Guttmacher Policy Review
GPR
**Summer 2014** | Volume 17 | Number 3

# More than a Pack of Pills: The Many Components and Health Benefits of Quality Family Planning

By Kinsey Hasstedt

In April, the U.S. Office of Population Affairs (OPA) released updated programmatic requirements for grantees of the Title X national family planning program—the first update since 2001.[1] Separately, and in conjunction with the Centers for Disease Control and Prevention (CDC), OPA also published evidence-informed clinical recommendations for the provision of quality family planning services in all contexts, both within and outside the Title X network.[2] The CDC/OPA report incorporates relevant recommendations not only from the CDC, but also from the U.S. Preventive Services Task Force (USPSTF) and select major medical associations; they are expected to be updated periodically as those underlying recommendations are updated.

Together, the programmatic requirements and clinical recommendations set the expectation for the provision and accessibility of care in all safety-net health centers that receive Title X funding. Beyond the Title X network, however, the clinical recommendations define the core services of family planning care and detail how that care should be delivered by all family planning providers, regardless of whether they receive Title X or not, or are publicly or privately funded. Moreover, Title X's updated and explicitly stated requirements—which incorporate the program's well-established tenets, including clients' voluntary participation, availability of a range of methods, confidentiality and accessibility for clients with varying needs—clearly establish a model for high-quality sexual and reproductive health care nationwide for all providers. The combined effect of these important policy statements will be to further ensure that all individuals can reap the wide-ranging health benefits of high-quality family planning care, which start with—but go well beyond—improving the ability to prevent unintended pregnancies.

## Contraceptive Care…and More

Although contraceptive methods and counseling remain at the heart of family planning care, the clinical recommendations released by OPA and the CDC define family planning to include an array of services that confer myriad health benefits in addition to enabling women and couples to time and space their pregnancies. The report further establishes that not only adult women, but also men and adolescents, need family planning care.

The recommendations encompass six different reasons for a family planning client's visit and how a clinician should address those needs: contraception, pregnancy testing and counseling, advice on becoming pregnant, basic infertility services, preconception health care, and STI screening and treatment (see chart). Clients should be offered a range of specific services that directly address their needs: for example, contraceptive counseling and methods, or specific tests for infertility, or tests, treatment and vaccinations for STIs. The family planning provider should also conduct certain assessments and screenings necessary to provide those services appropriately, in accordance with current clinical standards. This typically includes assessments of the client's medical history, reproductive life plan and sexual health, in addition to screenings for such issues as high blood pressure, diabetes,

intimate partner violence, alcohol and drug use and depression.

Additionally, and especially for clients for whom a family planning visit is their only source of care, providers should offer related preventive health services on-site or by referral, if necessary. Such services include Pap tests, clinical breast exams, mammography and genital exams. Finally, family planning providers without the capacity to offer more comprehensive preventive care, such as screenings for lipid disorders and nonreproductive cancers, should be able to provide referrals for these services.

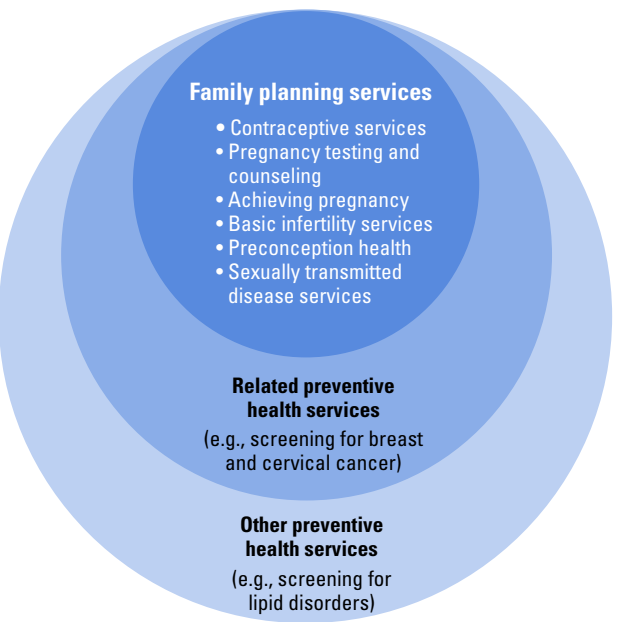
As to contraceptive methods and counseling, the wide-ranging health benefits of effective contraceptive use are well-documented.[3] The recommendations' detailed steps to providing quality contraceptive care consistently echo principles established under Title X, including clients' voluntary receipt of services and the provision of a wide range of contraceptive methods on-site or by referral. Informed method choice should be guaranteed through comprehensive (and noncoercive) education and counseling, and by confirming clients' understanding of method risks and benefits. And client confidentiality is paramount, particularly for adolescents, who need confidential care in addition to encouragement on communicating with a parent or guardian about their sexual and reproductive health. OPA recently affirmed the importance of confidential services for minors, by issuing specific guidance to Title X–supported providers underscoring that they may not require the consent or notification of a parent or guardian to provide family planning services to adolescents.[4] (Like other health care providers, Title X–supported centers must comply with state reporting laws in instances of child abuse or assault.)

The clinical recommendations also advance individuals' timely access to and effective use of contraceptives. Reflecting what has emerged as the standard of care relating to pelvic exams and Pap tests, these procedures should not delay otherwise healthy clients from starting their chosen methods, in part because such services can be costly or intimidating deterrents to women seeking contraception, particularly adolescents or those who are low-income. Contraceptive counseling and education should address method effectiveness and other potentially important considerations, such as whether a client feels able to use a given method consistently and correctly, has experienced intimate partner or sexual violence, or is dealing with mental health or substance use issues.

Beyond the central importance of contraceptive care, the recommendations detail the many other health services that comprise the core of quality family planning care. These include STI services, care to prevent cervical cancer and certain basic preventive screenings—all of which have long been among the services consistently available at Title X sites toward advancing the sexual, reproductive and overall health of their clients. A 2013 Guttmacher report reviewing the available evidence on the benefits of services at publicly funded family planning centers detailed and reinforced the case that these services confer considerable and wide-ranging individual and public health benefits, in addition to helping women and couples plan and space their pregnancies.[3]

## RECOMMENDED SERVICES

**The U.S. government's new clinical guidelines for family planning recommend that all clients be offered a range of family planning services and other preventive health services.**




*Source:* reference 2.

## STI Screenings, Treatment and Counseling

The newly released clinical recommendations firmly establish STI services as a key component of family planning care. Both female and male clients should receive STI services in line with the CDC's guidelines for STI screening and treatment, including HIV testing guidelines. Four distinct steps guide providers' delivery of care. First, they are to assess a client's overall and sexual health, and then conduct a detailed screening. If necessary, clinicians should provide appropriate treatment, counseling and rescreening for a client and the client's partner or partners. Finally, they should provide risk counseling wherein—according to a recommendation of the USPSTF—those with an STI or who may be at risk for one receive information on reducing risky sexual behaviors.

This framework addresses individual STIs in detail. For example, for chlamydia, providers should screen all sexually active women age 25 or younger on an annual basis, along with older women with risk factors and men who have sex with men, are exhibiting symptoms or are seeking care at a site where the prevalence among patients is high. Routine gonorrhea screening is recommended for all sexually active women with risk factors, which includes those age 24 or younger, and for men who have sex with men or who are exhibiting symptoms. Clients who have either a chlamydia or gonorrhea infection should be treated and rescreened after three months.

Both chlamydia and gonorrhea are quite common: In 2012, there were more than 1.4 million reported cases of chlamydia and nearly 335,000 reported cases of gonorrhea in the United States, with particularly high infection rates among women and those younger than age 25, including teens.[5] Moreover, both chlamydia and gonorrhea are likely substantially underreported since most people with an infection—especially women—are asymptomatic.[3] Because without symptoms, infections are more difficult to detect and many who are infected do not seek treatment, widespread screening (focusing on women) is critical to preventing transmission and averting adverse health consequences related to undetected, untreated infections. Among women, chlamydia untreated can result in pelvic inflammatory disease (PID), infertility, ectopic pregnancy, chronic pelvic pain and adverse pregnancy outcomes. Left untreated, gonorrhea can lead to inflammation in the urethra, epididymis or prostate among men, and to inflammation of the cervix and PID among women; these conditions can in turn contribute to difficulties becoming or remaining pregnant, and to adverse pregnancy and birth outcomes. Both chlamydia and gonorrhea increase the risk of contracting HIV.

Female and male family planning clients should also be tested for HIV in accordance with USPSTF recommendations and CDC guidelines. Specifically, all individuals aged 13–64 should be screened voluntarily, on an opt-out basis; this means individuals receive routine testing unless they explicitly choose not to.[6] Annual screening is recommended for those at high risk, including partners of HIV-positive individuals, injection drug users, commercial sex workers and those with multiple sexual partners.

The CDC estimates that more than 1.1 million U.S. adolescents and adults are living with HIV; of those, 16% are not aware of their positive status.[7] In 2011, nearly 50,000 individuals were newly diagnosed; new cases occurred disproportionately among men who have sex with men, African Americans and people in their 20s.[8] The rate of HIV infection overall has remained relatively stable since the late 1990s, in large part because of widespread testing and treatment efforts. Importantly, earlier detection and monitoring of HIV infection leads to earlier initiation of and more effective treatment, and treatment can reduce the likelihood of transmission—both among sexual partners and from pregnant women to their infants.[3,9] Routine testing should enhance these early detection efforts and help to decrease the stigma associated with HIV testing. Consistent and correct condom use is also recognized as one of the simplest and most cost-effective ways to prevent transmission of HIV and other STIs among partners.[3]

Expanding access to STI screening and counseling may help improve current rates of testing. A 2014 Kaiser Family Foundation survey of women's health found only about one-third of women

of reproductive age report having recent conversations with a health care provider about HIV and other STIs.[10] Furthermore, about four in 10 women report having been tested for either HIV or other STIs in the previous two years. However, Kaiser estimates that the screening rate may be even lower, because many women incorrectly assume that these tests are performed routinely during a standard check-up (as opposed to a family planning visit).

Title X health centers already lead the way in connecting clients to STI services (see chart). More than nine in 10 screen for STIs (including chlamydia, gonorrhea and HIV), provide condoms on-site and offer at least some STI treatment services.[11] More than one in three women of reproductive age who obtain STI testing, treatment or counseling and more than one in four who obtain an HIV test do so at a Title X or other publicly funded family planning center.[12]

## Cervical Cancer Prevention

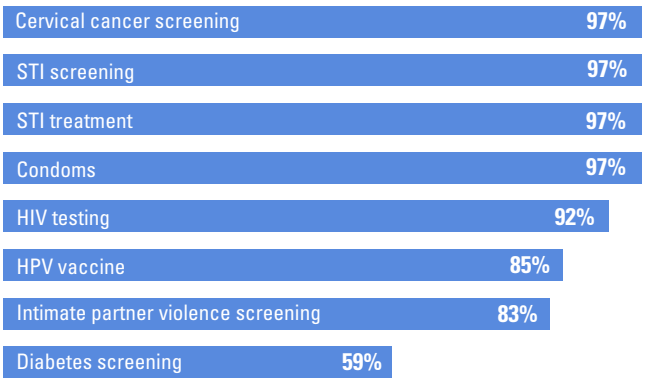
Human papillomavirus (HPV) is the most common STI in the United States.[13] Although HPV is largely asymptomatic and self-resolving, some strains can lead to serious health problems, such as genital warts and cancer, particularly cervical cancer.

Cervical cancer can be prevented in two ways: by vaccines to prevent HPV and by screenings. The newly released family planning recommendations address both strategies. In line with CDC guidelines, a three-dose HPV vaccine series should be given to young women and men ideally starting at age 11 or 12, but can be started as young as age nine. "Catch-up" vaccines are recommended for women through age 26 who have not previously completed the three-dose series and for unvaccinated men through age 21 (or through age 26 if at high-risk).

The USPSTF recommends both Pap tests and HPV screenings for female family planning clients. Women aged 21–65 should receive a Pap test every three years; those aged 30–65 who want to go longer between screenings can instead opt for a Pap test in conjunction with HPV testing every five years. Notably, Pap tests are no longer recommended on an annual basis or for

### SETTING THE STANDARD

**Most health centers supported by Title X already provide a wide range of key family planning and related reproductive health services on-site.**




*Source:* reference 11.

women younger than 21, and typically should not be required in order for a woman to initiate or continue a contraceptive method.

Cervical cancer rates and mortality have decreased significantly over the past four decades as a result of routine Pap tests.[14] Still, the CDC recently estimated that in 2010, nearly 12,000 women were newly diagnosed; that same year, some 4,000 women died from cervical cancer.[15] The increasingly widespread availability of more advanced technologies such as HPV testing could help; HPV screening has been proven effective in avoiding cervical cancer and significantly reducing cancer-related deaths, particularly when combined with Pap tests.[3] And because it is highly effective against the most common cancer-causing strains of HPV, the vaccine alone contributes to significant reductions in lifetime risk of cervical cancer—and is even more effective if combined with HPV screening.[3]

Yet, not all women obtain this life-saving care. The Kaiser Family Foundation reports that among women aged 18–64, seven in 10 have received a Pap test in the previous two years, although that number drops to about five in 10 among uninsured women.[10] More strikingly, a recent CDC survey found that 57% of young women aged 13–17 have received at least one dose of HPV vaccine, and only 38% have received all three.[16] This falls well short of the federal government's goal of

80% of women having received three doses by age 15.

Title X–supported centers reliably deliver these preventive services to their clients. In 2010, nearly all offered some form of cervical cancer screening; notably, most used a modern, more sensitive type of Pap test.[11] These health centers also commonly provide follow-up care for women with abnormal HPV or Pap test results, including continued monitoring, colposcopy to examine the cervix, biopsy to remove a small portion of the cervix for closer study or treatment to remove abnormal cells. Women diagnosed with cervical cancer are typically referred for follow-up care.

## Other Preventive Services

The OPA and CDC clinical recommendations define family planning to include an array of additional preventive services that advance the health not only of female and male clients, but also of their partners and children. This package of care largely overlaps with services that most private health plans must cover without patient cost-sharing under the Affordable Care Act's preventive services requirement (see "Beyond Contraception: The Overlooked Reproductive Health Benefits of Health Reform's Preventive Services Requirement," Fall 2012). In turn, this means family planning visits for female clients are one type of well-woman visit—intended to give clinicians the opportunity to take client histories and provide all recommended screenings and counseling—which plans must now cover without out-of-pocket costs.

Several of these preventive services are particularly notable. Consistent with CDC and USPSTF recommendations, all adult family planning clients should routinely have their blood pressure taken. (Blood pressure measurement is also specifically suggested for women who choose combined hormonal contraceptive methods, namely the pill, patch or ring.) The CDC estimates that one in every three adults has high blood pressure (hypertension), which is associated with heart disease—the leading cause of death among U.S. women and men.[17,18] Strong evidence supports regular blood pressure screening, as it can enable early identification of hypertension and treatment to reduce blood pressure and subsequent risks of heart attack, heart failure and stroke.[3]

Diabetes is one of the leading causes of death and disability in the United States and is associated with a number of negative health outcomes, including cardiovascular disease and stroke.[19] Rates of diabetes are on the rise, and the CDC estimates that 29 million people are affected; among these, about eight million have not yet received a diagnosis. Although no definitive evidence demonstrates that testing and early treatment reduces later complications, the CDC and USPSTF recommend diabetes screening for women and men with high blood pressure, because high blood pressure increases risk of diabetes itself and of cardiac complications commonly associated with diabetes.

Additionally, in line with USPSTF recommendations, women of reproductive age should be screened for interpersonal violence (IPV); those who have experienced violence should be referred for further counseling, care and intervention services. Moreover, past and current experiences with interpersonal and sexual violence are important considerations in discussing contraceptive method choice. Despite mixed evidence on whether screening reduces the incidence of IPV, it clearly offers an opportunity to raise awareness of and change attitudes about violence, as well as the chance for someone experiencing violence to obtain needed services.[3] Although most publicly funded family planning centers offer some sort of IPV screening, additional factors may contribute to more comprehensive violence prevention efforts, including staff training, partnerships with community organizations and state government investment in violence prevention.[20]

## What Quality Looks Like

The clinical recommendations from OPA and the CDC reflect a broad consensus on what makes up high-quality family planning care—both in terms of particular service components and how they should be delivered. Not surprisingly, the standard of care and the scope of services that Title X–supported health centers already commonly provide their clients are largely in line with these

recommendations. The health services that Title X helps make accessible—contraceptive methods and counseling, STI and HIV testing and treatment, cervical cancer prevention services and a number of preventive screenings—are all proven to advance sexual, reproductive and overall health, and decrease the risk of myriad negative health outcomes. Moreover, public investments in contraceptive care alone—not counting other family planning services such as STI screening and treatment or cervical cancer screening and vaccination—yield considerable savings in Medicaid expenditures at both the state and federal levels.[21]

However, women, men and adolescents cannot benefit fully from this newly established consensus on a quality approach to family planning care unless providers adopt the federal government's recommendations. Doing so may present opportunities and challenges for some types of providers. For instance, community health centers that provide family planning services as one component of more generalized care—particularly those that do not receive Title X support—have room to improve the quality and scope of their family planning care. A 2013 nationwide survey of community health centers' largest sites found that although nearly all offered some type of family planning services, significant proportions did not offer education and counseling needed by many family planning clients, did not provide a broad range of contraceptive methods on-site (particularly oral contraceptives, implants and IUDs) and did not routinely screen for chlamydia as recommended.[22] A follow-up analysis asserts the newly released clinical recommendations should translate well into the comprehensive care environment, suggesting their adoption would improve the quality of family planning care across community health centers.[23] The analysis makes a number of specific recommendations for the federal agency that helps run the community health center program, including new funding and additional technical assistance to help community health centers incorporate the newly released family planning guidelines into their practices.

Finally, the clinical recommendations released by OPA and the CDC must remain current to remain useful. Particularly as more and more providers offer care according to this standard, these guidelines must keep pace with an evolving health care reality, including advances in evidence and technology. Regular updates and wide distribution will help ensure that the best available information guides all providers. Quality family planning care is something that all providers should understand and strive to offer, and that all clients should know to expect. **www.guttmacher.org**

*This article was made possible by a grant from The JPB Foundation. The conclusions and opinions expressed in this article, however, are those of the author and the Guttmacher Institute.*

## REFERENCES

**1.** Office of Population Affairs, *Program Requirements for Title X Funded Family Planning Projects,* Rockville, MD: Department of Health and Human Services, 2014, <http://www.hhs.gov/opa/pdfs/ogc-cleared-final-april.pdf>, accessed Aug. 20, 2014.

**2.** Gavin L et al., Providing quality family planning services: recommendations of CDC and the U.S. Office of Population Affairs, *MMWR*, 2014, 63(RR-4):1–54, <http://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf>, accessed Aug. 20, 2014.

**3.** Kavanaugh ML and Anderson RM, *Contraception and Beyond: The Health Benefits of Services Provided at Family Planning Centers,* New York: Guttmacher Institute, 2013, <http://www.guttmacher.org/pubs/health-benefits.pdf>, accessed Aug. 20, 2014.

**4.** Office of Population Affairs, Clarification regarding "Program Requirements for Title X Family Planning Projects" Confidential Services to Adolescents, *OPA Program Policy Notice,* 2014, <http://www.hhs.gov/opa/pdfs/ppn2014-01-001.pdf>, accessed Aug. 20, 2014.

**5.** Centers for Disease Control and Prevention, *Sexually Transmitted Disease Surveillance 2012,* Atlanta: Centers for Disease Control and Prevention, 2014, <http://www.cdc.gov/sTD/stats12/Surv2012.pdf>, accessed Aug. 20, 2014.

**6.** Department of Health and Human Services, Opt-out testing, 2009, <http://aids.gov/hiv-aids-basics/prevention/hiv-testing/opt-out-testing/>, accessed Aug. 20, 2014.

**7.** Centers for Disease Control and Prevention, HIV in the United States: at a glance, 2013, <http://www.cdc.gov/hiv/statistics/basics/ataglance.html>, accessed Aug. 20, 2014.

**8.** Centers for Disease Control and Prevention, Diagnoses of HIV infection in the United States and dependent areas, 2011, *HIV Surveillance Report,* 2013, vol. 23, <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/>, accessed Aug. 9, 2014.

**9.** Moyer VA and U.S. Preventive Services Task Force, Screening for HIV: U.S. Preventive Services Task Force recommendation statement, *Annals of Internal Medicine*, 2013, 159(1):51–60.

**10.** Salganicoff A et al., *Women and Health Care in the Early Years of the Affordable Care Act,* Menlo Park, CA: Kaiser Family Foundation, 2014, <http://kaiserfamilyfoundation.files.wordpress.com/2014/05/8590-women-and-health-care-in-the-early-years-of-the-affordable-care-act.pdf>, accessed Aug. 20, 2014.

**11.** Frost JJ et al., *Variation in Service Delivery Practices Among Clinics Providing Publicly Funded Family Planning Services in 2010,* New York: Guttmacher Institute, 2012, <http://www.guttmacher.org/pubs/clinic-survey-2010.pdf>, accessed Aug. 20, 2014.

**12.** Frost JJ, *U.S. Women's Use of Sexual and Reproductive Health Services: Trends, Sources of Care and Factors Associated with Use, 1995–2010,* New York: Guttmacher Institute, 2013, <http://www.guttmacher.org/pubs/sources-of-care-2013.pdf>, accessed Aug. 20, 2014.

**13.** Centers for Disease Control and Prevention, Genital HPV infection: fact sheet, 2014, <http://www.cdc.gov/std/HPV/STDFact-HPV.htm>, accessed Aug. 20, 2014.

**14.** Centers for Disease Control and Prevention, Cervical cancer statistics, 2013, <http://www.cdc.gov/cancer/cervical/statistics/>, accessed Aug. 20, 2014.

**15.** U.S. Cancer Statistics Working Group, *United States Cancer Statistics: 1999–2010 Incidence and Mortality Web-based Report,* Atlanta: Centers for Disease Control and Prevention, 2013, <http://www.cdc.gov/uscs>, accessed Aug.20, 2014.

**16.** Centers for Disease Control and Prevention, Human papillomavirus vaccination coverage among adolescents, 2007–2013, and postlicensure safety monitoring, 2006–2014—United States, *MMWR*, 2014, 63(29):620–624, <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6329a3.htm>, accessed Aug. 15, 2014.

**17.** Centers for Disease Control and Prevention, High blood pressure facts, 2014, <http://www.cdc.gov/bloodpressure/facts.htm>, accessed Aug. 20, 2014.

**18.** Centers for Disease Control and Prevention, Heart disease facts, 2014, <http://www.cdc.gov/heartdisease/facts.htm>, accessed Aug. 20, 2014.

**19.** Centers for Disease Control and Prevention, *National Diabetes Statistics Report, 2014,* <http://www.cdc.gov/diabetes/pubs/statsreport14/national-diabetes-report-web.pdf>, accessed Aug. 20, 2014.

**20.** Battelle Centers for Public Health Research and Evaluation, *Family and Intimate Partner Violence Prevention in Title X-Supported Clinics: Summary Report*, Durham, NC: Battelle Centers for Public Health Research and Evaluation, 2005, <http://www.hhs.gov/opa/pdfs/partner-violence-prevention.pdf>, accessed Aug. 20, 2014.

**21.** Frost JJ, Zolna MR and Frohwirth L, *Contraceptive Needs and Services, 2010,* New York: Guttmacher Institute, 2013, <http://www.guttmacher.org/pubs/win/contraceptive-needs-2010.pdf>, accessed Aug. 8, 2014.

**22.** Wood S et al, *Health Centers and Family Planning: Results of a Nationwide Study,* Washington, DC: George Washington University, 2013, <http://www.rchnfoundation.org/wp-content/uploads/2013/04/Health_Centers_and_Family_Planning-final-1.pdf>, Aug. 20, 2014.

**23.** Rosenbaum S et al., *Health Centers and Family Planning Update: Implications of the 2014 Quality Family Planning Services Guidelines Issued by the CDC and the Office of Population Affairs,* Washington, DC: George Washington University, 2014, <http://publichealth.gwu.edu/pdf/hp/health-centers-family-planning-update.pdf>, accessed Aug. 20, 2014.