15. Barriers to the Development of STD Programs

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Introduction

Barriers to development of STD management programs within family planning settings may be at the country, provincial, programmatic or individual level. Recognizing the barriers present in each individual situation is essential prior to development and attempted implementation of new management strategies.

- **Cost**. The cost of developing and implementing STD management is significant and includes time, personnel, supplies, diagnostic tests and drugs. The cost of drugs may result in programs purchasing less than they need or buying drugs that are less expensive, but also less effective (Lande 1993). Several analyses have shown that the price of diagnostic tests is a more important factor driving overall costs than the cost of antimicrobials (Over and Piot 1991; Piot and Rowley 1992; Schulz, Schulte and Berman 1992).

- **Asymptomatic individuals**. Over one half of women with many sexually transmitted diseases are asymptomatic (Lande 1993), although they are still vulnerable to complications associated with these infections and are infectious to others. Their diseases may remain unrecognized because the women don't present for care at all or lack specific complaints. These women are most likely to be seen in settings such as prenatal and family planning clinics.

- **Lack of accurate diagnostic tests**. The lack of sensitive and specific diagnostic tests for sexually transmitted organisms can result in under-recognition of some infections using clinical diagnosis, as well as unnecessary treatment of infections which are not present using either the etiologic or syndromic approach.

- **Lack of providers/training issues**. Countries most in need of STD intervention often lack sufficient numbers of well-trained and experienced providers. Adequate training in and exposure to STDs is usually missing, particularly in clinical settings which have not routinely managed these infections.

- **Poor control over drug distribution**. Individuals with symptoms suggestive of a sexually transmitted infection may be unable or unwilling to seek help at an appropriate health care facility. Many countries have inadequate controls over drug dispensing, so that anyone can purchase a wide range of drugs without a prescription. Treatment of probable STDs then becomes based on recommendations from friends or from the drug store owner and is usually inadequate or completely ineffective. Such practices also promote the development of drug resistance.

- **Medication side effects**. Side effects from antimicrobial medication vary by drug and individual. When present, they range from mild to severe and occasionally involve life-threatening allergic reactions. If clients are not warned of potential side effects or reactions, they often discontinue treatment and may become distrustful of the provider or clinic.

- **Compliance issues**. Noncompliance with prescribed treatment occurs for several reasons: lack of understanding **of how** to take medications; lack of understanding about importance of treatment; cost of medications, often leading to treatment interruptions; and medication side effects. Certain populations are at particularly high risk for noncompliance, including adolescents, substance abusers and mentally ill or deficient individuals.

- **Need for partner treatment**. Partner treatment is an important part of STD management but is one of the most difficult things to achieve. Providers who have diagnosed a woman with trichomonas may be reluctant to tell her that her infection is sexually transmitted for fear of upsetting her or causing problems at home. A woman who finds she has gonorrhea and who knows she has been unfaithful to her husband may be afraid to tell him, for fear he will beat or divorce her. In both situations,appropriate treatment of the partner may not occur. On the other hand, the husband of the

woman with trichomoniasis probably has no symptoms and may refuse to take medications he thinks are unnecessary.

- **Lack of supplies/space** STD evaluation requires, at a minimum, a private area for examination and discussion, appropriate lighting, specula, gloves, swabs and the ability to practice good infection prevention techniques. Some of these essentials may be unavailable or in short supply.

- **Time constraints** Performing a STD evaluation, coupled with discussion, counseling and followup takes time—an average of 15 minutes in 20 health centers in Mozambique (Lande 1993). In a busy clinic with many clients and/or few providers this extra time is a significant barrier.

- **Stigma**. In most countries, STDs are stigmatizing to women and this is reinforced by conventional STD programs which are directed primarily to men and commercial sex workers. This stigma impacts on both clients and providers. Women are more likely to delay seeking care for a possible STD or may present to the family planning clinic or other site with an extraneous complaint because the are ashamed to voice their true concerns.

- **Cultural/religious beliefs**. Certain cultural practices such as dry sex, female circumcision or prolonged abstinence after childbirth may promote transmission of STDs or promote behaviors (e.g., use of commercial sex workers) which may increase risk of STDs. Religious beliefs may affect acceptability of condoms.

- **Lack of sufficient outcome information** There is a relative dearth of information regarding effectiveness of different interventions in reducing STD incidence and/or the incidence or severity of long-term complications.

- **Lack of support** Implementation of an effective STD management program requires support at the country, provincial and clinic management levels. There must be a country-wide health infrastructure in place, including surveillance activities, to support a STD program. There also must be a commitment to address this problem by policymakers nationally and regionally. Even if these pieces are in place, if those in clinic management positions do not support these efforts and consider them a priority, the program is unlikely to succeed.

- **Conflicts with family planning focus** Many family planning providers have raised concerns that integration of STD management will stigmatize the family planning effort or that the emphasis on condoms will result in lower use of more effective contraceptives and higher failure rates (Cates and Stone 1992a; Cates and Stone 1992b; Lande 1993). The focus of family planning efforts has been “health-oriented” and alternatives are generally offered in a nondirective fashion. In contrast, STD management is often “disease-oriented” and counseling is more directive.

Strategies for Implementing STD Management

Routine Risk Assessment

Information gathered in a screening history obtained from each client should include questions about sexual activity, previous STDs and current symptoms suggestive of a possible STD, in addition to more routine questions asked in family planning clinics. This information can be used to identify women with one or more factors placing them at increased risk for STDs. Recognized high-risk characteristics include: multiple partners (client or her partner); more than one partner in the last 3 months; new or casual partner; previous history of a STD; client with current symptoms of possible STD; and/or partner with symptoms of recent treatment for a possible STD. Other high-risk characteristics suggested relate to age, marital status or husband's occupation. Certain characteristics considered high-risk may be relatively locality-specific.

Screening

In the family planning clinic a woman who has symptoms or who has one or more high-risk characteristics, even if without symptoms, should be screened for the presence of a STD. Because of

the special considerations when an IUD is in place, it is advisable to perform a routine STD screening evaluation when IUD clients are seen.

Symptom Recognition

Women should be taught symptoms which might suggest the presence of a STD and encouraged to seek care immediately if they develop. Each woman should know the difference between a normal and abnormal vaginal discharge. Cultural constructions of different symptoms need to be acknowledged and explored.

Syndromic Diagnosis

In low resource settings, use of the syndromic approach to diagnosis of women with symptoms will be cost-effective and represent a more efficient use of time and other resources.

Development of Treatment Protocols

Treatment protocols, based upon current STD prevalence and drug resistance data for the region, should be developed and periodically reviewed. Protocols can be put into flow chart form based on identification of either a syndrome or of a specific organism. These can be easily adapted for use by providers at all levels. Treatment protocols must take into consideration the likelihood of coinfection with different organisms, such as gonorrhea and chlamydia.

"One-Stop Shopping"

Management will be most efficient and effective—and compliance maximized—when diagnosis, treatment and counseling take place in one location.

Provider Education

Providers of all types should receive both preservice and periodic inservice training about STDs and their management.

Client Education

Ideally, all clients will receive basic information about STDs (including HIV), their significance and prevention. This education can be in the form of wall posters, brochures, one-on-one sessions with a counselor or group sessions. Clients who are identified to be high-risk, even if no infection is found, should be especially targeted.

Counseling

Clients who are diagnosed with a STD require more in-depth attention. Counseling should include the following messages:

- what infection they have, how it was transmitted, and its possible sequelae
- how to cure the infection—instructions for taking medications, possible side effects and how to prevent them
- need for partner treatment
- how to prevent spread
- need for followup
- how to stay cured—condoms, monogamy (Philippines: A—abstinence; B—be faithful; C—condoms)
- issues related to HIV, perinatal infections

Partner Treatment

Partner treatment may be encouraged by seeing the partner in the family planning clinic. Alternatively, a relationship can be developed with a STD clinic or other provider for partner referral. Less optimally, an extra or double prescription (after checking for history of any drug allergies) may be given to the client for treatment of both individuals.

Drug Availability

Subsidized drug programs, in which treatment can be given free of charge or at a minimal cost, will increase the likelihood of successful management. The use of single-dose regimens of injectables, when clinically- and cost-effective, may improve compliance substantially. Available drugs should be at least 95 percent effective in terms of cure (Lande 1993).

Condom Availability

Condoms should be made available for clients in family planning clinics, along with instruction in their correct use. The use of water-based lubricants or spermicides in addition to condoms should be addressed. The use of condoms for infection prevention should be distinguished from their use for prevention of pregnancy. Women who are using condoms for protection against infection should use them during pregnancy, when amenorrheic because of breastfeeding or menopause, after sterilization or when using other effective means of contraception.

Followup

Each client diagnosed with a STD should be encouraged to return for followup after treatment is completed to ensure that the infection has resolved and to reinforce prevention messages. She should be asked to return sooner if symptoms worsen or stay the same or if medication side effects occur.

Referral

A referral site(s) should be identified for clients with persistent problems or more serious infections. A mechanism for communication about referrals should be established.

Networking

It is important to network with other existing governmental and nongovernmental programs to take advantage of whatever information and resources may be available to help implement STD management programs. Networking may also involve education of government officials and other policy makers about the magnitude and importance of STDs.

HIV Testing

HIV testing facilities need not necessarily be available in the family planning clinic but such sites should be identified for clients who need or request screening. This would include women with repeated STDs, unusual STD presentation and systemic signs or symptoms suggestive of possible HIV, or clients with high-risk behavior, especially in high HIV prevalence areas. Confidential HIV education and testing, coupled with condom availability, has been shown to result in increased use of condoms and a decrease in STDs (Allen et al 1992).

Cervical Screening

Clients with STDs, and in particular HPV, are at increased risk for cervical neoplasia and should have regular cervical cytologic screening.

Conclusion

There are numerous potential barriers to the development of STD management programs. These barriers vary dramatically in different settings but must be identified and addressed if effective programs are to be built. Several strategies for helping to implement STD management programs have been discussed and should be considered in their planning and development.

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