AMERICAN COLLEGE HEALTH ASSOCIATION

ACHA 2022 Sexual Health Services Survey

SURVEY REPORT

Issued October 25, 2023

Table of Contents

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.

We need look no further than the Tuskegee Study and the histories of contraception and the HIV pandemic to understand 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 cannot do this without consistent data collection and disaggregation. 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 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 such, future versions of this survey will ask SHSs to respond to surveillance questions according to race, ethnicity, sexual orientation and gender identity.**

We recognize that many SHSs will not have the ability to provide this information due to EHR and laboratory reporting limitations. For some illustration, our calendar year (CY) 2022 data presented in this report showed that only 60.2% of SHSs have the ability to run reports on gender identity data, and only 41.4% of SHSs have the ability to run reports on sexual orientation data.

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 student bodies 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.

In order 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. Changes were made to the survey again starting in CY 2020 to streamline data analysis and to reflect changes in guidelines and best practices.

As was announced during the CY 2020 survey cycle (the cycle of this report), there are now two versions of the survey that are distributed on alternating years. 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 Impact of the COVID-19 Pandemic

The COVID-19 pandemic continues to impact institutions of higher education in both known and unknown ways. National, state, and local stay-at-home orders that began in March of 2020 forced college health practitioners to transition their programs and services to virtual environments, while also trying to address the pandemic on their campuses. As such, the provision of sexual health services on many campuses was largely prioritized well below the immediate need to respond to COVID-19.

Since transitioning out of the national state of emergency, data in forthcoming years will be particularly valuable in gaining insight to the longer-term impacts of COVID-19. For example, health centers continue to see an increase in virtual visits compared to pre-pandemic practices. Additionally, in light of the pandemic, institutions of higher education continue to see a number of students enrolling in both in-person and online courses, which impacts students' presence on campus and how they utilize services.

Methods

This report contains data collected by ACHA Member Institutions for Calendar Year 2022 (January 1 - December 31) according to the Even 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 2022 to May 2023.

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.

ACHA Institutional Members were asked to participate in the survey, and non-member institutions were also welcome to participate. We did not receive any submissions from non-member institutions. Therefore, 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

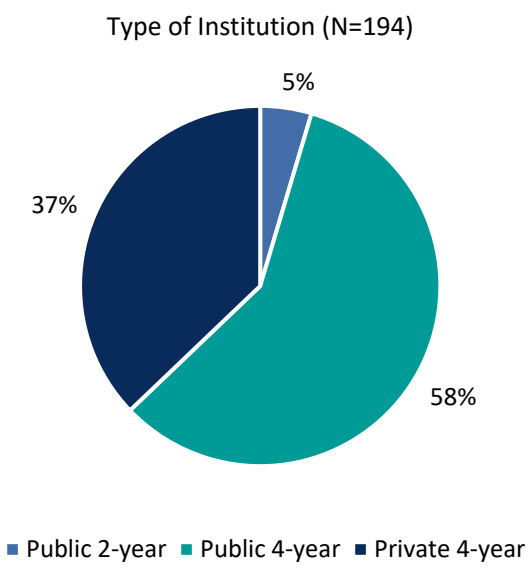
Not all laboratories and electronic health record systems (EHRs) collect and report gender identity data according to best practices that recognize and affirm trans and non-binary people[1]†. Past versions of the survey have attempted to better capture gender identity data by including "transgender" 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 2022, 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 60.2% of participating institutions currently have the ability to disaggregate their data based on gender identity. We know that there is still a 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.

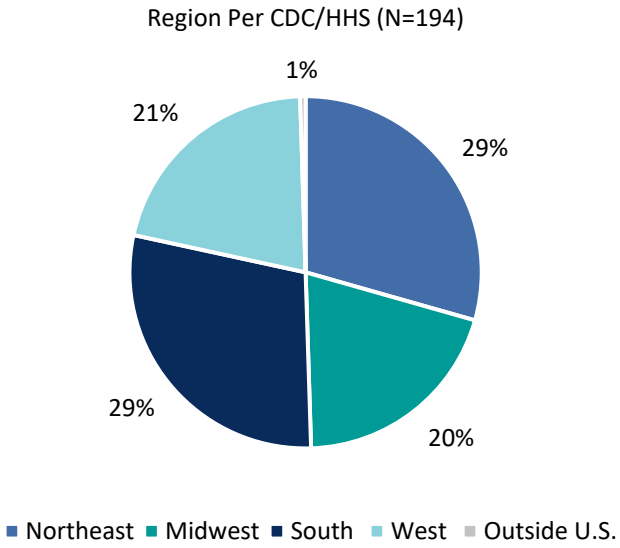
[1] †Collecting and reporting gender identity data is separate and distinctly different from collecting sex assigned at birth. According to ACHA's January 2020 Best Practices for Sexual Health Promotion and Clinical Care in College Health Settings document, it is recommended to collect this data "in 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".

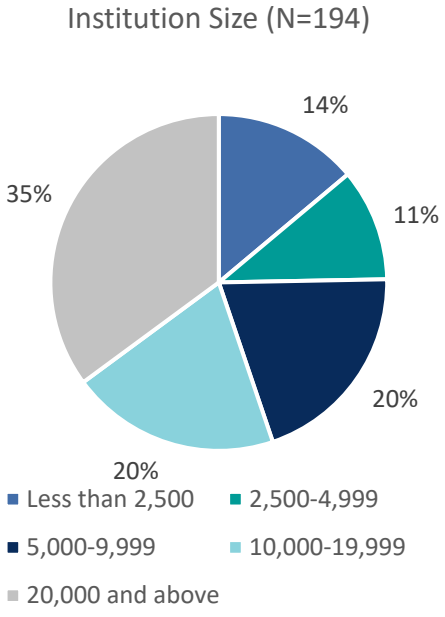
Findings

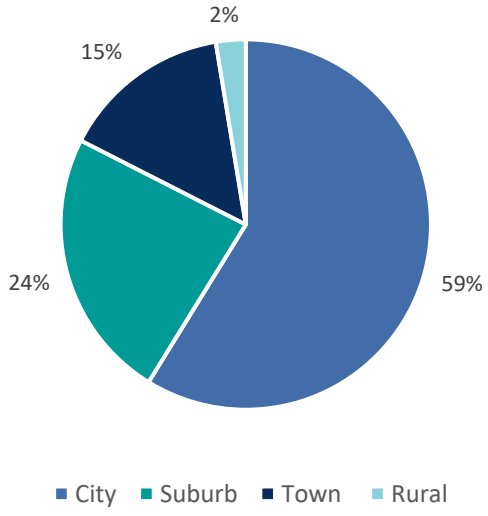
Demographics

Over the past several years, the number of participating institutions has ranged from a high of 181 in CY 2011 to a low of 113 in CY 2017. However, a record 209 schools completed the survey for CY 2022. Of these schools, 194 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 (58.2%) and schools with student populations of at least 20,000 (35.1%). All were institutional members of ACHA.









Clinical Data Disaggregation

In CY 2021, ACHA sought to better understand the clinical data disaggregation capabilities of participating institutions 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. As such, ACHA continued to collect this information in CY 2022. The most commonly used EHRs in CY 2022 are Point and Click Solutions (33%), Medicat (28.2%), and PyraMED (12.9%). All other EHRs are used by less than 10% of responding institutions. This year, more SHSs report the ability to disaggregate data based on the above-mentioned categories (Table 1). However, despite the ability to do so, most health centers do not run these reports (Table 2).

Table 1

Ability to disaggregate data based on:	**Valid percent (2021)***	**Valid percent (2022)***
Assigned sex	77.4%	83.1%
Gender identity	37.2%	60.2%
Race/ethnicity	52.6%	77.4%
Sexual Orientation	13.1%	41.4%

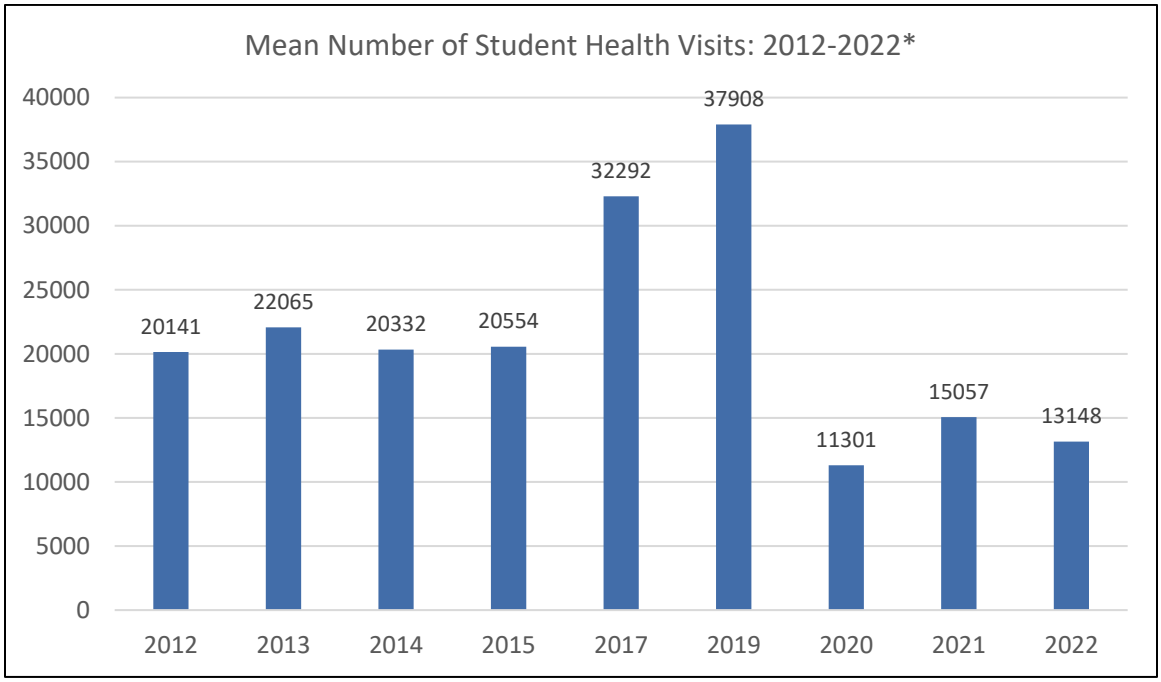
Table 2

Runs reports based on the following categories:	**Valid percent***
Assigned sex	55.6%
Gender identity	31.1%
Race/ethnicity	47.5%
Sexual orientation	17.3%

Clinic Utilization

This report represents sexual health data collected from within more than 2.4 million medical visits at student health services, nearly double the number of visits for CY20, though still notably less than pre-COVID-19 pandemic years. Nearly 11% of these visits were telehealth appointments. The mean number of student visits per calendar year are depicted in figure 1.

Figure 1



*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

While almost all of the institutions offering clinical sexual health services (N=194) responded that they offered pregnancy testing (99.0%), STI/HIV screening (94.8%), and contraception (91.8%), approximately two-thirds of SHSs offered PrEP (62.9%) and half offered PEP (50.5%) (see Figure 2). The under-provision of PrEP and PEP has been a consistent finding of this report over the last several years. Similarly, only 60.8% provided HPV vaccinations, a decrease from CY 2020. See Figures 3-4.

Figure 2

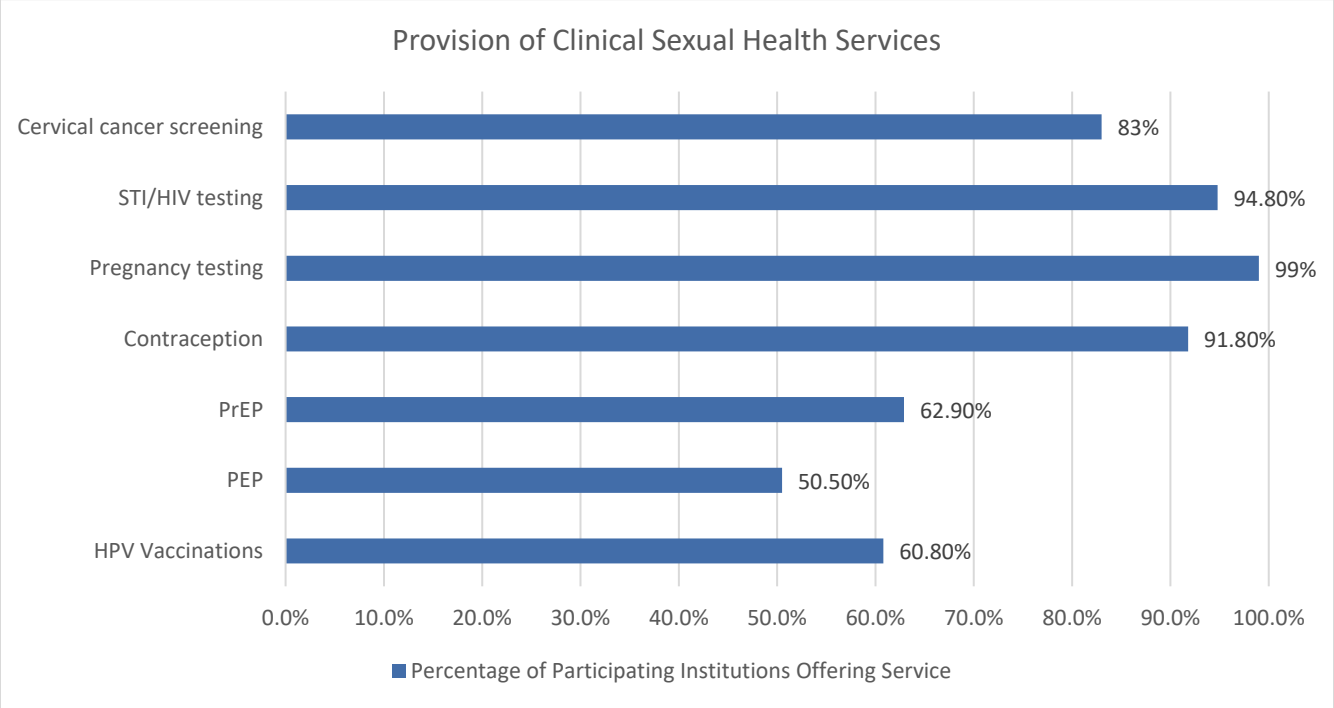
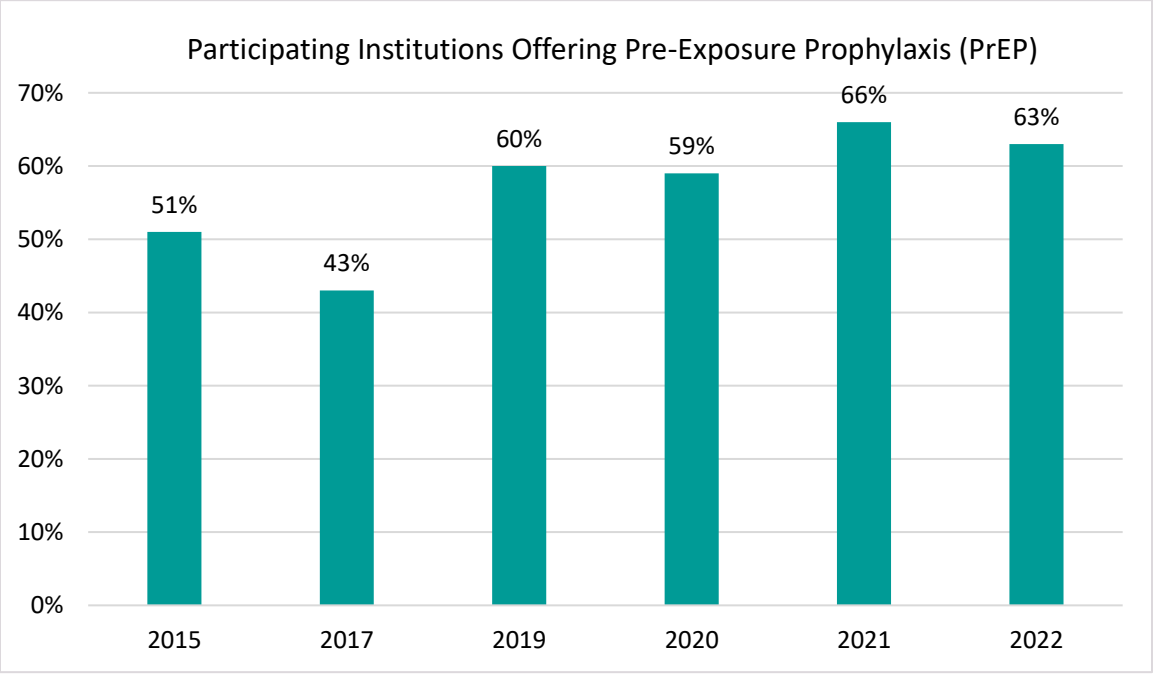
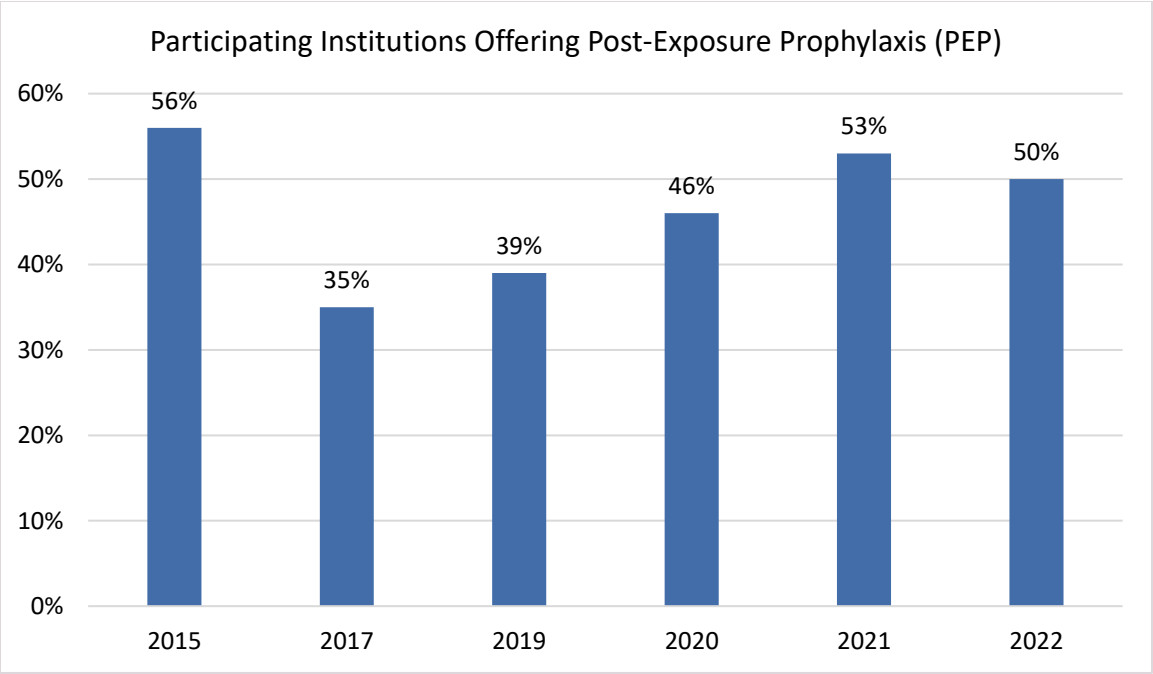


Figure 3



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

Figure 4



Surveillance Questions

Cervical cancer screening outcomes

- In 2022, SHSs conducted 32,035 total pap tests, more than double the number from 2020, likely due to fewer routine visits during the pandemic.
- 85.5% of Pap tests were reported as normal. Additionally, 6.8% were atypical squamous cells of undetermined significance (ASC-US) and 4.8% were low-grade squamous intraepithelial lesions (LSIL). See Figures 5-7.
- There was a slight decrease in the percentage of ASC-H results, from 0.9% in 2020 to 0.5% in 2022. There was an increase in the percentage of AGC or CIS results, from 0.01% in 2021 to 0.10% in 2022.

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	Abnormal squamous cells (cervical cells) that could become cancerous

Intraepithelial Lesions (HSIL)	in the future if not treated.
Atypical Squamous Cells, cannot exclude HSIL (ASC-H)	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 of abnormal growth in glandular tissue of cervix; pre-cancer and may become cancer if not treated.

Figure 5

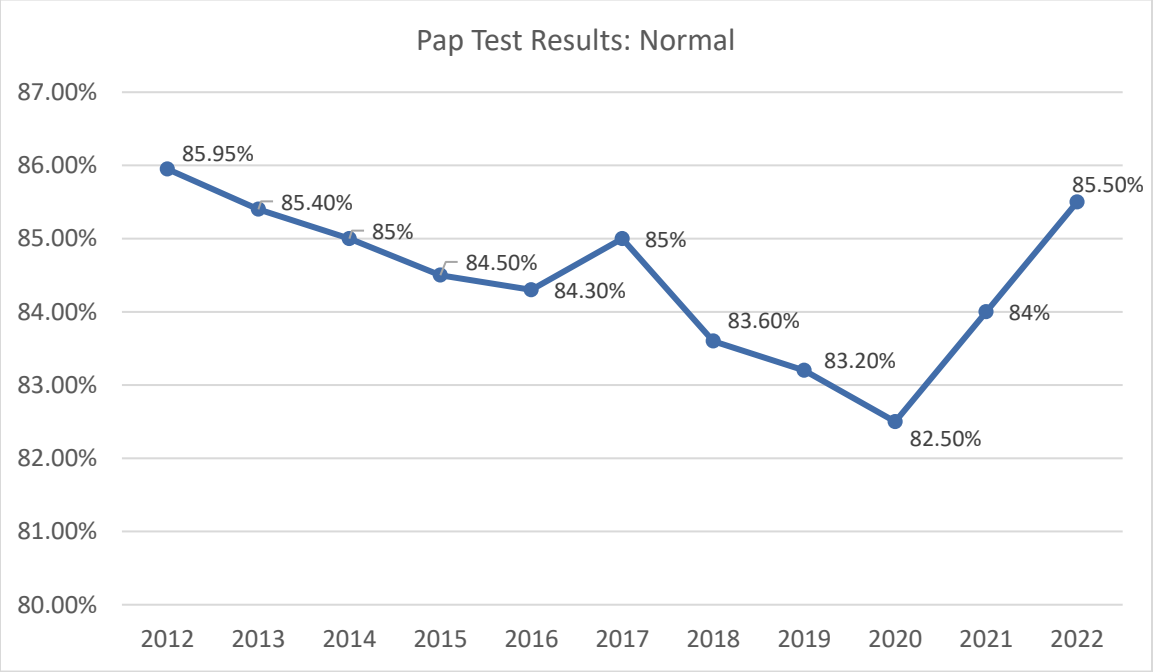


Figure 6

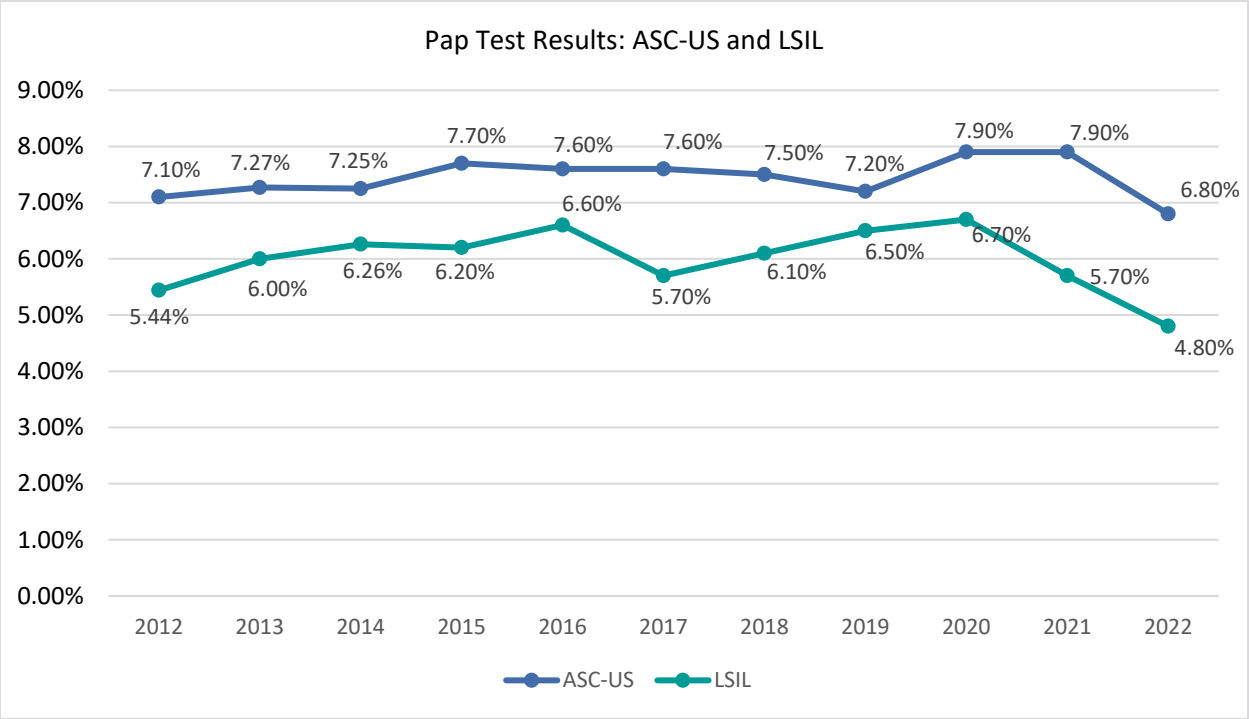
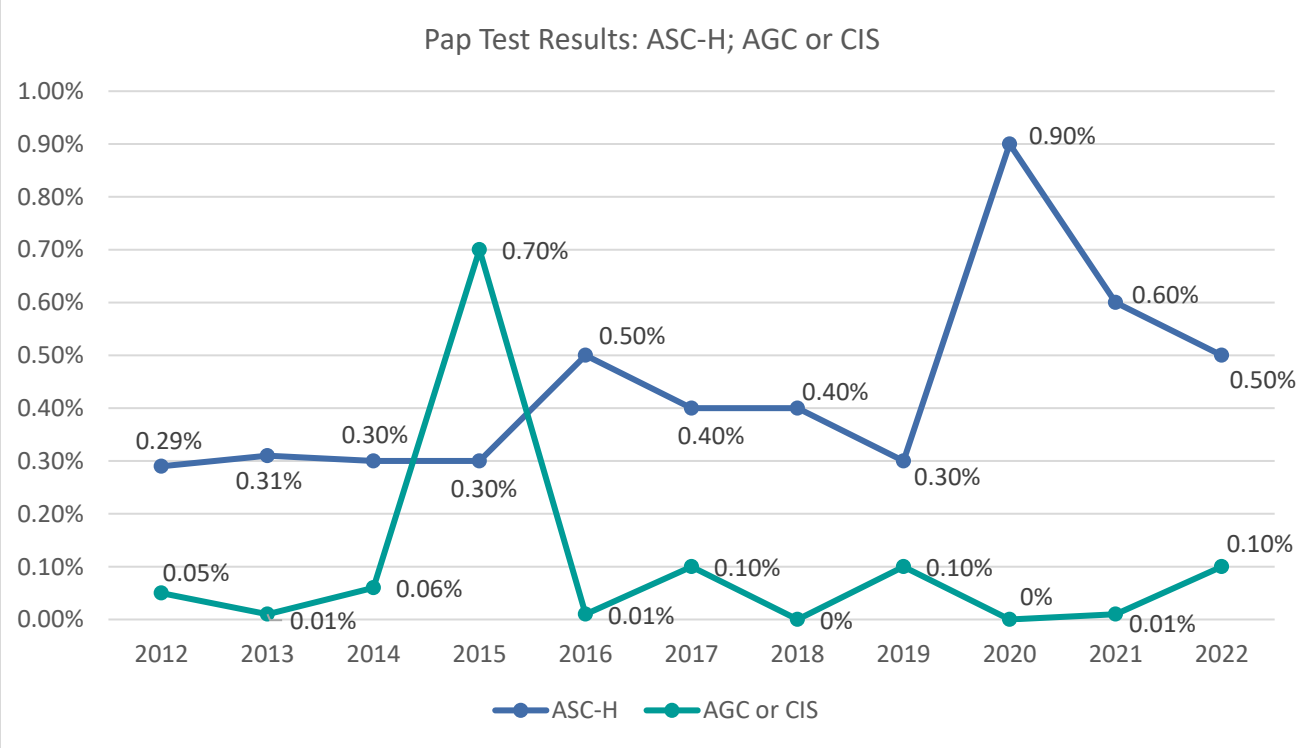


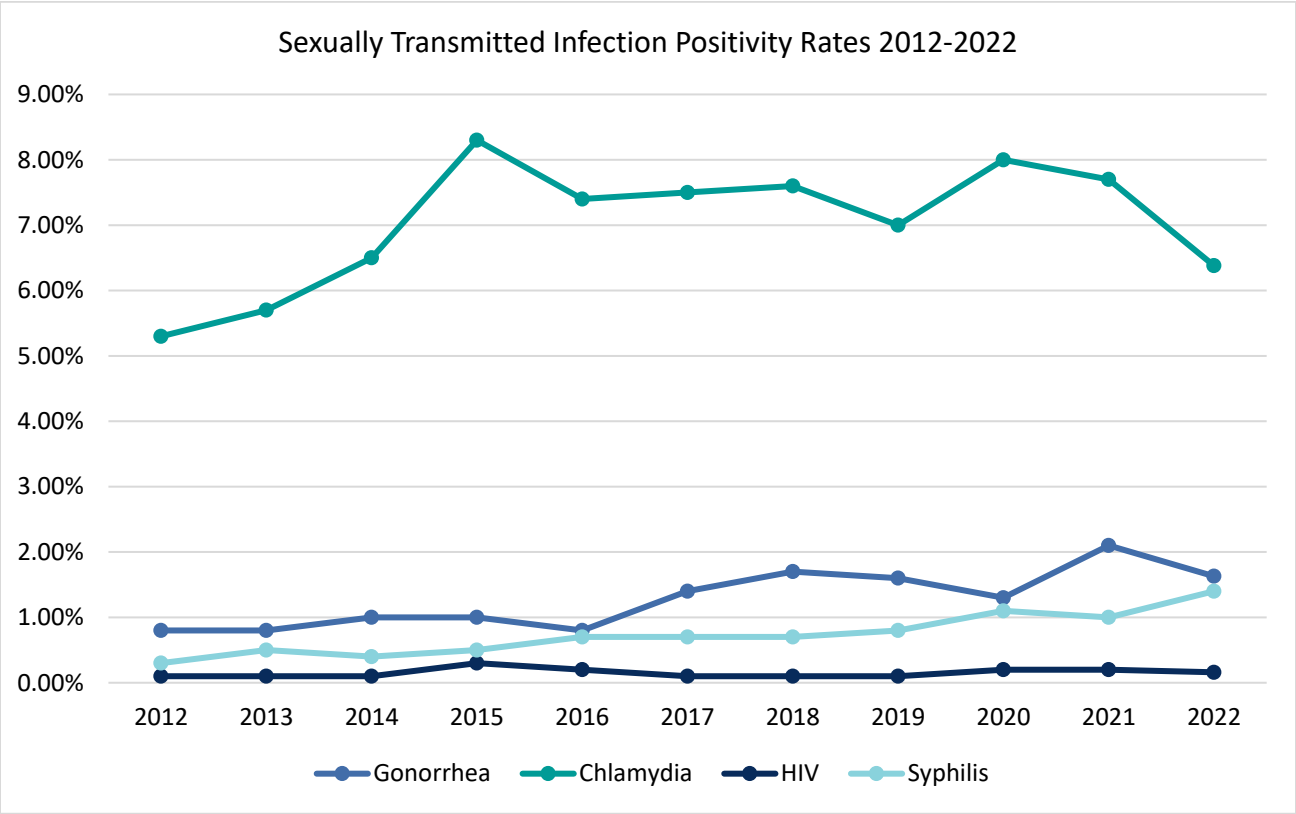
Figure 7



STI/HIV testing positivity

- Out of all patients assigned female at birth and under age 25, only 16% were tested for chlamydia. However, the positivity rate for chlamydia declined from 7.7% in CY 2021 to 6.38% in CY 2022.
- 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%.
- As shown in Figure 8, positivity rates for Syphilis have steadily increased in the last ten years.
- Of the patients who tested positive for Herpes Simplex Virus (HSV), the majority (66.3%) continue to be HSV-1. This shows an increase in positivity for HSV-1 from 60.5% in CY 2021.
- In CY 2022, there were 362 cases of trichomoniasis diagnosed at 160 schools, 13,542 cases of bacterial vaginosis diagnosed at 152 schools, and 1,048 cases of genital warts diagnosed at 152 schools.

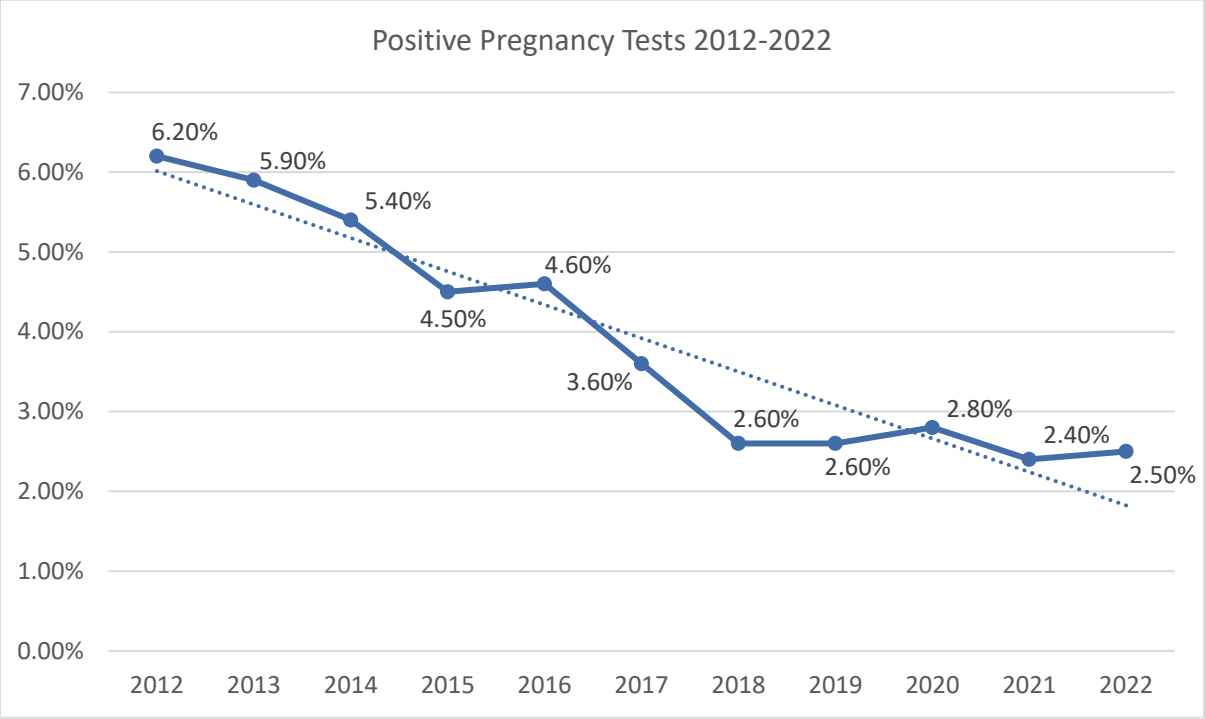
Figure 8



Pregnancy testing positivity

A total of 42,431 pregnancy tests were performed by participating institutions in CY 2022, a nearly 10,000-count increase from CY 2021 (32,891 tests). In CY 2022, 1,055 (2.5%) pregnancy tests were positive. Although this rate is 0.1% higher than CY 2021, pregnancy test positivity rates overall continue to decline (Figure 9).

Figure 9



General Practice Questions

Management of cervical cancer screening results

- The majority of institutions (51.6%, n=83) reported repeating a Pap test in 12 months as the usual practice for management of a first screening pap for patients under age 25 reported as ASC-US. The other most commonly reported practice was performing HPV DNA testing (33.5%).
- When queried about the usual cervical cytology screening test used for ages 21-24, most institutions (72%, n=116) reported using liquid-based cytology with reflex HPV-testing for ASC-US or LSIL.

STI/HIV testing practices and services

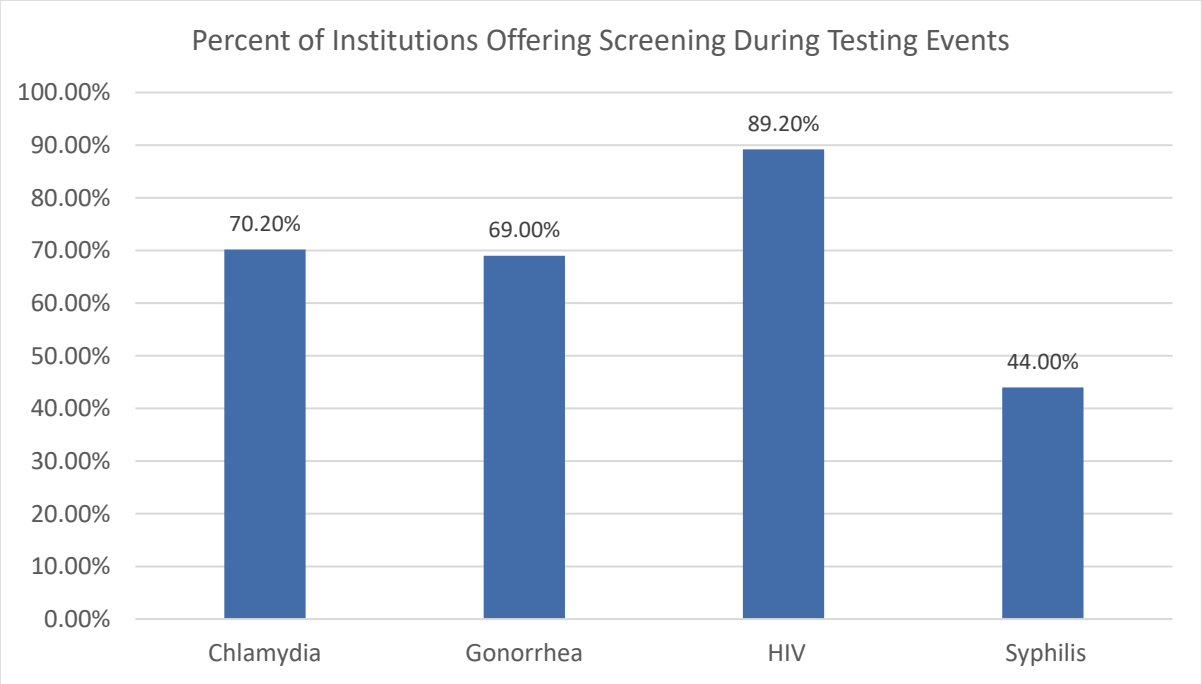
Extragenital Testing

- Over half of SHSs (57.9%) provided pharyngeal tests for chlamydia and gonorrhea screening for patients who perform oral sex on a penis.
- Some SHSs (16.4%) report that they only provide pharyngeal chlamydia and gonorrhea screenings for men who have sex with men (MSM).
- Similar numbers were reported for provision of rectal tests for chlamydia and gonorrhea screening for patients who received anal sex (58.5% of SHSs provide rectal screening, and 16.4% provide rectal screening only for MSM).

STI/HIV testing events

- Participating institutions were asked whether the SHS organizes a specific STI/HIV testing event on campus. Approximately 40% of institutions (n=84) indicated organizing such events.
- Of the SHSs that organize testing events, 42.9% (n=36) conduct events once per academic term.
- The tests at these events are administered primarily by a community organization or local health department (50%).
- Specific tests offered during such events include chlamydia (70.2%), gonorrhea (69%), HIV (89.2%), and syphilis (44%) (Figure 9).
- Of the institutions organizing testing events, 90.5% (n=76) offer free testing during the event.

Figure 9



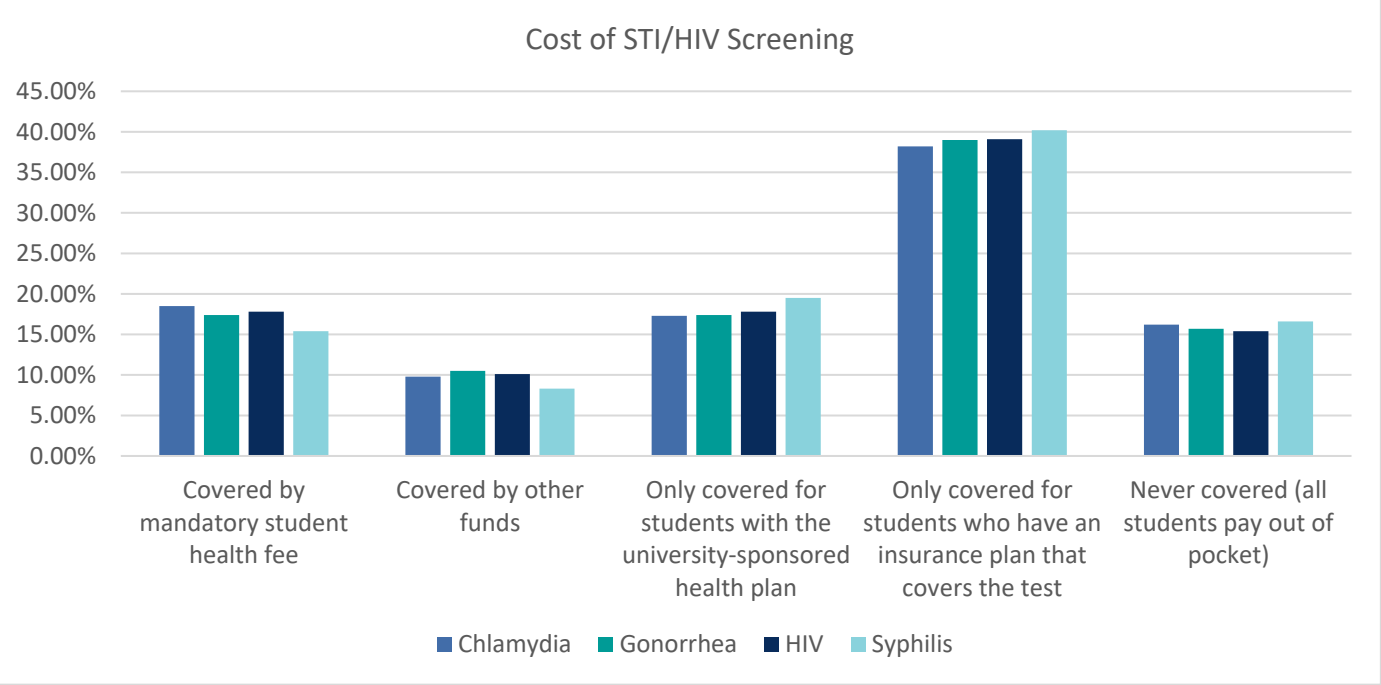
Anonymous HIV Testing

- Anonymous HIV testing is provided by 33.7% of SHSs, either by health center staff themselves or in partnership with a community organization or local health department. This rate decreased from CY 2020, when 37.5% of participating institutions reported offering anonymous HIV testing.
- 64% of SHSs report referring patients to community organizations and/or local health departments for anonymous HIV testing.
- Only 2.2% (n=4) of responding institutions report that anonymous testing is illegal in their state.

Cost of STI/HIV Screening (Figure 10)

- Approximately 40% of SHSs pay for various STI screenings by billing the student's insurance plan.
- In other instances, a mandatory student health fee or other fund source covered screening with no cost-sharing for all students.

Figure 10



Contraception provision

- In CY 2022, 74.1% of SHSs report providing OTC emergency contraception (EC), a 2% increase in provision since CY 2020. Furthermore, 11.8% of SHSs provide free OTC EC.
- Approximately 1 in 4 SHSs (n=46) do not provide OTC EC at their facilities.
- 68% of SHSs provided prescription EC (Ella). Less than half of SHSs (48.3%) dispense Ella through their clinic. While this is the same number of SHSs able to prescribe Ella, CY 2022 respondents report a decrease in ability to dispense Ella compared to CY 2020 (nearly 2 out of 3 SHSs dispensed Ella in the previous reporting cycle).
- Only 19.7% of SHSs provided the copper IUD as EC in CY 2022 (compared to 18% in CY 2020). In CY 2022, 20.2% of SHSs report that they neither provided this option nor referred to an outside provider, a five percent decrease from CY 2020.
- Provider-administered contraceptive methods, including long-acting reversible contraceptives (LARCs) such as IUDs and implants, have higher rates of effectiveness with regard to preventing pregnancy. However, CY 2022 saw a slight decline in the number of SHSs administering these forms of contraception. See Figure 12.

Figure 11

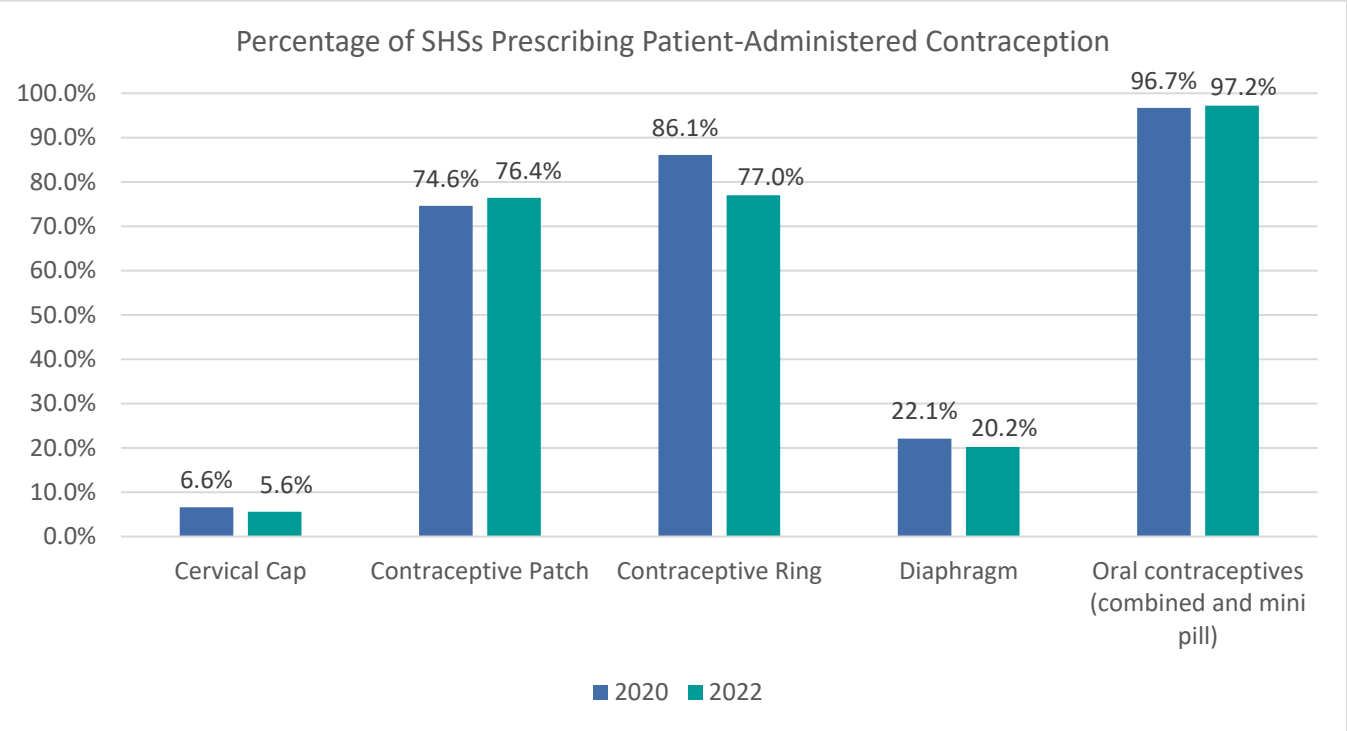
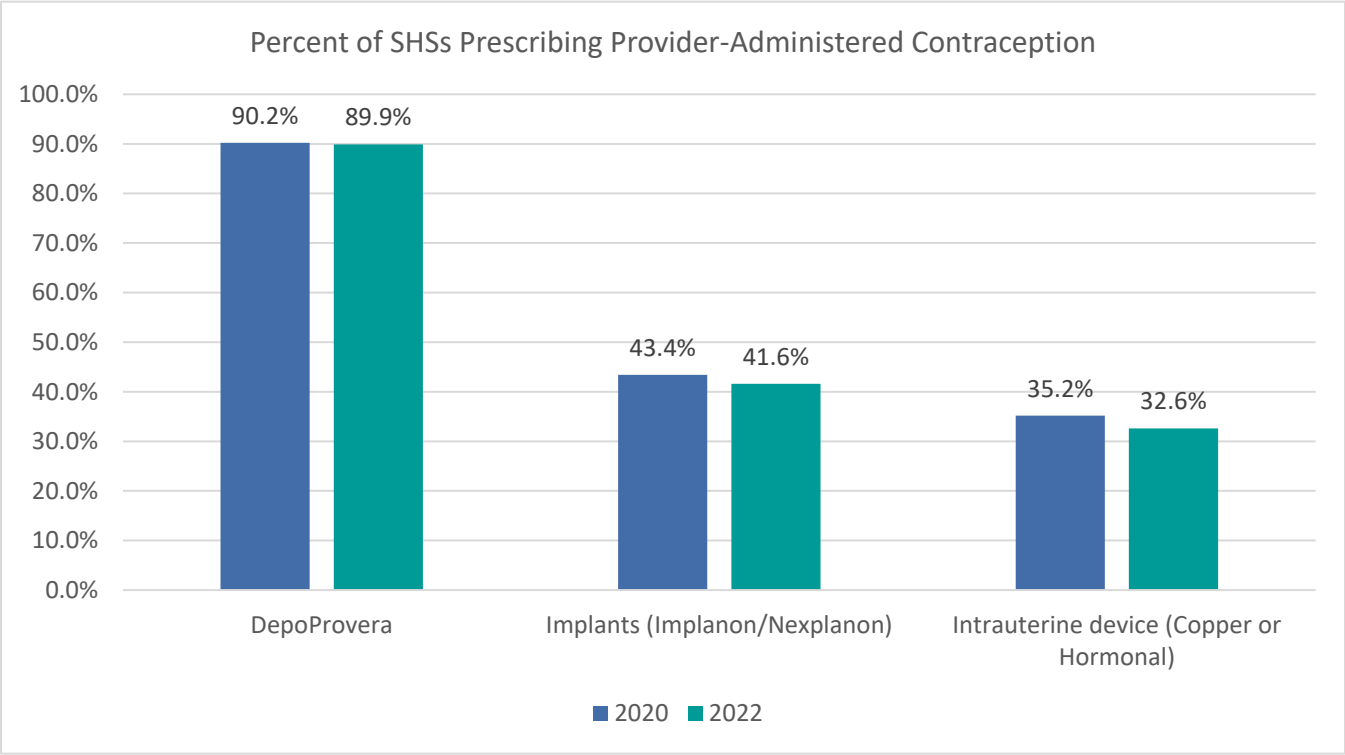


Figure 12



Services provided after positive pregnancy tests

- The majority of participating institutions provide counseling for either adoption services (67.4% of SHSs), abortion services (67.4%), or prenatal care (74.7%) following a positive pregnancy test.
- Similarly, most institutions provide referrals for the above-mentioned services and care.
- When asked about services available for students with a positive pregnancy test, 4.5% of SHSs reported that they are unable to provide referrals for abortion services due to legal limitations or school policy. Additionally, almost 10% of responding SHSs declined to answer when asked about referrals for abortion services.
- Less than 10% of responding institutions provide medication abortion services and less than 10% provide prenatal care at their SHS. Less than 3% of SHSs provide surgical abortion.
- Please see the complete table on page 35 in the appendix of this report.

Recommended Action Steps Based on These Data

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

Working Toward Health Equity

- Periodically disaggregate all clinical data according to race, ethnicity, gender identity and sexual orientation to identify gaps in equitable access to screening and appropriate diagnosis and treatment.
    - Gaps may include:
        - HPV vaccination uptake
        - Rates of new STI/HIV infections
        - STI/HIV testing uptake
        - Contraception use
        - Access to screening, diagnosis, and treatment of cervical precancer or cancer in a timely fashion

Cervical Cancer Screening and Management

- Follow appropriate cervical cancer screening guidelines
    - Perform first screening at age 21
- Follow appropriate guidelines for management of abnormal cervical cancer screening results
    - Current guidelines for the management of a first screening Pap test reported as ASC-US (either without HPV results or positive HPV) in women under age 25 recommend repeating cytology in 12 months as the preferred practice for management[3]
    - Place emphasis on personalized management based on the patient's risk of having or developing CIN 3+ and incorporate new test methods as they become available.
- Stay updated on current guidelines and use available technology to assist with decision-making

STI/HIV Prevention and Testing

Improving Access

- Advocate for coverage of STI/HIV testing via mandatory health fee or other fund to increase access and eliminate patient's need to navigate insurance -- especially if they are dependents
- Consider partnering with your local health department and/or AIDS service organization to provide free STI/HIV testing on campus on a regular basis
- Know where anonymous HIV testing is provided in the community (where legal) so that you can refer students who desire this service

Clinical Services

- Offer HPV vaccinations
- Screen all sexually active female patients under 25 for chlamydia annually
- Screen all appropriate anatomic sites for chlamydia and gonorrhea according to comprehensive sexual history, regardless of patient's gender identity
- Offer pre-exposure prophylaxis and post-exposure prophylaxis to reduce risk of HIV acquisition
- Offer expedited partner therapy (EPT) -- where legal -- to treat partner(s) and reduce risk of STI transmission
- Screen for HIV when screening for other STIs
- Provide routine, opt-out HIV testing in clinical settings

Reproductive Health

- Assess patients' reproductive goals to guide counseling and recommendations
- For those who do not desire pregnancy, begin contraceptive counseling by describing options in order of effectiveness (i.e., from long-acting reversible contraceptives to withdrawal)
- Provide all-options counseling for those with a positive pregnancy test
- Increase provision of copper intrauterine devices (IUDs) as emergency contraception (EC) to provide the most effective option for students of any weight
    - Over-the-counter (OTC) EC and prescription EC (ella) may not be as effective for those who weigh more than 165 and 195 pounds (respectively)
    - According to the Spring 2022 Undergraduate Reference Group Report of the National College Health Assessment, more than 1 in 3 (37%) cisgender women reported that they weighed more than 150 pounds, and 10% reported that they weighed more than 200 pounds.[3] The lack of wide provision of the copper IUD as EC among SHS in this sample is concerning, as the other EC options may not be as effective for a third of our students.
- Advocate for access to various forms of sexual and reproductive healthcare including education, counseling, testing for sexually transmitted infections and HIV, access to contraceptive options, emergency contraception, preconception counseling, pregnancy and postpartum care, and abortion.

Limitations

- The sample consists of only ACHA member institutions and may not be generalizable to all college health centers.
- The data in this report was collected for CY 2022, and the difference in some numbers (such as marked increase of clinic visits and pap tests) compared to CY 2020 could reflect the transition out of the COVID-19 pandemic. The survey also did not differentiate between telehealth and in-person visits. As previously mentioned, the offering of telehealth visits is also a likely outcome of the pandemic. While this option may increase access for some students, this makes it difficult to compare results from the CY 2020 and CY 2022 surveys with other years.
- As noted in the General Practice Questions section, 10% of responding institutions declined to answer when asked about providing referrals for abortion services. While it has also been noted that access to abortion is increasingly restricted in many states, this data reflects CY 2022. In the aftermath of the *Dobbs v. Jackson Women's Health Organization* ruling in June 2022, it is possible that SHSs in many states may have unclear guidelines and/or rapidly changing laws regarding abortion services. Thus, institutions may have opted to decline a response rather than answer “no” or “not legal in my state” due to the changing political climate around reproductive healthcare.
- Caution should be used when comparing Sexual Health Services Survey figures between data collection periods. Participating institutions change from year to year and any differences observed may be attributed to changes in the sample and not a true change in experience at the same clinics.

Resources

ACHA Resources:

- Best Practices in Sexual Health Promotion and Clinical Care in College Health Settings.
- Implementation Guide for Best Sexual Health Practices in College Setting
- HIV Pre-Exposure Prophylaxis Guidelines
- Webinars from the American College Health Foundation and Hologic, Inc.:
    - (Re)Introducing Best Practices in Sexual Health Promotion & Clinical Care in the COVID-19 Era (September 25, 2020)
    - Case Studies: Best Practices in Sexual Health Promotion & Clinical Care in College Health Settings (November 13, 2020)

Other Resources:

- United States Preventive Services Task Force (USPSTF), 2018. Cervical Cancer: Screening.
- American Cancer Society. 2020 Guideline Update: Cervical cancer screening for individuals at average risk.
- American Society for Colposcopy and Cervical Pathology. 2019. Risk-based management consensus guidelines for abnormal cervical cancer screening tests and cancer precursors.

References

1. World Health Organization, 2006. Defining Sexual Health.
2. ACHA, 2020. Sexual Health Services Survey CY 2019.
3. Perkins RB, Guido RS, Castle PE, et al. (2020). 2019 ASCCP Risk-based management consensus guidelines for abnormal cervical cancer screening tests and cancer precursors. *Journal of Lower Genital Tract Disease,* 24: 102-131.
4. ACHA Spring 2021 Undergraduate Reference Group Report of the National College Health Assessment
5. ACHA Spring 2020 Undergraduate Reference Group Report of the National College Health Assessment

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	9	4.6%	4	26.7%
Public 4-year	113	58.2%	3	20.0%
Private 4-year	72	37.1%	8	53.3%
Total	194	100%	15	100%

Institution Size

	Schools that provide Sexual Health Services		Schools that do **NOT** provide Sexual Health Services	
	Frequency	Percent	Frequency	Percent
Less than 2,500	27	13.9%	8	53.3%
2,500-4,999	21	10.8%	0	0.0%
5,000-9,999	39	20.1%	3	20.0%
10,000-19,999	39	20.1%	1	6.7%
20,000 and above	68	35.1%	3	20.0%
Total	194	100%	15	100%

Region per CDC/HHS

	Schools that provide Sexual Health Services		Schools that do **NOT** provide Sexual Health Services	
	Frequency	Percent	Frequency	Percent
Northeast	57	29.4%	2	13.3%
Midwest	39	20.1%	4	26.7%
South	56	28.9%	5	33.3%
West	41	21.1%	3	20.0%
Outside U.S.	1	0.5%	1	6.7%
Total	194	100%	15	100%

Campus Setting

	Schools that provide Sexual Health Services		Schools that do **NOT** provide Sexual Health Services	
	Frequency	Percent	Frequency	Percent
City	114	58.8%	9	60.0%
Suburb	46	23.7%	2	13.3%
Town	29	14.9%	3	20.0%
Rural	5	2.6%	1	6.7%
Total	194	100%	15	100%

Q6. Health center provides any clinical sexual health services

	Frequency	Percent
Yes	194	92.8%
No	15	7.2%
Total	209	100%

Q6A. Health center provides the following clinical sexual health services (n=194 health centers)

	Frequency	Valid Percent
Cervical cancer screening	161	83.0%
STI/HIV testing	184	94.8%
Pregnancy testing	192	99.0%
Contraception	178	91.8%
PrEP	122	62.9%
PEP	98	50.5%
HPV vaccinations	118	60.8%

Q6B. EHR products currently being used at health center (n=194)

	Frequency	Percent*
Careflow	0	0.0%
Cerner	5	2.4%
GE Centricity	0	0.0%
E-ClinicalWorks	2	1.0%
EPIC	8	3.8%
Magnus Health	0	0.0%
Medicat	59	28.2%
NextGEN	2	1.0%
NueMD	1	0.5%
Point and Click Solutions	69	33.0%
Practice Fusion	1	0.5%
PyraMED	27	12.9%
Titanium	3	1.4%
None- we use paper only	16	7.7%
Other EHR product (please specify):	6	2.9%

*Respondents could select more than one response

Q6C1. Electronic medical record captures the following categories at your health center

	Frequency	Valid Percent
Assigned sex (n=187)	170	90.9%
Gender identity (n=187)	132	70.6%
Race/ethnicity (n=187)	149	79.7%
Sexual orientation (n=185)	84	45.4%

Q6C2. Health center has the ability to run reports based on the following categories

	Frequency	Valid Percent
Assigned sex (n=178)	148	83.1%
Gender identity (n=176)	106	60.2%
Race/ethnicity (n=177)	137	77.4%
Sexual orientation (n=174)	72	41.4%

Q6C3. Health center runs reports based on the following categories

	Frequency	Valid Percent
Assigned sex (n=178)	99	55.6%
Gender identity (n=177)	55	31.1%
Race/ethnicity (n=177)	84	47.5%
Sexual orientation (n=173)	30	17.3%

Q7. Health Center Visits (includes both in-person and telemedicine) (n=185)

	Total number of student medical visits to your health center in 2022	Number of virtual/telemedicine visits
Mean	13,148	1,444
Median	5397	104
Minimum	3	0
Maximum	171,799	22,615
Sum	2,432,370	267,225

Section 2: Surveillance

Q8. CY 2022 Summary of all Pap test results (n=161)

	Frequency	Percent
Total # of Pap tests done	32,035	
Normal	27,382	85.5%
ASC-US	2,179	6.8%
LSIL	1,522	4.8%
ASC-H	175	0.5%
ACG or CIS	32	0.1%
Unsatisfactory, no dx	340	1.1%
other dx, not listed above	405	1.3%
no endocervical cells (with any dx above) (n=71)	1,556	4.9%

Q9. CY 2022 Chlamydia testing

Out of 395,872 female patients under age 25 seen at 125 health centers, 63,305 were tested for chlamydia (16.0%).

Q10-Q13 CY 2022 STI/HIV Positivity

	Gonorrhea (n=158)	**Chlamydia** (n=158)	**HIV** (n=155)	**Syphilis** (n=154)
# tested	200,060	195,386	80,464	66,689
# positive	3,266	12,462	126	905
Positivity Rate (%)	1.63%	6.38%	0.16%	1.4%

Q14. CY 2022 Herpes Positivity

	HSV overall
# tested	7,132
# positive for HSV-2	587
# positive for HSV-1	1,703
# positive for type unknown	277
Total positive for any type	2,567 (36.0%)

14. CY 2021 Breakdown for all positive Herpes tests

	All patients
Positive for HSV-2	587 (22.9%)
Positive for HSV-1	1,703 (66.3%)
Positive for type unknown	277 (10.8%)
Total positive for any type	2,567

15. Number of patients diagnosed with trichomoniasis in 2022: 362 at 160 schools

16. Number of patients diagnosed with bacterial vaginosis in 2022: 13,542 at 152 schools

17. Number of patients diagnosed with genital warts in 2022: 1,048 at 152 schools

Section 3: Pregnancy Testing

18. CY 2022 Number of Pregnancy tests done (n=165)

	All patients
Number of Pregnancy tests done	42,431
Positive pregnancy tests	1,055
Positivity Rate (%)	2.5%

18B. Does your EMR have the ability to report the outcome of a pregnancy?

	Frequency	Valid Percent
Yes	24	13.0%
No	160	87.0%
Total	184	100%

18C. Do you or someone in your Student Health Services know how to access pregnancy outcome data in your electronic medical record? (this question was only displayed to those who responded 'yes' to 18B)

	Frequency	Valid Percent
Yes	17	70.8%
No	7	29.2%
Total	24	100%

18D. Does your Student Health Services run reports on pregnancy outcome data? (this question was only displayed to those who responded 'yes' to 18C)

	Frequency	Valid Percent
Yes	2	11.8%
No	15	88.2%
Total	17	100%

Section 4: Cervical Cancer Screening

19. Cervical cytology screening test used (n=161 Health Centers)

Cervical Cytology Screening Test used	Ages 21-24	Valid Percent	Ages 25-29	Valid Percent	Ages 30-65	Valid Percent
Conventional slide	12	7.5%	7	4.3%	6	3.7%
Liquid-based cytology, alone	91	56.5%	75	46.6%	65	40.4%
Liquid-based cytology with reflex HPV-testing for ASC-US or LSIL	116	72.0%	138	85.7%	91	56.5%
Liquid-based cytology, with co-testing	41	25.5%	54	33.5%	117	72.7%
HPV testing alone	30	18.6%	38	23.6%	44	27.3%

20. Cervical Disease Management (Procedures Used)

Procedure	Frequency	Valid Percent
Colposcopy (n=160)	34	21.3%
Cryotherapy (n=160)	11	6.9%
Laser ablation or LEEP (n=160)	4	2.5%
Other (n=65)	1	1.5%

21. For clients/patients under age 25, usual practice for management of a first screening Pap test reported as ASC-US (n=161)

	Frequency	Valid Percent
HPV DNA test (reflex or otherwise)	54	33.5%
Repeat Pap in 6 months	8	5.0%
Repeat Pap in 12 months	83	51.6%
Immediate colposcopy	1	0.6%
Varies by provider, no standard practice	11	6.8%
Don't know	4	2.5%
Total	116	100.0%

22. Provision of pharyngeal tests for chlamydia and gonorrhea screening for anyone who performed oral sex on a penis:

	Frequency	Valid Percent
Yes	106	57.9%
Yes, only for MSM	30	16.4%
No	47	25.7%
Total	183	100%

23. Provision of rectal tests for chlamydia and gonorrhea screening for anyone who received anal sex:

	Frequency	Valid Percent
Yes	107	58.5%
Yes, only for MSM	30	16.4%
No	46	25.1%
Total	183	100%

24. Health center organizes STI/HIV testing events across campus:

	Frequency	Valid Percent
Yes	84	40.4%
No	124	59.6%
Total	208	100%

24A. How often are such events during the academic year (this question was only displayed to those who selected 'yes' for question 24) :

	Frequency	Valid Percent
Once per academic year	17	20.2%
Once per academic term	36	42.9%
Once per month	16	19.0%
More than once per month	15	17.9%
Total	84	100%

24B. Who conducts the testing during these events (this question was only displayed to those who selected 'yes' for question 24):

	Frequency	Valid Percent
Health center staff	18	21.4%
Community organization/local health department	42	50.0%
Both health center staff and community organization/local health department	24	28.6%
Total	84	100%

24C. Tests offered during these events (this question was only displayed to those who selected 'yes' for question 24) (n=84) (select all that apply)

	Frequency	Valid Percent
Chlamydia	59	70.2%
Gonorrhea	58	69.0%
HIV	75	89.2%
Syphilis	37	44.0%

24D. Are the tests free during these events (this question was only displayed to those who selected 'yes' for question 24):

	Frequency	Valid Percent
Yes, all the tests are free	76	90.5%
Yes, some tests are free	2	2.4%
No, none of the tests are free	6	7.1%
Total	84	100%

24E. Which tests are free: (n=2) (this question was only displayed to those who selected 'Yes, some tests are free' in question 24D) (select all that apply)

	Frequency	Valid Percent
Chlamydia	0	0%
Gonorrhea	0	0%
HIV	2	100%
Syphilis	1	50.0%

25. Health center provide anonymous HIV testing on campus:

	Frequency	Valid Percent
Yes, services are provided by health center staff	33	18.5%
Yes, services are provided by a community organization/local health department	27	15.2%
No, but we refer to community organizations/local health departments that provide anonymous HIV testing	114	64.0%
No, anonymous testing is illegal in our state	4	2.2%
Total	178	100%

26. How the cost of chlamydia screening was covered at your health service:

	Frequency	Valid Percent
Covered with no cost-sharing for all students by a mandatory student health fee	32	18.5%
Covered with no cost-sharing for all students by a fund other than a mandatory health fee	17	9.8%
Only covered for students with the university-sponsored health insurance plan	30	17.3%
Only covered for students who have an insurance plan that covers them	66	38.2%
Never covered (all students must pay out of pocket)	28	16.2%
Total	173	100%

26. How the cost of gonorrhea screening was covered at your health service:

	Frequency	Valid Percent
Covered with no cost-sharing for all students by a mandatory student health fee	30	17.4%
Covered with no cost-sharing for all students by a fund other than a mandatory health fee	18	10.5%
Only covered for students with the university-sponsored health insurance plan	30	17.4%
Only covered for students who have an insurance plan that covers them	67	39.0%
Never covered (all students must pay out of pocket)	27	15.7%
Total	172	100%

26. How the cost of HIV screening was covered at your health service:

	Frequency	Valid Percent
Covered with no cost-sharing for all students by a mandatory student health fee	30	17.8%
Covered with no cost-sharing for all students by a fund other than a mandatory health fee	17	10.1%
Only covered for students with the university-sponsored health insurance plan	30	17.8%
Only covered for students who have an insurance plan that covers them	66	39.1%
Never covered (all students must pay out of pocket)	26	15.4%
Total	169	100%

26. How the cost of syphilis screening was covered at your health service:

	Frequency	Valid Percent
Covered with no cost-sharing for all students by a mandatory student health fee	26	15.4%
Covered with no cost-sharing for all students by a fund other than a mandatory health fee	14	8.3%
Only covered for students with the university-sponsored health insurance plan	33	19.5%
Only covered for students who have an insurance plan that covers them	68	40.2%
Never covered (all students must pay out of pocket)	28	16.6%
Total	169	100%

27. Was OTC Emergency Contraception (Plan B) available through your Student Health Service in 2022?

	Frequency	Valid Percent
Yes, for free	21	11.8%
Yes, at some cost	88	49.4%
Yes, both free and at some cost	23	12.9%
No, it was not available for students through our Student Health Service	46	25.8%
Total	178	100%

28. Was prescription Emergency Contraception (Ella) provided through your Student Health Service in 2022?

	Frequency	Valid Percent
Yes, it was prescribed by our clinicians and dispensed through SHS	86	48.3%
Yes, it was prescribed by our clinicians but not dispensed through SHS	35	19.7%
No, it was not prescribed by our clinicians or dispensed through SHS	57	32.0%
Total	178	100%

29. Was copper IUD for Emergency Contraception (Paragard) provided through your Student Health Service in 2022?

	Frequency	Valid Percent
Yes, it was provided through our SHS for Emergency Contraception	35	19.7%
No, it was not provided through our SHS for Emergency Contraception; patients are referred to outside provider	107	60.1%
No, it was not provided through our SHS for Emergency Contraception and patients are not referred to outside provider	36	20.2%
Total	178	100%

30. Percentage and frequency of health center respondents indicating affirmative to prescribing and/or dispensing for the following <u>patient-administered</u> contraceptive methods. (n=178 health centers)

	Prescription		**Dispensation**	
	n	**%**	**n**	**%**
Cervical Cap	10	5.6%	0	0.0%
Contraceptive Patch	136	76.4%	45	25.3%
Contraceptive Ring	137	77.0%	53	29.8%
Diaphragm	36	20.2%	15	8.4%
Oral contraceptives (combined and mini pill)	173	97.2%	104	58.4%

31. Percentage and frequency of health center respondents indicating affirmative to provision and/or referring for the following <u>provider-administered</u> contraceptive methods. (n=178 health centers)

	Provided at SHS		**Referral to outside Provider**	
	n	**%**	**n**	**%**
DepoProvera	160	89.9%	79	44.4%
Implants (Implanon/Nexplanon)	74	41.6%	138	77.5%
Intrauterine device (Copper or Hormonal)	58	32.6%	150	84.3%
Tubal ligation	1	0.6%	115	64.6%
Vasectomy	1	0.6%	111	62.4%

32. For students with a positive pregnancy test, what services are available from your health center? (n=178 health centers)

	Yes		No		No, due to legal limitations		No, due to school policy		Decline to answer	
	n	%	n	%	n	%	n	%	n	%
Counseling for adoption services	120	67.4%	41	23.0%	0	0.0%	1	0.6%	16	9.0%
Counseling for abortion services	120	67.4%	33	18.5%	6	3.4%	2	1.1%	17	9.6%
Counseling for prenatal care	133	74.7%	30	16.9%	0	0.0%	1	0.6%	14	7.9%
Referral for adoption services	128	71.9%	32	18.0%	0	0.0%	1	0.6%	17	9.6%
Referral for abortion services	127	71.3%	25	14.0%	7	3.9%	1	0.6%	18	10.1%
Referral for prenatal care	157	88.2%	10	5.6%	0	0.0%	0	0.0%	11	6.2%
Medication abortion services provided at SHS	15	8.4%	141	79.2%	9	5.1%	2	1.1%	11	6.2%
Surgical abortion services provided at SHS	5	2.8%	151	84.8%	9	5.1%	2	1.1%	11	6.2%
Prenatal care services provided at SHS	15	8.4%	149	83.7%	0	0.0%	3	1.7%	11	6.2%