

The Public's Health and the Law in the 21st Century
5th Annual Partnership Conference

Concurrent Session

Legal Tools for Advancing Women's Health

Monday, June 12, 2006
4:00-5:30 pm

Moderator: Tanja Popovic, PhD, MD, MSc, Associate Director for Science, CDC, Atlanta, GA

Panel: Tim Mastro, MD, Acting Director, Division of HIV/AIDS Prevention, National Center for HIV, STD and TB Prevention, CDC, Atlanta, GA

Laurie Monnes-Anderson, BSN, MA, Senator, Oregon State Senate and Chair, Oregon Senate Health Policy Committee, Salem, OR

Pam Pitts, MPH, STD/HIV Prevention Services Director, Tennessee Department of Health, Nashville, TN

Amy Pulver, MBA, MA, Associate Director for Policy, Planning and External Relations, Division of STD Prevention, National Center for HIV, STD and TB Prevention, CDC, Atlanta, GA

Session Purpose:

The session will introduce and explain examples of legal tools for protecting women's health from two important such threats: chlamydia and other sexually transmitted diseases, and HIV. Law-based interventions include opt-out HIV testing for pregnant women in health care settings, and expedited partner therapy for partners of women diagnosed with bacterial sexually transmitted diseases.

The goals of the session, broadly oriented toward public health policy makers at the state level, are to explain the public health issues behind each of these law-based interventions, examine how the interventions were designed (including recognition of legal and other barriers to their implementation), and explore how each intervention can improve the health of women.

HIV in Pregnant Women

Early in the epidemic, HIV infection and AIDS were diagnosed in relatively few women. Today, the HIV/AIDS epidemic represents a growing and persistent health threat to women in the United States, especially young women and women of color. In 2001, HIV infection was the leading cause of death for African American women aged 25–34 years and was among the four leading causes of death for African American women aged 20-24 and 35–44 years, as well as for Hispanic women aged 35–44 years. Overall, in the same

year, HIV infection was the 6th leading cause of death among all women aged 25-34 years and the 4th leading cause of death among all women aged 35–44 years.

Of the more than one million persons living with HIV in the United States at the end of 2003, about one quarter (252,000 to 312,000 persons) are unaware of their HIV infections and therefore do not benefit from clinical care to reduce morbidity and mortality. Undoubtedly, some unknowingly transmit HIV.

CDC's "Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health Care Settings" updates previous recommendations for HIV testing in health-care settings and for screening of pregnant women, to increase routine HIV screening of patients in health care settings, including pregnant women; to foster the earlier detection of HIV infection; to identify and counsel persons with unrecognized HIV infection and link them to clinical and prevention services; and to reduce perinatal transmission of HIV. State laws in this area vary, especially in terms of "opt-out" provisions.

Chlamydia and Other STDs

Effective clinical management of patients with treatable sexually transmitted diseases (STDs) requires treatment of the patients' current sex partners to prevent reinfection and curtail further transmission. The standard approach to partner treatment has included clinical evaluation in a health care setting, with partner notification accomplished by the index patient, by the provider, by an agent of the provider, or by a combination of these methods. Provider-assisted referral is considered the optimal strategy for partner treatment, but is not available to most patients with gonorrhea or chlamydial infection because of resource limitations. The usual alternative is to advise patients to refer their partners for treatment.

In recent years, research supported by CDC has evaluated expedited partner therapy (EPT), where partners are treated without an intervening clinical assessment. EPT typically is accomplished by patients delivering medications or prescriptions to their partners.

Although used by many U.S. clinicians, EPT has not been generally recommended as a partner management strategy. With the assistance of representatives from the public and private health care sectors assembled in two advisory consultations, CDC recently reviewed the available evidence concerning EPT for gonorrhea and chlamydial infection, including three published or in-press randomized controlled trials. The review considered the effect of EPT on reinfection rates among patients and on patient and sex partner behaviors expected to reduce reinfection. The review also examined the existing barriers to EPT implementation.

CDC has concluded that EPT is a useful option to facilitate partner management, particularly for treatment of male partners of women with chlamydial infection or gonorrhea. CDC, and others, also concluded that the uncertain legal status of EPT is a barrier to broad implementation of this additional tool. CDC recommended that to maximize the STD prevention impact of EPT, public health programs, managed care organizations, professional associations, private health care providers, and other clinicians should seek opportunities to work with policy makers and other stakeholders to identify and address legal and administrative barriers to its use. To assist with such

identification, CDC undertook an assessment of state-level legal barriers to implementation of EPT.

Learning Objectives:

By the close of this session, conference participants will be able to:

- Illustrate generally how law can be used to facilitate positive outcomes and interventions in public health practice;
- Explain both the revised HIV guidelines and the concept of Expedited Partner Therapy; and
- Delineate how these innovative tools might work in their home state, and how potential legal barriers can be identified.

Session Convener:

The National Center for HIV, STD and TB Prevention, CDC

Resource Materials:

Centers for Disease Control and Prevention. Expedited partner therapy in the management of sexually transmitted diseases. Atlanta, GA: US Department of Health and Human Services, 2006, available at <http://www.cdc.gov/std/treatment/EPTFinalReport2006.pdf#search='cdc%20ept%20guidelines'>

Information on HIV/AIDS prevention guidelines are available at <http://www.cdc.gov/hiv/dhap.htm>. Specific information on testing is available at <http://www.cdc.gov/hiv/topics/testing/index.htm>.

Lessons Learned:

1. Amy Pulver:
Chlamydia infection (widely known as chlamydia) is a sexually-transmitted infection that can easily be cured with antibiotics, but it is usually asymptomatic and often undiagnosed. Chlamydia is the most commonly reported infectious disease in the United States, with 929,462 chlamydia diagnoses reported in 2004. CDC estimates that there are approximately 2.8 million new cases of chlamydia in the United States each year. Untreated, it can cause severe health consequences for women, including pelvic inflammatory disease (PID), ectopic pregnancy, and infertility. Up to 40 percent of females with untreated chlamydia infections develop PID, and 20 percent of those may become infertile. In addition, women infected with chlamydia are up to five times more likely to become infected with HIV, if exposed. Women, especially young women, are hit hardest by chlamydia. CDC and other professional health care organizations, including the United States Preventive Services Task Force (USPTF) recommend annual chlamydia screening for sexually-active women age 25 and under. Treating the current sexual partners of patients with chlamydia is critical to stopping infection transmission and to preventing re-infection of treated patients. Based on evidence from randomized control studies and surveys of practice, CDC has concluded that EPT is a useful option to facilitate partner

management, particularly for treatment of male partners of women with chlamydial infection or gonorrhea. EPT is permissible in only five states, though EPT may be possible in as many as 33 additional states, with some action. EPT is a promising practice for treating infected sexual partners of those diagnosed with chlamydia, but implementation likely requires policy or legislative action in most states.

2. Pam Pitts:
Expedited Partner Therapy (EPT) is a viable disease intervention strategy for advancing infertility prevention for women. The long-term sequelae of untreated chlamydia infection is often pelvic inflammatory disease, and possibly infertility. As STD resources shrink, public health leaders must utilize innovative approaches to achieve overarching program goals.

In 2002, the Tennessee Department of Health began the process of identifying and working through the legal/procedural barriers that surround EPT. Identifying the two or three key players who influence policies and/or laws, strengthening relationships to build advocacy for the issue, and remaining diligent through the process are crucial steps to navigating legal barriers to implementation.

3. Timothy D. Mastro:
CDC has recommended routine voluntary HIV testing for all pregnant women since 1995. Studies have shown that health care providers find requirements for HIV counseling and separate, written informed consent to be barriers to providing HIV testing. In April 2003, the CDC Director sent a letter to colleagues recommending universal "opt-out" HIV testing for pregnant women, i.e., all pregnant women should be notified that an HIV test is recommended as part of the standard panel of prenatal tests and that they will be tested unless they decline. Consent is inferred unless the patient specifically declines testing. While it is important that all women learn their HIV status to reduce perinatal transmission, it is equally important for women and their partners to know their HIV status to benefit their own health. Only by being tested can they avail themselves of life-extending treatment if found to be HIV-infected. In addition, most people who learn they have HIV reduce behaviors that risk infecting others. Some states have taken action to normalize HIV testing. For example, Texas law allows "opt-out" HIV testing in all clinical settings. In addition, the American College of Obstetricians and Gynecologists (ACOG) recommends "opt-out" HIV testing for all pregnant women and has worked with legislators in states that have modified their laws to develop a legislative toolkit to assist other states in adopting laws that allow and promote routine, opt-out HIV screening (available at rcarlson@acog.org.)

4. Oregon Senator Laurie Monnes-Anderson:
There have been three cases of HIV transmission from mother to child reported in Oregon. These might have been prevented by a prenatal HIV test. Early detection of HIV infection and antiviral treatment can dramatically reduce the transmission from mother to baby from 25 percent to two percent or less. In Indiana and New Mexico, where similar laws were adopted, prenatal HIV testing has increased from about 50 percent to 90 percent.

HB 2706, which went into effect on January 1, 2006, exempts testing of blood of pregnant women from informed consent requirements for HIV tests. This bill changed the HIV testing of pregnant women to an "opt-out" system in which women would be notified that an HIV test will be included in the standard set of prenatal tests. (Before this law was

passed in Oregon, pregnant women had to specifically consent to an HIV test. This is referred to as an "opt-in" system.) Women are still able to refuse HIV testing but must do so actively; the default option would be to test.