

Family Planning Clinics And STD Services

Publicly supported family planning providers play a significant role in the effort to bring testing and treatment services for sexually transmitted diseases to young and low-income Americans. Yet, family planning agencies currently face enormous financial and programmatic challenges that threaten their ability to serve those in need. Such challenges include keeping pace with increasing STD caseloads, affording state-of-the-art technologies, integrating family planning and HIV services, and expanding services to include men.

By **Cynthia Dailard**

Sexually transmitted diseases (STDs) are a major public health problem in the United States. According to estimates by the American Social Health Association (ASHA), there are approximately 15 million new STD cases in this country each year (see table).

Many STDs—namely bacterial infections, such as chlamydia, gonorrhea and syphilis—are treatable and curable; however, countless Americans live with the long-lasting health consequences that occur when these diseases go untreated. Additionally, as many as 65 million Americans are currently living with viral STDs, including genital herpes, human papillomavirus (HPV) and HIV. These diseases cannot be cured but often can be man-

aged over time and thus present unique treatment challenges. Furthermore, individuals living with chronic viral STDs or with untreated bacterial infections can transmit them to their sexual partners even when they are asymptomatic or unaware that they are infected.

Role of Family Planning Providers

STDs disproportionately affect women, racial and ethnic minorities, and teenagers—population groups that tend to rely heavily on family planning clinics for their reproductive health care. Women are not only biologically more susceptible than men to some STDs but also may suffer more serious consequences. Because STDs are less likely to produce symptoms in women, those who have been infected are more likely to go undiagnosed until only after they have developed serious health problems, such as cervical cancer or pelvic inflammatory disease (which in turn can cause chronic pain, infertility and ectopic pregnancy). Additionally, STDs in pregnant women can result in miscarriage, low birth weight and congenital and neonatal infections.

Some STDs are more common among minority groups. For example, gonorrhea and syphilis rates are as much as 30 times higher among blacks than among whites. Blacks account for more than half (54%) of all new HIV cases in the United States, although they make up only 13% of the U.S. population; Hispanics constitute 19% of new HIV cases, but only 12% of the population.

STD rates among teens are also particularly high. According to ASHA estimates, roughly four million teenagers acquire an STD annually, and about a quarter of all new cases of STDs each year occur among teens. By age 24, at least one in three sexually active people have contracted an STD, and youth aged 15–19 account for at least one-third of all cases of gonorrhea and chlamydia. Teens are at such great risk for STDs because they typically have relationships of short duration (and thus have multiple sex partners over time) and because they frequently engage in unprotected intercourse; teenage women are also biologically more susceptible to cervical infections than adult women.

Clinical STD services are largely delivered at dedicated STD clinics or at other community-based clinics that are supported by a patchwork of different federal and state programs. STD clinics are generally operated by state and local health departments and mostly serve men who seek treatment for specific symptoms.

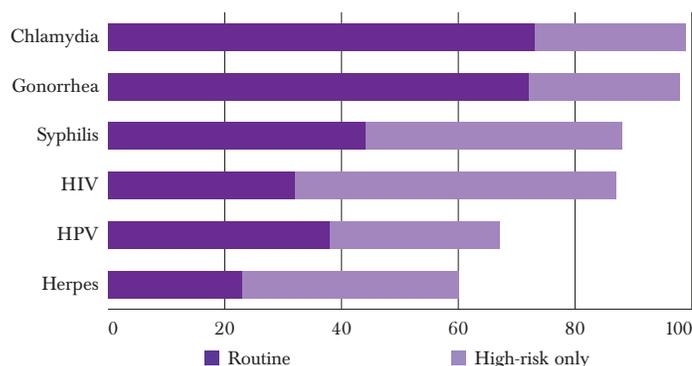
As women are less likely than men to have STD symptoms, they are far more likely to have their infections detected in the context of a routine health screen or contraceptive or prenatal visit. Family planning providers play a particularly important role. Indeed, the

INCIDENCE AND PREVALENCE OF SEXUALLY TRANSMITTED DISEASES		
STD	INCIDENCE (New cases every year)	PREVALENCE (People currently infected)
CHLAMYDIA	3,000,000	2,000,000
GONORRHEA	650,000	NA
HEPATITIS B	77,000	750,000
HERPES	1,000,000	45,000,000
HIV	20,000	560,000
HPV	5,500,000	20,000,000
SYPHILIS	70,000	NA
TRICHOMONIASIS	5,000,000	NA

Source: American Social Health Association, Sexually Transmitted Disease in America: How Many Cases and What Cost?, December 1998.

STD SCREENING

Whether family planning agencies perform routine STD screening or screen only high-risk clients varies by type of disease.



Source: Finer LB, Darroch JE and Frost JJ. U.S. agencies providing publicly funded contraceptive services in 1999, *Perspectives on Sexual and Reproductive Health*, 2002, 34(1):15-24.

large majority of the nation's more than 3,000 family planning agencies, which run more than 7,000 clinic sites serving approximately seven million women each year, either routinely screen all of their clients for chlamydia and gonorrhea or screen those considered to be at high risk (see chart). Of agencies that use risk factors as screening criteria, 97% screen clients with multiple sexual partners, 77% screen clients with new sexual partners, 64% screen based on youth (with the typical age ceiling of 21), 27% screen clients with a history of STDs and 25% screen clients who are single.

Whether a family planning agency provides treatment for a given STD is a more complicated issue than whether it provides screening, since such treatment can range from providing antibiotics for gonorrhea or chlamydia to the long-term management of HIV-related disease. Different types of family planning agencies vary in their ability to provide these services: For example, hospitals are far better equipped to care for HIV-infected individuals than are Planned Parenthood clinics. Thus, it is not surprising that there is considerable diversity in treatment services by agency type (see chart, page 10).

Overall, providers have an impressive record delivering STD services to low-income women and teens. Research published by The Alan Guttmacher Institute in 2001 found that women receiving contraceptive or other related services at family planning clinics are one-third more likely than those receiving such services from private physicians to report that they obtained an STD service. Each year, family planning clinics serve one in three women of reproductive age who obtain testing or treatment for STDs, one in four who obtain an HIV test and one in seven who obtain a Pap smear.

The 4,500 family planning clinics that receive funding under Title X of the Public Health Service Act, the pro-

gram guidelines of which strongly encourage clinics to provide extensive STD services, have a considerable record of their own. In 2000 alone, Title X-funded clinics administered 4.8 million STD tests, 428,000 HIV tests and 2.9 million Pap smears to low-income clients.

Key Challenges

Despite this impressive record, family planning providers today face several serious challenges that threaten their ability to continue delivering high quality STD services to those in need of subsidized care.

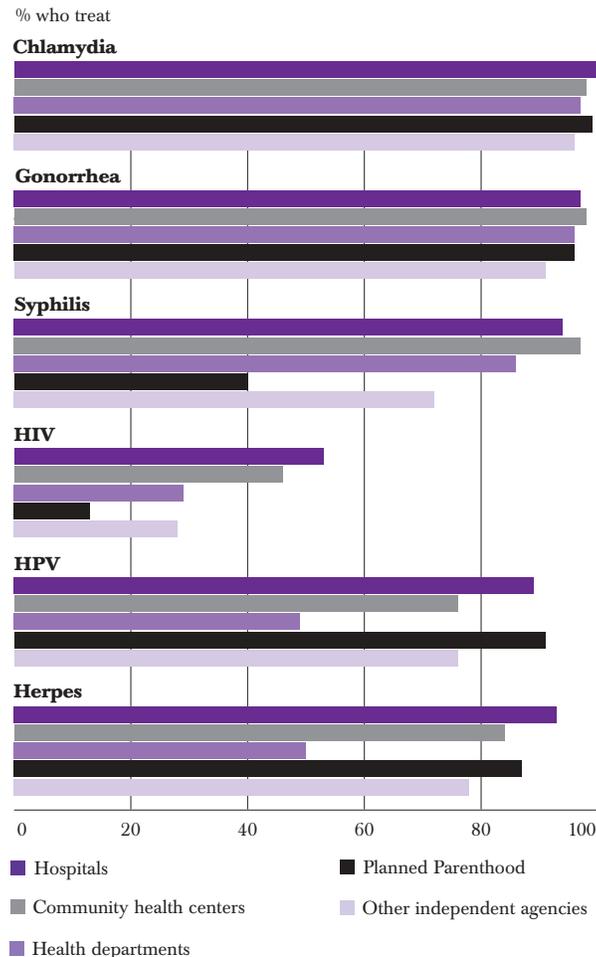
Increasing STD caseloads. Family planning providers routinely report that they are seeing more STDs in their patients than they did in the past. Deborah Gordis, vice president for government programs at Planned Parenthood of Metropolitan Washington, says that family planning clinics are seeing far more chlamydia, particularly among young women, as well as an increasing rate of abnormal or inconclusive Pap smears suggesting HPV. This statement is echoed by Jane Wilson, a family planning and reproductive health nursing care consultant with the Washington State Department of Health, who says that between 1996 and 2000, chlamydia and gonorrhea rates in her state rose 35% and 14%, respectively.

To some extent, the observed rise in STD rates may be attributed to more and better testing, particularly for asymptomatic STDs. "In the past," says Gordis, "testing for STDs was based much more on presenting symptoms. Now, with many STDs asymptomatic and the prevalence so high, testing has become much more routine." Furthermore, calls for routine screening are growing: Recent guidelines issued by the U.S. Preventive Services Task Force and the Centers for Disease Control and Prevention (CDC) now urge that all sexually active women in their teens and early 20s be screened for chlamydia, with the CDC also urging that all women with chlamydia be rescreened 3-4 months following treatment.

Better tests at higher cost. While family planning service providers are moving to screen larger populations of women, new STD tests are improving detection rates, enhancing patient care. These state-of-the-art tests, however, are expensive. For example, there are new DNA-based chlamydia tests on the market that are noninvasive and easy to use, because they involve a urine sample rather than a pelvic exam. While these tests could, in theory, greatly facilitate routine screening, they are twice the cost of current tests. Jessica Pollak, the director of family planning for the Louisiana Department of Health and Hospitals, says that because reinfection with chlamydia is so common, the state of Louisiana initiated a pilot project that used the urine-based test to test for reinfection among women who had received prior treatment for the disease and returned for Depo-

STD TREATMENT

Different types of family planning agencies vary in their ability to offer treatment for key STDs.



Source: Finer LB, Darroch JE and Frost JJ, U.S. agencies providing publicly funded contraceptive services in 1999, *Perspectives on Sexual and Reproductive Health*, 2002, 34(1):15-24.

Provera injections. Due to a lack of funding, however, the state had to discontinue the project. “We desperately would like to resume this practice,” says Pollak, “particularly where there is a high prevalence of chlamydia and documented high-risk behaviors.” Providers are encountering similar problems with new screening technology for cervical cancer and HPV (see box).

New treatment alternatives. Additionally, there are significant costs associated with providing state-of-the-art treatment to all those who test positive for STDs. For example, new single-dose antibiotics represent a significant advancement over the traditional treatment for chlamydia that requires two pills a day for a week. The single-dose regimen can be dispensed to clients at the clinic and taken on the spot, which ensures that patients do not discontinue the pills when they begin feeling better, thus risking reinfection or the development of drug-resistant strains. Yet, these new antibiotics are also

much more expensive: Leslie Tarr Laurie, CEO and president of Tapestry Health, an independent family planning agency serving western Massachusetts, reports that the single-dose treatment costs her agency more than 10 times the cost of the seven-day regimen (\$17.64 compared to \$1.50), making it financially prohibitive.

Integrating family planning and HIV services. Family planning service providers also face considerable hurdles integrating HIV counseling and testing with their family planning services. Gordis reports that Planned Parenthood of Metropolitan Washington found this much more challenging than expected. “HIV is not the same as any other STD, because the consequences for the client of a positive result are so different,” she says. Gordis also notes that ensuring that those responsible for providing HIV counseling are adequately trained is an enormous but critically important undertaking. “The counseling dynamic for HIV testing is very complicated. We need to ensure that our counselors have the maturity, empathy and communication skills” necessary for the job, “and that they can provide counseling consistent with CDC guidelines.” She also notes that pretest counseling alone can last anywhere between five and 20 minutes, “psychosocial support services must be immediately available for those who test positive” and clinic staff must have numerous referrals for medical and support services in place. “All of this requires strong relationships with local HIV/AIDS service providers and substantial time and resources,” she says.

Many clinics also wish to provide to their clients a new and more easily accepted HIV test that relies on a cheek swab rather than a traditional needle-stick blood test. Laurie says that the cheek-swab test is proving particularly critical as part of Tapestry Health’s efforts to bring services to homeless shelters and other off-site locations “where blood tests simply are not practical.” She continues, “If we had the resources, we would provide [the cheek-swab test] to all of our clients in an integrated setting, but the cost prevents us from doing so.”

Serving men. Finally, many providers are increasingly reaching out to serve men. Historically, many family planning agencies have provided STD services to the male partners of their female clients to prevent reinfection. Today, reinfection remains a major problem, and many clinics provide an infected woman with a dose of antibiotics to bring to her partner. Meanwhile, there is growing recognition that men have sexual and reproductive health needs of their own (“Looking at Men’s Sexual and Reproductive Health Needs,” *TGR*, May 2002, page 7). Accordingly, some agencies are now working to reach out to men by expanding their outreach department and hiring male educators. “While these efforts are critically important,” says Gordis, “they increase our costs, partic-

Family Planning Service Providers, Cervical Cancer Screening and HPV

The difficulty subsidized family planning service providers face in adapting to changing standards of care and providing high-quality STD services in their clinics is particularly vivid in the case of HPV, largely due to the nature of the disease. HPV is extremely common and usually harmless, with most cases being fought off by the body's immune system ("Wanted: A Balanced Policy and Program Response to HPV and Cervical Cancer," TGR, December 1999, page 1). However, certain HPV strains are associated with cervical cancer, although only a small proportion of infections by these "high-risk" strains ultimately progress to cancer.

Historically, it has been impossible for clinicians to determine whether a woman has one of the HPV strains that may place her at risk of developing cervical cancer. As a result, clinicians have struggled over how to treat a woman with an irregular Pap smear. Until recently, the Pap smear was the only means of detecting cervical cancer in its earliest stages; however, it also yields a high proportion of inconclusive results, and thus leads to unnecessary further testing. This has presented particular challenges for family planning providers, given the number of Pap smears they perform on a highly vulnerable population.

The emergence of two new technologies—a cervical cytology (marketed as "Thin Prep") that promises

greater accuracy than the Pap smear and a DNA-based test to identify high-risk strains of HPV—prompted a group of 29 medical professional and public health organizations to develop consensus guidelines regarding the management of inconclusive cervical cytologies, which were recently published in the Journal of the American Medical Association. Additional statements on the subject are also expected later this year from the American College of Obstetricians and Gynecologists, the American Cancer Society and the U.S. Preventive Services Task Force.

However, as the standard of care moves toward greater reliance on these new and more expensive technologies, family planning clinics potentially will be confronted with dramatic cost increases. According to Jessica Pollak, from the Louisiana health department, "Our clinics pay \$8 for a regular Pap smear; in comparison, it would cost us \$24 to offer Thin Prep, and \$100 to offer the DNA HPV test plus Thin Prep." Pollak, who notes that women in Louisiana have one of the highest rates of inconclusive and abnormal Pap smears in the nation, says that while it is crucial for family planning to keep up with changing standards of care, "absorbing the costs of these new technologies is more than [we] can bear."

ularly because many of the men we see in our clinics are low-income and uninsured." Indeed, Wilson of the Washington State Health Department reports that rising chlamydia and gonorrhea rates in her state may be due to clinics' inability to do more to reach men, given the state's lack of resources.

Looking Forward

Family planning clinics clearly play an important role in STD service delivery, and many providers are striving to do even more. Yet, many of these same providers feel they are already financially stretched to the limit, and worry simply about maintaining existing services to their current patient population. This is particularly true for family planning clinics that receive Title X funding, since two-thirds of Title X clients are eligible for completely subsidized care, because they have incomes under the federal poverty level. Moreover, federal funding for Title X has not kept pace with the increasing costs of these services: Taking inflation into account, the 2001 funding level of \$254 million is 57% lower than the 1980 level. Funding increases in the 1990s were largely earmarked for serving additional clients, rather than meeting the rising costs of service delivery. While Title X clinics can also draw on some of the funds available under the federal Infertility Prevention Program—created in 1992 to support the

screening and treatment of chlamydia—funding for the entire program in FY 2002 was only \$28 million.

Additionally, many states may be forced to cut back their own funding for these important services due to budgetary shortfalls brought on by the economic recession ("Post-Attack Economic Woes Create Challenges for Family Planning Advocates," TGR, December 2001, page 8). Laurie, whose state funding was cut \$40,000 this year and who expects further cuts next year, sums it up this way: "The crisis for family planning providers is that public resources are not keeping pace with technological developments in reproductive health. We are constantly balancing access to these services for the many with the quality of the services we can provide. At Tapestry, we have chosen to cut back on hours or even create waiting lists for certain services, rather than compromise quality." She continues, "The bottom line is that enhanced public resources are desperately needed if family planning providers are to intensify their screening efforts and take full advantage of the new testing and treatment options that promise to make further gains in the fight against STDs. ☉"

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