
- 12 states require that pregnant women only be tested for one infection: Syphilis (10), HIV (1), Hepatitis B (1)
- Only 5 require testing for Chlamydia (AL, DE, FL, NY, NC) and 7 for Gonorrhea; AL & NC include age or high designation to test

#### Who decides about testing?

- Disease specific options for women not wishing to be tested include "opt-out, decline, refuse": opt-out for HIV only (17), decline any test (3)
- 4 states have opt-in HIV requirements and remaining have some form of opt-out HIV requirement, usually in writing
- 8 jurisdictions permit exemption based on religious objections, while 4 others permit judges or physicians to waive the testing requirement
- NY & MS permit physicians to conduct testing for any STI without knowledge of the woman "if deemed necessary"
- Nearly all states designate the "Attendant" as responsible to order tests; IO has no designation, while GA & IN identify the "Physician"

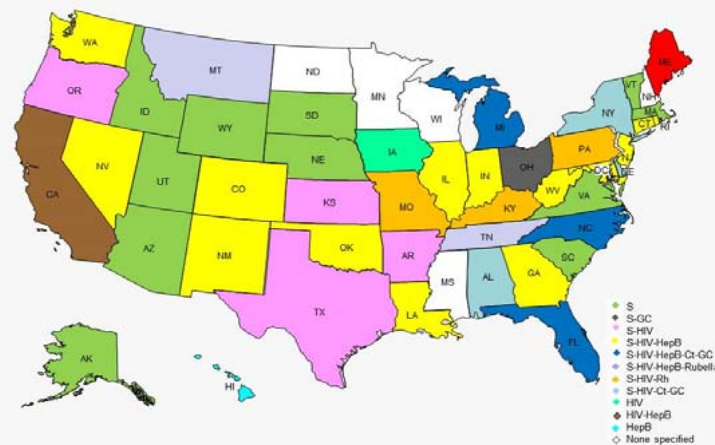
#### When to test?

- The greatest variability was associated with test timing: at diagnosis of pregnancy, early, at first professional visit, at first prenatal care (PNC) visit, between 1-30 days of entering PNC, and at prenatal examination. In addition notable range on repeat testing during 3<sup>rd</sup> trimester, at delivery with or without risk for subsequent testing, and often disease specific timing parameters
- Significant variability was noted in the time interval to report cases to public health authorities (immediately by phone to within 30 days), who had responsibility, where results should be reported (county or state), method to report (paper or electronic) and few require electronic reporting as the preferred method

#### Take away - While sexually transmitted

infections during pregnancy can cause grave adverse outcomes for women, fetus and newborns, there are no consistent national requirements for which infections, when, how frequently or whom has responsibility to assure screening or inform the woman. Further nationally there is no universal requirement for timely electronic reporting of test results.

Figure 1. STI Testing Requirements During Pregnancy - 2013



**Implications:** Findings have implications for targeted regulatory changes to enhance testing practice and expansion of electronic reporting to improve STI case management in pregnancy. Future changes should address the ambiguity, inconsistency, redundant and fragmented approach to prenatal population health in the interest of improved pregnancy and birth outcomes associated with STI acquisition during pregnancy. Regulations that permit agility to rapidly incorporate new test technology, disease distribution and normalize all STI testing as routine component of quality prenatal care merit the attention of providers and law makers alike.