ACHA 2021 SEXUAL HEALTH SERVICES SURVEY

Survey Report

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AMERICAN
COLLEGE
HEALTH
ASSOCIATION

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A Call to Action for Health Equity:

Collect and Report Race, Ethnicity, Sexual Orientation and Gender Identity Data

The rights to equality and non-discrimination are critical to the realization of sexual health[1]. Not only do systems of oppression such as racism, cissexism, heterosexism, sexism, and ableism directly cause poor health outcomes, but they also contribute to community distrust of public health institutions that prevents access to critical resources. There are several examples (ex. Tuskegee Study, HIV pandemic, etc.) demonstrating how the sexual health field is not outside of these systems. It is incumbent upon us as college health practitioners to recognize the impact of systemic inequities on the student populations we serve, examine our policies and practices, and take action within our organizations and field to eliminate those inequities wherever we find them.

We have a deep appreciation for the fact that we cannot do this without consistent data collection and disaggregation. We continue to recognize the fact that Black, Indigenous, and People of Color (BIPOC) and queer and trans (QT) people experience a multitude of health disparities, yet they historically have not been made visible by this survey. The purpose of the Sexual Health Services Survey (SHSS) has been to provide a broad overview of STI/HIV and cervical cancer screening results among patients visiting student health services (SHS). However, a commitment to health equity requires that we move beyond broad statistics. As promised last year, this version of the survey asked SHSs if they could respond to surveillance questions according to race, ethnicity, sexual orientation, and gender identity.

We recognize that many SHSs did not have the ability to provide this information due to EHR and laboratory reporting limitations. CY 2021 data show that only 52.6% of participating institutions are able to disaggregate clinical data based on race/ethnicity, only 37.2% can do so based on gender identity, and only 13.1% can do so based on sexual orientation.

We encourage all SHSs to work with their electronic health record (EHR) vendors to create reports that allow them to disaggregate and analyze their clinical data in a way that captures the diversity of the students they serve. While the time that can be dedicated to completing the SHSS is limited, please do not underestimate the impact of spending more time on the survey to make sure all students are visible and counted.

If you have a suggestion for how the Sexual Health Coalition can support SHSs with data disaggregation, please send an email to Christine Kukich at CKukich@acha.org.

Introduction and History

The American College Health Association (ACHA) has collected data from SHSs regarding STI/HIV surveillance, cervical cancer screening practices and management of abnormal results on a calendar year (CY) basis since 1991. Formerly known as the Pap Test and STI Survey, the purpose of the Sexual Health Services Survey (SHSS) is to provide benchmarking data on practices and STI/HIV testing outcomes for comparison among SHSs and analysis of trends over time. Previous reports can be found on the Sexual Health Services Survey page on ACHA's website.

To capture data from those institutions that engage in sexual health promotion but offer limited or no clinical services, a question regarding scope of sexual health services provided was added beginning with the CY 2018 & 2019 surveys. Over the past few years, several changes have been made to the survey to better capture health education and promotion activities and changes in guidelines and best practices.

As announced during the CY 2020 survey cycle, there are now two versions of the survey that are distributed on alternating years. CY 2020 was the first year with the two-version model, distributing the even year version of the survey. CY 2021 (what this report covers) is the first odd year collection cycle. Here is a general breakdown of what is included in each version:

Both Even and Odd Years:

- Surveillance Questions
    - Cervical cancer screening outcomes
    - STI/HIV testing positivity
    - Pregnancy testing positivity

Even Years:

- Surveillance Questions
- General Practice Questions
    - Management of cervical cancer screening results
    - STI/HIV testing practices and services
        - Cost of STI/HIV testing
        - Extragenital testing
        - STI/HIV testing outreach events
        - Anonymous HIV testing
        - Routine chlamydia testing among patients assigned female at birth
    - Contraception provision
    - Services provided after positive pregnancy tests

Odd Years:

- Surveillance Questions
- Organizational assessment in alignment with the Implementation Guide for Best Sexual Health Practices in College Settings developed by the American College Health Foundation with support from Hologic, Inc.

The Continuing Impact of the COVID-19 Pandemic

Sexual Health Services Survey (SHSS) CY 2021 data is the first full year of data after the start of the pandemic in March 2020. Additionally, CY 2021 saw several changes in the pandemic including: shifting federal, state, and local guidance; development and distribution of COVID-19 vaccinations and booster shots; the end of stay-at-home orders and loosening of other pandemic-related restrictions; new COVID-19 variants; and the re-opening of many institutions of higher education. It is unclear, and likely widely variable, how sexual health and sexual health services were prioritized on college campuses throughout CY 2021. This cycle's data is invaluable in continuing to capture and understand the impact of the COVID-19 pandemic on sexual health needs and services on college campuses.

Data in forthcoming years will be particularly valuable in gaining ongoing insight into the longer-term impacts the COVID-19 pandemic is having on sexual health and sexual health services.

Methods

This report contains data collected by ACHA Member Institutions for Calendar Year 2021 (January 1 - December 31) according to the Odd Years version of the SHSS. Survey questions were written and edited by members of the ACHA Sexual Health Coalition with assistance from ACHA staff members. The survey was administered using Qualtrics Research Suite online survey software (Qualtrics, Inc.), and response data were analyzed using IBM SPSS Statistics v23 (SPSS, Inc.). The response period was December 2021 to April 2022. Each Representative of the Member Institution (RMI) was emailed a unique survey link. The RMI was asked to either complete the survey or forward the survey link to the appropriate staff member for completion. Non-responders were sent reminder emails throughout the response period. Only ACHA Institutional Members were sent email invitations, but there was also an anonymous link available for non-members that was shared with interested schools. All but one school were ACHA institutional member schools. Because of this, the results of this survey may not be representative of all SHSs in the United States and extrapolation of these data to college populations in general may not be appropriate. For calculations of test result positivity in variables with numerical data, we excluded respondents that did not provide both a numerator and a denominator in their response (i.e., the number of positive tests and the number of total tests performed, respectively). All percentages reported reflect valid percentages. The data were reviewed for data entry errors as well (e.g., if there were more positive results than total number of tests performed); those responses were excluded from analysis.

A Note about Gender Identity Data Collection

Not all laboratories and electronic health record systems (EHRs) collect and report gender identity data[1][†] according to best practices that recognize and affirm trans and non-binary people. Past versions of the survey have attempted to better capture gender identity data by including "transgender" or "trans and non-binary" to the sex assigned at birth clinical number breakdowns. While this was an important inclusion, transgender and non-binary gender identities are not mutually exclusive from sex assigned at birth, meaning data collection was less accurate and did little to help us understand the needs and experiences of the trans and non-binary communities. In an attempt to meaningfully shift our data collection to accurately reflect gender identity and set the expectation that schools should be reporting on gender identity and not just sex assigned at birth, we removed the breakdown of clinical numbers by sex and gender identity. In lieu of collecting this data during CY 2021, a question was added asking participating institutions if they were able to break down their clinical test numbers by gender identity on future versions of the survey. Only 37.2% of participating institutions currently have the ability to disaggregate their data based on gender identity. We know that there is still a

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[†]Collecting and reporting gender identity data is separate and distinctly different from collecting sex assigned at birth. According to ACHA's January 2020 Best Practices for Sexual Health Promotion and Clinical Care in College Health Settings document, it is recommended to collect this data "in electronic health records (EHR) and other public health systems (i.e., needs assessments, program evaluations, infectious disease reports)". Specifically, colleting gender identity data "should be a two-step process, where the patient is first asked their gender identity followed by their sex assigned at birth".

lot of work to be done on this front and are actively working to find more accurate and meaningful ways to capture this data. We call on all participating institutions to invest time and effort into collecting data in a way that allows it to be disaggregated based on gender identity.

Findings

Demographics

Numbers of participating institutions over the past 10 years have ranged from a high of 181 in CY 2011 to a low of 113 in CY 2017. A total of 144 schools completed the survey for CY 2021. Of these schools, 138 (95.8%) provided clinical sexual health services at their student health center and were able to provide data for the survey. The majority of participating institutions were public, 4-year schools (62.5%) and schools with student populations over 20,000 (37.5%). Participating institutions are made up of both institutional members (n=143) and non-institutional members (n=1) of ACHA.

Type of Institution (N=136)

9%
35%
56%

■ Public 2-year ■ Public 4-year ■ Private 4-year

Region Per CDC/HHS (N=136)

1%
21%
24%
15%
39%

■ Northeast ■ Midwest ■ South ■ West ■ Outside U.S.

Institution Size (N=136)

22%

7%

17%

17%

37%

■ Less than 2,500   ■ 2,500-4,999
■ 5,000-9,999   ■ 10,000-19,999
■ 20,000 and above

Campus Setting (N=136)

3%

13%

22%

62%

■ City ■ Suburb ■ Town ■ Rural
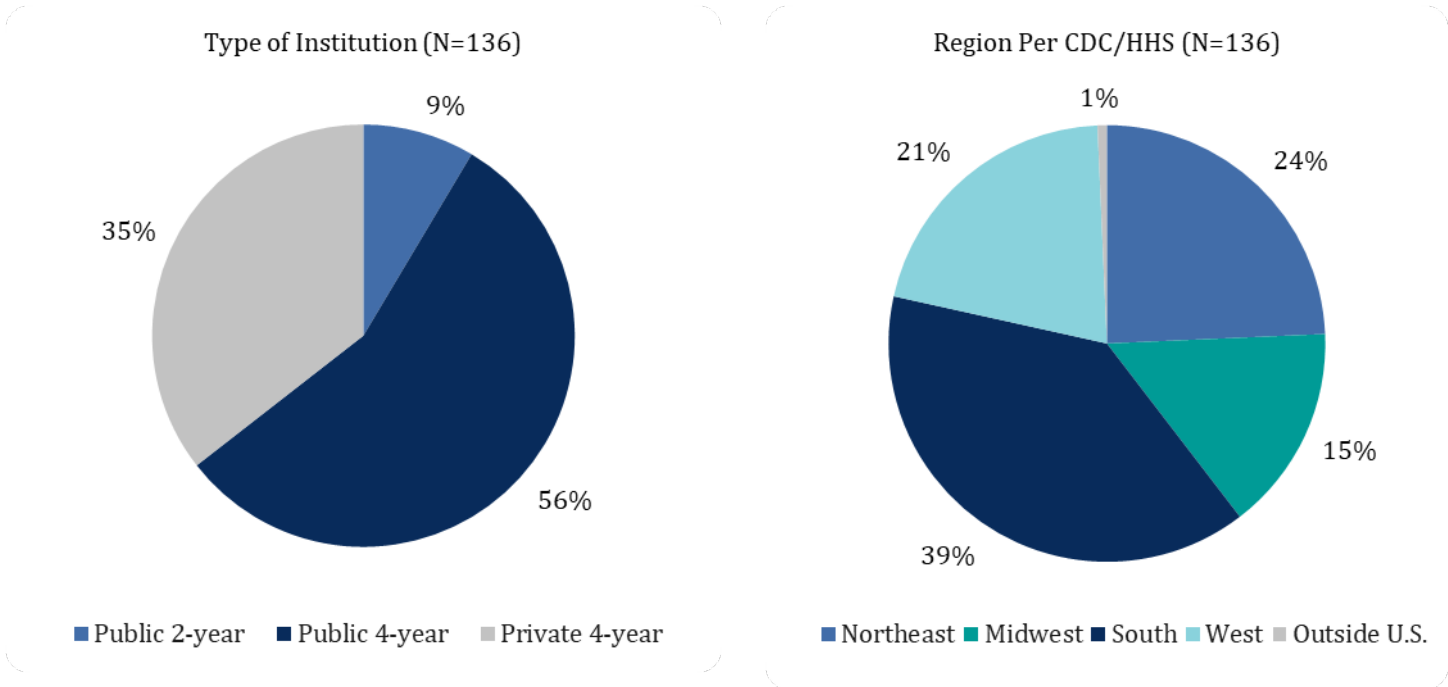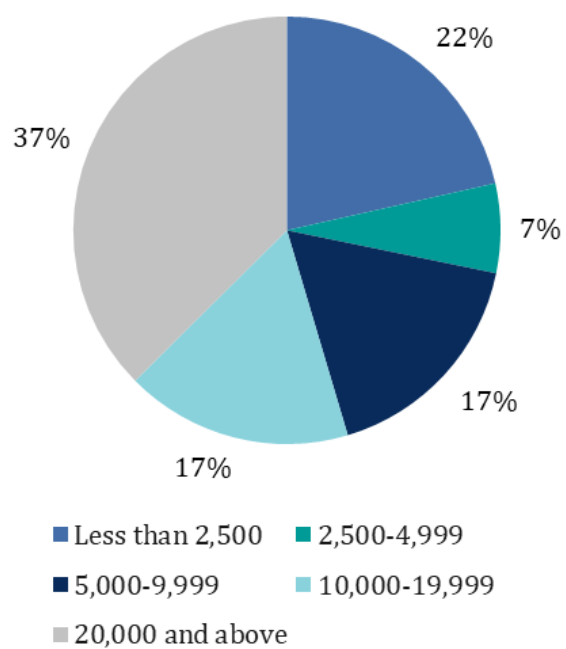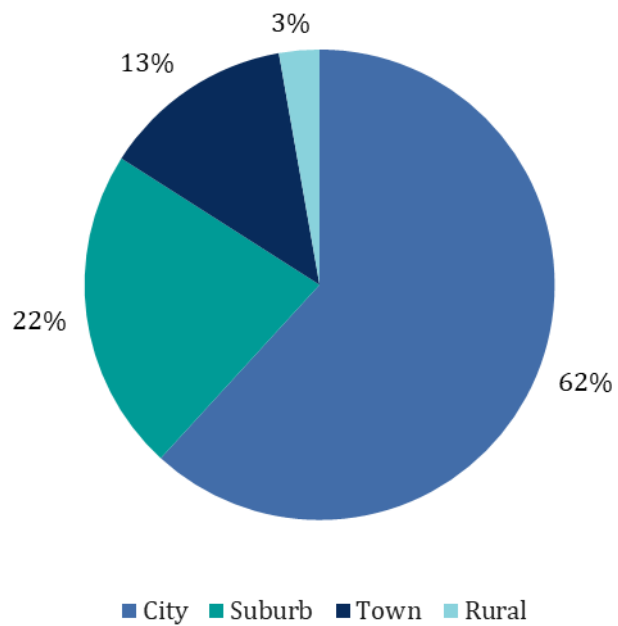
Clinical Data Disaggregation

This cycle of the survey sought to better understand the clinical data disaggregation capabilities participating institutions have by asking what electronic health record (EHR) they use and if they can disaggregate data based on: sex assigned at birth, gender identity, race/ethnicity, and sexual orientation. The most commonly used EHRs are Point and Click Solutions (29.2%) and Medicat (28.5%), with every other major EHR being used by 10% or less of responding institutions (Figure 1). Only 37.2% of responding institutions are able to disaggregate data by gender identity and only 13.1% are able to do so by sexual orientation (Table 1).

Figure 1

Electronic Health Record Used by Participating Institutions
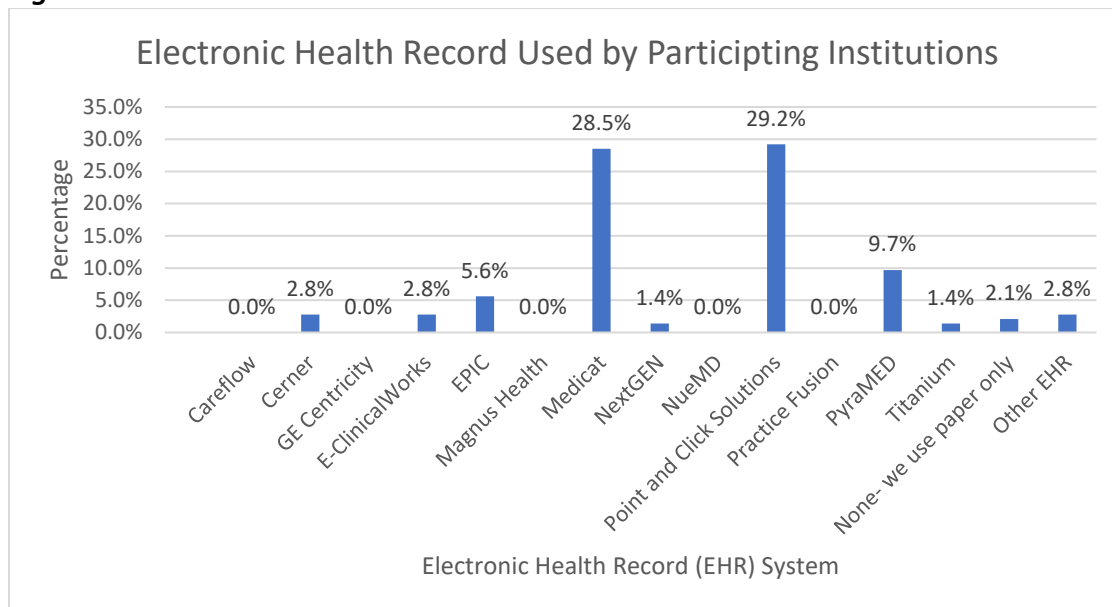
*Respondents could select more than one response

Table 1

Ability to disaggregate data based on:	Valid Percent*
Assigned sex	77.4%
Gender identity	37.2%
Race/ethnicity	52.6%
Sexual orientation	13.1%

Clinic Utilization

This report represents sexual health data collected from within more than 1.9 million medical visits at student health services. Though notably less than visits from most of the previous 10 years, this is over 600,000 more visits than in CY 2020, showing the impact of the shifts in the COVID-19 pandemic and the return to campus for many institutions of higher education[2]. The mean number of student visits per calendar year are depicted in figure 2. The CY 2021 SHSS was the first cycle of the survey that asked about virtual/telemedicine visits. Of these visits, just under 375,000 (19.0%) were telemedicine visits.

Figure 2
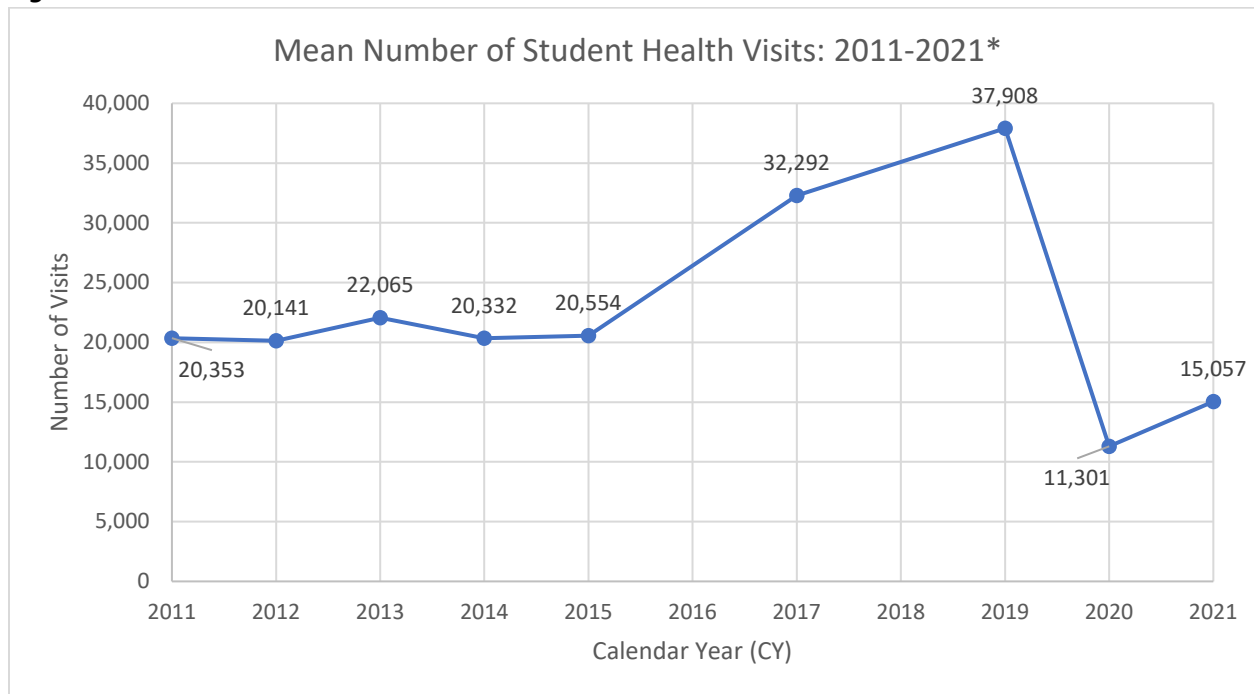
Mean Number of Student Health Visits: 2011-2021*

*CY 2016 and CY 2018 are not reflected in this graph because this data was not collected during those survey cycles.

Provision of Clinical Sexual Health Services

The great majority of institutions offering clinical sexual health services (N=138) responded that they offered pregnancy testing (99.3%), STI/HIV screening (93.5%), contraception (92.8%), and cervical cancer screening (87.0%). Only about 2 out of 3 SHSs offered PrEP (65.9%), just over half offered PEP (52.9%), and less than 3 out of 4 offered the HPV vaccine (69.6%) (Figure 3). While all of these numbers are lower than what would be ideal on campus[3], there was at least an increase of 5 percentage points in institutions offering PrEP and PEP compared to CY 2020 (Figures 4-5).

Figure 3

Provision of Clinical Sexual Health Services

Sexual Health Service	Percentage
HPV vaccinations	69.6%
PEP	52.9%
PrEP	65.9%
Contraception	92.8%
Pregnancy testing	99.3%
STI/HIV testing	93.5%
Cervical cancer screening	87.0%

*Sum is > 100% because respondents could select more than one response

Figure 4
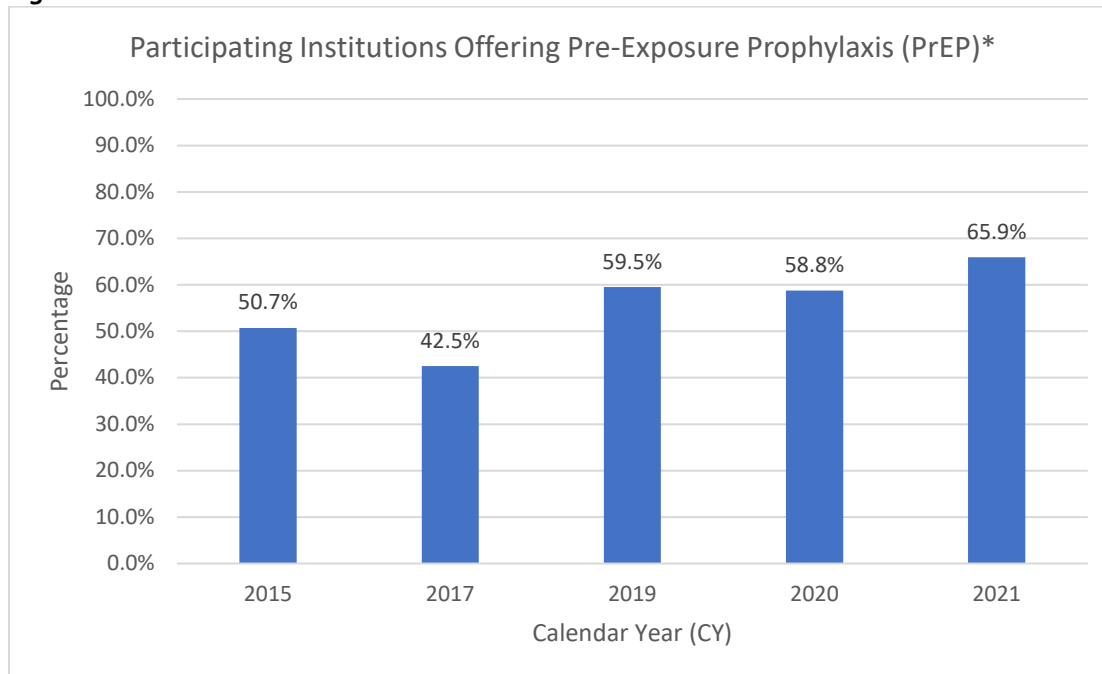
Participating Institutions Offering Pre-Exposure Prophylaxis (PrEP)*

Calendar Year (CY)	Percentage
2015	50.7%
2017	42.5%
2019	59.5%
2020	58.8%
2021	65.9%

*CY 2016 and CY 2018 are not reflected in this graph because this data was not collected during those survey cycles.

Figure 5
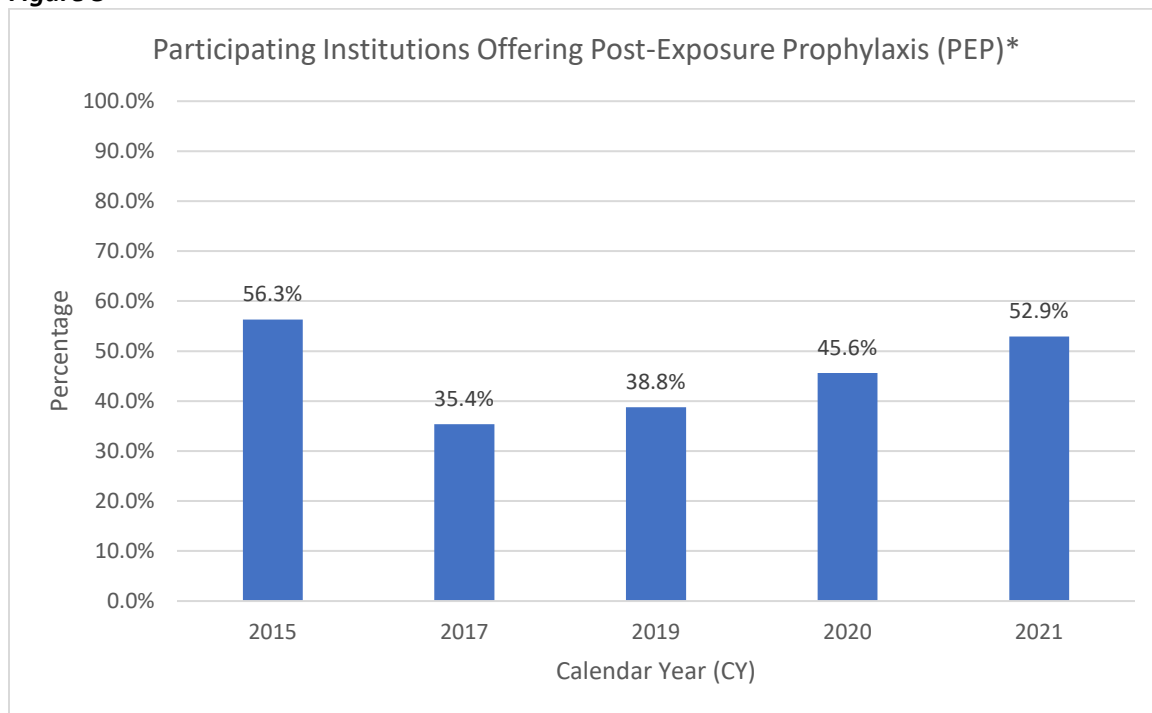
Participating Institutions Offering Post-Exposure Prophylaxis (PEP)*

*CY 2016 and CY 2018 are not reflected in this graph because this data was not collected during those survey cycles.

Surveillance Questions

Cervical cancer screening outcomes

- Of 23,804 Pap tests performed by participating institutions, 84.0% came back normal (Table 2).
- Of those that came back abnormal, the majority were atypical squamous cells of undetermined significance (7.9%) or low-grade squamous intraepithelial lesions (5.7%) (Table 2).
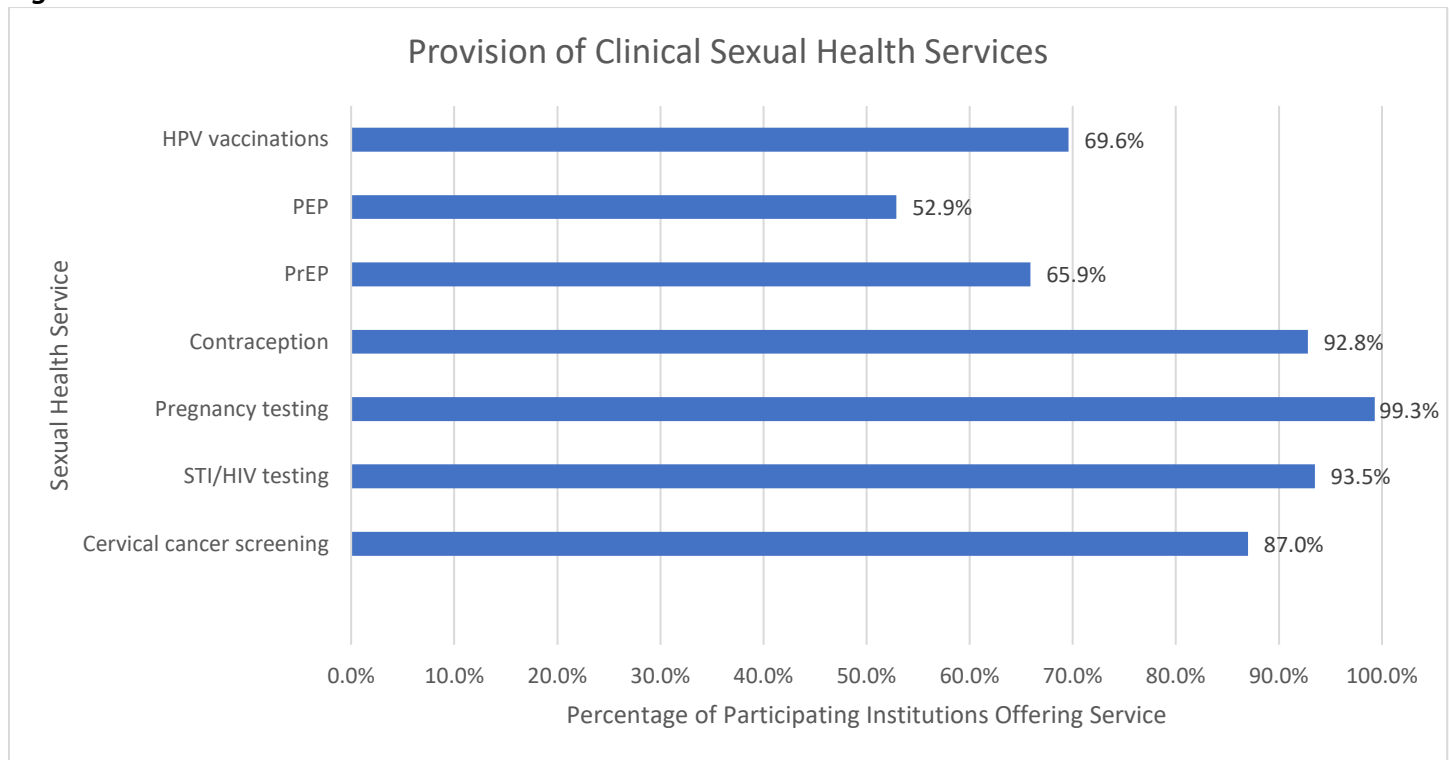
Pap Test Result	Meaning/Significance
Normal/Negative	No intraepithelial lesion or malignancy
Atypical Squamous Cells of Undetermined Significance (ASC-US)	Unclear or inconclusive. Some cells don't look completely normal, but the reason is unclear. May be related to HPV infection, yeast infection, polyps or hormone changes.
Low-Grade Squamous Intraepithelial Lesions (LSIL)	Low-grade changes that are usually caused by infection with HPV
High-Grade Squamous Intraepithelial Lesions (HSIL)	Abnormal squamous cells (cervical cells) that could become cancerous in the future if not treated.
Atypical Squamous Cells, cannot exclude HSIL	Some abnormal squamous cells that may become HSIL, but uncertain.
Atypical Glandular Cells (AGC)	Glandular cells that do not look normal; could signal problems inside the uterus.
Adenocarcinoma in situ (AIS)or (CIS)	Area abnormal growth in glandular tissue of cervix; pre-cancer and may become cancer if not treated.

Table 2

	Frequency	Percent
Total # of Pap tests done (n=120)	23,804	
Normal	20,003	84.0%
ASC-US	1,880	7.9%
LSIL	1,364	5.7%
ASC-H	137	0.6%
ACG or CIS	17	0.1%
Unsatisfactory, no dx	210	0.9%
other dx, not listed above	193	0.8%
no endocervical cells (with any dx above) (n=71)	924	3.9%

STI/HIV testing positivity

- Out of all patients who were assigned female at birth and under age 25, only 13.1% were tested for chlamydia.
- Positivity rates for Human Immunodeficiency Virus (HIV) and Syphilis have remained stable over the last decade, with HIV rates ranging from 0.1% to 0.3% and Syphilis rates ranging from 0.3% to 1.1% (Figure 6; Table 3).
- Gonorrhea positivity rates have remained relatively stable with a notable increase in CY 2021 to 2.1%, which is about 0.5% higher than the second highest rate from the last decade (Figure 6; Table 3).
- Of the patients that tested positive for Herpes Simplex Virus (HSV), the majority (60.5%) continue to be HSV-1.
- The number of patients tested for HSV has more than doubled between CY 2020 and CY 2021, but overall positivity rates decreased from 40.6% to 34.7%.

Figure 6
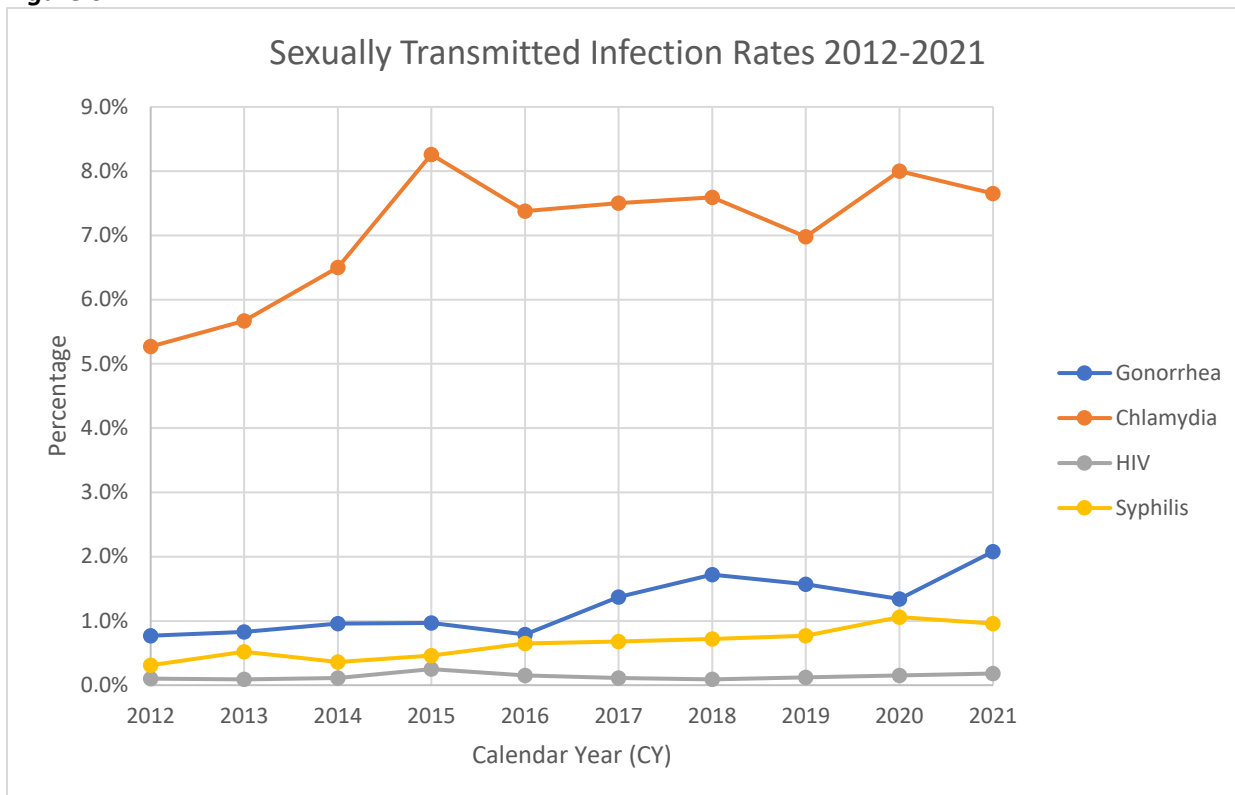
Table 3

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Gonorrhea	0.8%	0.8%	1.0%	1.0%	0.8%	1.4%	1.7%	1.6%	1.3%	2.1%
Chlamydia	5.3%	5.7%	6.5%	8.3%	7.4%	7.5%	7.6%	7.0%	8.0%	7.7%
HIV	0.1%	0.1%	0.1%	0.3%	0.2%	0.1%	0.1%	0.1%	0.2%	0.2%
Syphilis	0.3%	0.5%	0.4%	0.5%	0.7%	0.7%	0.7%	0.8%	1.1%	1.0%

Pregnancy testing positivity

A total of 32,891 pregnancy tests were performed by participating institutions in CY 2021, with 793 (2.4%) of those tests coming back positive. This is the lowest rate in over a decade, dropping from 7.5% in 2011 (Figure 7).

Figure 7
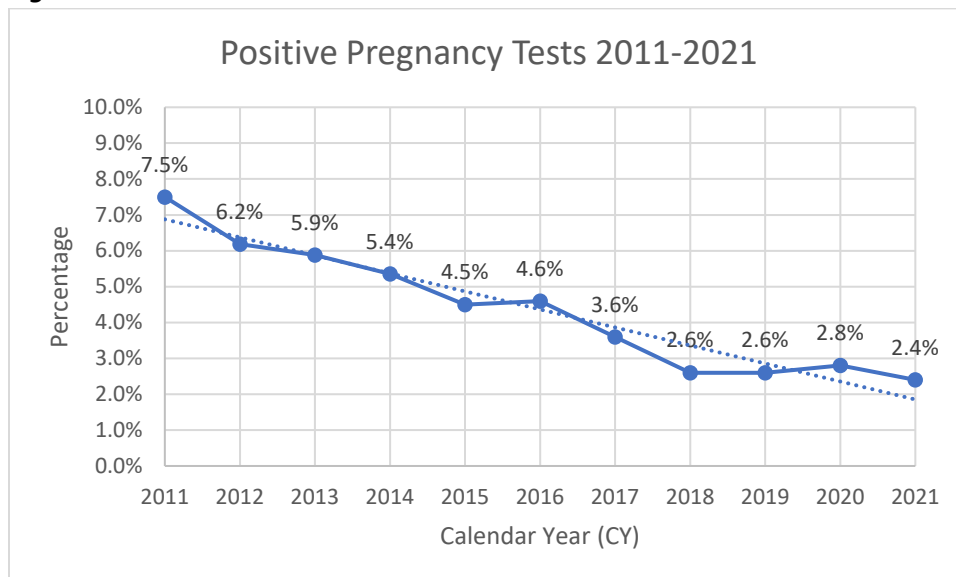
Best Practices Questions

In accordance with ACHA's Best Practices for Sexual Health Promotion and Clinical Care in College Health Settings white paper, published in January 2020, the SHSS for CY 2021 asked participating universities to assess their health center's progress in implementing best practices.

Do not intend to implement	Your health center does not intend to implement the best practice. Reasons may include issues related to legality, policy, lack of buy-in, resources, staffing, etc.
Intend to implement, but have not yet begun	Your health center is able to implement the best practice and intends to do so, but has not yet begun the process due to various constraints. For example, a best practice may be part of an organization's strategic plan but will not be addressed until the end of the current planning cycle.
Implementation in progress	Your health center has begun the process of implementing the best practice (e.g., a meeting has happened to move it forward, policies are currently being drafted, etc.).
Implemented & maintaining	Your health center has implemented the best practice, and is actively working to maintain it (e.g., regular staff trainings, budget line item, ongoing evaluation, etc.).

Incorporate Pleasure and Intimacy into Sexual Health Efforts

Pleasure and sexual satisfaction are important aspects of healthy and fulfilling sexual activity. Just under 3 out of 4 responding institutions provide safer sex supplies with a variety of options to support different types of sexual activity (Table 4, 4). However, less than half (37.9%) included pleasure and sexual satisfaction in their sexual education activities and over half have no intention to create EHR templates that include questions on these subjects (Table 4, 1-3).

Table 4

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining	
	N	%	N	%	N	%	N	%
1 - EHR templates and/or patient questionnaires used during routine wellness visits include questions about	79	56.8%	42	30.2%	4	2.9%	14	10.1%

	N	%	N	%	N	%	N	%	
sexual pleasure and satisfaction.									
2 - EHR templates and/or patient questionnaires used during problem-focused visits for sexual health include questions about pleasure and sexual satisfaction.	75	54.0%	48	34.5%	2	1.4%	14	10.1%	
3 - Health education programs include information about pleasure and sexual satisfaction.	45	32.1%	29	20.7%	13	9.3%	53	37.9%	
4 - Any office providing safer sex supplies provides a variety of options, styles, and sizes, including lubricant.	22	15.4%	7	4.9%	12	8.4%	102	71.3%	

Create a Welcoming Clinic Environment and Provide Inclusive Resources and Services

Only about 1 out of 3 institutions (36.4%) had inclusive and positive sexual health messaging on their websites, while over half require inclusivity training (51.4%) and have a strategic commitment to diverse representations (54.7%) (Table 5, 1, 3-4).

Table 5

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining		
	N	%	N	%	N	%	N	%	
1 - Website has sex-positive messages with same- and different-gender partners, as well as people of different	21	15.0%	44	31.4%	24	17.1%	51	36.4%	

ethnicities, races, gender expressions and physical abilities.								
2 - Posters, brochures and other materials have sex-positive messages with same- and different-gender partners, as well as people of different ethnicities, gender expressions and physical abilities.	13	9.4%	28	20.1%	22	15.8%	76	54.7%
3 - Staff are required to receive training on LGBTQIA+ inclusivity. Training should include informing patients of the confidentiality of sexual orientation and gender identity (SOGI) data.	13	9.4%	33	23.9%	21	15.2%	71	51.4%
4 - Strategic planning or goal setting includes ensuring staff are diverse and represent the communities they serve.	6	4.3%	23	16.5%	34	24.5%	76	54.7%

Considerations for Trans and Non-Binary Students

Supporting trans and non-binary students requires advocating for change on the individual, group, and policy levels. While almost 80% (77.5%) of responding institutions have gender-inclusive bathrooms, almost half (44.4%) do not intend to have clinicians provide gender-affirming hormone therapy for trans and non-binary students (Table 6, 2-4)

Table 6

	Do not intend to implement	Intend to Implement, but have not yet begun	Implementation in progress	Implemented & maintaining

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining		
1 - Policy is in place regarding appropriate staff interactions with trans and non-binary students.	19	13.9%	35	25.5%	19	13.9%	64	46.7%	
2 - Clinicians provide gender-affirming hormone therapy for trans and non-binary students.	63	44.4%	13	9.2%	9	6.3%	57	40.1%	
3 - Student health insurance policy explicitly covers services related to transgender care.	50	37.6%	6	4.5%	9	6.8%	68	51.1%	
4- Gender-inclusive restrooms are available and accessible.	16	11.3%	10	7.0%	6	4.2%	110	77.5%	

Collect Sexual Orientation and Gender Identity (SOGI) Data

Accurately and meaningfully collecting SOGI data is an important step toward health equity as it allows student health centers to identify and address health disparities. More than 4 out of 5 responding institutions were intending to implement, in the process or implementing, or successfully implementing all three SOGI data items (Table 7, 1-3).

Table 7

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining		
1 - EHR templates and/or patient questionnaires include specific field for name the student would like to be called (i.e., lived name), and this field is not referred to as a	22	15.8%	25	18.0%	15	10.8%	77	55.4%	

	N	%	N	%	N	%	N	%
"preferred name."								
2 - EHR templates and/or patient questionnaires include specific field for student's pronouns, and this field is not referred to as "preferred pronouns." An open-ended "other" option is also available.	15	10.9%	24	17.4%	21	15.2%	78	56.5%
3 - EHR templates and/or patient questionnaires include specific fields for gender identity in a two-step process, where student is first asked about gender identity and then their sex assigned at birth. Open-ended "other" options are available.	17	12.2%	44	31.7%	15	10.8%	63	45.3%

Use a Trauma-Informed Approach to Sexual Health Promotion and Clinical Care

Implementing trauma-informed practices during sexual health activities requires a commitment to doing so and subsequent strategic planning. However, about 1 in 5 participating institutions do not intend to infuse trauma-informed approaches into their mission statements or strategic planning activities (Table 8, 1-2). Conversely, health education and promotion efforts at over half of responding institutions infused a number of trauma-informed approaches in their events and activities (Table 8, 7-9).

Table 8

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining	
	N	%	N	%	N	%	N	%

1 - The mission statement for the department or program requires that services are trauma informed.	29	21.3%	54	39.7%	13	9.6%	40	29.4%
2 - Strategic planning or goal setting requires that services are trauma-informed.	25	18.4%	48	35.3%	13	9.6%	50	36.8%
3 - Policies or procedures are in place requiring clinicians to obtain patient histories while patients are clothed.	24	17.0%	23	16.3%	11	7.8%	83	58.9%
4 - Policies or procedures are in place to allow the presence of a support person for the patient during a clinical encounter.	18	12.8%	12	8.5%	10	7.1%	101	71.6%
5 - Policies or procedures are in place requiring clinicians to inform the patient that the patient is in control and is able to stop any clinical encounter at any time.	17	12.1%	23	16.3%	8	5.7%	93	66.0%
6 - Policies or procedures are in place requiring clinicians to use language patient uses for their own anatomy throughout the clinical encounter. EHR templates and/or patient questionnaires reflect this requirement.	36	26.5%	41	30.1%	12	8.8%	47	34.6%
7 - Health education programs always inform the audience of upcoming content -- sometimes called giving a trigger warning -- to empower	14	10.3%	25	18.4%	19	14.0%	78	57.4%

participants to choose whether or not to engage with the material.								
8 - Health education programs always affirm at the beginning that participants are free to leave for any reason at any time during the program to take care of themselves.	11	8.1%	19	14.1%	16	11.9%	89	65.9%
9 - Health education programs relevant to sexual health always set an expectation that participants will use inclusive language and honor participants' use of terms to describe themselves and their bodies.	12	8.9%	22	16.3%	19	14.1%	82	60.7%
10 - Staff are required to be trained in trauma-informed practice.	25	18.2%	55	40.1%	20	14.6%	37	27.0%

Address Confidentiality Concerns

Confidentiality is often a concern for students, especially when it comes to sexual health care. As such, the vast majority of participating institutions are successfully implementing several confidentiality-related best practices (Table 9, 1-4).

Table 9

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining	
	N	%	N	%	N	%	N	%

1 - Policy is in place protecting patient confidentiality to the maximum extent permitted by state law (e.g., explanation of benefits [EOB] is sent to patient, not policyholder).	8	5.9%	4	3.0%	2	1.5%	121	89.6%
2 - Website, EHR templates and/or patient questionnaires inform patients of the ways in which their health information is kept private and/or confidential, as well as any circumstances when information may be disclosed (e.g., Clery Reporting, Title IX). Patients are also informed that they do not have to answer any questions they do not want to answer when receiving services.	6	4.4%	6	4.4%	9	6.6%	116	84.7%
3 - Sexual health services are provided at low or no cost for patients who do not wish to bill their insurance for these services.	15	10.8%	4	2.9%	5	3.6%	115	82.7%
4 - Patient bills or account charges list services generically (e.g., "Student Health Center Fee" instead of "Birth Control Visit").	18	13.6%	6	4.5%	3	2.3%	105	79.5%
5 - Online student health portal explicitly encourages students to have different passwords than ones used for other	63	48.1%	13	9.9%	2	1.5%	53	40.5%
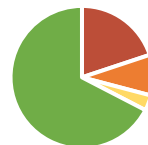
university accounts, and to avoid sharing those passwords with anyone.								

Make Referrals Appropriate

The vast majority of participating institutions are successfully taking steps to make appropriate referrals (Table 10).

Table 10

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining	
	N	%	N	%	N	%	N	%
1 - Organization maintains a referral list for sexuality professionals on campus and in the broader community.	14	10.3%	17	12.5%	9	6.6%	96	70.6%
2 - Policies and procedures are in place to refer a student and/or patient who discloses sexual or relationship violence to services not provided in-house (e.g., mental health services, academic accommodations, etc.)	3	2.1%	5	3.5%	9	6.4%	124	87.9%
3 - Policies or procedures are in place regarding reporting of student and/or patient disclosures of sexual or relationship violence to institution's Title IX and/or non-discrimination office (if required).	3	2.2%	3	2.2%	3	2.2%	130	93.5%

4 - Policies and procedures are in place to refer a trans patient to any gender-affirming care not provided in-house.	12	8.8%	11	8.0%	10	7.3%	104	75.9%
5 - Policies and procedures are in place for linking patients newly diagnosed with HIV to comprehensive medical and mental health care, including referral to Partner Services/Disease Intervention Specialists.	7	5.0%	7	5.0%	7	5.0%	120	85.1%
6 - Policies and procedures are in place to direct clinical staff to refer patients to specialists for complicated STI diagnoses.	6	4.3%	5	3.6%	8	5.7%	121	86.4%

Evaluate Your Efforts

Evaluation is critical to understand what sexual health care and practices are working and what needs additional thought and attention. Efforts to evaluate are mixed across institutions, for example, over 2 out of 3 institutions (67.6%) analyze and use data to evaluate and improve services and programming, but only 31.6% disaggregate clinical data to identify health disparities (Table 11, 2-4).

Table 11

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining	
	N	%	N	%	N	%	N	%

1 - Quantitative data are collected, analyzed and used to evaluate and improve services and programming at least once per year.	8	5.8%	19	13.7%	18	12.9%	94	67.6%
2 - Qualitative data are collected, analyzed and used to evaluate and improve services and programming at least once per year.	10	7.3%	20	14.6%	18	13.1%	89	65.0%
3 - Qualitative and quantitative data collection and analysis is disaggregated to identify and address health disparities for different populations (i.e., by race, ethnicity, sexual orientation, gender identity, first generation status, etc.).	18	13.2%	50	36.8%	25	18.4%	43	31.6%
4 - Qualitative and quantitative data collection and analysis include examination of utilization rates for sexual health services by different populations.	23	17.2%	50	37.3%	23	17.2%	38	28.4%
5 - A summary of evaluation efforts and responses made to improve services and programming is shared with community stakeholders at least once per year.	24	18.2%	38	28.8%	17	12.9%	53	40.2%

Use the Socioecological Model to Improve Sexual Health

Over 75% of institutions are successfully utilizing the socioecological model to guide efforts to improve sexual health and sexual health services (Table 12, 1-4).

Table 12

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining	
	N	%	N	%	N	%	N	%
1 - Interventions emphasize primary prevention.	6	4.3%	6	4.3%	11	7.9%	116	83.5%
2 - Interventions focus on campus life and the many environments in which students live, work and play.	6	4.3%	7	5.0%	12	8.6%	114	82.0%
3 - Interventions address individual, interpersonal, organizational, community and societal levels.	6	4.3%	8	5.8%	18	12.9%	107	77.0%
4 - Interventions are designed in partnership with the student community.	6	4.3%	10	7.2%	15	10.8%	108	77.7%

Implement and Inclusive, Evidence-Based Availability Program for Safer Sex Products

Across all measures, over half of responding institutions are implementing and maintaining inclusive, evidence-based availability programs for safer sex products, this includes providing a diverse range of safter sex products like condoms, dental dams, and lube (Table 13, 1-11). However, many items also had a large percentage of schools with no intention to make these products available (Table 13, 5-10).

Table 13

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining	
	N	%	N	%	N	%	N	%
1 - Safer sex supplies are available to students free of charge.	9	6.3%	1	0.7%	7	4.9%	125	88.0%
2 - Safer sex supplies are located in multiple spaces that are accessible to a variety of students.	15	10.6%	12	8.5%	9	6.3%	106	74.6%
3 - Safer sex product program is publicized to students (e.g., through social media, websites, posters in student spaces, etc.)	22	15.7%	12	8.6%	15	10.7%	91	65.0%
4 - Non-latex safer sex supplies are available.	18	12.7%	14	9.9%	7	4.9%	103	72.5%
5 - Dental dams are available.	35	25.0%	11	7.9%	7	5.0%	87	62.1%
6 - External condoms are available.	13	9.2%	5	3.5%	4	2.8%	119	84.4%

	N	%	N	%	N	%	N	%	
7 - Internal condoms are available.	32	23.0%	19	13.7%	4	2.9%	84	60.4%	
8 - Non-lubricated condoms are available.	35	25.4%	18	13.0%	4	2.9%	81	58.7%	
9 - Latex and/or nitrile gloves are available in multiple sizes.	53	38.1%	13	9.4%	5	3.6%	68	48.9%	
10 - Water-based lubricant is available.	27	19.4%	13	9.4%	5	3.6%	94	67.6%	
11 - Silicone-based lubricant is available.	55	39.9%	17	12.3%	4	2.9%	62	44.9%	

Leverage Social Media

Social media is a powerful tool to disseminate health information and is widely used by the college-aged population, meaning successful utilization of social media is vital to promoting healthy sexuality. 60% of institutions use social media to provide positive messaging around sexual health. Conversely, 1 in 5 institutions do not intend to implement any of the social media best practices described in Table 14.

Table 14

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining	
	N	%	N	%	N	%	N	%

	N	%	N	%	N	%	N	%	
1 - Social media is used to provide positive, engaging messaging about sexual health.	27	19.3%	17	12.1%	12	8.6%	84	60.0%	
2 - Social media metrics (e.g., impressions, shares, reach, etc.) are analyzed to assess effectiveness of content and measure engagement.	31	22.5%	27	19.6%	22	15.9%	58	42.0%	
3 - Social media content is created in consultation with students to amplify their voices regarding sexual health.	30	21.9%	28	20.4%	15	10.9%	64	46.7%	

Be Proactive about Sexual Health with All Patients and Take an Inclusive, Comprehensive Routine Sexual History

The majority of institutions reported conversations and EHR templates to discuss and record information about sexual health, but little work has been done around taking a more extensive sexual health history and/or making changes specifically to support trans and non-binary students (Table 15, 1-4).

Table 15

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining		
	N	%	N	%	N	%	N	%	
1 - Clinicians engage patients in conversations about sexual health, as appropriate, during preventive visits -- not just during problem-focused sexual health visits.	9	6.5%	6	4.3%	10	7.2%	113	81.9%	

	N	%	N	%	N	%	N	%	
2 - EHR templates and/or patient questionnaires use the "8 Ps approach" to obtain sexual history (i.e., Preferences, Partners, Practices, Protection from STIs/HIV, Past History of STIs, Pregnancy, Pleasure, and Partner Violence).	29	21.5%	46	34.1%	19	14.1%	41	30.4%	
3 - EHR templates and/or patient questionnaires on sexual history use open-ended questions with nonjudgmental tone and demeanor.	13	9.4%	14	10.1%	12	8.6%	100	71.9%	
4 - EHR templates and/or patient questionnaires include specific field for an organ inventory to guide screening and management of specific complaints for trans and non-binary patients.	34	25.8%	51	38.6%	14	10.6%	33	25.0%	

Assess Patients' Reproductive Goals

Over 2 out of 3 institutions that responded to each question had no intention to implement best practices related to patient's reproductive goals (Table 16, 1-2).

Table 16

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining		
	N	%	N	%	N	%	N	%	
1 - EHR templates and/or patient questionnaires include field for patient's reproductive goals for the next year.	53	39.8%	44	33.1%	9	6.8%	27	20.3%	

2 - EHR templates and/or patient questionnaires direct clinicians to counsel students desiring pregnancy or not using reliable forms of contraception or who are otherwise capable of pregnancy (i.e., transmasculine students having penis-vagina sex) to take a supplement containing 0.4-0.8 mg of folic acid daily for the prevention of neural tube defects.	49	36.3%	33	24.4%	9	6.7%	44	32.6%

Assess for Trauma and Violence

Policies and EHR templates largely supported or are working toward supporting those impacted by trauma and violence, with (Table 17, 1-2).

Table 17

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining	
	N	%	N	%	N	%	N	%
1 - EHR templates and/or patient questionnaires screen patients for trauma and trauma symptoms using non-gendered language, in private, annually.	25	18.4%	29	21.3%	16	11.8%	66	48.5%
2 - Policies and procedures are in place to provide patients who screen positive for trauma and trauma symptoms with ongoing support or referred to	13	9.5%	17	12.4%	15	10.9%	92	67.2%

appropriate agencies.								

Orient Clinical Care Toward Prevention

Less than 10% of responding institutions had no intention of implementing reminder EHR templates for testing, vaccination, and preventative care (Table 18).

Table 18

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining	
	N	%	N	%	N	%	N	%
1 - EHR templates, patient questionnaires, and/or other clinical decision support tools are used to remind clinicians of testing, vaccination, and other preventive care needs.	12	8.6%	19	13.6%	16	11.4%	93	66.4%

Vaccinations

Vaccination is a powerful public health tool to prevent the spread of infectious disease and illness. Responding institutions are actively doing work around vaccinations for HPV, HAV, and HBV with their students, including over half of institutions in each question already practicing and maintaining the best practice (Table 19).

Table 19

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining	
	N	%	N	%	N	%	N	%
1 - EHR templates and/or patient questionnaires for all patients age 45 years and younger include a question about human papillomavirus	27	19.6%	27	19.6%	6	4.3%	78	56.5%

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining	
(HPV) vaccination status.								
2 - Policies and/or procedures are in place for clinicians to recommend HPV vaccine to all patients age 45 years and younger who are not fully vaccinated.	22	16.1%	24	17.5%	10	7.3%	81	59.1%
3 - Policies and/or procedures are in place for clinicians to recommend vaccination against hepatitis A virus (HAV) for any patients who are men who have sex with men (MSM), who have not previously been vaccinated.	23	17.0%	31	23.0%	10	7.4%	71	52.6%
4 - Policies and/or procedures are in place for clinicians to recommend vaccination for Hepatitis B virus (HBV) for patients not previously vaccinated, patients at risk for HBV infection (i.e., through sexual exposure) or patients requesting protection from HBV without a specific risk factor.	17	12.3%	20	14.5%	13	9.4%	88	63.8%

Cervical Cancer Screening

80% or more of institutions are implementing and maintaining best practices across all cervical cancer screening measures (Table 20).

Table 20

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining	
	N	%	N	%	N	%	N	%

1 - Policies and/or procedures are in place for clinicians to recommend screening for cervical cancer (via Pap test) for all patients with a cervix based on current national guidelines, regardless of sexual activity.	11	7.9%	8	5.7%	2	1.4%	119	85.0%
2 - Policies and/or procedures are in place for clinicians to decide whether to perform a pelvic exam based on medical history or symptoms, in partnership with the patient.	16	11.4%	3	2.1%	4	2.9%	117	83.6%
3 - Policies and/or procedures are in place for clinicians to offer smaller-sized speculums during pelvic exams for patients who have never had penetrative vaginal sex, patients with a physical or psychological sensitivity, or if the patient expresses a preference.	19	13.6%	5	3.6%	4	2.9%	112	80.0%

STI and HIV Screening

With over half of new STIs being in youth aged 15-24[4], STI and HIV screening in accordance with all recommendations is vital prevention work on a college campus. Below outlines best practices for STIs along with the percentage of institutions currently implementing them. Notably, only 51.5% of institutions have 4th generation rapid HIV Ab/Ag POC testing available and 36.8% do not intend to implement it (Table 21, 3).

Table 21

	Do not intend to implement	Intend to Implement, but have not yet begun	Implementation in progress	Implemented & maintaining

	N	%	N	%	N	%	N	%	
1 - Policies and/or procedures are in place to allow asymptomatic patients who have not had a known exposure to be screened for STIs/HIV without a provider visit.	35	25.2%	13	9.4%	10	7.2%	81	58.3%	
2 - Policies and/or procedures are in place to provide routine, opt-out HIV screening following recommendations published by the CDC.	35	25.9%	19	14.1%	3	2.2%	78	57.8%	
3 - 4th-generation rapid HIV Ab/Ag POC testing is available.	50	36.8%	13	9.6%	3	2.2%	70	51.5%	
4 - Policies and procedures are in place to ensure an HIV test is offered when STI testing is requested, and STI testing is offered when HIV testing is requested.	14	9.9%	6	4.3%	4	2.8%	117	83.0%	
5 - Policies and/or procedures are in place for clinicians to screen for STIs at all appropriate anatomical sites, following recommendations published by the CDC and USPSTF, regardless of patient's sexual orientation or gender identity.	16	11.4%	8	5.7%	6	4.3%	110	78.6%	
6 - Policies and/or procedures are in place to permit patients to self-swab when possible, including oral and rectal samples, for self-motivated patients as	28	19.9%	13	9.2%	5	3.5%	95	67.4%	

| | indicated. | | | | | | | | |

Implement Expedited Partner Therapy (EPT) Where Legal

EPT consists of supplying the sex partners of patients diagnosed with chlamydia or gonorrhea with medication without requiring a visit to a healthcare provider[5]. Due to the variability of laws between different states, EPT is not legal in every state, preventing responding institutions from implementing it. Less 40% of participating institutions have implemented each of the best practices listed below (Table 22).

Table 22

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining	
	N	%	N	%	N	%	N	%
1 - At least once per year, the legal status of EPT in the state is reviewed with staff.	47	35.9%	27	20.6%	7	5.3%	50	38.2%
2 - If legal, policies and/or procedures are in place to require clinicians to offer EPT to students.	54	41.2%	25	19.1%	5	3.8%	47	35.9%

Offer Pre-Exposure Prophylaxis (PrEP) as Appropriate

Half of the measures below had more responding institutions that do not intend to implement best practices related to PrEP than institutions who have implemented them (Table 23).

Table 23

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining	
	N	%	N	%	N	%	N	%

1 - Policies and/or procedures are in place to require clinicians to offer PrEP.	48	35.0%	22	16.1%	9	6.6%	58	42.3%
2 - EHR templates and/or patient questionnaires used during routine wellness visits include questions about PrEP.	43	32.6%	40	30.3%	10	7.6%	39	29.5%
3 - EHR templates and/or patient questionnaires used during PEP visit includes a question about PrEP, especially if the patient is in a sexual relationship with someone who is living with HIV.	46	34.8%	39	29.5%	6	4.5%	41	31.1%
4 - Patients eligible for PrEP are provided with resources to navigate insurance and enhance access (i.e., patient assistance programs, community resources, etc.).	26	18.7%	14	10.1%	8	5.8%	91	65.5%
5 - PrEP patients are sent reminders for follow-up appointments.	48	36.1%	33	24.8%	11	8.3%	41	30.8%
6 - PrEP patients who miss their follow-up appointments are contacted to be rescheduled.	43	32.3%	29	21.8%	13	9.8%	48	36.1%

Offer Post-Exposure Prophylaxis (PEP) as Appropriate

PEP is an important responsive tool for those who are exposed or may have been exposed to HIV. However, more institutions do not intend to require clinicians to offer PEP (39.3%) than institutions who have implemented and are maintain offering PEP (38.5%) (Table 24).

Table 24

	Do not intend to implement		Intend to Implement, but have not yet begun		Implementation in progress		Implemented & maintaining	
	N	%	N	%	N	%	N	%
1 - Policies and/or procedures are in place to require clinicians to offer PEP.	53	39.3%	23	17.0%	7	5.2%	52	38.5%

Best Practices: Qualitative Feedback

Participating universities were invited to share additional thoughts and details about the challenges they face at their institutions when working to implement best practices. The biggest challenge described in these responses revolved around lack of resources, specifically not having enough staffing and/or a significant enough budget to implement the best practices. Another notable challenge shared in the responses was around conflicts with either school mission, university's religious affiliation, and/or political landscape.

Recommended Action Steps Based on These Data

Best practice guidelines and other implementation resources for these recommendations can be found in the Resources section at the end of this document.

Working Toward Health Equity
- Work with Electronic Health Record (EHR) carriers to allow sexual health data to be disaggregated according to race, ethnicity, gender identity, and sexual orientation to better identify gaps in equitable access to screening and appropriate diagnosis and treatments.
- Expand student access to preventative sexual health services by offering:
  - Pre-Exposure Prophylaxis (PrEP)
  - Post-Exposure Prophylaxis (PEP)
  - HPV vaccines
- Increase access to STI/HIV testing by:
  - Reducing or eliminating costs of testing
  - Establish avenues of getting STI/HIV tests that do not require insurance, especially for dependents
  - Partnering with the local health department and other local organizations
  - Being knowledgeable about community resources for STI/HIV testing

Best Practices
- Advocate within the student health center to implement the guidance put forward in the Implementation Guide for Best Sexual Health Practices in College Settings developed by the American College Health Foundation with support from Hologic, Inc.

- Add EHR templates that include questions about pleasure and sexual satisfaction.
- Provide gender-affirming hormone therapy to trans and non-binary students.
- Infuse a commitment to trauma-informed practices into health center mission statements and strategic planning.
- Analyze clinical data to identify health disparities and determine strategic priorities and actionable goals.
- Diversify safer sexual health supplies, including offering nitrile gloves, dental dams, and both water-based and silicone-based lubricants.
- Continue to utilize social media to disseminate inclusive, medically accurate, and comprehensive sexual health information.
- Expand EHR templates to be gender-inclusive and collect information that supports the care of trans and non-binary students.
- Require clinicians to offer PrEP and PEP to all students.

Limitations

While CY 2021's survey was open to ACHA member and non-member institutions, it was an opt-in survey that schools elected to participate in, meaning that it may not be generalizable to all college health centers. Additionally, the longer-term healthcare impacts of COVID-19 are still largely unknown, meaning this data does offer some insight into the early impacts of the pandemic, but is simultaneously difficult to meaningfully compare to pre-pandemic data. Finally, questions asking participants to break down data by sex assigned at birth and gender identity were removed because they did not accurately reflect the nuances of sex and identity. While this was a necessary step toward health equity and meaningful data collection, it did mean removing a level of data that had previously been collected. In lieu of collecting this information, a question asking participating institutions about their ability to provide data broken down by gender identity was added.

Resources

- Best Practices for Sexual Health Promotion and Clinical Care in College Health Settings (2020)
- U.S. Preventive Services Task Force Final Recommendation Statement on *Chlamydia and Gonorrhea: Screening* (2021)
- Centers for Disease Control and Prevention *What Should I Know about Cervical Cancer Screening* (2021)
- https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-human-immunodeficiency-virus-hiv-infection-pre-exposure-prophylaxis
- USPSTF PrEP Grade A recommendation
- USPSTF Grade B recommendation

References

1. World Health Organization, 2006. Defining Sexual Health.
2. ACHA, 2021. Sexual Health Services Survey 2020.
3. ACHA, 2020. Best Practices for Sexual Health Promotion and Clinical Care in College Health Settings.
4. Centers for Disease Control and Prevention, 2021. STI Prevalence, Incidence, and Cost Estimates.
5. Centers for Disease Control and Prevention (CDC), 2021. Expedited Partner Therapy.

Appendix: Response Tables

Section 1: Institutional Demographics and Visit Data

Type of Institution

	Schools that provide Sexual Health Services		Schools that do **NOT** provide Sexual Health Services	
	Frequency	Percent	Frequency	Percent
Public 2-year	5	3.6%	2	33.3%
Public 4-year	89	64.5%	1	50.0%
Private 4-year	44	31.9%	3	16.7%
Total	138		6	

Institution Size

	Schools that provide Sexual Health Services		Schools that do **NOT** provide Sexual Health Services	
	Frequency	Percent	Frequency	Percent
Less than 2,500	13	9.4%	2	33.3%
2,500-4,999	11	8.0%	0	0%
5,000-9,999	25	18.1%	3	50.0%
10,000-19,999	27	19.6%	1	16.7%
20,000 and above	61	44.9%	0	0%
Total	138		6	

Region per CDC/HHS

	Schools that provide Sexual Health Services		Schools that do **NOT** provide Sexual Health Services	
	Frequency	Percent	Frequency	Percent
Northeast	32	23.2%	3	50.0%
Midwest	19	13.8%	3	50.0%
South	56	40.6%	0	0%
West	30	21.8%	0	0%
Outside U.S.	1	0.1%	0	0%
Total	138		6	

Campus Setting

	Schools that provide Sexual Health Services		Schools that do **NOT** provide Sexual Health Services	
	Frequency	Percent	Frequency	Percent
City	86	62.3%	3	50.0%
Suburb	32	23.2%	0	0%
Town	17	12.3%	2	33.3%

Rural	3	2.2%	1	16.7%
Total	138		6	

Q6. Health center provides any clinical sexual health services

	Frequency	Percent
Yes	138	95.8%
No	6	4.2%
Total	145	100%

Q6A. Health center provides the following clinical sexual health services (select all that apply) (n=138 health centers)

	Frequency	Valid Percent*
Cervical cancer screening	120	87.0%
STI/HIV testing	129	93.5%
Pregnancy testing	137	99.3%
Contraception	128	92.8%
PrEP	91	65.9%
PEP	73	52.9%
HPV vaccinations	96	69.6%

*Sum is > 100% because respondents could select more than one response

Q6B. EHR products currently being used at health center (n=138)

	Frequency	Valid Percent*
Careflow	0	0.0%
Cerner	4	2.8%
GE Centricity	0	0.0%
E-ClinicalWorks	4	2.8%
EPIC	8	5.6%
Magnus Health	0	0.0%
Medicat	41	28.5%
NextGEN	2	1.4%
NueMD	0	0.0%
Point and Click Solutions	42	29.2%
Practice Fusion	0	0.0%
PyraMED	14	9.7%
Titanium	2	1.4%
None- we use paper only	3	2.1%
Other EHR product (please specify):	4	2.8%

*Respondents could select more than one response

Q6C. Clinical data can be broken down by the following categories at your health center (select all that apply) (n=138 health centers)

	Frequency	Valid Percent*
Assigned sex	106	77.4%
Gender identity	51	37.2%
Race/ethnicity	72	52.6%
Sexual orientation	18	13.1%

Q7. Health Center Visits (includes both in-person and telemedicine) (n=131)

	Total number of student medical visits to your health center in 2021	Number of virtual/telemedicine visits
Mean	15,057	2,862
Median	7968	573
Minimum	0	0
Maximum	85,276	31,087
Sum	1,972,542	374,982

Section 2: Surveillance

Q8. CY 2021 Summary of all Pap test results

	Frequency	Percent
Total # of Pap tests done (n=120)	23,804	
Normal (n=120)	20,003	84.0%
ASC-US (n=120)	1,880	7.9%
LSIL (n=120)	1,364	5.7%
ASC-H (n=120)	137	0.6%
ACG or CIS (n=120)	17	0.1%
Unsatisfactory, no dx (n=120)	210	0.9%
other dx, not listed above (n=120)	193	0.8%
no endocervical cells (with any dx above) (n=71)	924	3.9%

Q9. CY 2021 Chlamydia testing
Out of 385,299 female patients under age 25 seen for any reason at 89 health centers, 51,401 were tested for chlamydia (13.3%).

Q10-Q13 CY 2021 STI/HIV Positivity

	Gonorrhea (n=111)	Chlamydia (n=110)	HIV (n=113)	Syphilis (n=112)
# tested	139,937	139,180	52,137	42,422
# positive	2,912	10,652	93	407
Positivity Rate (%)	2.08%	7.65%	0.18%	0.96%

Q14. CY 2021 Herpes Positivity

	HSV overall
# tested	5986
# positive for HSV-2	378
# positive for HSV-1	1255
# positive for type unknown	443
Total positive for any type	2,076 (34.7%)

14. CY 2021 Breakdown for all positive Herpes tests

	All patients
Positive for HSV-2	378 (18.2%)
Positive for HSV-1	1255 (60.5%)
Positive for type unknown	443 (21.3%)
Total positive for any type	2,076

15. Number of patients diagnosed with trichomoniasis in 2021: 251 at 108 schools

16. Number of patients diagnosed with bacterial vaginosis in 2021: 11,738 at 105 schools

17. Number of patients diagnosed with genital warts in 2021: 711 at 101 schools

Section 3: Pregnancy Testing

18. CY 2021 Number of Pregnancy tests done (n=123)

	All patients
Number of Pregnancy tests done	32,891
Positive pregnancy tests	793
Positivity Rate (%)	2.4%