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LSU-CrescentCare Sexual Health Center: An inter-organizational partnership initiative to improve access to sexual health services in New Orleans, Louisiana, United States

Stephanie N Taylor [1], Rebecca A Lillis [1], Ronald D Wilcox [1,2], Laura Damioli [1,3], David H Martin [1], Alice Riener [2], Julio E Figueroa [1], M Jacques Nsuami [1]*

[1] Section of Infectious Diseases, Department of Internal Medicine, School of Medicine, Louisiana State University Health Sciences Center, New Orleans, LA, USA
[2] CrescentCare, New Orleans, LA, USA
[3] Division of Infectious Disease, Department of Medicine, University of Colorado, Aurora, CO, USA
***Corresponding Author:** mnsuam@lsuhsc.edu

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ABSTRACT

Objectives: To describe a partnership between CrescentCare and Louisiana State University (LSU) School of Medicine that created a new Sexual Health Clinic in New Orleans, and to assess the health services that patients sought and received at the new clinic in the opening months of its creation.

Methods: When the new clinic opened, signs were posted on New Orleans streets, flyers were placed in selected emergency rooms and healthcare facilities, radio and bus stop advertisements were purchased, and the CrescentCare website was updated with the addition of a page for the new clinic. The new clinic opened on 15 June 2015. A survey questionnaire was administered to 706 patients who visited the new clinic from 1 October 2015 to 30 December 2015 to capture 3 quality improvement patient indicators. Their medical records were retrospectively reviewed to assess the services they came to seek at the new clinic.

Results: Patients were 64.7% men, 35.0% women, 0.3% transgender women, 64.9% black, 94.6% non-Hispanic, 35.4% men who have sex with women, 23.4% men who have sex with men, and 29.5% women who have sex with men. Patients most frequently learned about the new clinic from friends. They mostly chose the new clinic because of the walk-in availability of services and the convenience of its location. Reasons for the visits included sexually transmitted infection (STI) symptoms, STI screening, STI treatment, STI contact, and laboratory test results. Past STI histories were highly frequent, as well as the prevalence of positive STI tests the day of the visit.

Conclusions: The LSU-CrescentCare Sexual Health Center is a model of a successful community-driven, public-private collaborative initiative aimed at ensuring that in the New Orleans region, everyone has an equal opportunity to achieve their best possible sexual health, regardless of race, ethnicity, sexual orientation, income, education, or zip code.

Keywords: community-driven initiatives, federally qualified health centers, health disparity, health equity, global health, sexual and reproductive health, sexually transmitted diseases, sexually transmitted infections

INTRODUCTION

There is not one single American healthcare system, but a collection of systems ranging from for-profit and non-profit to public institutions, each designed to serve the healthcare needs of different populations. The American healthcare is funded by various entities including private insurance, government insurance programs such as Medicare and Medicaid, philanthropy, and public financing for the uninsured [1, 2]. Although all institutions are legally required to provide emergency and inpatient care for indigent patients, there is no such requirement for outpatient care, which includes most sexual health services. Insured patients generally receive sexual health services within the for-profit or non-profit health systems. Underinsured and uninsured patients primarily rely on the public health systems that are funded by government appropriations or philanthropy. Sexual health services are delivered by professionals that include family physicians, pediatricians, infectious disease physicians and nurses, who practice in family planning clinics, sexually transmitted disease (STD) clinics, adolescent clinics, school health clinics, with funding provided by the government and private organizations [2, 3].

For more than seven decades, the New Orleans Health Department operated the Delgado STD Clinic to deliver sexual health services to local populations. For over 20 years, the Section of Infectious Diseases of the Louisiana State University (LSU) School of Medicine was contracted to provide the medical director and to manage the clinic. To our knowledge, no recorded history of the clinic exists, but stored medical records of patients treated for syphilis at the clinic dated back

to 1948. For years, the clinic was centrally located near a major bus transfer point in downtown New Orleans. Along with nurses and staff from the New Orleans Health Department, physicians and nurses from the Section of Infectious Diseases of LSU School of Medicine in New Orleans delivered health services to patients and provided clinical research opportunities at the clinic for over 30 years [4-10]. In 1983, a young investigator (DHM, co-author) established a STD research laboratory within the LSU School of Medicine, which provided technical support for all clinical research that physicians and nurses from the Section of Infectious Diseases of the LSU School of Medicine conducted at the Delgado STD Clinic [4-10].

In the New Orleans region, there were a series of events that dramatically affected the delivery of health services in general, two of which particularly affected the delivery of sexual health services. First, the economic recession in the 2000s resulted in nationwide cuts in public funding for sexual health services that affected operations at the Delgado STD Clinic [11]. Second, Hurricane Katrina in 2005 devastated much of New Orleans and its public and private healthcare institutions. The Delgado STD Clinic was closed for a year while the city struggled to recover [12]. Although the clinic reopened through a collaboration between the Section of Infectious Diseases of the LSU School of Medicine, the Louisiana Office of Public Health, and the New Orleans Health Department, after a few years the clinic building was no longer available for use, and the clinic had to be moved.

On the other hand, the devastation that the human immunodeficiency virus (HIV) pandemic caused to New Orleans populations in the early 1980s led to the founding of NO/AIDS Task Force in 1983. What began as a single phone line with an answering machine staffed by lay volunteers from the community [13] became a full-service clinic for individuals living with HIV. Throughout the 1990s and early 2000s, NO/AIDS Task Force added case management, mental health services, a meal delivery program, and a community prevention and education project. In 2013, NO/AIDS Task Force became a Federally Qualified Health Center under *The Patient Protection and Affordable Care Act of 2010*, changed its name to CrescentCare, and began to provide comprehensive health and wellness services for all New Orleans communities, with a health equity vision of "a community without barriers to care, where all people have the power to be healthy and whole" (https://www.crescentcare.org).

It is in this context of constant innovative thinking that CrescentCare and the LSU School of Medicine developed a partnership initiative to create a robust Sexual Health Clinic within the new Federally Qualified Health Center, aimed at improving access of New Orleans communities to much needed sexual health services [14, 15]. In June 2015, the clinic, named LSU-CrescentCare Sexual Health Center, opened in a newly renovated clinic building approximately 2.2 miles from the former Delgado STD Clinic site. In this report, we retrospectively describe this inter-organizational partnership initiative, and we present the assessment of health services that patients who visited the new clinic in its early months of operation sought, to identify the healthcare resources that would adequately address the needs of the patient population that the new clinic was going to serve.

MATERIALS AND METHODS

Setting and Design

When the new clinic opened, signs were posted on the streets of New Orleans, flyers were placed in selected local emergency rooms and healthcare facilities, radio and bus stop advertisements were purchased, and the CrescentCare website was updated with the addition of the Sexual Health and Wellness page (https://crescentcare.org/sexual-health-and-wellness/). The bus stop signs included pictures of providers who worked at the Delgado STD Clinic for decades with an anticipation that patients would recognize them and notice their relocation. Participants who were enrolled in an ongoing clinical trial at the Delgado STD Clinic [16] were called and sent postcards at their home address, so they would report to the new location for their study follow-up visits. On 15 June 2015, the LSU-CrescentCare Sexual Health Center officially opened at the CrescentCare Federally Qualified Health and Wellness Center facility, located on one of the main avenues leading to the New Orleans Central Business District, and accessible by public transportation with a 2-minute walk from a bus stop 250 feet from the building's entrance. The facility has 84 marked parking slots that the public can use on a first-come first-serve basis.

In the opening months of the new clinic, a survey questionnaire was designed to capture 3 patient indicators for quality improvement purposes:

(1) how patients learned about the new clinic;

(2) why they chose the new clinic; and

(3) where they went for sexually transmitted infection (STI) screening and care in the past.

The survey was a paper-and-pencil self-administered survey, which all patients who visited the new clinic from 1 October 2015 to 30 December 2015 were asked to complete. For each patient who completed the survey, demographic information, reason for the visit, payor source, sexual behaviors, prior STI history, tests performed, diagnoses made, and any referrals to other services, were retrospectively abstracted from their electronic medical record. Patients were not paid for completing the survey questionnaire. No patient identifier was abstracted from the medical record. All survey data and data abstracted from the electronic medical record were recorded on a data collection form.

Designed as a quality improvement survey and a retrospective chart review study, the protocol was exempt from Institutional Review Board (IRB) oversight (LSU Health Sciences Center-New Orleans IRB #: 9246).

Data Analysis

Recorded data were entered into a Microsoft Access database and analyzed with SPSS software using descriptive statistics procedures (IBM SPSS Statistics 25). Comparisons between study groups were by chi-square tests for categorical variables and *F* test for continuous variables, with two-tailed $p < .05$ considered statistically significant. Data were analyzed and reported separately by gender.

Table 1. Age, race, ethnicity, and sexual orientation of the 706 survey respondents

Characteristics	Cisgender men (n = 457)	Cisgender women (n = 247)	Total (n = 706)*
Age, years			
Mean (standard deviation)	33.4 (10.0)	30.5 (9.1)	32.3 (9.8)*
Minimum-maximum	18-72	16-58	16-72
Median	31.0	29.0	30.0
Race			
Black	269 (58.9%)	188 (76.1%)	458 (64.9%)**
White	168 (36.8%)	52 (21.1%)	221 (31.3%)**
Asian	6 (1.3%)	1 (0.4%)	7 (1.0%)
Native American/Eskimo	4 (0.9%)	2 (0.8%)	6 (0.8%)
Pacific Islander	1 (0.2%)	0 (0.0%)	1 (0.1%)
Other	8 (1.8%)	3 (1.2%)	11 (1.6%)
Missing	1 (0.2%)	1 (0.4%)	2 (0.3%)
Ethnicity			
Non-Hispanic	425 (93.0%)	241 (97.6%)	668 (94.6%)*
Hispanic	23 (5.0%)	4 (1.6%)	27 (3.8%)
Not documented	9 (2.0%)	2 (0.8%)	11 (1.6%)
Sexual orientation			
Men who have sex with women	250 (54.7%)	-	250 (35.4%)
Men who have sex with men	164 (35.9%)	1 (0.4%)¶	165 (23.4%)
Women who have sex with men	-	208 (84.2%)	208 (29.5%)
Bisexual	31 (6.8%)	25 (10.1%)	58 (8.2%)*
Women who have sex with women	-	7 (2.8%)	7 (1.0%)
Transgender women	1 (0.2%)§	0 (0.0%)	1 (0.1%)
Transgender men	1 (0.2%)§	0 (0.0%)	1 (0.1%)
Not documented	10 (2.2%)	6 (2.4%)	16 (2.3%)

Note. *Total includes 2 transgender women; **Total includes 1 transgender woman; ¶Data transcription error, non-Hispanic black; & §Non-Hispanic black

RESULTS

Study Population

Data were obtained from 706 unique patients who visited the new Sexual Health Clinic from 1 October 2015 to 30 December 2015. Patients were 64.7% cisgender men (n = 457), 35.0% cisgender women (n = 247), and 0.3% transgender women (n = 2). **Table 1** shows the age, race, ethnicity, and sexual orientation of survey respondents by gender. Men were between 18 and 72 years of age (mean: 33.4 ± 10.0 years; median: 31.0 years) and women were between 16 and 58 years of age (mean: 30.5 ± 9.1 years; median: 29.0 years). Two-thirds (64.9%; n = 458) were black, one-third (31.3%; n = 221) were white, and 94.6% (n = 668) were non-Hispanic. Two hundred fifty men self-identified as men who have sex with women (MSW, 35.4%), 165 self-identified as men who have sex with men (MSM, 23.4%), 208 women self-identified as women who have sex with men (WSM, 29.5%), and 58 men and women (8.2%) self-identified as bisexual. One woman had sexual orientation transcribed as a man who had sex with men. Transgender women were both non-Hispanic and self-identified as bisexual. Of the 247 women, 7 (2.8%) self-identified as women who have sex with women (WSW). Similar proportions of men (2.2%; n = 10) and women (2.4%; n = 6) did not indicate their sexual orientation.

Age, Race, Ethnicity, and Sexual Behaviors

Table 2 shows the age, race, ethnicity, and sexual behaviors by sexual orientation among men. Men who have sex

Table 2. Age, race, ethnicity, and sexual behaviors by sexual orientation among men

Characteristics	MSW (n = 250)	MSM (n = 164)	Bisexual (n = 31)	Not documented (n = 10)	p-value
Age, years					
Mean (standard deviation)	34.4 (10.3)	31.6 (9.0)	32.6 (10.9)	37.6 (9.3)	**.021***
Minimum-maximum	18-63	18-72	20-60	28-56	
Median [inter-quartile range]	32 [27-41]	29 [26-36]	31 [24-35]	34.5 [30.5-45]	
Race, n (%)					
Black	185 (74.0)	67 (40.9)	13 (41.9)	2 (20.0)	**< .0001¶**
White	58 (23.2)	88 (53.7)	16 (51.6)	6 (60.0)	
Other	7 (2.8)	9 (5.5)	2 (6.5)	2 (20.0)	
Ethnicity, n (%)					
Non-Hispanic	234 (93.6)	150 (91.5)	30 (96.8)	9 (90.0)	.578¶
Hispanic	13 (5.2)	8 (4.9)	1 (3.2)	1 (10.0)	
Not documented	3 (1.2)	6 (3.7)	0 (0.0)	0 (0.0)	
New partner, last 3 months, n (%)					
Yes	97 (38.8)	72 (43.9)	15 (48.4)	1 (10.0)	**< .0001¶**
No	125 (50.0)	49 (29.9)	9 (29.0)	1 (10.0)	
No answer	28 (11.2)	43 (26.2)	7 (22.6)	8 (80.0)	
# of partners, last 3 months					
Mean (standard deviation)	1.92 (2.1)	3.89 (5.5)	2.81 (5.5)	1.00 (1.4)	**< .0001***

Table 2 (Continued). Age, race, ethnicity, and sexual behaviors by sexual orientation among men

Characteristics	MSW (n = 250)	MSM (n = 164)	Bisexual (n = 31)	Not documented (n = 10)	p-value
Minimum-maximum	0-20	0-30	0-30	0-2	
Median [inter-quartile range]	1.0 [1.0-2.0]	2.0 [1.0-4.0]	2.0 [1.0-3.0]	1.0 [0.0-NA]	
# of partners, last 12 months					
Mean (standard deviation)	4.04 (4.8)	11.31 (19.1)	8.33 (14.4)	2.50 (3.5)	**< .0001***
Minimum-maximum	0-40	0-100	1-75	0-5	
Median [inter-quartile range]	3.0 [1.0-5.0]	5.0 [2.0-10.0]	4.0 [3.0-7.0]	2.5 [0.0-NA]	
Condom use, n (%)					
Always	15 (6.0)	18 (11.0)	3 (9.7)	0 (0.0)	**< .0001¶**
Usually	57 (22.8)	43 (26.2)	9 (29.0)	0 (0.0)	
Sometimes	92 (36.8)	56 (34.1)	12 (38.7)	1 (10.0)	
Never	54 (21.6)	13 (7.9)	2 (6.5)	0 (0.0)	
No answer	32 (12.8)	34 (20.7)	5 (16.1)	9 (90.0)	
Condom use, last intercourse, n (%)					
Yes	73 (29.2)	39 (23.8)	5 (16.1)	1 (10.0)	**< .0001¶**
No	155 (62.0)	91 (55.5)	21 (67.7)	0 (0.0)	
No answer	22 (8.8)	34 (20.7)	5 (16.1)	9 (90.0)	

Note. *F test; ¶Chi-square test; **Boldface** denotes a statistically significant difference; MSM: Men who have sex with men; MSW: Men who have sex with women; The two men who reported transgender sexual partnerships (**Table 1**) had a new sex partner in the last 3 months, used condom sometimes, and did not use one at last intercourse; The one who had transgender women partners had 2 partners in the last 3 months and 2 partners in the last 12 months; & The one who had transgender men partners had 30 partners in the last 3 months and 70 partners in the last 12 months

with women were significantly older than MSM (mean age: 34.4 ± 10.3 vs. 31.6 ± 9.0 years, respectively; p = .021). The proportions of white men were 53.7% among MSM and 51.6% among bisexual men compared to 23.2% among MSW (p < .0001), but ethnicity was not distributed significantly differently by sexual orientation (p = .578).

One-half of MSW (50.0%) and one-third of MSM (29.9%) reported not having a new sex partner in the last 3 months, with significantly higher proportions of MSM, bisexuals, and men with undocumented sexual orientation than MSW not answering this question (p < .0001). Men who have sex with men reported significantly higher numbers of sex partners in the last 3 months (mean: 3.89 ± 5.5) and in the last 12 months (mean: 11.31 ± 19.1) compared to MSW (means: 1.92 ± 2.1 and 4.04 ± 4.8, respectively; p < .0001 for both comparisons). More MSW than MSM never used condom, but men with undocumented sexual orientation and MSM did not answer condom use questions at comparatively higher proportions than MSW (p < .0001).

Table 3 shows the age, race, ethnicity, and sexual behaviors by sexual orientation among women. The proportion of white women was 64.0% among bisexuals and 16.3% among

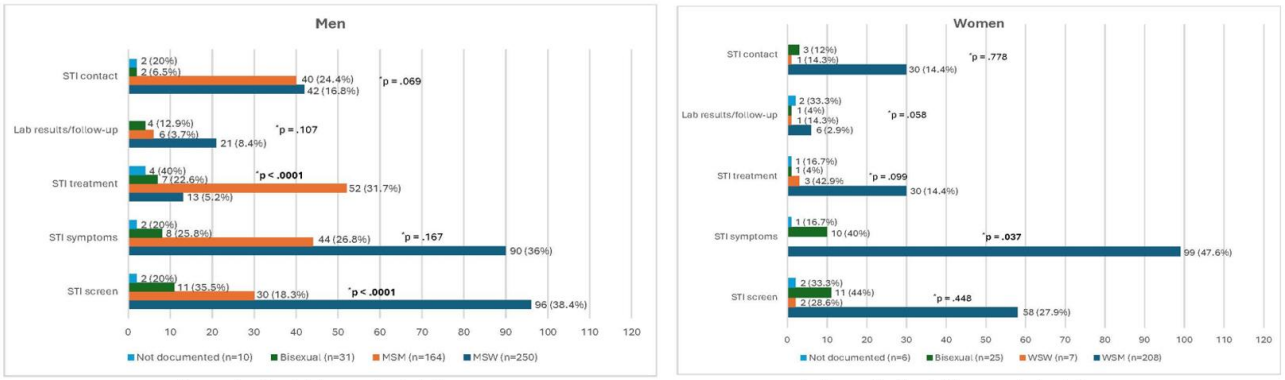
Table 3. Age, race, ethnicity, and sexual behaviors by sexual orientation among women

Characteristics	WSM (n = 208)	WSW (n = 7)	Bisexual (n = 25)	Not documented (n = 6)	p-value
Age, years					
Mean (standard deviation)	30.5 (9.3)	34.3 (8.3)	28.8 (6.5)	35.0 (11.2)	.313*
Minimum-maximum	16-58	21-46	20-41	27-57	
Median [inter-quartile range]	29 [23-36]	31 [31-40]	28 [25-32]	31 [28-41]	
Race, n (%)					
Black	169 (81.3)	6 (85.7)	7 (28.0)	5 (83.3)	**< .0001¶**
White	34 (16.3)	1 (14.3)	16 (64.0)	1 (16.7)	
Other	5 (2.4)	0 (0.0)	2 (8.0)	0 (0.0)	
Ethnicity, n (%)					
Non-Hispanic	203 (97.6)	7 (100.0)	25 (100.0)	5 (83.3)	.151¶
Hispanic	3 (1.4)	0 (0.0)	0 (0.0)	1 (16.7)	
Not documented	2 (1.0)	0 (0.0)	0 (0.0)	0 (0.0)	
New partner, last 3 months, n (%)					
Yes	66 (31.7)	1 (14.3)	18 (72.0)	0 (0.0)	**< .0001¶**
No	105 (50.5)	6 (85.7)	5 (20.0)	1 (16.7)	
No answer	37 (17.8)	0 (0.0)	2 (8.0)	5 (83.3)	
# of partners, last 3 months					
Mean (standard deviation)	1.51 (1.2)	1.29 (0.8)	3.37 (2.1)	-	**< .0001***
Minimum-maximum	0-10	1-3	1-8	-	
Median [inter-quartile range]	1.0 [1.0-2.0]	1.0 [1.0-1.0]	2.0 [2.0-4.0]	-	
# of partners, last 12 months					
Mean (standard deviation)	2.73 (4.0)	1.71 (1.9)	6.35 (4.4)	-	**.001***
Minimum-maximum	0-40	1-6	1-16	-	
Median [inter-quartile range]	2.0 [1.0-3.0]	1.0 [1.0-1.0]	6.0 [3.0-10.0]	-	
Condom use, n (%)					
Always	19 (9.1)	0 (0.0)	8 (32.0)	0 (0.0)	**< .0001¶**
Usually	41 (19.7)	5 (71.4)	5 (20.0)	0 (0.0)	
Sometimes	49 (23.6)	0 (0.0)	7 (28.0)	0 (0.0)	
Never	59 (28.4)	0 (0.0)	4 (16.0)	0 (0.0)	

Table 3 (Continued). Age, race, ethnicity, and sexual behaviors by sexual orientation among women

Characteristics	WSM (n = 208)	WSW (n = 7)	Bisexual (n = 25)	Not documented (n = 6)	p-value
No answer	40 (19.2)	2 (28.6)	1 (4.0)	6 (100.0)	
Condom use, last intercourse, n (%)					
Yes	45 (21.6)	5 (71.4)	10 (40.0)	0 (0.0)	**< .0001**¶
No	132 (63.5)	1 (14.3)	15 (60.0)	0 (0.0)	
No answer	31 (14.9)	1 (14.3)	0 (0.0)	6 (100.0)	

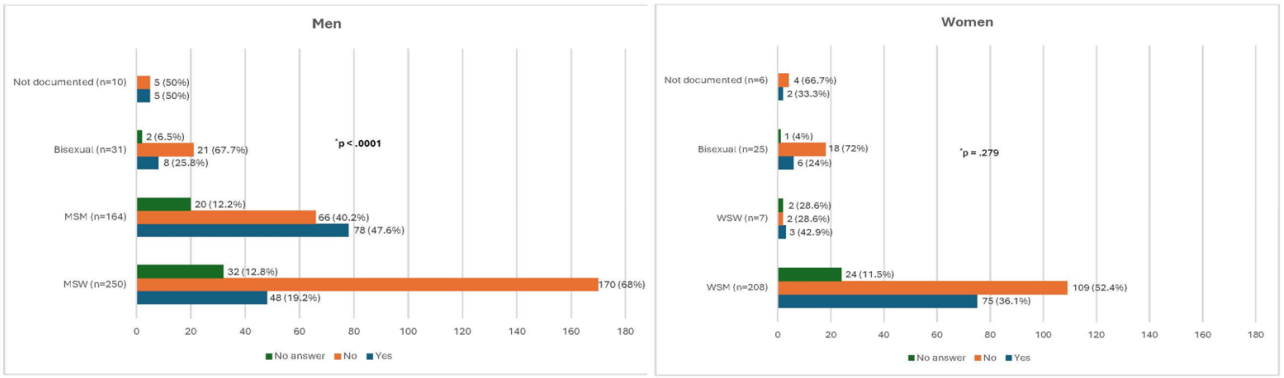
Note. *F test; ¶Chi-square test; **Boldface** denotes a statistically significant difference; WSM: Women who have sex with men; WSW: Women who have sex with women; & The woman whose sexual orientation was transcribed as a man who had sex with men (**Table 1**) had no new sex partner in the last 3 months, 1 partner in the last 3 months and 1 partner in the last 12 months, used condom sometimes, and did not respond to the question on condom use at last intercourse



a. Reason for the visit by sexual orientation, men

b. Reason for the visit by sexual orientation, women

Figure 1. Reasons for the visit by sexual orientation (Source: Authors' own elaboration)



a. Does patient have a primary care doctor (men)?

b. Does patient have a primary care doctor (women)?

Figure 2. Does patient have a primary care doctor? (Source: Authors' own elaboration)

WSM ($p < .0001$). There were no significant differences in the distributions of age ($p = .313$) and ethnicity ($p = .151$) by sexual orientation.

Bisexual women were significantly more likely than WSM to report a new sex partner in the last 3 months (72.0% vs. 31.7%, respectively; $p < .0001$), higher numbers of sex partners in the last 3 months (means: 3.37 ± 2.1 vs. 1.51 ± 1.2, respectively; $p < .0001$) and in the last 12 months (means: 6.35 ± 4.4 vs. 2.73 ± 4.0, respectively; $p = .001$), and to always use condom (32.0% vs. 9.1%, respectively; $p < .0001$). More than 70% of WSW reported using condom usually and at last intercourse compared to 19.7% using condom usually ($p < .0001$) and 21.6% using condom at last intercourse for WSM ($p < .0001$), respectively. None of the 6 women with undocumented sexual orientation answered sexual behavior questions, except for one "no" answer to the question on whether they had any new sex partner in the last 3 months.

Both transgender women reported no new sex partner in the last 3 months, ≥ 8 partners in the last 12 months, and their reported use of condom varied.

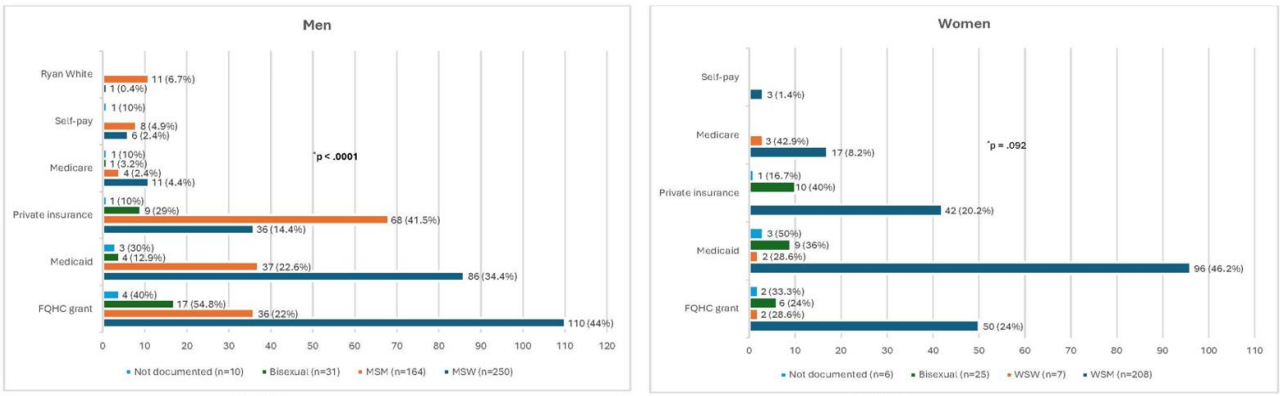
Reasons For the Visit

Figure 1 shows respondents' reasons for the visit by sexual orientation. Among men (part a in **Figure 1**), MSW significantly visited the new Sexual Health Clinic for an STI screen (96/250, 38.4% vs. 30/164, 18.3% for MSM; $p < .0001$), and MSM significantly visited the new Sexual Health Clinic for STI treatment (52/164, 31.7% vs. 13/250, 5.2% for MSW; $p < .0001$). Among women (part b in **Figure 1**), most visited the new Sexual Health Clinic for an STI screen ($p = .448$), because of STI symptoms ($p = .037$), for STI treatment ($p = .099$), or because of STI contact ($p = .778$). Both transgender women visited the new Sexual Health Clinic for an STI screen.

Healthcare Access and Utilization

Men who have sex with men were significantly more likely to have a primary care physician (78/164, 47.6%) compared to MSW (48/250, 19.2%; $p < .0001$) (part a in **Figure 2**).

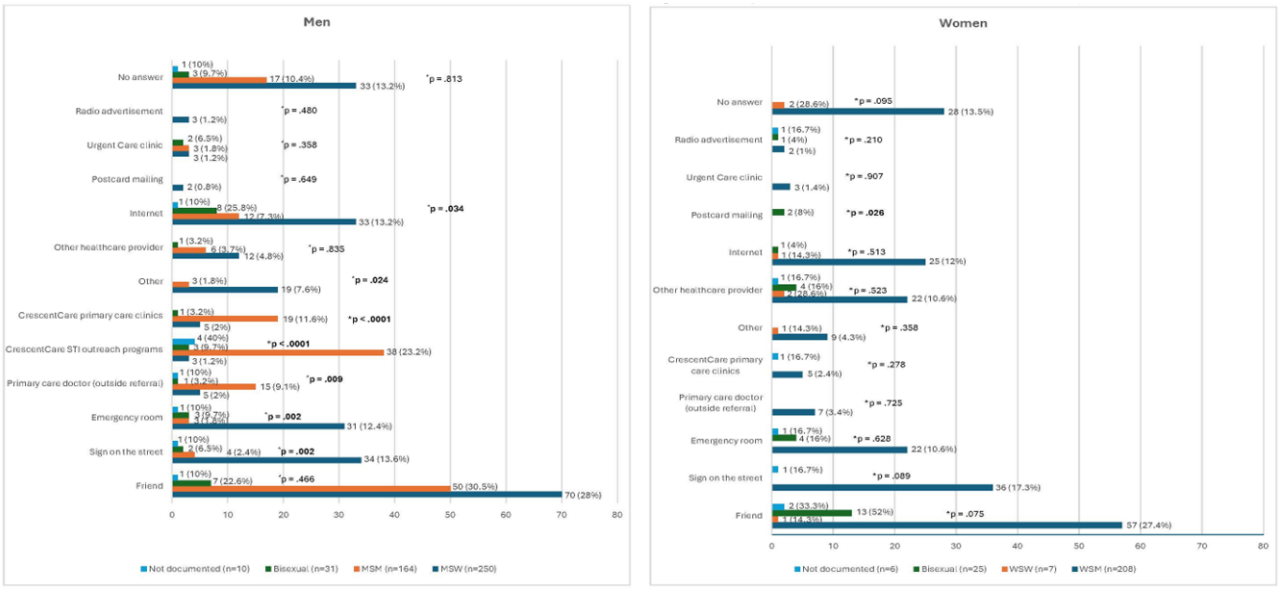
Compared to MSW, MSM more significantly had private insurance (68/164; 41.5%) or coverage through the Ryan White



a. Healthcare coverage, men

b. Healthcare coverage, women

Figure 3. Healthcare coverage (Source: Authors' own elaboration)



a. How patients learned about the new Sexual Health Clinic, men

b. How patients learned about the new Sexual Health Clinic, women

Figure 4. How patients learned about the new Sexual Health Clinic (Source: Authors' own elaboration)

program (11/164; 6.7%) vs. 36/250 (14.4%) and 1/250 (0.4%), respectively, and MSW and bisexuals were more frequently below 200% of the Federal Poverty Level and qualified for a sliding fee scale through a Federally Qualified Health Center grant and other funding sources (110/250, 44.0% for MSW and 17/31, 54.8% for bisexuals) than MSM (36/164, 22.0%; p < .0001) (part a in **Figure 3**). Among 63 black and white MSM who had private insurance, 23 (36.5%) were black and 40 (63.5%) were white (p < .0001).

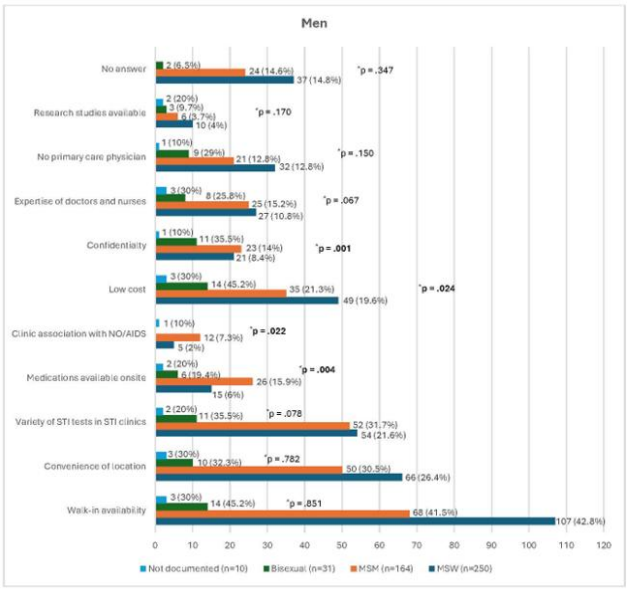
Among women, there were no significant differences in whether the respondent had a primary care physician (part b in **Figure 2**; p = .279) and in health insurance coverage (part b in **Figure 3**; p = .092).

How Patients Learned About the New Sexual Health Clinic

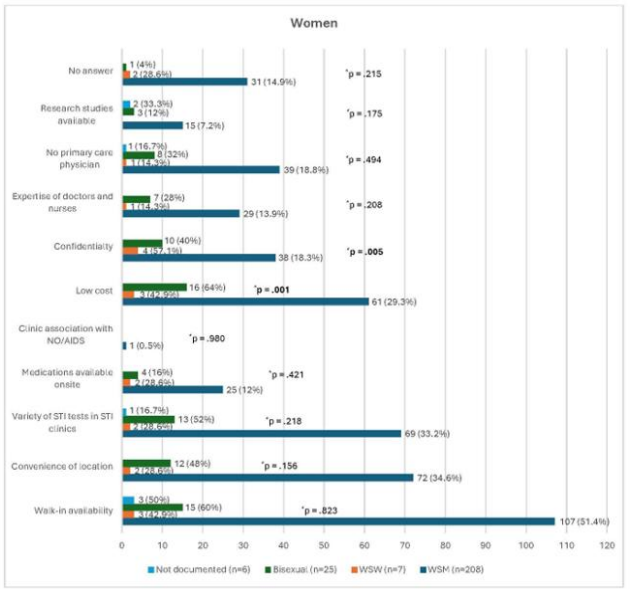
How patients learned about the new Sexual Health Clinic is shown in **Figure 4**. Patients most frequently learned about the new Sexual Health Clinic from friends. Friends were cited as source by 28.0% of MSW (70/250), 30.5% of MSM (50/164), and 22.6% (7/31) of bisexual men (part a in **Figure 4**), and by 27.4% of WSM (57/208), 52.0% of bisexual women (13/25), and 33.3% (2/6) of women with undocumented sexual orientation (part b in **Figure 4**). Comparing MSW to MSM, MSW significantly learned about the new Sexual Health Clinic from signs on the streets (34/250, 13.6% vs. 4/164, 2.4%; p = .002) or from an emergency room (31/250, 12.4% vs. 3/164, 1.8%; p = .002), and MSM significantly learned about the new Sexual Health Clinic through referral by a primary care physician (15/164, 9.1% vs. 5/250, 2.0%; p = .009), from CrescentCare STI outreach programs (38/164, 23.2% vs. 3/250, 1.2%; p < .0001), or from CrescentCare primary care clinics (19/164, 11.6% vs. 5/250, 2.0%; p < .0001). "Other" sources cited included addiction rehabilitation and homeless care centers (n = 16), television (n = 8), Court/Traffic Court (n = 4), flyer (n = 2), Delgado (n = 1), and school (n = 1).

Reasons For Choosing the New Sexual Health Clinic

The most frequent feature that attracted patients to check-in with the new Sexual Health Clinic was the walk-in availability of services, followed by the convenience of its location (**Figure 5**). Several reasons for choosing the new Sexual Health Clinic were significantly different by sexual orientation. Among men (part a in **Figure 5**), MSM were significantly more likely than MSW to choose the new Sexual Health Clinic because of the availability of medications onsite (26/164, 15.9% vs. 15/250, 6.0%, respectively; p = .004) and because of the new clinic's association with NO/AIDS (12/164, 7.3% vs. 5/250, 2.0%, respectively; p = .022). Bisexuals were significantly more likely than MSW to choose the new clinic because of the low cost of services (14/31, 45.2% vs. 49/250, 19.6%, respectively; p = .024),

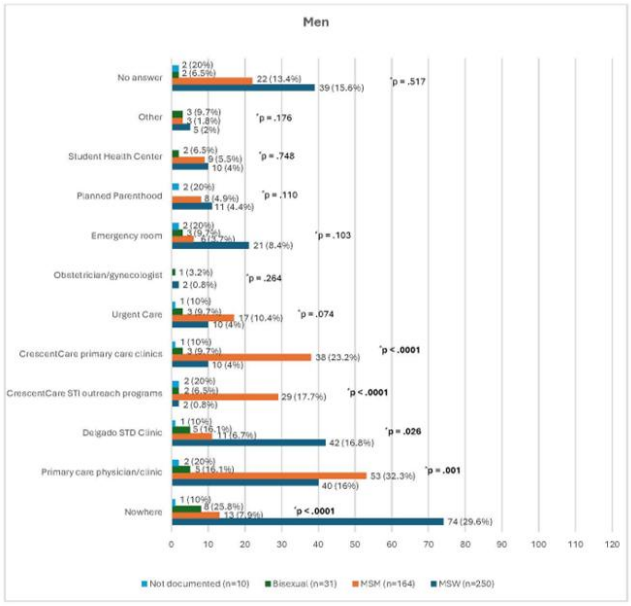


a. Reasons for choosing the new Sexual Health Clinic, men

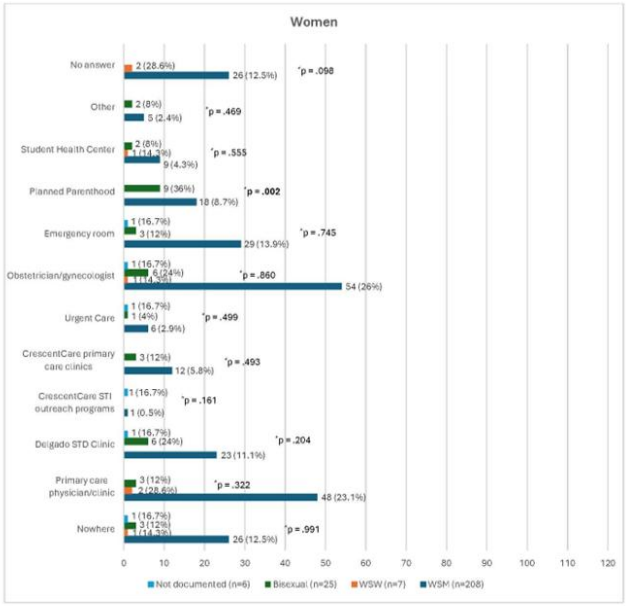


b. Reasons for choosing the new Sexual Health Clinic, women

Figure 5. Reasons for choosing the new Sexual Health Clinic (Source: Authors' own elaboration)



a. Where patients received STI screening and care in the past, men



b. Where patients received STI screening and care in the past, women

Figure 6. Where patients received STI screening and care in the past (Source: Authors' own elaboration)

and because of confidentiality (11/31, 35.5% vs. 21/250, 8.4%, respectively; p = .001).

Among women (part b in **Figure 5**), bisexuals and WSW significantly than WSM chose the new Sexual Health Clinic because of the low cost of services (bisexuals: 16/25, 64.0% and WSW: 3/7, 42.9% vs. 61/208, 29.3% for WSM; p = .001), and because of confidentiality (bisexuals: 10/25, 40.0% and WSW: 4/7, 57.1% vs. 38/208, 18.3% for WSM; p = .005). Other features including the variety of STI tests offered in STI clinics and a lack of a primary care physician attracted men and women to the new clinic quite frequently (part a and part b in **Figure 5**).

Where Patients Received STI Screening and Care in the Past

Among men, MSW had in the past significantly sought STI screening and care nowhere (29.6%, 74/250) compared to MSM (7.9%, 13/164; p < .0001), or when they did, they more likely sought these services at the Delgado STD Clinic (16.8%, 42/250) than MSM (6.7%, 11/164; p = .026) (part a in **Figure 6**). Men who have sex with men significantly than MSW sought STI screening and care in the past at a primary care physician (32.3%, 53/164 vs. 16.0%, 40/250, respectively; p = .001), at a CrescentCare STI outreach program (17.7%, 29/164 vs. 0.8%, 2/250, respectively; p < .0001), or at a CrescentCare primary care clinic (23.2%, 38/164 vs. 4.0%, 10/250, respectively; p < .0001) (part a in **Figure 6**).

In general, women had in the past frequently seen a primary care physician (23.1%, 48/208 WSM and 28.6%, 2/7 for WSW) or an obstetrician/gynecologist (26.0%, 54/208 WSM and 24.0%, 6/25 for bisexuals) for STI screening and care (part b in **Figure 6**); but bisexuals more significantly than WSM sought STI screening and care in the past at a Planned Parenthood (36.0%, 9/25 vs. 8.7%, 18/208, respectively; p = .002).

Prior History of STI

There were 32.9% of MSM, 6.5% of bisexual men, 2.4% of MSW (p < .0001; **Table 4**), and 2.9% of WSM (p = .778; **Table 5**)

Table 4. Previous history of STI and diagnosis made the day of visit among men (data are n [%] or n/N [%])

Characteristics	MSW	MSM	Bisexual	Not documented	p-value*
Currently known HIV status	**(n = 250)**	**(n = 164)**	**(n = 31)**	**(n = 10)**	
Positive (+)	6 (2.4)	54 (32.9)	2 (6.5)	0 (0.0)	**< .0001**
Negative	244 (97.6)	110 (67.1)	29 (93.5)	10 (100.0)	
If HIV+, is patient in care?	**(n = 2)**	**(n = 53)**	**(n = 2)**	**(n = 0)**	
Yes	1 (50.0)	49 (92.5)	2 (100.0)	n/a	.198
No	1 (50.0)	3 (5.7)	0 (0.0)	n/a	
Unknown	0 (0.0)	1 (1.9)	0 (0.0)	n/a	
If HIV+ and in care, is patient on ARV?	**(n = 1)**	**(n = 49)**	**(n = 2)**	**(n = 0)**	
Yes	1 (100.0)	45 (91.8)	2 (100.0)	n/a	.781
No	0 (0.0)	4 (8.2)	0 (0.0)	n/a	
Is the patient on PrEP?	**(n = 244)**	**(n = 109)**	**(n = 29)**	**(n = 10)**	
Yes	0 (0.0)	12 (11.0)	1 (3.4)	0 (0.0)	**< .0001**
No	244 (100.0)	97 (89.0)	28 (96.6)	10 (100.0)	
Prior history of STI	**(n = 124)**	**(n = 115)**	**(n = 15)**	**(n = 1)**	
Syphilis	7 (5.6)	49 (42.6)	7 (46.7)	0 (0.0)	**< .0001**
Gonorrhea	55 (44.4)	52 (45.2)	11 (73.3)	1 (100.0)	.098
Chlamydia	64 (51.6)	41 (35.7)	5 (33.3)	1 (100.0)	**.043**
Trichomonas	6 (4.8)	0 (0.0)	0 (0.0)	0 (0.0)	.090
Nongonococcal urethritis	10 (8.1)	5 (4.3)	1 (6.1)	0 (0.0)	.667
Human papilloma virus	5 (4.0)	18 (15.7)	1 (6.1)	0 (0.0)	**.021**
Herpes simplex virus	13 (10.5)	10 (8.7)	1 (6.1)	0 (0.0)	.902
Molluscum	2 (1.6)	2 (1.7)	1 (6.7)	0 (0.0)	.603
Diagnosis the day of visit					
New HIV infection (n = 237)	1/169 (0.6)	3/48 (6.3)	0/18 (0.0)	0/2 (0.0)	.117
Syphilis (n = 306)	2/191 (1.0)	12/92 (13.0)	1/18 (5.6)	2/5 (40.0)	**< .0001**
Primary	0/191 (0.0)	2/92 (2.2)	1/18 (5.6)	0/5 (0.0)	.081
Secondary	0/191 (0.0)	3/92 (3.3)	0/18 (0.0)	0/5 (0.0)	.070
Early latent	0/191 (0.0)	4/92 (4.3)	0/18 (0.0)	0/5 (0.0)	**.024**
Late latent	2/191 (1.0)	3/92 (3.3)	0/18 (0.0)	2/5 (40.0)	**.010**
Gonorrhea					
Urogenital (n = 337)	17/211 (8.1)	18/104 (17.3)	2/19 (10.5)	0/3 (0.0)	.093
Pharyngeal (n = 226)	7/101 (6.9)	32/105 (30.5)	1/17 (5.9)	2/3 (66.7)	**< .0001**
Rectal (n = 118)	3/11 (27.3)	20/95 (21.1)	5/11 (45.5)	1/1 (100.0)	.123
Chlamydia					
Urogenital (n = 337)	20/211 (9.5)	13/104 (12.5)	0/19 (0.0)	0/3 (0.0)	.351
Pharyngeal (n = 226)	3/101 (3.0)	10/105 (9.5)	1/17 (5.9)	0/3 (0.0)	.260
Rectal (n = 118)	1/11 (9.1)	23/95 (24.2)	1/11 (9.1)	1/1 (100.0)	.117
Nongonococcal urethritis (n = 92)	31/62 (50.0)	8/26 (30.8)	1/4 (25.0)	n/a	.188
Genital herpes (n = 21)	3/15 (20.0)	2/2 (100.0)	1/3 (33.3)	0/1 (0.0)	.113
Screen only (all tests negative)	**(n = 250)**	**(n = 164)**	**(n = 31)**	**(n = 10)**	
Yes	121 (48.4)	43 (26.2)	12 (38.7)	4 (40.0)	**< .0001**
No	129 (51.6)	121 (73.8)	19 (61.3)	6 (60.0)	

Note. ***Boldface** denotes a statistically significant difference; ARV: Anti-retroviral therapy; MSM: Men who have sex with men; MSW: Men who have sex with women; PrEP: Pre-exposure prophylaxis; Both men who had transgender partners (**Table 1**) were HIV-negative; & One was not on PrEP, reported prior history of syphilis and gonorrhea; the other was on PrEP, reported prior history of gonorrhea and chlamydia

who had HIV. Almost all patients living with HIV were on anti-retroviral therapy. Among patients who did not have HIV, 11.0% of MSM and 3.4% of bisexual men were on pre-exposure prophylaxis (PrEP) for HIV prevention (**Table 4**). Among men (**Table 4**), prior history of syphilis in MSM (42.6%) and bisexuals (46.7%) was significantly higher than in MSW (5.6%) ($p < .0001$), prior history of chlamydia was significantly higher in MSW (51.6%) than in MSM (35.7%) and bisexuals (33.3%) ($p = .043$), and prior history of human papillomavirus (HPV) was significantly higher in MSM (15.7%) than in MSW (4.0%) and bisexuals (6.1%) ($p = .021$).

Among women, there were no significant differences in the distributions of prior STI histories by sexual orientation (**Table 5**). Both transgender women were HIV-negative and not on PrEP; one had a prior history of HPV.

Laboratory Diagnoses Made the Day of Visit

There were 576/706 patients (81.6%) who had a laboratory test performed and 130 (18.4%) who were not tested. Patients tested had the following tests performed: rapid HIV testing (n = 405), syphilis tests (n = 495; Syphilis Health Check only: 420, RPR/TPPA only: 36, both Syphilis Health Check and RPR/TPPA: 39), chlamydia/gonorrhea tests (urogenital chlamydia/gonorrhea: 550, pharyngeal chlamydia/gonorrhea: 348, and rectal chlamydia/gonorrhea: 147), urethral smear (n = 90 men), wet mount KOH (n = 178; ciswomen: 177, transgender woman: 1), herpes simplex virus (HSV) tests (n = 35; HSV serology: 22, HSV nucleic acid amplification test: 13).

On the day of the study visit, a new HIV infection was diagnosed in 4 male patients, one from the 169 MSW tested (0.6%) and 3 from the 48 MSM tested (6.3%; $p = .117$; **Table 4**). Among men, MSM were significantly more frequently diagnosed with syphilis (13.0%; $p < .0001$) and with pharyngeal gonorrhea (30.5%; $p < .0001$), and less likely to have all tests

Table 5. Previous history of STI and diagnosis made the day of visit among women (data are n [%] or n/N [%])

Characteristics	WSM	WSW	Bisexual	Not documented	p-value*
Currently known HIV status	**(n = 208)**	**(n = 7)**	**(n = 25)**	**(n = 5)**	
Positive (+)	6 (2.9)	0 (0.0)	0 (0.0)	0 (0.0)	.778
Negative	202 (97.1)	7 (100.0)	25 (100.0)	5 (100.0)	
If HIV+, is patient in care?	**(n = 5)**	**(n = 0)**	**(n = 0)**	**(n = 0)**	
Yes	5 (100.0)	n/a	n/a	n/a	n/a
No	0 (0.0)	n/a	n/a	n/a	
If HIV+ and in care, is patient on ARV?	**(n = 5)**	**(n = 0)**	**(n = 0)**	**(n = 0)**	
Yes	4 (80.0)	n/a	n/a	n/a	n/a
No	1 (20.0)	n/a	n/a	n/a	
Is the patient on PrEP?	**(n = 202)**	**(n = 7)**	**(n = 25)**	**(n = 5)**	
Yes	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	n/a
No	202 (100.0)	7 (100.0)	25 (100.0)	5 (100.0)	
Prior history of STI	**(n = 134)**	**(n = 5)**	**(n = 14)**	**(n = 2)**	
Syphilis	12 (9.0)	1 (20.0)	2 (14.3)	1 (50.0)	.220
Gonorrhea	33 (24.6)	0 (0.0)	6 (42.9)	0 (0.0)	.104
Chlamydia	62 (46.3)	4 (80.0)	8 (57.1)	1 (50.0)	.424
Trichomonas	42 (31.3)	0 (0.0)	5 (35.7)	0 (0.0)	.150
Mucopurulent cervicitis	5 (3.7)	0 (0.0)	0 (0.0)	0 (0.0)	.686
Pelvic inflammatory disease	1 (0.7)	0 (0.0)	1 (7.1)	0 (0.0)	.244
Human papilloma virus	6 (4.5)	0 (0.0)	2 (14.3)	0 (0.0)	.409
Bacterial vaginosis	41 (30.6)	0 (0.0)	8 (57.1)	1 (50.0)	.078
Candida vaginitis	9 (6.7)	0 (0.0)	0 (0.0)	0 (0.0)	.439
Herpes simplex virus	14 (10.4)	0 (0.0)	1 (7.1)	1 (50.0)	.248
Molluscum	1 (0.7)	1 (20.0)	0 (0.0)	0 (0.0)	.205
Diagnosis the day of visit					
New HIV infection (n = 164)	0/138 (0.0)	0/4 (0.0)	0/19 (0.0)	0/3 (0.0)	n/a
Syphilis (n = 184)	3/157 (1.9)	1/4 (25.0)	0/20 (0.0)	0/3 (0.0)	.226
Primary	0/157 (0.0)	0/4 (0.0)	0/20 (0.0)	0/3 (0.0)	n/a
Secondary	0/157 (0.0)	0/4 (0.0)	0/20 (0.0)	0/3 (0.0)	n/a
Early latent	2/157 (1.3)	0/4 (0.0)	0/20 (0.0)	0/3 (0.0)	.951
Late latent	1/157 (0.6)	1/4 (25.0)	0/20 (0.0)	0/3 (0.0)	.141
Gonorrhea					
Urogenital (n = 209)	16/179 (8.9)	0/4 (0.0)	1/23 (4.3)	0/3 (0.0)	.749
Pharyngeal (n = 119)	6/97 (6.2)	0/2 (0.0)	1/20 (5.0)	n/a	.866
Rectal (n = 27)	4/20 (20.0)	0/7 (0.0)	n/a	n/a	.545
Chlamydia					
Urogenital (n = 209)	35/179 (19.6)	0/4 (0.0)	2/23 (8.7)	1/3 (33.3)	.396
Pharyngeal (n = 119)	12/97 (12.4)	0/2 (0.0)	3/20 (15.0)	n/a	.820
Rectal (n = 27)	4/20 (20.0)	0/7 (0.0)	n/a	n/a	.545
Genital herpes (n = 14)	5/12 (41.7)	1/2 (50.0)	n/a	n/a	1.00
Screen only (all tests negative)	**(n = 208)**	**(n = 7)**	**(n = 25)**	**(n = 6)**	
Yes	50 (24.0)	4 (57.1)	10 (40.0)	4 (66.7)	**.021**
No	158 (76.0)	3 (42.9)	15 (60.0)	3 (33.3)	

Note. ***Boldface** denotes a statistically significant difference; ARV: Anti-retroviral therapy; PrEP: Pre-exposure prophylaxis; WSM: Women who have sex with men; WSW: Women who have sex with women; & The woman whose sexual orientation was recorded as a man who had sex with men (**Table 1**) was HIV-negative and not on PrEP

negative (26.2%; p < .0001). Four women were diagnosed with syphilis: 3/157 (1.9%) among WSM and 1/4 (25.0%) among WSW (p = .226; **Table 5**). Women who have sex with men were significantly less likely to have all tests negative (24.0%; p = .021).

Other laboratory and clinical diagnoses were made that are not displayed in **Table 4** and **Table 5** because of uncertainties in the denominators. Among men, the following diagnoses were also made: *Candida* balanitis (MSW: 16, MSM: 2), trichomoniasis (MSW: 5), genital warts (MSW: 5, MSM: 7), epididymitis (MSW: 1, MSM: 1), scabies (MSM: 2), other dermatitis (MSW: 16, MSM: 5), proctitis (MSW: 1, MSM: 3). There were 121 MSW and 43 MSM who had all tests negative, and 9 MSW and 3 MSM who came to the new clinic for study follow-up only. Among women, the following are the other diagnoses that were made: bacterial vaginosis (n = 77), *Candida* vaginitis (n = 31), trichomoniasis (n = 23), mucopurulent cervicitis (n = 14), pelvic inflammatory disease (n = 3), scabies (n = 1), other dermatitis (n = 1). There were 50 women who had all tests negative.

Patient Referrals

There were 71 patients referred to primary care, 10 to HIV care, 21 to a PrEP clinic, 56 to obstetrics/gynecology, and 7 other referrals including dermatology (n = 4), emergency room (n = 1), surgery clinic (n = 1), and urology clinic (n = 1). The 10 patients referred to HIV care included the 4 newly diagnosed HIV infections (**Table 4**) and 6 known HIV-positive men who either were out of care (n = 4) or were interested in transferring care to CrescentCare (n = 2). PrEP was discussed with 24 MSM and 5 bisexual men, who all (n = 29) declined PrEP referral. PrEP was also discussed with two men who were already undergoing PrEP evaluation.

DISCUSSION

In this report, we retrospectively described the community-driven [13] CrescentCare-LSU School of Medicine partnership initiative which resulted in the creation of the LSU-CrescentCare Sexual Health Center in New Orleans, at a time of transformational developments of CrescentCare as a Federally Qualified Health Center. Several important considerations that contributed to the success of this partnership and that have not been described in this narrative were built into the steps both organizations were taking to create the LSU-CrescentCare Sexual Health Center. To better fulfill its mission, CrescentCare considered the choice of the Federally Qualified Health Center's site, the adequacy of clinic spaces, and electronic medical record support. The LSU School of Medicine on its part considered issues of flexible scheduling with walk-in capability for the Sexual Health Clinic, as well as funding of personnel and of operations.

In planning the addition of the Sexual Health Clinic into the organizational structure of CrescentCare after the partnership was logistically established, we used several advertising strategies to communicate, including signage around the city, radio and bus stop advertisements, and website updates. In addition, subjects enrolled in ongoing research at the Delgado STD Clinic were called and mailed postcards to inform them of the relocation of the research team and site. This survey indicates that word of mouth from friends followed by posted signs and referrals from emergency departments or other healthcare providers were the most effective communication. Other healthcare providers not only informed their patients about the new Sexual Health Clinic, but more importantly referred them for services. There were 32 respondents (19 MSW, 3 MSM, 9 WSM, and 1 WSW) who learned about the new Sexual Health Clinic from "other" sources not categorized under "other healthcare providers"; the most frequently cited such other source was an addiction rehabilitation center (n = 15).

Radio advertisements and postcard mailing were sources for learning about the new Sexual Health Clinic for seven and four respondents, respectively. Nonetheless, these efforts should not be discounted. The finding that friends were the most frequent source for learning about the new Sexual Health Clinic indicates that one person who learned about the clinic became a source for spreading the word to others. That only two men and two women learned about the new Sexual Health Clinic through postcard mailing reflects the fact that postcards were mailed from the Delgado STD Clinic only to a small number of subjects who were already enrolled in an ongoing drug trial [16] before the research team moved the research site to a new location, and the other few enrollees would have been instructed in-person to report to the new location for their study follow-up visits. Remarkably, no subject enrolled in this trial was lost to follow-up because of the relocation of the study site.

In terms of clinic operations, the most important factors that patients considered in selecting the new Sexual Health Clinic were walk-in availability, convenience of location, variety of STI tests in STI clinics, availability of medications onsite, low cost, and confidentiality [17, 18]. After potential users learned that walk-in services were available onsite, the ease of accessing the location and the free parking accommodation added to the attractiveness of the new clinic.

To characterize the patient population that the LSU-CrescentCare Sexual Health Center was going to serve, we described the demographic characteristics, the sexual orientation, the sexual behaviors, the healthcare access and utilization, and the health services that patients sought during the opening months of operation of the facility as a new clinic. Although 88% of clinic users could be categorized as MSW, MSM, and WSM, the clinic also provides services to transgender women, bisexuals, and WSW. With MSM, these other sexual minority groups [19] sought the same services as those sought by heterosexual men and women.

As indicators of healthcare access and utilization [19], we asked respondents whether they had a primary care physician, and we retrospectively extracted de-identified healthcare insurance coverage information from their medical record. The finding of 41.5% of MSM having private insurance was encouraging. However, there were still 47.0% who had their healthcare covered through Medicaid (22.6%), Medicare (2.4%), or qualified for health coverage provided through a Federally Qualified Health Center grant (22.0%), proportions that were even higher for MSW (82.8%) and WSM (78.4%) (**Figure 3**). Additionally, we found a racial inequality in private insurance coverage among MSM, with a two-to-one private insurance coverage for white MSM over black MSM [14, 15]. Nine of the 12 respondents who were covered through the Ryan White Program (part a in **Figure 3**) were HIV-positive MSM; data for the other three were recorded as HIV-negative (2 MSM and 1 MSW), which probably are data transcription errors because the Ryan White Program covers HIV-infected individuals [20, 21].

In the past, MSW had mostly sought STI screening and care at the Delgado STD Clinic, while MSM had mostly sought STI screening and care at a primary care physician, at a CrescentCare STI outreach program, or at a CrescentCare primary care clinic. Within the structural organization of CrescentCare, there are several outreach initiatives that provide education, and HIV/STI prevention services to MSM, people living with HIV, and gay, trans, and bisexual people of color, in addition to primary care clinics (https://www.crescentcare.org).

The race, sexual orientation, and sexual behaviors in this study reflected the patients' past STI histories [19, 22], which were corroborated by the laboratory diagnoses they received the day of the visit [23-32]. In addition to the higher prevalence of syphilis and pharyngeal gonorrhea among MSM compared to MSW (**Table 4**), other differences in STI detection were observed that did not achieve statistical significance. Some may be due to the smaller numbers of patients tested [33]. For example, pharyngeal chlamydia was 9.5% among 105 MSM and 3% among 101 MSW (p = ns; **Table 4**). We would need to test the pharyngeal site of 252 MSM and 252 MSW to have a 50-percent statistical power to detect a 5-percent difference between MSM and MSW at the α-level of 0.05 [33, 34]. Among 179 WSM who were tested for urogenital chlamydia and gonorrhea (**Table 5**), prevalences for chlamydia and gonorrhea were not significantly different from the 22.5% chlamydia prevalence and 14.5% gonorrhea prevalence reported among 400 women tested at the Delgado STD Clinic two decades earlier [35].

During the third quarter of 2019, the LSU-CrescentCare Sexual Health Center registered 4364 patient-encounters (Figueroa JE, personal communication). In 2020, the lockdowns and social distancing measures implemented in response to the COVID-19 pandemic did not affect operations

of the then 4-year-old Sexual Health Clinic independently of the disruptions that the pandemic caused at the local, state, national, and international levels. After active control measures for COVID-19 pandemic were lifted and all operations had resumed, the clinic registered 3360 patient-visits from July 2022 to June 2023 (Figueroa JE, personal communication). For 10 years, the clinic has been well-established within the CrescentCare Health and Wellness Center system, delivering outpatient sexual health services to all-comers; it is a referral and consultation resource for complicated cases and, with the technical support of the Louisiana STD Research Center laboratory started at LSU School of Medicine since 1983 (DHM), it provides clinical research opportunities [16, 36].

CONCLUSION

We have presented a retrospective narrative of the creation of a specialty health clinic within an organization that was expanding its mission of service as a dedicated community health center in New Orleans, Louisiana. The Sexual Health Clinic created through this partnership, with CrescentCare, an organization historically committed to providing comprehensive care and wellness services to local populations, and the Section of Infectious Diseases of the LSU School of Medicine providing the sexual health specialty expertise, was intended to better serve the sexual health needs of vulnerable local area communities where the epidemiology of HIV/AIDS and other STDs is inextricably linked to the vestiges of slavery, discrimination, and poverty [14, 15]. The LSU-CrescentCare Sexual Health Center serves as a model of a successful community-driven, public-private collaborative initiative aimed at ensuring that in the New Orleans region, everyone has an equal opportunity to achieve their best possible sexual health, regardless of factors such as race, ethnicity, sexual orientation, income, education, or zipcode of residence [19, 22, 37].

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REFERENCES

1. Torrens PR. Historical evolution and overview of health services in the United States. In: Williams SJ, Torrens PR, editors. Introduction to health services. 6th ed. Albany, NY: Delmar; 2002. p. 2-17.
2. Torrens PR, Contributors. Overview of the organization of health services in the United States. In: Williams SJ, Torrens PR, editors. Introduction to health services. 6th ed. Albany, NY: Delmar; 2002. p. 18-46.
3. Altarum Institute. Take charge of your sexual health: What you need to know about preventive services. Washington, DC: Altarum Institute; 2014.
4. Martin DH, Mroczkowski TF, Dalu ZA, et al. A controlled trial of a single dose of azithromycin for the treatment of chlamydial urethritis and cervicitis. N Engl J Med. 1992;327(13):921-5. https://doi.org/10.1056/NEJM199209243271304 PMid:1325036
5. Mena L, Wang X, Mroczkowski TF, Martin DH. Mycoplasma genitalium infections in asymptomatic men and men with urethritis attending a sexually transmitted diseases clinic in New Orleans. Clin Infect Dis. 2002;35(10):1167-73. https://doi.org/10.1086/343829 PMid:12410476
6. Kissinger P, Mohammed H, Richardson-Alston G, et al. Patient-delivered partner treatment for male urethritis: A randomized controlled trial. Clin Infect Dis. 2005;41(5):623-9. https://doi.org/10.1086/432476 PMid:16080084
7. Howard EJ, Xu F, Taylor SN, et al. Patient preference for patient-delivered partner therapy: Exploratory findings from three sexually transmitted disease clinics. Sex Transm Dis. 2011;38(2):148-9. https://doi.org/10.1097/OLQ.0b013e3182036d45 PMid:21209597
8. Taylor SN, DiCarlo RP, Martin DH. Comparison of methylene blue/gentian violet stain to Gram's stain for the rapid diagnosis of gonococcal urethritis in men. Sex Transm Dis. 2011;38(11):995-6. https://doi.org/10.1097/OLQ.0b013e318225f7c2 PMid:21992973
9. Lillis RA, Nsuami MJ, Myers L, Martin DH. Utility of urine, vaginal, and rectal specimens for detection of Mycoplasma genitalium in women. J Clin Microbiol. 2011;49(5):459-65. https://doi.org/10.1128/JCM.00129-11 PMid:21411587 PMCid:PMC3122633
10. Taylor SN, Morris DH, Avery AK, et al. Gepotidacin for the treatment of uncomplicated urogenital gonorrhea: A phase 2, randomized, dose-ranging single-oral dose evaluation. Clin Infect Dis. 2018;67(4):504-12. https://doi.org/10.1093/cid/ciy145 PMid:29617982 PMCid:PMC6070052
11. Gift TL, Cuffe KM, Leichliter JS. The impact of budget cuts on sexually transmitted disease programmatic activities in state and local health departments with staffing reductions in fiscal year 2012. Sex Transm Dis. 2018;45(11):e87-9. https://doi.org/10.1097/OLQ.0000000000000894 PMid:30044336 PMCid:PMC6785808
12. Infectious Diseases Section, Louisiana State University Health Sciences Center. Challenges facing the Infectious Diseases Section of the Louisiana State University Health Sciences Center. Clin Infect Dis. 2006;43(4):485-9. https://doi.org/10.1086/505980 PMid:16838238
13. Kaiser MA, Manning DT, Balson PM. Lay volunteers' knowledge and beliefs about AIDS prevention. J Community Health. 1989;14(4):215-26. https://doi.org/10.1007/BF01338873 PMid:2621263
14. Thomas JC. From slavery to incarceration: Social forces affecting the epidemiology of sexually transmitted diseases in the Rural South. Sex Transm Dis. 2006;33(7 Suppl):S6-10. https://doi.org/10.1097/01.olq.0000221025.17158.26 PMid:16794556

15. Farley TA. Sexually transmitted diseases in the Southeastern United States: Location, race, and social context. Sex Transm Dis. 2006;33(7 Suppl):S58-64. https://doi.org/10.1097/01.olq.0000175378.20009.5a PMid: 16432486
16. Taylor SN, Marrazzo J, Batteiger BE, et al. Single-dose zoliflodacin (ETX0914) for treatment of urogenital gonorrhea. N Engl J Med. 2018;379(19):1835-45. https://doi.org/10.1056/NEJMoa1706988 PMid:30403954
17. Mettenbrink C, Al-Tayyib A, Eggert J, Thrun M. Assessing the changing landscape of sexual health clinical services after the implementation of the Affordable Care Act. Sex Transm Dis. 2015;42(12):725-30. https://doi.org/10.1097/OLQ.0000000000000375 PMid:26562704
18. Ellison JE, Hanchate AD, Kazis LE, Cole MB. Association of the National Dependent Coverage Expansion with insurance use for sexual and reproductive health services by female young adults. JAMA Network Open. 2020;3(12):e2030214. https://doi.org/10.1001/jamanetworkopen.2020.30214 PMid:33337495 PMCid: PMC7749438
19. Trinh M-H, Agénor M, Austin SB, Jackson CL. Health and healthcare disparities among U.S. women and men at the intersection of sexual orientation and race/ethnicity: A nationally representative cross-sectional study. BMC Public Health. 2017;17(1):964. https://doi.org/10.1186/s12889-017-4937-9 PMid:29258470 PMCid:PMC5735619
20. Ginossar T, Oetzel J, Van Meter L, Gans AA, Gallant JE. The Ryan White HIV/AIDS Program after the Patient Protection and Affordable Care Act full implementation: A critical review of predictions, evidence, and future directions. Top Antivir Med. 2019;27(3):91-100. PMid:31634860 PMCid:PMC6892620
21. Hatcher W. The Ryan White Program is vital to end the HIV epidemic. Am J Public Health. 2020;110(1):51-2. https://doi.org/10.2105/AJPH.2019.305376 PMid:31800277 PMCid:PMC6893341
22. Cohn T, Harrison CV. A systematic review exploring racial disparities, social determinants of health, and sexually transmitted infections in black women. Nurs Womens Health. 2022;26(2):128-42. https://doi.org/10.1016/j.nwh.2022.01.006 PMid:35182482
23. Chow EPF, Wilson DP, Zhang L. HIV and syphilis co-infection increasing among men who have sex with men in China: A systematic review and meta-analysis. PLoS One. 2011; 6(8):e22768. https://doi.org/10.1371/journal.pone.0022768 PMid:21857952 PMCid:PMC3156129
24. Hung P, Osias E, Konda KA, et al. High lifetime prevalence of syphilis in men who have sex with men and transgender women versus low lifetime prevalence in female sex workers in Lima, Peru. Sex Transm Dis. 2020;47(8):549-55. https://doi.org/10.1097/OLQ.0000000000001200 PMid: 32541611 PMCid:PMC7357539
25. Zhao P, Yang Z, Zhang Y, et al. Prevalence of syphilis and risk factors among HIV-positive men who have sex with men in Guangdong province. Front Public Health. 2022; 10:1025221. https://doi.org/10.3389/fpubh.2022.1025221 PMid:36438237 PMCid:PMC9682027
26. Tobian AAR, Quinn TC. Herpes simplex virus type 2 and syphilis infections with HIV: An evolving synergy in transmission and prevention. Curr Opin HIV AIDS. 2009; 4:294-9. https://doi.org/10.1097/COH.0b013e32832c1881 PMid:19532067 PMCid:PMC2752434
27. Kops NL, Bessel M, Horvath JDC, et al. Factors associated with HPV and other self-reported STI coinfections among sexually active Brazilian young adults: Cross-sectional nationwide study. BMJ Open. 2019;9:e027438. https://doi.org/10.1136/bmjopen-2018-027438 PMid: 31230011 PMCid:PMC6596954
28. Pauli S, Kops NL, Bessel M, et al. Sexual practices and HPV infection in unvaccinated young adults. Sci Rep. 2022; 12(1):12385 https://doi.org/10.1038/s41598-022-15088-8 PMid:35859090 PMCid:PMC9300667
29. Rincon NL, McDowell KR, Weatherspoon D, et al. Racial and ethnic disparities in human papillomavirus (HPV) vaccine uptake among United States adults, aged 27-45 years. Hum Vaccin Immunother. 2024;20(1):2313249. https://doi.org/10.1080/21645515.2024.2313249 PMid:38538572 PMCid: PMC10984122
30. Bamberger DM, Graham G, Dennis L, Gerkovich MM. Extragenital gonorrhea and chlamydia among men and women according to type of sexual exposure. Sex Transm Dis. 2019;46(5):329-34. https://doi.org/10.1097/OLQ.0000000000000967 PMid:30676485
31. Gaspari V, Marangoni A, D'Antuono A, et al. Pharyngeal chlamydia and gonorrhea: A hidden problem. Int J STD AIDS. 2019;30(8):732-8. https://doi.org/10.1177/0956462419838922 PMid:31046619
32. Ribeiro S, de Sousa D, Medina D, Castro R, Lopes A, Rocha M. Prevalence of gonorrhea and chlamydia in a community clinic for men who have sex with men in Lisbon, Portugal. Int J STD AIDS. 2019;30(10):951-9. https://doi.org/10.1177/0956462419855484 PMid:31284840 PMCid:PMC6732818
33. Eng J. Sample size estimation: How many individuals should be studied? Radiology. 2003;227(2):309-13. https://doi.org/10.1148/radiol.2272012051 PMid:12732691
34. Fleiss JL, Levin B, Paik MC. Statistical methods for rates and proportions. 3rd ed. Hoboken, NJ: Wiley Interscience; 2003; p. 660. https://doi.org/10.1002/0471445428
35. Lillis RA, Martin DH, Nsuami MJ. Mycoplasma genitalium infections in women attending a sexually transmitted disease clinic in New Orleans. Clin Infect Dis. 2019;69(3):459-65. https://doi.org/10.1093/cid/ciy922 PMid:30351348
36. Ross JDC, Wilson J, Workowski KA, et al. Oral gepotidacin for the treatment of uncomplicated urogenital gonorrhoea (EAGLE-1): A phase 3 randomised, open-label, non-inferiority, multicentre study. Lancet. 2025;405(10489): P1608-20. https://doi.org/10.1016/S0140-6736(25)00628-2 PMid:40245902
37. Liburd LC, Hall JE, Mpofu JJ, Williams SM, Bouye K, Penman-Aguilar A. Addressing health equity in public health practice: Frameworks, promising strategies, and measurement considerations. Annu Rev Public Health. 2020;41:417-32. https://doi.org/10.1146/annurev-publhealth-040119-094119 PMid:31900101