



**SIECUS**

Sexuality Information and Education  
Council of the United States

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# **ENSURING EQUITABLE ACCESS TO HIGH-QUALITY SEXUAL HEALTH CARE SERVICES**

**A SPECIAL REPORT BY THE**

**SEXUALITY INFORMATION AND EDUCATION COUNCIL OF THE UNITED STATES**

December 1, 2014

## INTRODUCTION

*Ensuring Equitable Access to High-Quality Sexual Health Care Services* is part of SIECUS' work to define, frame, and support a public discourse on sexual health and well-being and create a sexually healthy America. An individual's ability to access high-quality health care, particularly sexual health care services, is essential to creating a sexually healthy America. While fundamental to our humanity, sexuality is also one of the most complex and politicized issues debated in the public health arena. Addressing sexuality and sexual health openly and honestly can be a powerful force for achieving significant outcomes in public and individual health, gender equity, and social justice.

This report, *Ensuring Equitable Access to High-Quality Sexual Health Care Services*, aims to address sexual health care in a comprehensive and integrated fashion by:

- Providing a political and financial overview of sexual health care services, including the federal policies and funding mechanisms that support access to services, as well as the barriers to accessing services.
- Offering a definition of high-quality sexual health care services that integrates the often segregated aspects of care including reproductive health care and STD testing and treatment.
- Examining the unique sexual health care needs of five subpopulations: adolescents; gay men and men who have sex with men; transgender and gender non-conforming people; the incarcerated, including those in the juvenile justice system; and the aging. These subpopulations are disproportionately affected by both negative sexual health outcomes and the lack of access to services. They are offered as examples, rather than the full breadth or any prioritization, of additional subpopulations facing sexual health and services disparities.
- Providing specific recommendations for ensuring equitable access to sexual health care services.

This report is the result of a series of interviews with key experts in the field and a comprehensive review of existing materials including standard of care guidelines developed by a number of national and international public health and medical organizations, such as, but not limited to: the American Academy of Pediatrics; the American College of Obstetricians and Gynecologists; the American Medical Association; the Center for HIV Law & Policy; the Center of Excellence for Transgender Health; the Centers for Disease Control and Prevention; Futures Without Violence; the Guttmacher Institute; the Institute of Medicine; the Kaiser Family Foundation; the National Commission on Adolescent Sexuality; the National Commission on Correctional Health Care; the Society for Adolescent Health and Medicine; the United States Department of Health and Human Services; the World Health Organization; and many others.

It is our hope that by researching and summarizing what is currently in place and providing accompanying recommendations of what high-quality sexual health care services can look like in the future, this report will help move our field closer to ensuring accessible, affordable, and confidential sexual health care services for people at different ages and stages of life.

## **BACKGROUND: DEFINING HIGH-QUALITY SEXUAL HEALTH CARE SERVICES**

Human sexuality is defined and influenced by physical, ethical, spiritual, cultural, psychological, emotional, and moral concerns. All persons are sexual, in the broadest sense of the word, and sexual feelings, desires, and activities are present throughout the life cycle.<sup>1</sup>

In its seminal report, *Defining Sexual Health*, the World Health Organization defined sexual health as:

[A] state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.<sup>2</sup>

Sexual rights are human rights, and they are based on the inherent freedom, dignity, and equality of all human beings. Sexual rights include: the right to bodily integrity, sexual safety, sexual privacy, sexual pleasure, and sexual healthcare; the right to make free and informed sexual and reproductive choices; and the right to have access to sexual information based on sound scientific evidence.<sup>3</sup> As noted by the World Association for Sexual Health, “Sexual rights are an integral component of basic human rights and therefore are inalienable and universal.”<sup>4</sup> The 1994 International Conference on Population and Development (ICPD) marked the beginning of significant progress in the recognition of sexual health as an essential dimension of overall health by numerous governments. The ICPD Programme of Action—adopted by 179 countries including the United States—provided the first definition of sexual health negotiated and agreed upon by national governments from around the globe. It “situated sexual health within a broader rubric of reproductive health care and recognized the important multifaceted contribution that sexual health makes to human well-being.”<sup>5</sup>

...Reproductive health care is defined as the constellation of methods, techniques, and services that contribute to reproductive health and wellbeing by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproductive and sexually transmitted diseases.<sup>6</sup>

SIECUS’ long-held position statements have also declared that all people have a right to health care services that promote, maintain, and if needed, restore sexual and reproductive health. All people, regardless of age or socioeconomic status, should have access to affordable, confidential sexual health services and age-appropriate information and health care services concerning sexual feelings, attitudes, and behaviors throughout their life course. In addition, healthcare providers should assess sexual and reproductive health needs and concerns as integral parts of each individual’s health and wellness care and make appropriate resources available.<sup>7</sup>

With these diverse position statements in mind, which underscore the need for all people, regardless of age, gender, gender identity, socioeconomic status, or race and ethnicity, to have access to affordable, safe, confidential sexual health services, SIECUS created the following definition of high-quality sexual health care services. Following the definition are additional details about the components and how to ensure equitable access to the services contained therein.

## HIGH-QUALITY SEXUAL HEALTH CARE SERVICES: A DEFINITION

High-quality sexual health care services address and acknowledge the linkages between physical, emotional, mental, and social well-being, including as integral to health and well-being the promotion of sexual health, and not merely the absence of disease or dysfunction. High-quality sexual health care services require a respectful approach to sexuality and sexual relationships, acknowledging the sexual rights of all persons and promoting the possibility of having pleasurable and safe sexual experiences and personal relationships that are free of coercion, discrimination, and violence. These services are age-appropriate, affordable, and accessible. They include a sexual health history and sexual risk assessment as a part of routine care and address the critical importance of prevention in addition to care and treatment.

High-quality sexual health care services include, but are not limited to:

- a full range of confidential sexual and reproductive health services that take into account the complex multi-layered interactions between race, ethnicity, gender, and socioeconomic status and include cultural messages tailored for distinct populations, including adolescents, the aging, gay men and men who sex with men, lesbians, transgender and gender non-conforming individuals, people living with HIV and AIDS, the incarcerated, the homeless, foster-care youth, and the disabled;
- confidential counseling and health care services for the prevention, screening, vaccination, diagnosis, and treatment of HIV, viral hepatitis, and other sexually transmitted infections (STIs);
- screening and counseling for domestic and interpersonal violence;
- safe, affordable, and accessible contraceptive and abortion services, pre- and post-natal care, adoption services, and assisted reproductive technologies; and
- the provision of contraceptive education, counseling, and affordable services for the prevention of pregnancy, HIV, and other STIs, including condoms and emergency contraception, to all people regardless of gender or sexual orientation.

High-quality sexual health care services are coordinated in one setting and address sexual health promotion for all individuals, and address typical barriers and gaps in care that result from a disconnectedness of providers, settings, and services. Finally, high-quality sexual health care services focus on individual health, but also emphasize the inter-related aspects of public health and focus on environmental influences on sexual health.

*Beyond Disease Prevention to Health Promotion.* High-quality health care services should address and acknowledge the connections between an individual's physical, emotional, mental, and social well-being. Sexual health care services require a positive and respectful approach to sexuality and sexual relationships, respecting the sexual rights of all persons and promoting the possibility of having pleasurable and safe sexual experiences that are free of coercion, discrimination, and violence. These services should be age-appropriate, affordable, and accessible and address the critical importance of prevention in addition to care and treatment, moving from a focus on sickness and disease to one based on prevention and wellness.<sup>8</sup> They must include a full range of confidential sexual and reproductive health services and be culturally competent.

*Patient-Centered Communication about Sexual Health.* In order to achieve high-quality sexual health care services, health care providers should routinely initiate conversation with all patients, as appropriate, about sexual health, satisfaction, and well-being. Unfortunately, physicians regularly miscalculate the prevalence of sexual

concerns in their patients, contributing to the underestimation of patients' desire to have this crucial conversation. One study found that only 58 percent of primary care physicians report that they take a sexual history at a routine visit, but only 12 to 34 percent felt comfortable asking about the components of the history.<sup>9</sup> Physicians are often reluctant to address sexual health issues for the following reasons: (1) embarrassment, (2) feeling ill-prepared, (3) belief that the sexual history is not relevant to the chief complaint, and (4) time constraints.<sup>10</sup> In addition, patients report that physician discomfort and an anticipated non-empathetic response to sexual problems are primary barriers to discussing sexual health with their provider.<sup>11</sup>

To help foster an environment in which patients are more comfortable discussing their sexual health, providers should, at a minimum, avoid using terms that make assumptions about a patient's sexual behavior, relationship status, sexual orientation, or gender identity. In patient interviews and on intake forms, use gender-neutral terms like "partner" or "spouse" instead of "husband," "wife," "boyfriend," or "girlfriend." When taking a sexual health history and a sexual risk assessment, providers should ask patients about the number of partners they have or if they are in a relationship, rather than about whether or not they are married. Patients should also be asked if they have sex with men, women, or both and providers should recognize that sexual behavior is fluid—it may change over time—and sexual orientation is not necessarily synonymous with sexual behavior. For example, a woman may say she is a lesbian, but engage in occasional sex with men, or a man may state he is gay but may occasionally have sex with women.

A comprehensive sexual health history and sexual risk assessment can promote sexual health and help patients identify ways to reduce unhealthy sexual decision-making that may increase their risk for HIV, other STIs, and unintended pregnancy. It also allows a provider to recommend preventive care measures, such as immunizations against the human papilloma virus (HPV), and hepatitis A and B, testing and treatment for HIV and other STIs to patients and their partners when appropriate, or referral to mental health and intimate partner violence support services, when appropriate. It can also allow a physician to address issues of sexual dysfunction with a patient, which may be symptomatic of organic or psychiatric disease, such as diabetes or depression, or the side effects of medication, which may impact adherence. Finally, it can lead to decreased morbidity and mortality, and enhance well-being and longevity in the patient.<sup>12</sup>

*Tailored to Unique Needs of Diverse Populations.* High-quality sexual health care services must take into account the complex multi-layered interactions between race, ethnicity, gender, and economic status and include cultural messages tailored for distinct populations, including adolescents, the aging, gay men and men who sex with men, lesbians, transgender and gender non-conforming individuals, people living with HIV and AIDS, the incarcerated, homeless and foster-care youth, and the disabled. These subpopulations are often invisible in conversations about health care and often lack the access and resources necessary to avail themselves of services. In addition, they are often those who face discrimination in health care settings.

*Coordinated, Culturally Competent Care.* Ideally, sexual health care practitioners, providers, and settings should coordinate with one another in order to address the common barriers and gaps in care that result from disconnectedness and result in subpar provision of services for all individuals. Many health problems are inter-related and have common etiologies, yet the typical approaches taken by medical and clinical establishments tend to be narrow in focus, relying on a categorical approach that "ignores the fact that there are many common antecedents to seemingly disparate health problems."<sup>13</sup> According to the Centers for Disease Control and Prevention (CDC), research has unequivocally shown that risk behaviors tend to cluster and that engaging in one risk behavior often contributes to related negative health outcomes. For example, sexual health care services for adolescents are often "highly fragmented, poorly coordinated, and delivered in multiple public and private settings,"<sup>14</sup> resulting in many health care providers and services

being poorly equipped to foster disease and pregnancy prevention in a connected fashion. They may discuss contraception with a young woman or HIV prevention with a young gay man while never addressing interrelated topics that are, in fact, relevant to each individual. In addition, these fragmented approaches tend to stem from a medical model that only addresses acute medical issues and fails to address the broader aspects of sexual health that will support an individual's overall health and well-being.

*Confidential, Comprehensive Care.* High-quality sexual health care services must include confidential counseling and comprehensive health care services for the prevention, screening, diagnosis, and treatment of HIV, viral hepatitis, and other STIs as well as the promotion of overall sexual health. High-quality services must include information about different prevention methods, including male and female condoms; routine screening for the early detection of HIV, viral hepatitis, and other STIs; and linkages to affordable and accessible care and treatment for those diagnosed. In order to assure the treatment and care of sex partners of persons with positive diagnoses for STIs or HIV as soon as is possible after diagnosis, providers should engage in Partner Services for HIV or STIs, or Expedited Partner Therapy—the clinical practice of treating the sex partners of patients diagnosed with chlamydia or gonorrhea by providing prescriptions or medications to the patient to take to his/her partner without the health care provider first examining the partner<sup>15</sup> when permissible or allowable by law.<sup>16</sup>

High-quality sexual health care services must include reproductive health care services and support structures for people of all genders, including those who are pregnant, parenting, or want to prevent childbearing. Reproductive health (as distinct from sexual health) can be defined as the ability to have or not have children at a time and with a partner of one's choosing.<sup>17</sup> Such services should help prevent unintended pregnancy—through the provision of contraceptive education, counseling, and affordable services, including emergency contraception—as well as HIV and other STIs—through the promotion of knowledge about, and compliance with, screening and vaccinations for STIs, including HIV, and the prevention of mother-to-child transmission for those that are HIV-positive. In addition, high-quality services should include safe, affordable, and accessible contraceptive and abortion services, pre- and post-natal care, adoption services, and assisted reproductive technologies. Every woman, regardless of age or income, should have the right to obtain an abortion under safe, legal, affordable, easily accessible, confidential, and dignified conditions. Every woman is entitled to have full knowledge of the options available to her, and to obtain complete and unbiased information and counseling about carrying a pregnancy to term, birth, abortion, and adoption. The provision of contraceptive education, counseling, and affordable services for the prevention of pregnancy, including condoms and emergency contraception, should be provided to males as well as females. Finally, patients who are pregnant should be advised about factors that may negatively influence birth outcomes, such as alcohol, tobacco and other drugs, poor nutrition, stress, lack of prenatal care, and chronic illness or other medical problems.

## FEDERAL ROLE IN SUPPORTING ACCESS TO SEXUAL HEALTH CARE SERVICES

Federal, state, and local government agencies play significant roles, both directly and indirectly, in the sexual health of individuals and of communities by developing policies, crafting regulations, implementing programs, and providing funding for programs and research. At the federal level, policies are set that affect how individuals access sexual health care and the type of information available in such places as schools, communities, correctional and juvenile justice facilities, and foster care settings. Federal agencies are also able to set national priorities and provide guidance by disseminating research, information, and guidelines on best practices and program approaches.

The section below focuses on five seminal documents developed by agencies of the federal government that seek to advance the sexual and reproductive health of Americans. In addition, key funding mechanisms that provide essential sexual health services are described as well as a summary of some of the key current and future implications of the *Patient Protection and Affordable Care Act (ACA)*.

### Government Guidelines and Reports

The United States government has released several guiding documents and reports that frame how the federal government can and should be addressing sexual health care services. While there are still significant barriers to implementation and full realization of these guidelines, in large part due to lack of financial resources and political will, these documents outline an agenda for clinicians and advocates about how to approach issues of sexual health care, particularly for populations that are marginalized or at higher risk. Realization of these strategies would go a long way to ensuring equitable access to sexual health care services by all individuals, and particularly those that are members of underserved populations.

#### *Surgeon General's Call to Action To Promote Sexual Health and Responsible Sexual Behavior*

In July 2001, U.S. Department of Health and Human Services Surgeon General David Satcher released the groundbreaking *Surgeon General's Call to Action To Promote Sexual Health and Responsible Sexual Behavior (Call to Action)*. The *Call to Action* was the first formal government recognition of the importance of a sexual health framework to enhance population health in the United States and provided an evidence-based foundation for developing a national and public health approach to sexual health and responsible sexual behavior. In releasing the report, Dr. Satcher called for “strategies that focused upon increasing awareness, implementing and strengthening interventions, and expanding the research base relating to sexual health matters.”<sup>18</sup> The report outlined that, as is the case with many public health problems, there are serious disparities in the realm of sexual health and “the economically disadvantaged, racial and ethnic minorities, persons with different sexual identities, disabled persons, and adolescents often bear the heaviest burden.”<sup>19</sup> However, the *Call to Action* was a call for sexual health for all Americans and notes that it is important to “recognize that persons of all ages and backgrounds are at risk and should have access to the knowledge and services necessary for optimal sexual health” and “that it is important throughout the entire lifespan, not just the reproductive years.”

Importantly, the *Call to Action* addressed the role that individuals as well as communities must play in ensuring sexual health, outlining how sexual responsibility should be understood in its “broadest sense.”

While personal responsibility is crucial to any individual’s health status, communities also have important responsibilities. Individual responsibility includes: understanding and awareness of one’s sexuality and sexual development; respect for oneself and one’s partner; avoidance of physical or emotional harm to either oneself or one’s partner; ensuring that pregnancy occurs only when welcomed; and recognition and tolerance of the diversity of sexual values within any community.

Community responsibility includes assurance that its members have: access to developmentally and culturally appropriate sexuality education, as well as sexual and reproductive health care and counseling; the latitude to make appropriate sexual and reproductive choices; respect for diversity; and freedom from stigmatization and violence on the basis of gender, race, ethnicity, religion, or sexual orientation.

*A Public Health Approach for Advancing Sexual Health in the United States: Rationale and Options for Implementation*

In April 2010, the CDC’s National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) convened a consultation, effectively launching a new sexual health initiative. The consultation aimed to build upon the United States Surgeon General’s 2001 *Call to Action* and present a sexual health framework to normalize dialogue around sexuality and sexual behavior, enhance educational and preventive services, and improve health outcomes. The resulting report, *A Public Health Approach for Advancing Sexual Health in the United States: Rationale and Options for Implementation*, noted that in the 10 years since the *Call to Action* was released, “many measures of adverse health outcomes of sexual behaviors have worsened, prompting a need for refocused national attention on sexual health-related issues, especially HIV prevention and adolescent sexual health outcomes (e.g., unplanned pregnancy and STDs).”<sup>20</sup> The report notes that current health outcomes, as well as opportunities presented by health care reform, “highlight the importance of exploring the potential benefits of using a broad sexual health prevention approach” and provide the opportunity to advance a “more positive health-based approach addressing sexual behavior across the lifespan...serving as a potential framework for public health action.”<sup>21</sup> In addition, the report includes six objectives for a public health approach to advance sexual health in the U.S.:<sup>22</sup>

1. Increase healthy, responsible, and respectful sexual behaviors and attitudes.
2. Increase the awareness and ability to make healthy and responsible choices, free of coercion.
3. Promote healthy sexual functioning and relationships, including ensuring that individuals have control over, and decide freely on, matters related to their own sexual relations and health.
4. Optimize and educate about reproductive health.
5. Increase access to effective preventive, screening, treatment, and support services that promote sexual health.
6. Decrease adverse individual and public health outcomes including HIV/STDs, viral hepatitis, unintended pregnancies, and sexual violence.

Dr. Kevin Fenton, former director of NCHHSTP, has noted that the CDC’s sexual health initiative was “grounded in the principles of public health and intended to complement core efforts in the area of disease-focused actions with a more positive, health-based approach characterized by understanding complex factors that shape human sexual behavior.”<sup>23</sup> Of note, in its Strategic Plan for 2010–2015, the CDC’s NCHHSTP included strategies related to sexual health, specifically developing a sexual health research agenda under their goals of “Prevention through Health Care” and working with internal and external partners to promote sexual health in the U.S. under “Program Collaboration and Service Integration”—clearly indicating that the Department of Health and Human Services (HHS) and the CDC intend to continue this work moving forward.<sup>24</sup>

#### *National HIV/AIDS Strategy*

The *National HIV/AIDS Strategy* (NHAS), released in 2010, is a landmark document outlining the federal government’s blueprint for combating the rampant HIV/AIDS epidemic in the United States at the federal, state, and local levels, relying on the involvement of the public and private sectors. The NHAS has three primary goals: 1) reducing the number of people who become infected with HIV; 2) increasing access to care and optimizing health outcomes for people living with HIV; and 3) reducing HIV-related health



disparities. It “provides an opportunity for working to advance a public health approach to sexual health that includes HIV prevention as one component.”<sup>25</sup> It also stresses the importance of including information about HIV in any wellness context promoting healthy behaviors, including sexual health, and that health and wellness practitioners, including intake specialists, doctors, nurses, and other health professionals, are also educated about HIV, especially in programs for underserved communities. The NHAS stresses the importance of prevention and screening in clinical and community settings and in getting those who are HIV positive into care and adherent in their treatment regimen in order to prevent transmission of the virus and increase positive health outcomes for those living with the virus.<sup>26</sup>

### *Healthy People 2020*

*Healthy People 2020* provides a comprehensive agenda for nationwide health promotion and prevention of disease, disability, and premature death. It serves as a road map for improving the health of all Americans during the second decade of the 21st century. Released in December 2010, *Healthy People 2020*'s systematic approach to health improvement reflects what the U.S. Department of Health and Human Services calls an “ambitious, yet achievable, 10-year agenda for improving the Nation’s health.”<sup>27</sup> *Healthy People 2020* strives to: identify nationwide healthy improvement priorities; increase public awareness and understanding of determinants of health, disease, disability, and opportunities for progress; and provide measurable health objectives and goals that are applicable at national, state, and local levels. It is founded on four overarching goals:<sup>28</sup>

- Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death.
- Achieve health equity, eliminate disparities, and improve the health of all groups.
- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development, and healthy behaviors across all life stages.

*Healthy People 2020* includes over 120 indicators related to sexual health. Notably, two of the “Leading Health Indicators” for *Healthy People 2020* relate to reproductive and sexual health:<sup>29</sup>

- Sexually active females aged 15 to 44 years who received reproductive health services in the past 12 months (FP-7.1)
- Persons living with HIV who know their serostatus (HIV-13)

In addition, several topic areas of *Healthy People 2020* are directly related to sexual health: Family Planning; HIV; lesbian, gay, bisexual, and transgender (LGBT) Health; Maternal, Infant and Child Health; and STIs. Additional sexual health-related objectives fall under a number of other topic areas, for example, under cancer (breast, cervical, and prostate cancer screening and death rates), adolescent health (middle and high schools that prohibit harassment based on a student’s sexual orientation or gender identity), injury and violence prevention (violence by current or former intimate partners and sexual violence), and immunization and infectious disease (HPV vaccinations for adolescents).<sup>30</sup>

### *U.S. National Prevention Strategy*

The *U.S. National Prevention Strategy*, released in June 2011 by the Office of the Surgeon General, has the goal of increasing the number of Americans who are healthy at every stage of life with a vision of moving from a focus on sickness and disease to one based on prevention and wellness.<sup>31</sup> The *National Prevention Strategy* looks at sexual and reproductive health as being critical in enabling people to “remain healthy and actively contribute to their community”<sup>32</sup> and unequivocally states that access to “quality health services and support for safe practices can improve physical and emotional well-being and reduce teen and unintended

pregnancies, HIV/AIDS, viral hepatitis, and other sexually transmitted infections (STIs).<sup>33</sup> The *National Prevention Strategy* links sexual health care services to having positive impacts not only on sexual health outcomes, but also on graduation rates, parenting skills, educational attainment, employment opportunities, and financial stability. Like the NHAS, it also emphasizes the importance of early detection of HIV, viral hepatitis, and other STIs through routine screening as well as improving linkage to care for those in need of such services, particularly because of the positive health outcomes, reduced transmission, and improvements in quality and length of life that result.<sup>34</sup>

### **Federal Policies and Funding Mechanisms Supporting Access to Sexual Health Care Services**

Health insurance coverage is a critical factor in making health care, including sexual health care, accessible to people of all ages. Those with health coverage are more likely to obtain the preventive, primary, and specialty care services they need and to have access to advances in health care services that may help them thrive. According to the Kaiser Family Foundation, more than 47 million nonelderly Americans were uninsured in 2012. While this is a decrease of 1.9 million uninsured people since 2010—the change resulted from stability in private coverage and the availability of Medicaid to buffer loss of health insurance for the low-income population—the number of uninsured has grown by 3.9 million people since the recession began in 2007.<sup>35</sup>

Over half of people under the age of 65 obtain health coverage through employer coverage. Medicare covers virtually all of the elderly.<sup>36</sup> However, those who are under the age of 65 who do not have access to or cannot afford private insurance often go without health coverage and care unless they qualify for the Medicaid program, the Children’s Health Insurance Program (CHIP), or other state-subsidized insurance programs, or are able to access care through other government-funded programs such as the Ryan White Program or the Title X family planning program.<sup>37</sup> Implementation of the *Patient Protection and Affordable Care Act* (ACA) will significantly impact health insurance coverage and access to sexual health care services for a variety of populations. However, it is still too early in its implementation to gauge its full impact.

Outlined below are some of the federal policies and funding mechanisms that support, and inhibit, access to sexual health care services, as well as highlights of ACA and how it will impact the profile of health insurance coverage and access to services for millions of Americans.

#### *Medicaid*

Medicaid is the joint federal-state program that is the principal safety net health insurance program for low-income Americans and those living with disabilities. The program finances health services for over 60 million low-income individuals.<sup>38</sup> Medicaid plays a critical role in the provision of sexual health care services. It acts as the single largest source of health insurance coverage for people living with HIV, accounting for more than half of all spending on HIV care by the federal government,<sup>39</sup> and is also the single largest source of public funding for family planning services nationwide.<sup>40</sup> It also serves as an important source of health care for the LGBT community, which has higher unemployment and poverty rates, particularly among communities of color, than does the general U.S. population.<sup>41</sup>

Since the beginning of the epidemic, Medicaid has served as an important, and for many people their primary, source of health insurance coverage for people living with HIV. As people living with HIV and AIDS have benefited from highly effective treatment, HIV-related illness and death have decreased significantly, allowing people with HIV/AIDS to live and stay healthier longer. However, the standard of HIV care today is expensive and complex and “HIV disease...remains a disabling condition for many who often must turn to Medicaid for health insurance.” Additionally, those who are newly infected with HIV are increasingly likely to be low income.<sup>42</sup>

HIV-positive individuals make up less than one percent of the Medicaid population; however, almost half (47 percent) of people living with HIV are estimated to be in regular care. Roughly three-quarters of people living with HIV who qualify for Medicaid do so through the disability eligibility pathway, which means that in order to receive Medicaid benefits a doctor must certify that they are disabled. This is in contrast to only about one-fifth of non-HIV-positive Medicaid enrollees. According to the Kaiser Family Foundation, this is likely due to current federal Medicaid eligibility rules which “categorically exclude non-disabled adults without dependent children.” This results in low-income people with HIV who don’t have dependent children typically not qualifying for Medicaid until they become disabled. (See *The Affordable Care Act’s Impact on Sexual Health Care Services* section below for information on how this will be remedied.) In addition, nearly 30 percent of enrollees with HIV are dually eligible for both Medicaid and Medicare. Enrollees with HIV accounted for roughly two percent of overall Medicaid spending, \$5.3 billion in Fiscal Year 2007, with prescription drugs accounting for the largest share of spending for enrollees with HIV. Enrollees with HIV cost the program nearly \$25,000 per capita, as compared to about \$5,100 per capita for those who are not HIV positive in the program.<sup>43</sup>

Services for people living with HIV and AIDS covered by Medicaid include mandatory and optional services. Mandatory services that are important to people with HIV/AIDS are inpatient and outpatient hospital services, physician and laboratory services, and long-term care. States also have the opportunity to cover a set of optional services and receive matching federal funds if they choose to do so. The optional services include prescription drugs, which all states have chosen to cover, dental care, clinic, diagnostic, screening and preventive services<sup>44</sup>, home and community-based and rehabilitation services, and case management. Notably, many of the latter services are not covered by Medicare or private insurance.<sup>45</sup>

Medicaid also serves as an important provider of health coverage for women, particularly in the provision of family planning services. Women make up three-quarters of the Medicaid population, even though the only women who qualify are those who are very low-income, pregnant, have children under the age of 18 living at home, or are disabled. Women over 65 also qualify for Medicaid; however, women without children or disabilities are typically ineligible no matter how low their income.<sup>46</sup> Beginning in 1972, Congress recognized the importance of family planning and established a legal entitlement to family planning for Medicaid beneficiaries nationwide by requiring all states to include “family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies.”<sup>47</sup> Of note, although it is the states’ option to cover prescription drugs, contraceptives are included under the family planning mandate as family planning supplies, and are therefore required in all state programs.<sup>48</sup>

Medicaid provided \$1.8 billion toward family planning services in FY 2010, accounting for 75 percent of total public funding for family planning.<sup>49</sup> Medicaid is also responsible for financing almost half of all births in the U.S.<sup>50</sup> According to the Guttmacher Institute and The Brookings Institution, every dollar invested in pregnancy prevention saves up to six dollars in Medicaid expenditures that otherwise would have been needed for pregnancy-related care.<sup>51</sup>

As of March 1, 2014, 30 states have obtained federal approval to extend Medicaid eligibility for family planning services to individuals who would otherwise not be eligible, either under a waiver from the federal government (19 states) or through a State Plan Amendment (11 states).<sup>52</sup> In addition, all states had established Medicaid programs to pay for breast and cervical cancer treatment for certain low-income uninsured women.<sup>53</sup> Under the Breast and Cervical Cancer Prevention and Treatment Act of 2000, states

have the option to provide full Medicaid benefits to uninsured women under age 65 who are diagnosed with cervical or breast cancer through the National Breast and Cervical Cancer Early Detection Program. Coverage extends throughout the duration of treatment. All 50 states and DC have opted to participate in the federal program, though coverage does differ by state regarding the provider a woman may see for screening.<sup>54</sup>

### *Children's Health Insurance Programs*

Together, Medicaid and the Children's Health Insurance Program (CHIP) provide health insurance coverage for more than 43 million children and adolescents, including half of the low-income children and adolescents in the U.S.<sup>55</sup> CHIP is specifically responsible for covering nearly 8 million children and adolescents in families with incomes too high to qualify for Medicaid but who cannot afford private insurance.<sup>56</sup> Dependents up to age 19 in families with incomes up to \$45,000 per year (for a family of four) are likely to be eligible for coverage though most have expanded their coverage so children in families with higher incomes can also qualify.<sup>57</sup> Medicaid and CHIP have helped to greatly reduce the rate of uninsured low-income children and adolescents in the past decade. A record 90 percent of children have health care coverage through either public or private, including employer-based, health insurance.<sup>58</sup>

While the federal government set minimum guidelines for Medicaid eligibility, as noted above, CHIP allows states to expand coverage beyond that minimum threshold. All states have expanded coverage for children and on average, children living in families with an income that is 241 percent of the Federal Poverty Level (FPL) are eligible for CHIP.<sup>59</sup> CHIP covers U.S. citizens and certain legal immigrants and states have the option of covering children and pregnant women who are lawfully residing in the U.S.; undocumented immigrants are not eligible for coverage under CHIP.

CHIP gives states three options for designing and administering their CHIP programs. They can expand their Medicaid programs to include newly eligible children, develop their own programs, or implement a combination of both strategies. States also have the flexibility to design their own CHIP program within federal guidelines. This results in state-by-state variations as to which specific benefits are part of state CHIP programs.<sup>60</sup> However, all states are required to cover routine check-ups, immunizations, dental and vision care, inpatient and outpatient hospital care, and laboratory and X-ray services.<sup>61</sup> In addition, pregnant women may be eligible for CHIP.<sup>62</sup>

For those states whose CHIP programs are an expansion of their Medicaid program, they are required to provide comprehensive services, including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for youth under age 21 on Medicare. EPSDT includes screening, diagnostic, and treatment services and are required in four areas: medical, vision, dental, and hearing.<sup>63</sup>

While coverage varies state-by-state, some of the sexual health services that are covered under EPSDT may include: evaluation of adolescent maturation; gynecological and pelvic exams; family planning, including birth control, pre- and post-natal care, labor, and delivery; STI and HIV screening, care, and treatment; age-appropriate anticipatory guidance on sexual activity; and such services as mental health screening and substance use and abuse prevention and treatment. In addition, states are required to cover immunizations using the Advisory Committee on Immunization Practices (ACIP) vaccine list as their guide. States that have CHIP programs that are separate from their Medicaid programs must also cover ACIP-recommended vaccines for beneficiaries.<sup>64</sup> This includes vaccines for HPV and hepatitis A and B.<sup>65,66</sup>

As in Medicaid, Medicaid-expansion CHIP family planning services are a mandatory and confidential benefit. In state-designed CHIP programs, it is at the state's discretion if they include family planning

services as a benefit. The vast majority of states provide coverage for reproductive health services for adolescents as part of their CHIP programs. However, programs are inconsistent in requiring the provision of information to adolescents about the full range of reproductive health services or how to access those services.<sup>67</sup>

In addition, while many laws protect the confidentiality of adolescents, few states report guaranteeing that confidentiality.<sup>68</sup> In particular, administrative and billing practices utilized by Medicaid and CHIP may make confidentiality protections put in place by minor consent laws effectively nonexistent. For example, the practice of mailing home Explanation of Benefits (EOB) statements may violate adolescent confidentiality even in states where minors have the right to consent for certain services, afforded by either state or federal law. EOBs generally list the recipient's name, services provided, date of service, and a description of the services provided, as well as other details. For adolescents participating in CHIP, state policies regarding EOBs vary depending on the type of program and whether Medicaid or another agency administers the program.<sup>69</sup> (For more on adolescent confidentiality, see *Spotlight: Barriers to Access* below.)

### *Medicare*

Medicare is the federal insurance program for people age 65 and older and younger adults who are permanently disabled. The program provides health insurance coverage to over 47 million people, including 39 million people age 65 and older and 8 million younger adults with permanent disabilities, and pays for health care services including hospitalizations, physician services, and prescription drugs.<sup>70</sup> Medicare provides broad health care coverage for basic health care services, including hospital insurance (Part A), medical insurance (Part B), and prescription drug coverage (Part D). Medicare also includes Medicare Advantage (Part C), in which private plans (primarily HMOs) contract with Medicare to provide Part A, Part B, and, in most cases, the Part D drug benefit, to enrollees.<sup>71</sup>

Medicare Part B preventative care coverage includes HIV and STI screening tests and counseling, mammograms, pap tests and pelvic exams, prostate cancer screening, and hepatitis B vaccination, as well as a "Welcome to Medicare" preventative visit and a yearly "Wellness" visit.<sup>72</sup> Medicare also covers up to two individual behavioral counseling sessions each year for people who meet certain criteria—"sexually active adults who are at an increased risk for STIs." While STI screening tests and counseling are covered under Part B, this is only the case in a primary care doctor's office or clinic; behavioral counseling sessions conducted in an inpatient setting, like a skilled nursing facility, are not covered as a preventive service under Part B however, STI screenings are covered in this setting.<sup>73</sup>

Medicare is an important source of health coverage for an estimated 100,000 people with HIV, covering approximately one-fifth of people living with HIV that are receiving care in the U.S. Most of these enrollees are under the age of 65 and qualify because they are disabled. In Fiscal Year 2011, federal Medicare spending on HIV/AIDS care totaled \$5.4 billion.<sup>74</sup> Even so, Medicare spending on HIV represents less than 1 percent of total Medicare spending. According to the Centers for Medicare and Medicaid Services, the government agency responsible for overseeing the Medicare and Medicaid programs, Medicare spending on HIV surpassed Medicaid spending for the first time in 2006, becoming the single largest source of federal financing for HIV care.

In addition, while Medicare provides basic coverage, it does not cover all services that may be important to people living with HIV and AIDS and the aging, such as long-term care and routine dental and eye care.<sup>75</sup> Most beneficiaries with HIV have some form of supplemental coverage to cover the full range of health care services they need. The main source of supplemental coverage is Medicaid; the Ryan White Program and private insurance are also important sources of supplemental coverage.<sup>76</sup>

As with private insurance, transgender people sometimes encounter limitations in their Medicare coverage or confusion about what is covered, both for transition-related care and for routine preventive care. While Medicare covers routine preventive services for all eligible persons, according to the National Center for Transgender Equality, it may automatically refuse coverage of services that “appear inconsistent with a gender marker in Social Security records as a means of preventing erroneous or fraudulent billing, with the unintended consequence of denying claims for procedures that many transgender people need.”<sup>77</sup> Medicare does cover medically necessary hormone therapy, though if hormone therapy were prescribed “for cosmetic purposes,” it would not be covered.<sup>78</sup> In addition, Medicare does not cover sex reassignment surgery for transgender people. This exclusion is due to a decades-old policy that categorizes such treatment as “experimental” or as cosmetic surgery, which is not covered under Medicare.

### *The Ryan White Program*

The Ryan White Program is the single largest federal program designed specifically for people living with HIV in the United States. It is estimated to reach more than half a million people with HIV each year.<sup>79</sup> First authorized in 1990, the Ryan White Program provides funding to cities, states, and local community-based organizations and has played an increasingly essential role in the provision of care for people living with HIV/AIDS.<sup>80</sup> The program acts as the “payer of last resort,” providing care and support services for individuals and families affected by the disease who do not have sufficient health coverage or the financial resources to successfully manage the disease.<sup>81</sup>

After Medicare and Medicaid, the Ryan White Program is the third largest source of federal funding for HIV care in the U.S. Some states and localities also provide supplemental funding to their Ryan White programs.<sup>82</sup> In addition to providing care and support services, the most recent reauthorization of Ryan White in 2009 included provisions aimed at strengthening the Program’s role in identifying individuals who are HIV positive but do not yet know their status. As a result of these provisions, the Secretary of Health and Human Services was required to establish a new national HIV testing goal of five million tests per year, to be met by Ryan White and other federal programs.<sup>83</sup>

In order to meet the needs of the different communities and population affected by HIV/AIDS, the Ryan White Program is comprised of several parts.

- Part A provides emergency assistance to Eligible Metropolitan Areas and Transitional Grant Areas that are most severely affected by the HIV/AIDS epidemic.
- Part B provides grants to all 50 States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and five U.S. Pacific Territories or Associated Jurisdictions. Part B also includes the AIDS Drug Assistance Program (ADAP) that provides medications to people with HIV who cannot afford them.
- Part C funds public and private organizations that provide primary health care in an outpatient setting for people living with HIV, including reaching people newly diagnosed with HIV with services such as HIV testing, case management, and risk reduction counseling.
- Part D provides funding to public and private organizations to provide community-based and family-centered services to children, youth, and women living with HIV/AIDS and their families. These services include outreach, prevention, primary and specialty medical care and psychosocial services.
- Part F funds several programs including:

- AIDS Education and Training Centers that provide education and training for providers who treat people living with HIV and AIDS;
- Dental Program that provides additional funding to increase access to dental care for people living with HIV and AIDS;
- Minority AIDS Initiative that strengthens organizational capacity, expands HIV-related services in minority communities, and is tasked with evaluating and addressing the disproportionate impact of HIV/AIDS on African Americans and other minorities; and
- Special Projects of National Significance Program that addresses emerging needs of clients and supports the development of effective delivery systems for HIV care and treatment, including assisting in the development of a standard electronic client information data system.

What originally began as an emergency program, the Ryan White Program has grown to become a centerpiece of HIV/AIDS care and treatment in the U.S. However, Ryan White is dependent on yearly appropriations by Congress and funding levels, of late, have not kept up with the demand of those that need services, the actual costs of services, and the increased demand for the Program due to recent economic conditions.<sup>84</sup> In addition, the future role of Ryan White is unclear as both the National HIV/AIDS Strategy and health reform are implemented.

Legislative Spotlight: *Ending the HIV/AIDS Epidemic Act of 2013* (H.R. 3117)

Congresswoman Barbara Lee (D-CA), a stalwart leader in the fight to end the HIV/AIDS epidemic and founding member of the Congressional HIV/AIDS Caucus, introduced the *Ending the HIV/AIDS Epidemic Act of 2013* (H.R. 3117) on September 17, 2013. The legislation “articulates a policy and financing framework to achieve an AIDS-Free Generation in the United States and globally.”<sup>85</sup> It aims to achieve this goal by increasing federal resources for HIV/AIDS prevention, care, and treatment and targeting those resources for communities most at risk; intensifying the fight against stigma and discrimination against people living with HIV and AIDS; eliminating or reforming laws that violate human rights and diminish the impact of available resources; and maximizing federal efforts to ensure optimal efficiency among HIV/AIDS programs. The bill “establishes a system to expand targeted efforts to prevent HIV infection using a combination of effective, evidence-based approaches and accelerated research and educational reforms to addressing the epidemic at home and abroad.”<sup>86</sup> In addition, it provides for distributing condoms in prisons and monitoring HIV care.

*Title X*

Signed into law by President Richard Nixon and enacted in 1970 as part of the Public Health Service Act, Title X is the only federal program wholly devoted to providing comprehensive family planning and related preventive health services. According to the U.S. Department of Health and Human Services, Title X “is intended to assist individuals in determining the number and spacing of their children...promot[ing] positive birth outcomes and healthy families.”<sup>87</sup> In the past 15 years, funding for family planning has increasingly become a collaboration between Medicaid and the Title X family planning program with Medicaid paying predominantly for clinical care and Title X funding wrapping around that “core to buttress the system of family planning centers and fill gaps in services and coverage.”<sup>88</sup>

Known as “America’s family planning program,” Title X provides access to contraceptive services, supplies, and information. Through Title X, the federal government not only subsidizes direct client services (using 90 percent of appropriated funding), but also is responsible for putting family planning centers in communities and supporting their ongoing infrastructure development. Title X grantees provide family

planning services to almost five million women and men through a network of over 4,100 service sites that include: state and local health departments, tribal organizations, hospitals, university health centers, independent clinics, community health centers, faith-based organizations, and other public and private nonprofit agencies.<sup>89</sup> By law, Title X prioritizes providing services to low-income women and men<sup>90</sup> and these services are provided free of charge to clients with incomes below the federal poverty level (FPL). Other clients receive services either on a sliding scale on the basis of their income, or, if they have an income above 250 percent of FPL, are charged the full fee.<sup>91</sup>

Current Title X program guidelines require that all clients receiving services at a health care provider receiving Title X funding must offer a “package” of contraceptives and related preventive services, which include a pelvic exam, Pap test to screen for cervical cancer, physical exam, blood pressure check, and a breast exam. Women who are considered to be at “high risk” for STIs are to be offered testing, counseling, treatment, and medical referral for follow-up care if necessary. Pregnancy testing is also a core service and a client who tests positive for pregnancy is entitled to nondirective counseling, and referral for all of her legal options, including prenatal care, adoption, and abortion. By statute, Title X grant dollars have always been expressly prohibited from funding abortion services.<sup>92</sup> Title X is notable for its confidentiality requirement, which includes adolescents. Title X was amended in 1981 to encourage, but not mandate, parental involvement, requiring grantees “to the extent practical” to “encourage family participation in the decision of minors to seek family planning services.”<sup>93</sup> Finally, Title X is responsible for setting the standard of care for the delivery of family planning service nationwide.<sup>94</sup>

According to the Guttmacher Institute, in 2010, publicly funded services provided nine million women with contraceptive services. That included more than two million women served by private doctors and clinicians and nearly seven million women served by the nation’s network of “more than 8,000 family safety net health centers providing family planning services in 2010.”<sup>95</sup> This resulted in helping women and couples avoid 2.2 million unintended pregnancies, which would have resulted in 1.1 million births and 760,000 abortions. Guttmacher estimates that, without these services, unintended pregnancy, teen pregnancy, and abortion in the U.S. would be nearly two-thirds higher among women overall and 70% higher among poor women. In addition, the subset of services provided by publicly supported family planning centers resulted in almost 1.2 million unintended pregnancies averted in 2010 at a net savings to taxpayers of \$5.3 billion. This amounted to nearly \$6 saved for every \$1 spent providing contraceptive care.<sup>96</sup>

#### *Community Health Centers (Federally Qualified Health Centers)*

Serving the primary health care needs of more than 22 million patients in over 9,000 locations through 1,200 organizations across America since 1965, Community Health Centers (CHCs) offer a crucial resource for the 46 million Americans without insurance, the working poor and other marginalized subpopulations in the U.S.<sup>97</sup> They specifically target medically underserved populations, making CHCs critical to ensuring equitable access to health care services, including sexual health care.<sup>98</sup> In 2010, 93% of CHC patients had incomes below 200% poverty and utilized CHCs as their entry point into the health care system. Four out of five of these patients consider CHCs their usual source of care.<sup>99</sup>

CHCs offer sexual health care as a component of their primary care health services. Additionally, women comprise more than half of CHC patients and almost half of those women are of childbearing age.<sup>100</sup> In 2010 alone, CHCs provided 1.1 million patients with contraceptive services.<sup>101</sup>

Authorized under the Public Health Services Act, federal funding for CHCs has increased since FY 2002.<sup>102</sup> A large source of CHC revenue comes from grants and contracts, while Medicaid makes up more than one



third of most centers' revenues (38.1%).<sup>103</sup> CHCs also secured federal support through the ACA, which authorized an \$11 billion five-year trust for expansion, construction, and operations. Similar to other safety-net provider systems, CHCs are an economically smart choice, with health center costs of care growing slower than national health expenditures<sup>104</sup> and saving \$24 billion annually for the health care system.<sup>105</sup>

#### *Maternal and Child Health Block Grant*

The Title V Maternal and Child Health (MCH) Program is the nation's oldest federal-state partnership, enacted in 1935 as part of the *Social Security Act*, and provides a foundation for ensuring the health of women, mothers, children and youth, including children and youth with special health needs, and their families.<sup>106</sup> The Title V MCH Program was converted to a block grant in 1981.<sup>107</sup> As a "block grant," states and territories are able to prioritize their MCH investments to meet their specific needs and a formula is used to determine funding allocations based on population size and need.<sup>108</sup> Federal funding is matched by the state or territory receiving funds—for every four dollars in federal funding appropriated by Congress, states and territories are required to match three dollars with state revenue. It is estimated that federal and state funding for the Title V MCH Block Grant total over two billion dollars a year.<sup>109</sup>

The Title V MCH Block Grant provides funding to a total of 59 states and jurisdictions. In fiscal year 2009, State Title V programs served over 39 million individuals. Among the individuals served were 2.5 million pregnant women, 4.1 million infants, 27.6 million children, and 1.9 million children with special health care needs.<sup>110</sup> While authorized at \$850 million, in 2010 the Title V MCH Block Grant was funded at \$662 million — almost \$60 million less than the 2002 funding level of \$730 million over a decade ago.<sup>111</sup>

The Maternal and Child Health Bureau of the Health Resources and Services Administration, which is responsible for overseeing the Title V MCH Block Grant, details that MCH programs have an impact on four levels. The top level is "direct health care services," which include basic health care such as prenatal care and family planning. The second level is "enabling services," which are those services that bolster and support direct care, including transportation, health education, and family support services. Third are "population-based services," which includes activities performed by state and territorial health departments, such as newborn screening, immunization, and public education, that address the maternal and child health needs of populations, and not just individual patients. Finally, the foundation is "infrastructure-building services" such as data collection and analysis, needs assessment, and standards development.<sup>112</sup>

#### *School Based Health Centers*

Defined as a partnership between schools and community health organizations, school-based health centers (SBHCs) work to provide on-site medical and mental health services to school-age children and adolescents, without concern for students' ability to pay. Working together with school nurses and other service providers in the community or school, SBHCs provide another avenue to ensuring equitable access to sexual health services by offering primary care, mental health care, and reproductive health care.<sup>113</sup> HHS' Health Resources and Services Administration (HRSA) reports that SBHCs are currently serving more than 790,000 young people in schools.<sup>114</sup>

According to the School-Based Health Alliance 2010-2011 Census Report, the 1,930 SBHCs around the country receive nearly 40% of their funding through Section 330 of the Public Health Services Act (PHSA), about 25% of funding from the American Recovery and Reinvestment Act (ARRA), and 14% from Title X family planning funding. Other funding sources come from the Substance Abuse and Mental Health Services Administration (SAMSHA) Safe Schools/Healthy Communities, Teen Pregnancy Prevention Programs, and the Social Security Act Title V Maternal and Child Health Block Grant.<sup>115</sup> The ACA appropriated a total of \$200 million for FY 2010 through FY 2013 to improve and expand services at

SBHCs.<sup>116</sup> SBHCs also report additional funding sources from state governments, private foundations, school districts, hospitals, and billing among other resources.<sup>117</sup> SBHCs have been proven to be economically beneficial as their patients cost Medicaid an average of \$30.40 less than comparable, non-SBHC patients.<sup>118</sup>

Nearly all SBHCs are located in a school building or on school grounds (94.4%) and the majority (54.2%) serve urban communities. Not only serving students on site, SBHCs also serve families of students, students from other schools, faculty, and members of the community. Additionally, these health centers serve youth from ethnically diverse backgrounds, with Black/African American students representing almost one third of the students served and Hispanic/Latino students representing over one third.<sup>119</sup>

SBHCs are important in ensuring sexual health access. The majority of sites that serve middle and high school-aged students offer abstinence counseling, provide diagnosis and treatment for STDs, including HIV testing and HIV/AIDS counseling, as well as pregnancy testing. However, half of all SBHCs are prohibited from dispensing contraceptives, citing school district policy, school policy, or health center policy as main reasons why dispensing contraceptives is prohibited.<sup>120</sup> The Guttmacher Institute found that older centers are more likely than newer ones to provide contraceptives on-site, noting that as these sites develop a relationship of trust with parents and the community, they will be able to introduce much needed changes.<sup>121</sup>

#### **SPOTLIGHT: BARRIERS TO ACCESS**

##### *Confidentiality for Sexual Health Care Services*

Confidentiality is all but accepted as a universal and fundamental principle undergirding the provision of health care. Despite this, confidentiality in accessing health care services is a concern for many and is often cited as a barrier to seeking sexual health care services.

The health insurance billing and claims process widely utilized today, particularly the practice of sending Explanation of Benefits forms (EOBs) to the insurance policyholder whenever care is provided under her or his policy, routinely, albeit unintentionally, violates the basic guarantee of confidentiality for anyone enrolled as a dependent on someone else's policy. While this de facto lack of confidentiality may effect any dependent seeking care, the issue may be all the more critical for those seeking sensitive services and may make a person less likely to seek a range of sexual and reproductive health services, mental health services, substance abuse treatment, or disclose intimate partner to a health care provider.<sup>122</sup>

A significant number of Americans access health insurance coverage through the policy of a family member. This is true for nearly all adolescents who have private health insurance who are covered under a parent's policy. In 2008, nearly two-thirds of full-time college students were insured through a parent<sup>123</sup> as were nearly one-in-five 19-23 year-olds who were not students in 2005.<sup>124</sup> In addition, roughly 25 percent of adult women are insured as a dependent, compared with 13 percent of adult men.<sup>125</sup> Health care reform has already significantly expanded the number of young people on their parent's insurance plan. As a result of the ACA, since 2010, young people have been able to stay on their parent's health insurance that includes dependent coverage until they reach age 26 and in order to qualify for coverage, the young adult does not need to be living with his or her parents, be a full-time student, or be listed as a dependent on the parents' tax return.<sup>126</sup> A 2013 study reports that between September 2010 and December 2011 more than three million young adults have gained coverage as a result.<sup>127</sup>

Federal law allows minors to receive family planning services without parental consent at Title X-funded family planning clinics and also from participating Medicaid providers. In addition, laws in all states explicitly give certain minors the right to consent to specific services that might include general medical care and sensitive services.<sup>128</sup> According to the Guttmacher Institute, over the past 30 years states have expanded minors' authority to consent to health care, including care related to sexual activity. Twenty-one states and the District of Columbia explicitly allow all minors to consent to contraceptive services and 25 states explicitly permit minors to consent to contraceptive services in one or more circumstances. However, four states have no explicit policy on minors' authority to consent to contraceptive services.<sup>129</sup> Most states also allow minors to consent to prenatal care and delivery.<sup>130</sup> All 50 states and the District of Columbia explicitly allow minors to consent to STI services without parental involvement, although 11 states require that a minor be of a certain age (generally 12 or 14) to do so. Thirty-one states explicitly include HIV testing and treatment in the package of STI services to which minors may consent.<sup>131</sup> Finally, most states allow minors to consent for substance abuse treatment, and in about half of states, they are specifically authorized to consent to outpatient mental health care.<sup>132</sup>

The potential for harm when it comes to delayed or forgone sexual health services is significant. For example, someone may forego or even delay testing and treatment for STIs, which puts not only herself or himself at risk, but her or his partners as well. In addition, a pregnant woman who is concerned about telling her husband that she is pregnant may delay entry into prenatal care, with potentially serious consequences. Fear of disclosure may also make a woman decide to decline to use their insurance to cover an abortion. This may be particularly true for young women where lack of confidentiality under private insurance plans is “tantamount to a de facto parental notification requirement, provisions clearly shown to create serious impediments for many teens.” Data shows that state laws which deny confidential access to abortion for adolescents cause delays in access to the procedure, reducing safety and resulting in more costly later-term abortions.<sup>133</sup>

Lack of confidentiality may also inhibit utilization of contraception services, particularly for married women who do not want their husbands to know they are using contraception or for adolescents who may decide to forgo contraceptive use if their parents will be notified. For adolescents, a guarantee of confidentiality may be the deciding factor as to whether they seek necessary sexual health care. One nationwide study of adolescents attending family planning clinics found that 60 percent of those under the age of 18 said their parents knew they received sexual health services at a clinic—predominantly because the adolescent had told their parents themselves or their parents had suggested they go to the clinic. Among adolescents who had not already disclosed their clinic visit to a parent, 70 percent reported they would not seek family planning services and 25 percent said they would have unsafe sex if they were unable to obtain confidential care.<sup>134</sup>

#### *Access to Abortion for Low-Income Women*

While Medicaid covers the majority of family planning and reproductive health services, including birth control, routine gynecological exams, and sterilization, since 1977 it has been prohibited from covering abortion with few exceptions. Medicaid is the principal federal safety net health insurance program for low-income Americans and those living with disabilities. (See *Medicaid* section above for additional information about the program.)

When abortion first became legal in 1973, Medicaid covered abortion just as it did other medical procedures, as a standard of medical care. In the years just after abortion became legal in the United States, Medicaid paid for over one-third of all abortions performed in the U.S. According to the National Network of Abortion Funds, “[i]t became clear that Medicaid coverage of abortion is essential for low-income women

to build the lives they want.”<sup>135</sup> But in 1976, Congress passed what is known as the “Hyde Amendment,” which barred Medicaid from covering abortions—the only medical procedure that has ever been banned from coverage under Medicaid.<sup>136</sup> Of his amendment, Representative Henry Hyde (R-IL) once commented, “I would certainly like to prevent, if I could legally, *anybody* having an abortion: a rich woman, a middle class woman, or a poor woman... Unfortunately, the only vehicle available is the [Medicaid] bill.”<sup>137</sup>

While there are 15 states that use their own money to pay for abortion care as part of their Medicaid programs, there are 35 that do not.<sup>138</sup> In addition, in the over three-and-a-half decades since its passage, the Hyde Amendment policy has become part of nearly a dozen other federal laws that now prevent federal health care programs from covering abortion, including Medicare, the Indian Health Service, the Peace Corps, the Federal Employees Health Benefits Program, the military’s Tricare program, and federal prisons.<sup>139</sup> Further, it is the only health care service that is treated unfavorably in ACA and insurance providers who offer plans that include abortion coverage in the health insurance exchanges have restrictions placed on them by ACA. (See *The Affordable Care Act’s Impact on Sexual Health Care Services* section below for additional information.)

While the Hyde Amendment and the subsequent inclusion of its language in other federal programs has had some impact on all women, low-income women and women of color bear the brunt of this policy. Women enrolled in Medicaid are by definition those with the fewest resources and 2010 marked the highest poverty rate for women in 17 years. At the same time, the unintended pregnancy rate for low-income women was increasing—50 percent increase for women below the poverty line between 1994 and 2006—even while rates for more affluent women were decreasing— for women with incomes at or above the poverty line the unintended pregnancy rate decreased by almost 30 percent. As stated clearly by the Center for American Progress:<sup>140</sup>

Put another way, abortion is becoming a poor woman’s problem—just as more women are becoming poor... At a time when Americans are experiencing record rates of poverty and economic hardship, the Hyde Amendment only compounds an already difficult situation and cuts off aid to those who need it most.

### **The Affordable Care Act’s Impact on Sexual Health Care Services**

When President Barack Obama signed the ACA into law in March 2010, he set in motion the largest reform of the U.S. health insurance system since the creation of Medicare and Medicaid in the 1960s and one of the most significant pieces of health promotion legislation ever passed. The ACA has and will continue to significantly impact access to and affordability of sexual health care services. Some highlights follow below.

#### *People Living with HIV and AIDS*

People living with HIV and AIDS have long had a difficult time obtaining private health insurance, often being denied coverage for their pre-existing conditions. They have been particularly vulnerable to insurance industry abuses and historically faced barriers to obtaining quality care from qualified providers. The ACA makes considerable strides in addressing these concerns and advancing equitable care for people living with HIV and AIDS.<sup>141</sup>

- As of September 23, 2010:
  - insurers are no longer able to deny coverage to children living with HIV or AIDS,

- insurers cannot cancel or rescind coverage to adults or children unless they can show evidence of fraud in an application, and
- insurers can no longer impose lifetime caps on insurance benefits.
- Beginning in 2014:
  - insurers will not be allowed to deny coverage to anyone or impose annual limits on coverage,
  - Medicaid eligibility is expanded to generally include individuals with income below 133 percent of FPL and eliminates the disability requirement for Medicaid coverage for people living with HIV,
  - the Medicare Part D “donut hole”<sup>142</sup> will be phased out giving Medicare enrollees living with HIV and AIDS a better chance of being able to afford their medications, and
  - new insurance plans are required to offer coverage without cost-sharing for HIV screening tests for at-risk individuals, meaning that plans can no longer charge a patient a copayment, coinsurance, or deductible for these services when they are delivered by a network provider.

In addition, the ACA extends federal non-discrimination protection to the federally funded health care system for the first time. This includes the *Americans with Disabilities Act* and the *Rehabilitation Act*, which protect individuals living with HIV or AIDS.

### *Women*

Beginning August 1, 2012, women gained access to a range of essential “no-cost” preventative health care services through their private insurance. The new services will be offered to the roughly 47 million insured women who are eligible to receive the copay-free services, which include:<sup>143</sup>

- annual well-woman visits,
- screening for gestational diabetes, osteoporosis, and colon cancer,
- pap smears and pelvic exams,
- testing for the high-risk strains of the human papilloma virus (HPV),
- counseling for sexually transmitted infections,
- counseling and screening for HIV and other STIs,
- all FDA-approved methods of contraception and counseling,
- breastfeeding supplies, support, and counseling, and
- screening and counseling for domestic and interpersonal violence.

For low-income women, the ACA allows states to expand access to family planning services for lower-income women. States are now able to provide family planning services under Medicaid using the same eligibility they use for pregnant women, usually 200 percent of the federal poverty level.

The exception to the expansion of coverage for women is that while abortion can be covered under ACA, it is treated differently than every other health care service and there are numerous restrictions placed on it.<sup>144</sup> Women enrolled in Medicaid have long had abortion coverage restricted and the ACA extends these restrictions to all women getting premium assistance credits to pay for health insurance through the health insurance exchanges. Health plans operating the exchanges that offer coverage of abortion will be required to collect separate payments for abortion care and for all other health care. It is unclear how this may impact private insurance plans, although abortion coverage remains available in the private market, subject to state restrictions.<sup>145</sup>

As of 2014, insurance providers are prohibited from charging women higher premiums simply because of their gender (a.k.a. “gender rating”). Gender discrimination will also be prohibited in all federally funded health care for the first time. This means any insurance company receiving federal funds, such as tax credits, subsidies and contracts will be prohibited from discriminating against women.<sup>146</sup>

### *LGBT Individuals*

Lesbian, gay, bisexual, and transgender people have historically been poorly served by the current health care system in the United States. Beginning in 2014:<sup>147</sup>

- insurance companies will be prohibited from denying coverage on the basis of pre-existing conditions, including transgender medical history,
- any adult under the age of 65 who makes less than \$15,000 a year will be eligible for Medicaid under the new national threshold for Medicaid eligibility, significantly impacting many LGBT and gender non-conforming people and their families who often face pervasive discrimination in the workplace and in relationships and are disproportionately likely to make less than \$15,000 per year, and
- state health care exchanges are prohibited from discriminating on the basis of sexual orientation or gender identity in any of their activities.

As noted, the ACA extends federal non-discrimination protection to the federally funded health care system for the first time. In addition to the *Americans with Disabilities Act* and the *Rehabilitation Act*, this includes Title IX of the education amendments of 1972, which offer protections on the basis of sex, which has recently been interpreted by the courts and the Department of Health and Human Services, among other federal agencies, to include gender identity, though not sexual orientation.<sup>148</sup>

### *Adolescents and Young Adults*

Beginning in 2010, young people are able to stay on their parent’s health insurance that includes dependent coverage until they reach age 26.<sup>149</sup> Beginning in 2014:<sup>150</sup>

- Medicaid eligibility will expand to include any adult under the age of 65 who has an income no greater than 133 percent of the federal poverty level, or roughly \$15,000 a year,
- states will be required to continue Medicaid coverage for youth who age out of foster care until they reach age 26, as long as the youth were the responsibility of the state on their 18<sup>th</sup> birthday and were enrolled in Medicaid while they were in foster care,
- states will be required to provide Medicaid coverage for all youth through age 18 who are in families making less than 133 percent of the federal poverty level,
- states are required to maintain March 2010 eligibility levels in their Medicaid and CHIP through 2019,
- newly eligible adolescents and young adults under the age of 21 will be able to receive the full range of Medicaid benefits when they gain coverage and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services will be expanded to all Medicaid beneficiaries under age 21,
- all new private insurance plans must cover HPV vaccines as well as Pap tests for the recommended populations without consumer cost-sharing because they are recommended by ACIP.<sup>151</sup>

### *Immigrants*

As a result of ACA, legal immigrants are:<sup>152</sup>

- permitted to purchase coverage in the state health insurance exchanges,
- eligible for temporary high-risk pools and “basic health plans” offered by a state,
- eligible for premium tax credits, cost-sharing reductions, and subsidies to purchase coverage in the exchanges if their incomes fall below 400 percent of the federal poverty line, and
- barred from enrolling in Medicaid and CHIP during their first five years in the U.S., though states now have the option to lift this prohibition for pregnant women and children.

In addition, the ACA does not alter current eligibility for immigrants so they are able to enroll in Medicaid or CHIP; however, current federal immigrant eligibility restrictions in Medicaid remain in place, including the five-year-or-more waiting period for most documented, low-income immigrant adults.

On the other hand, undocumented immigrants are:<sup>153</sup>

- prohibited from purchasing coverage in the state insurance exchanges,
- prohibited from enrolling in Medicare, nonemergency Medicaid, or CHIP,
- still eligible for emergency care under federal law, and
- eligible for Emergency Medicaid if low-income.

In addition, the Obama administration ruled in August 2012 that young immigrants who are granted a reprieve from deportation will not be eligible for Medicaid, CHIP, or other health insurance coverage under the ACA.<sup>154</sup>

## CONCLUSION AND RECOMMENDATIONS

The ability of individuals to access high-quality health care, particularly sexual health care services, is essential to creating a sexually healthy America. Sexuality is also one of the most complex and politicized issues debated in the public health and health care arenas, but it is essential that sexuality and sexual health be addressed openly and honestly in order to achieve significant outcomes in public and individual health, gender equity, and social justice. The right of all people—regardless of age, socioeconomic status, gender, gender identity, or sexual orientation—to have access to affordable, confidential sexual health services including healthcare services that promote, maintain, and if needed, restore sexual and reproductive health should be ensured. Government agencies at the federal, state, and local levels have a significant role to play, both directly and indirectly, in advancing the sexual health of individuals and of communities by developing policies, crafting regulations, implementing programs, and providing funding for programs and research.

Many subpopulations—including adolescents, gay men and men who have sex with men, transgender and gender non-conforming individuals, incarcerated individuals, and older adults—are rendered invisible in health care conversations, often lacking the resources and access necessary to support and advance their own sexual health and well-being. When these subpopulations are able to access such services, they often face discrimination in health care settings, particularly in conversations about sexuality and sexual health. All individuals, including these subpopulations, face significant barriers to care in the form of lack of funding and access to health care, laws, and policies that stand in the way of accessing sexual health care.

The following recommendations aim to address these barriers to care so that, as a society, we can change the public discourse on sexual health and well-being to ensure access to high-quality sexual health care services.

- ***From Medical Model to Sexual Health Promotion.*** Health care providers and settings should shift from a medical model that only addresses acute medical issues to one that addresses the broader aspects of sexual health that will support an individual’s overall health and well-being. This means addressing sexual health promotion that focuses on an individual’s well-being and ability to be healthy in their sexual expression, behavior, and activity, as opposed to only addressing disease treatment and prevention.
- ***Provider Training.*** Health care providers should increase their level of awareness of sexual health promotion and sexual issues and address the topic as a relevant discussion for all of their patients, particularly those who are adolescents, older adults, gay men and MSM, transgender and gender non-conforming individuals, and those who are incarcerated. Education of administrative, nursing, and clinical staff is critical to creating and maintaining health care environments in which all patients feel safe and open to discussing their sexual health needs.<sup>155</sup>
- ***Culturally Competent Sexual Health Care Services.*** Health care providers should create a safe and welcoming environment for all patients—supportive, respectful, culturally competent services that includes factual and non-judgmental counseling are essential for reaching people throughout the lifespan with the sexual health care information and services they need. Such an approach will encourage patients to seek care and address all health-related matters with their health care provider. Providers should use non-judgmental, gender-neutral language when inquiring about sexual partners



or significant others, focus on sexual behavior as opposed to sexual orientation, and provide age-appropriate and not ageist care to their patients.

- ***Coordinated Sexual Health Care Services.*** Services should be integrated to offer individuals a multidisciplinary and holistic approach to age-appropriate health care that includes primary care, sexual health care, reproductive health care, STI and HIV testing and treatment, substance abuse treatment, mental health care, and education and counseling in one location.
- ***Confidentiality.*** All individuals, including adolescents and incarcerated individuals, should be ensured confidentiality as they access the range of sexual health care services. In particular, minors should be allowed by law to consent to sexual health care services, including contraceptive services, prenatal care and delivery, and STI, including HIV, prevention, screening, care, and treatment. For adolescents, parental involvement should be encouraged; however, parental consent or notification should not be required. In addition, incarcerated individuals should be ensured confidentiality in the receipt of all medical services, including those related to sexual health.
- ***Resource Allocation.*** Local, state, and federal governments, as well as foundations and organizations, need to provide adequate resources to support sexual health and well-being, particularly for marginalized and economically disenfranchised populations. Political will and adequate funding are necessary to achieve a sexually healthy America, including the goals laid out in the National HIV/AIDS Strategy, the US National Prevention Strategy, and Healthy People 2020.

## **THE SEXUAL HEALTH CARE NEEDS OF FIVE VULNERABLE POPULATIONS**

As a follow up to this report, SIECUS examined the specific needs of vulnerable populations, those that are often invisible in conversations about health care and who often lack the access, and resources necessary to avail themselves of services. It is also important to continue to prioritize the health of those that often face discrimination in health care settings. In this vein, we have chosen five subgroups—adolescents; gay men and men who have sex with men; transgender and gender non-conforming people; the incarcerated, including those in the juvenile justice system; and older adults—to address their unique sexual health care needs. We recognize that these are not the only vulnerable subgroups in need of additional focused attention, resources, and research. A series of reports by SIECUS, each detailing the state of sexual health care services, the challenges faced, and recommendations to improve sexual health care services for these five vulnerable populations follow.



**SIECUS**

Sexuality Information and Education  
Council of the United States

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## **THE SEXUAL HEALTH CARE NEEDS OF ADOLESCENTS**

**A SPECIAL FOLLOW-UP REPORT TO  
ENSURING EQUITABLE ACCESS TO HIGH-QUALITY SEXUAL HEALTH CARE SERVICES**

**BY THE  
SEXUALITY INFORMATION AND EDUCATION COUNCIL OF THE UNITED STATES**

SIECUS recognizes the importance of looking at sexual health across the lifespan and the affordability and accessibility of high-quality sexual health care services for all populations. We also recognize the importance of highlighting the specific needs of marginalized populations, those that are often invisible in conversations about health care and who often lack the access and resources necessary to avail themselves of services. It is important to continue to prioritize the health of those that often face discrimination in health care settings. In this vein, we have chosen five subgroups, including adolescents, to address their unique sexual health care needs.

### **THE SEXUAL HEALTH CARE NEEDS OF ADOLESCENTS**

Sexuality is a normal part of adolescent development and adolescents have distinct sexual health care needs from adults that require “special attention and services to promote healthy development and a safe transition to adulthood.”<sup>156</sup> Adolescents are often invisible in conversations about health care and routinely lack access and resources necessary to obtain services. In addition, they often face discrimination in health care settings that lack coordinated, youth-friendly services that support their sexual health and well-being and focus on more than just the prevention of disease and pregnancy. As a result, adolescents are disproportionately affected by negative sexual health outcomes.

The second decade of life is a time of significant growth and development that provides a unique opportunity to develop the behaviors and habits that will have life-long implications for well-being. Adolescence is a time when young people develop the knowledge, attitudes, skills, and behaviors they need to become sexually healthy. These attitudes and behaviors may determine their health habits in adulthood, creating long-term positive and negative health implications.<sup>157</sup> This developmental time period provides an opportunity to lay a foundation for a lifetime of sexual health and well-being. A growing body of evidence indicates that childhood circumstances such as exposure to infectious diseases, different socialization towards risk-taking and deferred gratification, and a sense of autonomy and control over one’s surroundings have an enduring effect on health. These effects simply cannot be erased by advantaged conditions in adulthood.<sup>158</sup> And as noted by Former-Surgeon General Jocelyn Elders, “Improving the health status of adolescents is critical to improving the health status of the population.”<sup>159</sup> If adolescents develop healthful

habits and experience physical and mental health conditions that do not jeopardize their immediate health, this can contribute to superior health in adulthood.<sup>160</sup>

As they grow and mature, young people need access to accurate information about their sexuality and to high quality sexual health care services. Ensuring that adolescents have access to high quality, developmentally and age-appropriate, and affordable health care services can lay the foundation for a lifetime of good health and health habits. Achieving adolescent sexual health means moving beyond the prevention of unintended teen pregnancy, sexually transmitted infections (STIs), and HIV, and developing adolescent's capacity to form and maintain healthy relationships with family, peers, and significant others. Personal, social, psychological, educational, environmental, and economic factors, among others, all play a role in achieving sexual health.

While young people in the U.S., aged 15–25, make up only one-quarter of the sexually active population, they contract about half of the 19 million sexually transmitted diseases (STDs) annually. The Centers for Disease Control and Prevention (CDC) estimates that one in four young women aged 15–19 has an STD.<sup>161</sup> Many professional groups, including the American Academy of Pediatrics (AAP),<sup>162</sup> the Society for Adolescent Health and Medicine (SAHM),<sup>163</sup> and the American Medical Association (AMA)<sup>164</sup> recognize that all young people are at current or future risk for STIs, including HIV. They recommend that all young people receive behavioral counseling to prevent STIs, including the recommendation that they delay sexual activity and use barrier methods, including condoms, if sexually active.

Adolescents and young adults may also need vaccinations as part of their preventative sexual health care services. HPV is the most common STD in the U.S., causing almost all cases of genital warts and cervical cancer. The expansion of adolescent vaccine requirements to include the HPV vaccine has provided additional opportunities for risk counseling, because discussion regarding this vaccination affords a natural segue into discussions of other STDs and HIV.<sup>165</sup> Based on the recommendation of the Advisory Committee on Immunization Practices, the HPV vaccine (i.e., Cervarix or Gardasil) should be administered routinely to all 11- to 12-year-old females, as well as 13- to 26-year-olds who were not previously vaccinated. The vaccines can also be given to females as young as nine years of age. Further, the CDC recommends that 11 and 12 year-old boys, and males 13 through 21 years of age, who did not get any or all of the shots when they were younger, receive the Gardasil vaccination to protect against most genital warts and anal cancer.<sup>166</sup> According to the CDC, missed clinical opportunities are one of the most important factors in achieving high levels of HPV vaccine uptake, noting the range of settings where HPV vaccines may be administered should broaden to specifically include racial and ethnic minorities and other groups.<sup>167</sup>

Young people aged 13–29 account for over one-third of the estimated 50,000 new HIV infections each year in the U.S., the largest share of any age group.<sup>168</sup> This is the only age group in which HIV incidence is rising, due in large part to an increase among young men who have sex with men (YMSM), particularly YMSM of color.<sup>169</sup> As with adults, most adolescents become HIV-positive through sexual transmission. The number of new cases among people aged 13–29 years increased by 21 percent from 2006 to 2009, fueled by a 34 percent increase in HIV infections among young gay and bisexual men. In 2010, YMSM accounted for 72 percent of new HIV infections among persons aged 13–24 and 30 percent of infections among all men who have sex with men.<sup>170</sup>

In 2006, an estimated 48 percent of HIV-positive adolescents and young adults were unaware of their status,<sup>171</sup> as compared to 20 percent of the full 1.1 million people living with HIV/AIDS in the U.S. who do not know their status,<sup>172</sup> a group that accounts for up to 70 percent of new infections.<sup>173</sup> The CDC recommends universal and routine opt-out HIV testing for all patients aged 13–64 years who are seen in

health care settings. A 2005 American Academy of Pediatrics survey revealed that nearly 50 percent of pediatricians recommend that all sexually active youth be screened for STIs; however, only 28 percent of them recommend that all adolescents be tested for HIV.<sup>174</sup> HIV counseling and testing is central to prevention and treatment efforts and it should be part of routine sexual care services for adolescents and readily available and affordable for any young person who wants to be tested, in a confidential manner. Notably, all youth at risk on the basis of current or past behaviors, especially youth who reside in areas with high prevalence rates, should be identified and urged to undergo testing.<sup>175</sup>

Adolescents who have become infected, as well as the increasing numbers of HIV-positive young people who were infected perinatally and are reaching sexual maturity, are in need of counseling related to sexual activity and other risk behaviors, as well as discussions with their medical providers about the potential for childbearing and leading productive adult lives.<sup>176</sup> As noted by the Society for Adolescent Health and Medicine, “this complex medical and psychosocial care is usually best provided by collaboration between an HIV specialist and strongly adolescent-oriented or adolescent-specific primary health care services, or by transitioning these adolescents to adolescent-specific HIV practitioners, where all of their various needs can be better addressed.”<sup>177</sup>

The U.S. also has one of the highest teen pregnancy rates in the developed world. Each year in the U.S., more than 730,000 women aged 15–19 become pregnant with more than 80 percent of these pregnancies unintended.<sup>178</sup> In 2008, 68 pregnancies occurred per 1,000 women aged 15–19, a record low representing a 42 percent decline from the peak rate of in 1990.<sup>179</sup> The vast majority of the decline in the teen pregnancy rate (86 percent) is due to teens’ improved contraceptive use, while the rest (14 percent) is due an increase in the number of teens choosing to delay sexual activity.<sup>180</sup> Between 2008 and 2011, the abortion rate fell by 13 percent, reaching its lowest level since 1973.<sup>181</sup> However, despite significant declines, disparities among racial and ethnic groups continued to be significant—black and Hispanic teens experience pregnancy and abortion rates two to four times higher than their white peers.<sup>182</sup> The rate of teen fatherhood also declined 25 percent between 1990 and 2006 among males aged 15–19. While this decline was far more substantial among blacks than among whites (38 percent vs. 18 percent), teen fatherhood rates still vary considerably by race with black males aged 15–19 twice as likely to become a father as their white counterparts.<sup>183</sup>

According to the 2006–2010 National Survey of Family Growth (NSFG), 86 percent of female teens and 93 percent of male teens reported using contraceptives at last intercourse.<sup>184</sup> These proportions represent a marked improvement since 1995, when only 71 percent of female teens and 82 percent of male teens had reported using a method at last intercourse. However, the proportions were unchanged between the 2002 and 2006–2010 NSFGs.<sup>185</sup> Condoms are the most common contraceptive method used by adolescents at first intercourse with 68 percent of females and 80 percent of males using them the first time they have intercourse. The 2006–2010 NSFG also found that 96 percent of female teens who had been “sexually active” had used a condom at least once, 57 percent had ever used withdrawal, and 56 percent had used the pill. Smaller proportions had used other methods. During the same period, one in five sexually active female teens (20 percent) and one-third of sexually active male teens (34 percent) reported using both a condom and a hormonal method the last time they had intercourse for protection against both pregnancy and STIs.<sup>186</sup>

The Society for Adolescent Health and Medicine recommends that contraceptive education, counseling, and low or no-cost contraceptive services should be made available to all male and female adolescents desiring such care on the adolescents’ own consent without legal or financial barriers in communities and schools. They note that parental involvement should be encouraged but that consent or notification should not be a requirement.<sup>187</sup> Similarly, the American Academy of Pediatrics recommends that adolescents “postpone

consensual sexual activity until they are fully ready for the emotional, physical, and financial consequences of sex,” while also recognizing that some young people will choose to be sexually active. They state, “as health care providers, the responsibility of pediatricians includes helping teens reduce risks and negative health consequences associated with adolescent sexual behaviors, including unintended pregnancies and sexually transmitted infections.”<sup>188</sup>

SAHM also recommends: “pregnancy detection and subsequent prenatal care, counseling, educational, and postnatal services (including child care) should be available and accessible to adolescents who choose to continue their pregnancies, without legal or financial barriers.” They note that the special needs of school-age mothers, especially those under the age of 16 should receive interventions that “lessen the potential for low birth weight babies.”<sup>189</sup> SAHM also notes that while the prevention of unintended pregnancy is the priority, all adolescents, regardless of socio-economic status, must have access to pregnancy-related options, including access to “elective termination of pregnancy as a legal, safe, available alternative to continuing a pregnancy...[and] the adolescent should have access to abortion without legal or financial barriers without interference...Although involvement of significant others should be strongly encouraged, particularly for minors, mandatory parental consent and/or notification should not be required.”<sup>190</sup>

While sexual, dating, domestic, and intimate partner violence affect all people regardless of their age, young women and teens are most likely to experience these behaviors.<sup>191</sup> Approximately one in three adolescent females in the United States is a victim of physical, emotional or verbal abuse from a dating partner—a figure that far exceeds reported incidence rates for other types of violence affecting youth.<sup>192</sup> In a nationwide survey, 9.4 percent of high school students report being hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend in the 12 months prior to the survey. In addition, roughly one in five women and nearly one in seven men who ever experienced rape, physical violence, and/or stalking by an intimate partner, first experienced some form of partner violence between 11 and 17 years of age.<sup>193</sup> Teens in same-sex relationships experience rates of violence and abuse similar to rates experienced by teens in heterosexual relationships. Nearly one in four teens and young adults (ages 12–21 years) in same-sex romantic or sexual relationships reported some type of partner violence victimization in the past year-and-a-half. One in ten reported experiencing physical violence by a dating partner. Females were more likely to report victimization than males.<sup>194</sup>

Violence limits young women’s ability to manage their reproductive health and exposes them to STIs and unintended pregnancy. Adolescent girls in physically abusive relationships were three times more likely to become pregnant than non-abused girls. Twenty to 25 percent of pregnant teens reported physical or sexual abuse during pregnancy and pregnant teens who experience abuse are more likely to miscarry than their non-abused peers.<sup>195</sup> One study found that adolescents who had experienced dating violence were nearly three times more likely to fear the perceived consequences of negotiating condom use and more than two-and-a-half times more likely to fear talking with their partner about pregnancy prevention. That same study found that a history of dating violence was associated with being nearly three times more likely to have had an STI and half as likely to use condoms consistently in the past six months.<sup>196</sup> In addition, teens who have experienced dating violence are more likely than their non-abused peers to smoke, use drugs, engage in unhealthy diet behaviors, engage in high risk sexual behaviors, and attempt or consider suicide.<sup>197</sup>

Despite this reality, critical gaps remain in the delivery of health care to those who have experienced sexual violence, “with many providers discharging a woman with only the presenting injuries being treated, leaving the underlying cause of those injuries not addressed.”<sup>198</sup> In four different studies of survivors of abuse, 70-81 percent of the patients studied reported that they would like their healthcare providers to ask them privately about intimate partner violence.<sup>199</sup>

Futures Without Violence, which works to prevent and end violence against women and children around the world, recommends that all health care providers seeing children and adolescents should provide intimate partner violence assessment as part of routine patient care. The American Academy of Family Physicians notes that, “[d]espite barriers to the diagnosis and treatment of victims of family violence, family physicians are in an ideal position to take on this challenge and are compelled to do so by the sheer magnitude of the problem”<sup>200</sup> and recommends that questions about family violence become part of anticipatory guidance for pediatricians who should become familiar with existing guidelines for managing situations of abuse.<sup>201</sup>

The health system, including the settings and providers delivering sexual health care services play an important role in promoting healthful behavior, managing health conditions, and preventing disease during adolescence.<sup>202</sup> Ideally, these services are integrated to offer adolescents a multidisciplinary and holistic approach to adolescent health care that includes primary care, sexual and reproductive health care, STI and HIV testing and treatment, substance abuse treatment, mental health care, and education and counseling in one location. However, several factors hinder adolescents’ use of, or access to, sexual health care services and related programs that may help them achieve and maintain sexual health. Firstly, adolescents need the ability to develop their capacity to function as independent agents in the health care system.<sup>203</sup> While health care ideally is implemented in conjunction with the goal of involving adolescents’ parents and families in care and the health decision-making of their children, confidentiality protections for adolescents are essential. The issue of confidentiality has been identified by both providers and youth as “a significant access barrier to health care.”<sup>204</sup>

Second, health care providers should create supportive, respectful, youth-friendly environments in order to effectively serve young people. According to SAHM, “creating a safe environment for teenagers to discuss issues concerning their health will facilitate the best possible care and counseling to respond to their needs.”<sup>205</sup> They also note that particular attention should be focused on the needs of LGBT youth, as well as youth who are homeless, runaways, or “made vulnerable by learning, emotional or family challenges,” as well as those in state custody or the justice system.<sup>206</sup> The AAP also suggests that discussing same-sex and other-sex attractions, sexual identity, sexual activity, and exposure to sexual violence or abuse are vital components of discussion when taking sexual histories and providing health guidance to adolescents.<sup>207</sup>

Another significant barrier to adolescent access to sexual health care services is their lack of health insurance coverage. Adolescents lack health insurance at higher rates than younger children and young adults have the lowest rate of insurance over the lifespan.<sup>208</sup> Nine percent of adolescents 12–17 years of age do not have health insurance<sup>209</sup> and the uninsured rate for young people aged 19 to 25 decreased from 29.8 percent in 2010 to 27.7 percent in 2011, when 8.3 million of them had no health insurance.<sup>210</sup> A large reason for this decrease is a provision in ACA that enables young people to remain on their parents’ health insurance plans until they turn 26. Like all age groups, adolescents and young adults need access to high-quality and affordable sexual health care services, financially accessible through both private insurance and through publicly funded safety net programs.

One publicly funded safety net for adolescents is school-based health care, which has been described as “a little known resource for closing the achievement gap and improving life outcomes for millions of children.”<sup>211</sup> School-based health centers (SBHCs) generally provide both primary care, including sexual health care, and mental health services to students. Because of their focus on low-income children and adolescents, SBHC’s provide a health care “home” for millions of families and assist in reducing pervasive health disparities, particularly among the uninsured, underinsured, and communities of color.<sup>212</sup> There are

nearly 2,000 SBHCs serving primarily low-income children in 44 states and the District of Columbia. SBHCs are typically located on school property or through a mobile unit operated by another entity like a community health center, hospital, or health department.

According to the National Assembly on School-Based Health Care's National Census, a survey of SBHCs, in 2007–2008, about 60 percent of SBHCs provide gynecological exams and PAP tests.<sup>213</sup> Approximately 65 percent provide STD testing and treatment and some form of HIV testing.<sup>214</sup> Eighty percent offer pregnancy testing, but about 60 percent preclude the provision of contraceptives most often because of a local school district policy.<sup>215</sup>

### ***Conclusion and Key Recommendations:***

Adolescents are disproportionately affected by both negative sexual health outcomes and lack of access to services, particularly those that support their sexual health and well-being and focus on more than just the prevention of disease and pregnancy. Adolescence is a time when young people develop the knowledge, attitudes, skills, and behaviors they need to become sexually healthy. The attitudes and behaviors molded during adolescence lay a foundation for a lifetime of sexual health and well-being. Yet adolescents often lack the information to know why or how to access sexual health care services, lack the resources necessary to access such care, and these services are often not coordinated or youth-friendly.

- ***Confidentiality.*** While ideally implemented in conjunction with the goal of involving adolescents' parents and families in care and the health decision-making of their children, confidentiality protections for adolescents are essential in order to achieve the goal of complete disclosure by adolescents to their health care providers.
- ***Coordinated, Youth-Friendly Services.*** Creating supportive, respectful, youth-friendly services that include factual and non-judgmental counseling is essential for reaching young people with the sexual health care information and services they need and to encourage adolescents to be forthcoming with their medical histories and share complete information with their healthcare providers. These services should be integrated to offer adolescents a multidisciplinary and holistic approach to adolescent health care that includes primary care, sexual health care, reproductive health care, STI and HIV testing and treatment, substance abuse treatment, mental health care, and education and counseling in one location.
- ***Health Insurance Coverage.*** Like all age groups, adolescents and young adults need access to high-quality and affordable sexual health care services, financially accessible through both private insurance and through publicly funded safety net programs that guarantee their confidentiality.
- ***School-Based Health Centers.*** SBHCs represent a major sexual health care access point for adolescents, particularly those who are low-income. Support of SBHCs and future sustainability and growth lies at the state and national levels.
- ***Sexually Transmitted Infections, including HIV.*** All young people should receive behavioral counseling to prevent STIs, including the recommendation that they delay sexual activity and use barrier methods, including condoms, if sexually active. Adolescents and young adults should receive any age-appropriate vaccinations as part of their preventative sexual health care services. HIV counseling and testing is central to prevention and treatment efforts and it should be part of routine

sexual health care services for adolescents and readily available and affordable for any young person who wants to be tested, in a confidential manner.

- ***Contraception, Pregnancy, and Abortion.*** All adolescents, regardless of gender, should have access to contraceptive education, counseling, and low or no-cost contraceptives and services. All adolescents, regardless of socio-economic status, should have access to pregnancy-related options, including access to pregnancy testing and subsequent pre-natal care, counseling, educational, and post-natal services (including child care) for adolescents who choose to continue their pregnancies. They should also have access to safe, legal abortion without interference or the requirement of parental consent and/or notification. All services should be available without legal or financial barriers. Parental involvement should be encouraged; however, parental consent or notification should not be required.
- ***Family, Teen Dating, and Intimate Partner Violence.*** All health care providers seeing children and adolescents should provide intimate partner violence assessment as part of routine patient care in public health, private practice, and managed care settings. Questions about family violence should be part of anticipatory guidance for pediatricians who should understand the dynamics of abusive relationships and become familiar with guidelines for managing situations of abuse.





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## **THE SEXUAL HEALTH CARE NEEDS OF GAY MEN AND MEN WHO HAVE SEX WITH MEN**

**A SPECIAL FOLLOW-UP REPORT TO  
ENSURING EQUITABLE ACCESS TO HIGH-QUALITY SEXUAL HEALTH CARE SERVICES**

**BY THE  
SEXUALITY INFORMATION AND EDUCATION COUNCIL OF THE UNITED STATES**

SIECUS recognizes the importance of looking at sexual health across the lifespan and the affordability and accessibility of high-quality sexual health care services for all populations. We also recognize the importance of highlighting the specific needs of marginalized populations, those that are often invisible in conversations about health care and who often lack the access and resources necessary to avail themselves of services. It is important to continue to prioritize the health of those that often face discrimination in health care settings. In this vein, we have chosen five subgroups, including gay men and men who have sex with men (MSM), to address their unique sexual health care needs.

### **THE SEXUAL HEALTH CARE NEEDS OF GAY MEN AND MEN WHO HAVE SEX WITH MEN**

Demographers have found it difficult to quantify how many gay men and men who have sex with men (MSM) live in the United States. While estimates may put the number somewhere around two percent,<sup>216</sup> many health care providers and health care organizations have noted that all providers should assume there are gay men and MSM in their communities and should prepare as though they are in their primary health care practice.<sup>217</sup> Much of the focus regarding gay men and MSM has focused on HIV infection, in large part due to the disproportionate impact of HIV among the population—at least a quarter million gay men and MSM are living with HIV in the U.S. and approximately 20,000 more will likely become infected this year. Nevertheless, the vast majority of gay men and MSM are not HIV-infected but still require high-quality sexual health care that is culturally competent, targeted to their needs,<sup>218</sup> and moves beyond the disease-prevention paradigm.

Although most major health care issues for gay men and MSM are similar to the routine health recommendations for all men, independent of sexual orientation or sexual behavior, there are unique issues to consider that take into account the potential medical implications related to an individual's sexual identity, orientation, and behavior. Some of these issues include: screening for and immunizing against hepatitis A and B virus; routine screening for STIs, including HIV; routine screening for certain cancers (i.e., anal cancer related to HPV); assessing drug, alcohol, and tobacco use; screening for psychological health and mental health disorders, domestic violence, hate crimes, and post-traumatic stress; and helping patients deal

with stigma associated with being a sexual minority as well as the social and psychological issues of coming out.<sup>219</sup>

The Institute of Medicine has noted that in order to explore the health of lesbian, gay, bisexual, and transgender (LGBT) people, it is important for health care providers to understand the contextual factors that influence their lives. They underscore that LGBT people face barriers to equitable health care that profoundly affect their overall well-being and may influence gay men and MSM's interactions with health services and health care providers and their utilization thereof. Such barriers include a lack of health insurance, fear and perception of discrimination from providers, lack of knowledge on the part of providers, lack of perceived severity of medical conditions, and dissatisfaction with services.<sup>220</sup>

In 2009, the Gay Men's Health Agenda outlined the complexities that must be addressed in order for gay men and MSM to achieve sexual health.

We understand that many of our health challenges arise in complex associations with each other (e.g. HIV and substance abuse, poverty and sexually transmitted infections, homelessness and victimization to violence, stigma and mental health disorders, etc.) and therefore must be assessed, treated, and managed holistically. Moreover, other social determinants impact our health and wellness, such as lack of comprehensive, age appropriate health and sexuality education in our schools, homophobia and transphobia in law enforcement practices, and unresponsive health and social service systems across most of the nation.<sup>221</sup>

In order for health care providers to properly support the sexual health and well-being of their patients who are gay or MSM, as well as to properly screen for risk factors and provide more comprehensive care, they first need to know if their male patient is gay, bisexual, or has sex with men. Gay and bisexual men and MSM may sometimes consciously avoid medical care because of fear of discrimination and may withhold sensitive, yet important information from their health care provider for the same reason.<sup>222</sup> One study found that 44 percent of self-identified gay men had not told their primary care physician about their sexual orientation.<sup>223</sup> As noted by the Gay and Lesbian Medical Association, "it is vital that health care providers create a safe and welcoming environment for gay and bisexual men to self-identify and discuss their sexual histories and behaviors and other health-related issues. Establishing a gay and [MSM]-friendly practice will encourage your patients to seek care and address all health related matters openly."<sup>224</sup>

Steps that providers can take to create a health care environment friendly to MSM and/or gay-identified patients include using terms on intake forms and during interviews that avoid making assumptions about a patient's sexual behavior or sexual orientation. For example, use gender-neutral terms like "partner" or "spouse" instead of "husband," "wife," "boyfriend," or "girlfriend" or ask about "relationship status" as opposed to "marital status" and include options like "partnered." When taking a sexual health history and a sexual risk assessment, providers should use gender-neutral language when inquiring about sexual partners or significant others and focus on sexual behavior as opposed to sexual orientation, so as not to deter MSM who may not identify as gay from being forthcoming with important medical information. In addition, all staff in the health care setting should participate in sensitivity training. Education of administrative, nursing, and clinical staff is critical to creating and maintaining health care environments in which MSM feel safe and welcome.<sup>225</sup>

While it is important for clinicians to recognize the medical implications of sexual behavior, it is also important they identify patients whose sexuality may be evolving and who may want help "coming out" and identifying themselves as gay to friends, family, and society. Coming out may happen at any age and

clinicians should be aware that even those who are middle-aged or older and have been in heterosexual marriage or other long-term relationships may also engage in the process. This process can be particularly difficult for MSM from communities of color who may experience dual stigma associated with being both a sexual and racial/ethnic minority. They may experience homophobia within their own racial/ethnic group as well as racism from the mainstream gay community—a combination which may increase their level of social exclusion.<sup>226</sup> For gay men and MSM of any age, “a knowledgeable and caring physician can be an important resource helping gay youth overcome the challenges associated with a sexual minority identity and to lead happy, healthy, and productive lives.”<sup>227</sup>

High-quality sexual health care for gay men and MSM must also include mental health services focused not only on depression and suicide but also on mood disorders and anxiety.<sup>228</sup> Multiple studies have shown that depression and anxiety affect gay men at a higher rate than the general population, and are often more severe for men who remain “in the closet.” Factors such as stigma, discrimination, victimization, violence, verbal and physical harassment, negative experiences related to “coming out” (including level of family acceptance), substance use, child abuse, and isolation all contribute to higher rates of suicidal attempts and completions among gay men and youth than among other populations.<sup>229</sup> Many risk factors that have been implicated in suicidal behavior of young people tend to be higher among sexual minority youth, including depression, substance use, early sexual initiation, not feeling safe at school, cigarette smoking, and inadequate social support. Culturally sensitive mental health services that specifically target gay men have been shown to be more effective in the prevention, early detection, and treatment of these conditions,<sup>230</sup> and should be incorporated into high-quality sexual health care services for gay men and MSM of all ages.

While HIV and STIs are certainly not the only issue facing gay men and MSM, HIV infection and other viral and bacterial STIs are still a primary sexual health concern for gay men and MSM, particularly those subgroups at higher risk such as young MSM and MSM of color. The frequency of unsafe sexual practices and the reported rates of bacterial STIs and incident HIV infection declined substantially in MSM from the 1980s through the mid-1990s; however, since that time, increased rates of syphilis (primary, secondary, or early latent), gonorrhea, and chlamydial infection and higher rates of unsafe sexual behaviors have been documented among gay men and MSM in the U.S.,<sup>231</sup> as well as higher rates of HIV among some subgroups of MSM.<sup>232</sup> MSM are still disproportionately impacted by HIV—56 percent of persons living with an HIV diagnosis are MSM or MSM with a history of injection drug use (MSM-IDU). In 2009, MSM accounted for 61 percent of all new HIV infections, and MSM-IDU accounted for an additional 3 percent of new infections. Younger men and men of color have been particularly affected and are experiencing a disproportionate increase in the number of new cases of HIV.<sup>233</sup> The number of new cases among people aged 13–29 years increased by 21 percent from 2006 to 2009, fueled by a 34 percent increase in HIV infections among young gay and bisexual men. It is also important to note that HIV/AIDS impacts not only younger but also older gay men and MSM. However, few HIV prevention programs target older adults, a cohort that also has been deeply affected by the losses caused by AIDS.<sup>234</sup> An increase in syphilis among MSM has also been reported in Chicago, Seattle, San Francisco, Southern California, Miami, and New York City. It is now known that contracting syphilis also makes one more likely to transmit or acquire HIV infection and these areas have experienced high rates of syphilis and HIV co-infection, ranging from 20 to 70 percent.<sup>235</sup>

The CDC observes that these adverse trends in selected sexual health outcomes likely reflect the changing attitudes concerning HIV infection that have accompanied advances in HIV therapy, resulting in improved quality of life and survival for HIV-infected persons; changing patterns of substance abuse; demographic shifts in MSM populations; and, changes in sex partner networks resulting from new venues for partner acquisition, such as the internet. They recommend that clinicians routinely inquire about the gender of sex

partners for all male patients in order to assess their STI-related risk. They also recommend that MSM, regardless of HIV status, should routinely undergo straightforward, non-judgmental STI, including HIV, risk assessments and client-centered prevention counseling to reduce the likelihood of acquisition or transmission of HIV or other STIs. MSM who have multiple or anonymous partners, who have sex in conjunction with illicit drug use (particularly methamphetamine), or who have partners who participate in these activities should be screened for STIs more frequently, at three to six month intervals. In addition, vaccination for Hepatitis A and B is recommended for all MSM for whom previous infection or vaccine cannot be documented.<sup>236</sup>

Gay men and MSM may also be at increased risk for several types of cancer, including prostate, testicular, and colon cancer.<sup>237</sup> In addition, people who have receptive anal sex, including gay men and MSM, are at higher risk for anal cancer because of an increased risk of HPV infection. Gay and bisexual men are estimated to be 17 times more likely to develop anal cancer than heterosexual men.<sup>238</sup> Unfortunately, the same strains of HPV that are associated with cervical cancer (usually types 16 and 18) can also develop into anal carcinoma. While treatments for HPV do exist, recurrences of the warts and the rate at which the infection can be spread between partners are very high. The CDC recommends that 11 and 12 year-old boys, and males 13 through 26 years of age, who did not get any or all of the shots when they were younger, receive the Gardasil vaccination to protect against most genital warts and anal cancer.<sup>239</sup> However, studies have noted that screening services may be severely limited in large part to the challenges that gay men and MSM face in receiving culturally sensitive care.<sup>240</sup> Gay men may be more likely to have difficulty dealing with the medical community of mainly heterosexually oriented urologists and oncologists and, as noted, previously, gay men and MSM may be wary of a “real or feared homophobia and heteronormative focus of clinicians.”

Data shows that gay men generally experience two types of violent victimization: criminal violence based on their sexual minority status, and violence from an intimate male partner. Intimate partner violence occurs at the same rate in same-sex relationships as it does in opposite-sex relationships, making discussions about whether clients feel physically safe in their relationships an important part of the care of MSM.<sup>241</sup> Gay survivors of hate crimes have been found to manifest significantly more symptoms of depression, anger, anxiety, and post-traumatic stress compared with lesbian and gay victims of comparable crimes unrelated to their sexual orientation. There is limited information about gay elders experiences with violence; however, one study that looked at LGB adults and their lifetime experiences with violence found that 63 percent reported verbal abuse, 29 percent had been threatened with violence, 16 percent had experienced assault, 12 percent had experienced assault with a weapon, and 11 percent had had an object thrown at them.<sup>242</sup> In addition, LGBT youth also report experiencing elevated levels of violence, victimization, and harassment compared with heterosexual and non-gender-variant youth. As a result, providers should routinely assess their male clients for a history of domestic violence and/or victimization at every age.<sup>243</sup>

### ***Conclusion and Key Recommendations***

Gay men and MSM require high-quality sexual health care that is culturally competent and targeted to their unique needs. Although most major health care issues for gay men and MSM are similar to the routine health recommendations for all men, independent of sexual orientation or sexual behavior, there are unique issues to consider that take into account the potential medical implications related to an individual’s sexual identity, orientation, and behavior. The coordination of prevention, care, and treatment that focuses on and addresses these unique needs is necessary to not only support the prevention of disease and reduce health disparities faced by gay men and MSM but also to support their overall sexual health and well-being.

- ***Gay- and MSM-Friendly Health Practices.*** Health care providers need to understand the contextual factors that influence the lives of gay men and MSM. They should create a safe and welcoming environment for gay men and MSM to self-identify and discuss their sexual histories and behaviors and other health-related issues. Establishing a gay- and MSM-friendly practice will encourage patients to seek care and address all health related matters openly. Providers should use terms on intake forms and during interviews that avoid terms that make assumptions about a patient’s sexual behavior or sexual orientation. When taking a sexual health history and a sexual risk assessment, providers should use gender-neutral language and focus on sexual behavior as opposed to sexual orientation.
- ***Medical Provider Education.*** In addition to provider training around issues of cultural competency, as noted by the Fenway Institute, the nation’s first community-based HIV research program, “[i]ncreasing the profession’s awareness of the core medical issues for gay men...is the first step. All these diseases are easy to diagnose and treat, but if newer trends in prevalence are not acknowledged in medical education, physicians are unlikely to pay appropriate attention to necessary behavioral change and medical treatment when seeing patients in clinical settings...What message do we as physicians send to our patients, gay or straight, when we ignore safety issues related to sexual behavior”<sup>244</sup>
- ***Mental Health Support and Services.*** High-quality sexual health care for gay men and MSM must also include mental health services focused not only on depression and suicide but also on mood disorders and anxiety. Culturally sensitive mental health services that specifically target gay men and MSM should be incorporated into high-quality sexual health care services for gay men and MSM of all ages.
- ***STIs, including HIV.*** All gay men and MSM should routinely receive straightforward, non-judgmental risk assessment, screening, and prevention counseling to reduce the likelihood of acquisition or transmission of HIV or other STIs.



Sexuality Information and Education  
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At the Nexus of Policy and Implementation

## **THE SEXUAL HEALTH CARE NEEDS OF TRANSGENDER AND GENDER NON-CONFORMING INDIVIDUALS**

**A SPECIAL FOLLOW-UP REPORT TO  
ENSURING EQUITABLE ACCESS TO HIGH-QUALITY SEXUAL HEALTH CARE SERVICES**

**BY THE  
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SIECUS recognizes the importance of looking at sexual health across the lifespan and the affordability and accessibility of high-quality sexual health care services for all populations. We also recognize the importance of highlighting the specific needs of marginalized populations, those that are often invisible in conversations about health care and who often lack the access and resources necessary to avail themselves of services. It is important to continue to prioritize the health of those that often face discrimination in health care settings. In this vein, we have chosen five subgroups, including transgender and gender non-conforming individuals, to address their unique sexual health care needs.

### **THE SEXUAL HEALTH CARE NEEDS OF TRANSGENDER AND GENDER NON-CONFORMING INDIVIDUALS**

Transgender and gender non-conforming people are individuals whose gender identity differs from the sex they were originally assigned at birth or whose gender expression varies significantly from what may be traditionally associated with their biological sex. Also included are individuals who vary from or reject traditional cultural conceptualizations of gender in terms of the male–female dichotomy. Gender identity is a separate construct from sexual orientation—the overall term used to describe people’s physical and/or romantic attractions to other people—or sexual behavior—conduct of a sexual nature, including sexual activity that may or may not be related to sexual orientation.

The transgender population is diverse in gender identity, expression, and sexual orientation. In addition, some transgender individuals have undergone medical interventions to alter their sexual anatomy and physiology, while others might wish to undergo such procedures in the future, and still others do not wish to have any medical intervention. Transgender people can be any sexual orientation and while some lesbians, gay men, and bisexuals are transgender, most are not.<sup>245</sup>

While most major health care issues for transgender and gender non-conforming individuals are similar to the routine health recommendations for all people, independent of sexual identity, sexual orientation, or sexual behavior, there are unique issues to consider to support sexual health and well-being that take into account the potential medical implications related to an individual’s sexual and gender identity.

Research indicates that the lack of access to health care is a significant concern for transgender individuals. One of the major barriers is that, some notable exceptions aside, health insurance and other third-party payers, such as Medicare, exclude coverage of transgender-specific health care, even when these needs are not related to a gender transition<sup>246</sup> but particularly when they are.<sup>247</sup> A large portion of the issues that transgender people have with their insurance is the result of difficulties with coding systems that are designed to provide certain procedures for individuals of one sex or the other. For example:

[I]f a transman who is enrolled in the insurance system as a male (which facilitates coverage for his labs that compare results with ‘male’ values) develops uterine fibroids and requires a hysterectomy, the insurance carrier typically denies coverage with the rationale that hysterectomy is only covered for females.<sup>248</sup>

Once an insurance provider labels a patient as transgender, many medical procedures may be routinely denied even if they would be covered if the patient had not been identified as transgender. Most insurance companies also fail to cover the cost of transgender-specific care, including “mental health services, cross-sex hormone therapy, or gender affirmation surgery.” The American College of Obstetricians and Gynecologists notes “[t]his barrier exists despite evidence that such treatments are safe and effective and that cross-gender behavior and gender identity issues are not an issue of choice for the individual and cannot be reversed with psychiatric treatment. . . . With medical and psychiatric care that affirms transgender identity, the transgender individual can lead an enhanced, functional life.”<sup>249</sup>

The Institute of Medicine notes “the cost of medical care, lack of access to specialists, and a paucity of transgender-friendly and -knowledgeable providers are perceived barriers to care. On the other hand, being under the care of a physician is associated with reduced high-risk behavior, such as smoking cessation, medically supervised hormone therapy, and access to clean needles for hormone injection.”<sup>250</sup> Unfortunately, transgender people report high levels of unreceptive and uninformed providers. The National Transgender Discrimination Survey reported that 28 percent of transgender respondents experienced verbal harassment in a medical setting, and 50 percent encountered providers that lacked knowledge of some aspect of their health needs.<sup>251</sup> The consequences of this ill-informed and inadequate treatment of transgender patients has been substantial. Transgender individuals often “resort to the illegal and dangerous use of self-administered silicone injections to spur masculine or feminine physiologic changes” and utilize injected hormones that were obtained illegally or outside conventional medical establishments.<sup>252</sup>

Health care providers and settings should create a safe and welcoming environment for transgender and gender non-conforming individuals to self-identify and discuss their sexual histories and behaviors and other health-related issues. Health care providers’ discomfort with transgender patients results in their feeling alienated, resulting in inadequate or lower quality care. This may also lead transgender individuals to not seek care in the future. In their guidelines for primary care for transgender patients, Vancouver Coastal Health, through their Transgender Health Program, recommends that clinicians refer to transgender patients by their preferred name and pronoun, reassure the patient about confidentiality, and respect the patient’s wishes regarding potentially sensitive physical exams and tests, such as pelvic examinations or mammograms.<sup>253</sup>

The Center of Excellence for Transgender Health further suggests that when treating transgender patients, providers should keep in mind that: “For trans people, their anatomy does not define them, even though that anatomy may require treatments that are typically provided for persons of the opposite sex...Respect the

patient's gender identity, and treat the body as if it belongs to them, rather than defines them.”<sup>254</sup> They also note that even when giving weight to the patient's gender identity and preferred pronouns, the most important principle to apply in general prevention and screening is to “provide care for the anatomy that is present, regardless of the patient's self-description or identification, presenting gender, or legal status.”<sup>255</sup>

There is a dearth of available research related to the health of transgender people.<sup>256</sup> Studies of how medical interventions, such as hormone therapy or sexual reassignment surgeries, affect physical and sexual health and well-being are seriously limited in number and scope.<sup>257</sup> While several thousand transgender individuals have been treated with cross-sex hormones and surgical procedures for over 70 years in Western Europe and over 60 years in the U.S., stigma of gender-variance and sex reassignment has discouraged funding for research.<sup>258</sup> The limited research available suggests that transgender elders may experience negative health outcomes as a result of long-term hormone therapies, that transgender people may struggle with sexual functioning problems as a result of hormone therapy, and that hormone therapy may have an effect on fertility.<sup>259</sup> Additionally, osteoporosis has been reported in both older transgender men and women, and is frequently associated with poor compliance with the hormone regimen.<sup>260</sup> The Institute of Medicine recommends that an “evidence base for providing transgender-specific health care to address gender dysphoria should be created. Most such research is based on small, non-probability samples. A more rigorous research program is needed to understand the health implications of hormone use and other transgender-specific issues.”<sup>261</sup>

The transgender community has been significantly impacted by the HIV/AIDS epidemic, even though the exact prevalence of HIV among the population is unknown because of a lack of systematic surveillance and reporting.<sup>262</sup> Most available research related to HIV and transgender people has focused on transgender women (those who were designated as male sexed at birth and have a female gender identity and/or expression). Stigma and discrimination experienced by many transgender women puts them at increased risk for HIV. A large percentage of transgender women also report engaging in behaviors that place them at increased risk for HIV, including having unprotected receptive anal intercourse, having multiple partners who were predominantly male, having sex while under the influence of alcohol or drugs, or engaging in sex work.<sup>263</sup> Studies of transgender women in the U.S. find not only high prevalence of HIV among the population but also high numbers of transgender women who are HIV positive and do not know their status.<sup>264</sup> Transgender women of color, who also experience stigma and discrimination due to their race and/or ethnicity, are also at heightened risk with African-American and Latina transgender women having the highest prevalence rates of HIV.<sup>265</sup>

Comparatively, due to the assumption of low rates of HIV among transgender men relative to other groups, there has not been much research on their risk behaviors.<sup>266</sup> The limited studies available report HIV prevalence in transgender men as estimated to range from zero to three percent.<sup>267</sup> Similarly to HIV and AIDS, there is a lack of systematic surveillance of STIs among transgender people. The limited research available has shown, however, there are varying prevalence rates within the population and syphilis is of particular concern given its high overall rate.<sup>268</sup>

Intimate partner violence has also been found to be prominent among transgender people, particularly for transgender women of color.<sup>269</sup> Studies suggest that 16–60 percent of transgender people are victims of physical assault or abuse and 13–66 percent are victims of sexual assault. Vancouver Coastal Health recommends that all transgender patients be screened for mental health issues, including the impact of psychosocial stresses, such as transphobic harassment, discrimination, and violence and, if applicable, be referred to a trans-competent mental health provider.<sup>270</sup>



### ***Conclusions and Recommendations:***

The transgender population is diverse in gender identity, expression, and sexual orientation as well as if they have undergone, will undergo, or wish to undergo any medical intervention to affirm their gender identity. Transgender and gender non-conforming individuals predominantly have the same major health care issues as the general population and should receive basic preventive care and treatment that is similar to the routine health recommendations for all people, independent of sexual identity, sexual orientation, or sexual behavior. However, transgender and gender non-conforming individuals should be provided with the care required to meet their specific needs and support their sexual health and well-being.

- ***Transgender-Specific Health Care.*** There are unique issues to consider in support of the sexual health and overall well-being of transgender individuals. Providers should take into account the potential medical implications related to any individual's sexual and gender identity, including gender affirmation surgery, hormone therapy, osteoporosis, and fertility issues, as well as particular mental health needs of this population.
- ***Transgender-Friendly Services.*** Health care providers and settings should always provide care in a sensitive, respectful, and affirming manner that recognizes the patient's self-identification. They should resist defining the person by the biological sex assigned at birth, and give weight to the patient's gender identity and preferred pronouns. Clinicians should reassure the patient about confidentiality and respect the patient's wishes regarding potentially sensitive physical exams and tests, such as pelvic examinations or mammograms. In addition, all staff in the health care setting should participate in sensitivity training.
- ***Insurance Coverage.*** Public and private health insurance plans should cover the treatment of transgender-specific health care and care related to gender transition, including, but not limited to mental health services, cross-sex hormone therapy, and gender affirmation surgery. Coverage for transgender patients should also extend to services not related to gender transition and address difficulties within the coding system that only provide certain procedures for individuals of one sex or the other.
- ***Research.*** The dearth of available research related to the health of transgender people and the lack of systematic surveillance and reporting of HIV and STI prevalence among transgender people must be corrected. As the Institute of Medicine recommends: the "evidence base for providing transgender-specific health care to address gender dysphoria should be created. Most such research is based on small, non-probability samples. A more rigorous research program is needed to understand the health implications of hormone use and other transgender-specific issues."<sup>271</sup>



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## **THE SEXUAL HEALTH CARE NEEDS OF INCARCERATED INDIVIDUALS**

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SIECUS recognizes the importance of looking at sexual health across the lifespan and the affordability and accessibility of high-quality sexual health care services for all populations. We also recognize the importance of highlighting the specific needs of marginalized populations, those that are often invisible in conversations about health care and who often lack the access and resources necessary to avail themselves of services. It is important to continue to prioritize the health of those that often face discrimination in health care settings. In this vein, we have chosen five subgroups, including incarcerated individuals, to address their unique sexual health care needs.

### **THE SEXUAL HEALTH CARE NEEDS OF INCARCERATED INDIVIDUALS**

Over two million people are incarcerated in the United States and low-income men and women, particularly those who are Black and/or African-American, are disproportionately represented. Incarcerated men, women, and young people face the same sexual health care needs as the general population and are in need of services that support their sexual health and well-being, but they are also at increased risk for a range of negative sexual health outcomes, such as STI, HIV, unintended pregnancy, and sexual assault and are more likely to come from medically underserved populations. Inmates living in U.S. correctional facilities report higher rates of disabling health conditions than the general U.S. population. In addition, incarcerated individuals are disproportionately those with serious health issues related to socioeconomic status resulting from poverty, poor housing, or homelessness.<sup>272</sup>

Individuals in custody do not cease to be sexual beings upon entering prison and their desire for sexual expression and sexual intimacy does not vanish upon entering custody. Due to official policies that suppress any sexual expression, sexual behavior, or intimate relationships between and among inmates, inmates may face significant barriers to accessing the sexual health care they need. These policies also may inhibit an institutions' ability to acknowledge that sexual health care services, beyond, for example pre-natal care or treatment for sexual violence, are a legitimate part of the scope of health care services they should be providing inmates. There is "great benefit to acknowledging that inmates do not lose their sexuality once they enter prison and managing these interactions is part of the work required of corrections agencies."<sup>273</sup>

Notably, the incarcerated are the only group with a constitutional right to medical care in the U.S. This right, born out of the Eighth Amendment's prohibition against cruel and unusual punishment, was solidified in 1976 when the Supreme Court recognized that when the government punishes someone by incarceration, it is obligated to meet that person's basic needs, including their health and medical needs. However, the U.S. has no national standards for the implementation of health care in correctional facilities and typically each system—the federal Bureau of Prisons, the federal Bureau of Immigration and Customs Enforcement, state Departments of Corrections, and thousands of local jails—establishes its own policies and procedures for health care provision to inmates.

The level, availability, and access to care varies among settings and the short and often unpredictable duration of incarceration makes continuity of care difficult. Health care for inmates may be provided on site by health care providers, via arrangements with local hospitals or clinics either on site or by inmate transport, or by an on-site health care provider contractor. However, adequate care is still often not delivered because of a lack of resources given the number of inmates incarcerated.<sup>274</sup> In addition, financing for health care in correctional facilities often depends on annual federal, state, and local appropriations and must compete with other priorities.<sup>275</sup> Most inmates encounter multiple barriers to care—“from co-payments they cannot afford to having to convince a guard that they need to see a doctor.”<sup>276</sup> In addition, typically Medicaid funding cannot be used for the health care of adults or adolescents in secure confinement.<sup>277</sup>

While common perception is that many inmates contract HIV while in prison, due to both consensual and nonconsensual unprotected sex and shared needles used for substance use and tattooing, recent reports show that inmates have a higher prevalence rate before they are incarcerated.<sup>278</sup> Drug addiction, poverty, poor housing, and homelessness, as well as increased prevalence of HIV among many of these populations, contribute to their increased risk for HIV and other diseases. Roughly 1.5 percent of all inmates in state and federal prisons have HIV or AIDS, four times the prevalence rate of the general population.<sup>279</sup> Each year, an estimated one in seven people living with HIV pass through a correctional facility,<sup>280</sup> with more than half (51 percent) of all prisoners with HIV or AIDS being imprisoned in California, Florida, New York, and Texas.<sup>281</sup> Two percent of women in state and federal prisons in 2008 were known to be HIV positive.<sup>282</sup>

Correctional facilities are often the first place incarcerated men and women are diagnosed with HIV and provided treatment. The CDC recommends HIV testing as part of routine medical care and in correctional facilities, recommends HIV testing upon entry and before release, as well as periodically during incarceration.<sup>283</sup> And while testing is recommended and HIV prevalence in prisons is high, the data may actually underestimate both HIV prevalence and incidence because of the reluctance of some inmates to test for fear of a positive result and the stigma and fear associated, as well as concerns about medical confidentiality. This fear and stigma also leads to non-disclosure of HIV-positive status, which places prisoners at elevated risk of infection. As noted by Gay Men's Health Crisis, “The true danger of living with HIV in prisons is not, after all, the risk of infecting another inmate, but the stigma and abuse that accompanies a disclosed diagnosis.”<sup>284</sup>

HIV-positive inmates also have to worry about a number of discriminatory practices and human rights violations, including, but not limited to, involuntary disclosure of HIV status to family, staff, and other inmates and assignment to higher security prisons where segregated HIV units are housed. The vast majority of states now integrate HIV-positive inmates into the general inmate population, considered a best practice in health care in correctional facilities. However, Alabama and South Carolina still institute segregation policies, also enforcing HIV testing of all inmates upon entry. In each state, if an inmate tests

positive, they are immediately segregated, and most are required to wear a marker, such as an armband, signifying that they are HIV positive for the duration of their sentence.<sup>285</sup>

According to the CDC, providing clean syringes and condoms to sexually active persons are integral to HIV prevention, but most U.S. correctional facilities specifically prohibit the distribution and possession of these items. “Although sex and substance use are forbidden in jails and prisons, the reality is that some incarcerated men and women have consensual or forced sex and some use illicit drugs.”<sup>286</sup>

Standards for sexual health care services in correctional facilities also include screening for STIs. The American Public Health Association recommends the screening of all prisoners in adult and juvenile facilities, and specifically routine screening for cervical cancer, chlamydia and trichomoniasis in women.<sup>287</sup> The National Commission on Correctional Health Care and American Correctional Association emphasize that diagnostic testing for STIs should be part of the initial health assessment for all incoming inmates.<sup>288</sup> The National Coalition of STD Directors also recommends that to be successful, STI screening should be integrated into the intake process and that highly sensitive urine tests are a convenient, accurate tool for testing for gonorrhea and chlamydia, which is of great advantage in the correctional environment.<sup>289</sup>

Similarly to their adult counterparts, adolescents in juvenile justice facilities are overwhelmingly members of the communities most affected by, and at risk for, HIV, other STIs, unintended pregnancy, and sexual violence, including those who are low-income, African American and Latino, LGBT and gender non-conforming, and survivors of violence and other abuse. Adolescents in juvenile justice facilities have higher rates of sexual risk behaviors, lower rates of condom use, and higher rates of STIs, including HIV, than youth who are not in state custody. A number of studies have found that upon admission to a juvenile justice facility 20-35 percent of juvenile detainees tested were found to be positive for an STI, 20 percent reported having parented a child, and 10 percent were pregnant at admission.<sup>290</sup>

For many young people, incarceration is preceded by homelessness or a period of time living on the streets, engaging in substance use and abuse and risky sexual behavior, often in exchange for shelter, food, or money, thereby increasing their risks for HIV, other STIs, and sexual violence. These health threats are particularly high for LGBT and gender-nonconforming young people who “may be more likely to be funneled through the juvenile justice system and, once in the system, face additional threats to their sexual health and safety due to their LGBTQ status,” including harassment, discrimination, isolation, and abuse.<sup>291</sup> Youth, and particularly LGBT youth, are often left without access to adequate sexual health care services while incarcerated. In general, there are no “consistent, enforceable policies” that ensure young people are provided basic sexual health care services. Despite this fact, the U.S. Department of Justice notes that when a young person becomes incarcerated:

[A] unique opportunity exists to prevent HIV infection, improve public health, and provide important preventative and therapeutic services for youths who may have no other means of accessing them...[I]n order to take full advantage of this opportunity, more juvenile systems should make counseling, education and voluntary HIV testing available.<sup>292</sup>

Teen SENSE, a project of the Center for HIV Law and Policy, recommends that youth in state custody be given screenings that address both their physical and mental health, as well as examinations that include their sexual histories. Just as for inmates of all ages, they further recommend that providers offer information and treatment related to the prevention of STIs, pregnancy, and sexual abuse and offer all youth testing and counseling for STIs, including HIV.<sup>293</sup> In their guide for clinicians for managing STDs in

the correctional setting, the National Coalition of STD Directors also recommend vaccination against HPV be provided in juvenile detention facilities.<sup>294</sup>

**Legislative Spotlight: *Stop AIDS in Prisons Act of 2013*  
(H.R. 895)**

Introduced by Congresswoman Maxine Waters (D-CA), the *Stop AIDS in Prison Act of 2013* requires the Federal Bureau of Prisons to develop a comprehensive policy to provide HIV prevention, testing, and treatment for inmates in federal prisons. The bill would require the Bureau of Prisons to take 11 concrete steps to combat HIV in prison, promote awareness, and improve medical care. All testing and medical care would be required to be strictly confidential, with penalties for any breach of confidentiality. HIV testing would be provided with consent during intake, within three months prior to release, and upon request once a year, or following high-risk exposure or pregnancy. Those who tested positive for HIV would have the option of “partner notification services.” Inmates would be able to refuse testing at any time, for any reason, without penalty. Inmates would also be entitled to comprehensive medical care in a timely fashion, with confidential consultations about managing the virus. In addition, prisons would need to provide educational opportunities for inmates about transmission.

At greater risk of rape and sexual assault than the general population, inmates often experience sexual assault and rape that is violent, causing trauma as well as abrasions and tears to the anus, which can consequently increase their vulnerability of contracting STIs, including HIV. A recent meta-analysis found that research suggests rates of sexual victimization in prison may be as high as 41 percent or as low as less than one percent and estimates a “conservative ‘average’ prevalence estimate of prison sexual assault” at 1.9 percent.<sup>295</sup> One study, which reported that up to one-fifth of federal inmates were victims of rape, found that particularly those who are newly incarcerated or perceived to be gay are at greatest risk. Another report on sexual victimization in prisons identified specific subgroups as more vulnerable than other to sexual assault and rape and, consequently, communicable diseases and trauma: women, gay and bisexual individuals, and individuals that are survivors of sexual assault.<sup>296</sup>

Recognizing and granting inmates a degree of sexual expression may “enhance inmate safety by decreasing prison rape.” By recognizing and regulating such conduct, “states can better prevent incidences of violence and diseases associated with prison rape and help prisoners learn healthy and responsible sexual behavior prior to returning to their communities.”<sup>297</sup> Evidence has shown similar interventions to have positive impact when used in situations involving illegal sex work or when sex is prohibited in other institutional settings, such as “nursing homes, homes for the mentally retarded, and psychiatric settings.”<sup>298</sup>

Incarcerated adolescents are also at increased risk for sexual violence and abuse when they are charged as adults, which happens to tens of thousands of young people each year. The subsequent negative impact on sexual health is stark—adolescents who are incarcerated with adults are more likely to be raped, battered, or driven to suicide than young people served by the juvenile justice system.<sup>299</sup> Youth housed in adult facilities may also have limited availability to access health services tailored to their specific needs, which are essential to their sexual health. Like all young people, youth in correctional facilities need sexual health care services that are confidential, youth friendly, and culturally competent.

Women and adolescent females represent an increasing proportion of inmates in the U.S. correctional system, representing roughly 10 percent of all inmates. Between 1990 and 2009, the number of incarcerated women increased 153 percent. Most women are incarcerated for non-violent crimes with drug offenses being the most common felonies committed by women in both federal (72 percent) and state (34 percent) prison systems, and the second most common offense committed by women in local jails (30 percent). In 2010, adolescent females accounted for 29 percent of all juvenile arrests. Like male offenders, they may be housed in juvenile justice facilities or in adult prisons or jails.<sup>300</sup> Of note, women are often housed in facilities that have predominately male populations, thereby limiting the availability of health services tailored to the specific needs of women.

According to the American College of Obstetricians and Gynecologists (ACOG), incarcerated women and adolescent females typically come from “economically, educationally, socially, and emotionally disadvantaged environments; a disproportionate number have acute and chronic illnesses, substance abuse problems, and undetected health issues, including reproductive health needs.”<sup>301</sup> The majority of incarcerated females are of reproductive age and are at high risk of unintended pregnancy in addition to STIs, including HIV. For example, one study found that 27 percent of incarcerated women had chlamydia and 8 percent had gonorrhea, compared with rates of 0.46 percent and 0.13 percent in the general population, respectively.<sup>302</sup>

Approximately 6–10 percent of incarcerated females are pregnant; however, there are few studies about birth outcomes for women who continue pregnancies during incarceration.<sup>303</sup> One government study found, however, that 20 percent of pregnant women in prison reported getting no prenatal care.<sup>304</sup> As noted by the Center for Women Policy Studies, among the most serious problems pregnant women face in custody are prison staff’s refusal to take bleeding seriously—a problem associated with miscarriage and stillbirth; their failure to recognize when women are in labor—a problem often resulting in women giving birth inside their cells; as well as the failure to provide post-partum care. In addition, staff of correctional facilities who have no medical training are all too often found to be making judgment calls about complicated medical issues and health care policies of correctional facilities are notably silent on when to take a woman in labor to the hospital.<sup>305</sup> The use of restraints during labor has also been a long-standing problem even though international human rights organizations and national medical and public health associations oppose the shackling of laboring women as demeaning, dangerous, and unnecessary. Federal courts are increasingly agreeing with this view and states have recently started passing laws prohibiting the shackling of women during labor—16 states now have statutes limiting the use of restraints, an increase from just three states in 2008.<sup>306</sup> Finally, HIV-positive pregnant women who are incarcerated are rarely provided with the specialists and services they need for themselves and to prevent mother-to-child transmission of the virus.<sup>307</sup>

Women retain their legal rights to abortion while incarcerated, but a woman’s ability to obtain an abortion varies widely by state, region, and individual prison.<sup>308</sup> According to the Center for Women Policy Studies, in at least 20 states and the District of Columbia, “women have had to fight for the right to abortion – and in some cases, have lost and been forced to continue pregnancies against their will.”<sup>309</sup> Many correctional facilities have no official written policy to tell women “how to go about requesting an abortion, and staff members how to go about meeting a woman’s request, since obtaining an abortion will always entail a trip to an outside medical provider.”<sup>310</sup> One-quarter of state prison systems have no official written policy on abortion. ACOG recommends that “care for incarcerated women and adolescent females should be provided using the same guidelines as those for women and adolescent females who are not incarcerated, with attention to the increased risk of infectious diseases and mental health problems common to incarcerated populations,” including access to adequate contraception, prenatal care, abortion services, pap

tests and appropriate follow-up, health education, adequate planning before release from correctional facilities, and avoiding restraints and promoting breastfeeding for pregnant women.<sup>311</sup>

### ***Conclusion and Key Recommendations***

Once incarcerated, people are still sexual beings who desire sexual expression and intimacy and are still in need of high-quality health care that supports their sexual health and well-being. Incarcerated men, women, and adolescents face the same sexual health care needs as the general population, but are also at increased risk for a range of negative sexual health outcomes, such as STI, HIV, unintended pregnancy, and sexual assault. They are more likely to come from medically underserved populations and be disproportionately impacted by serious health issues related to socioeconomic status resulting from poverty, poor housing, or homelessness. All incarcerated individuals, and particularly those that are young, pregnant, LGBT, or survivors of sexual assault, should not be relegated to receiving a lower standard of care because they are incarcerated.

- ***Sexual Health Care.*** National standards of care for correctional facilities should be established to provide a full range of sexual health care services in order to ensure a standard level of available, appropriate, and accessible care. Adequate resources need to be appropriated to ensure the provision of adequate health care for incarcerated individuals.
- ***Sexual Expression.*** Even though prohibited, as noted by the CDC, some inmates do participate in consensual sex or are subject to forced sex. Policies that recognize and allow sexual expression by prisoners may provide correctional officials with the opportunity to place sexual health care and sexual behavior within general health care. Acknowledging that varying degrees of sexual activity occurs in correctional settings for a variety of reasons would improve upon current policies that “provide a blanket prohibition against sex.” This would likely provide greater access to sexual health care services and enable prison officials to take appropriate health measures, such as condom distribution, HIV-prevention programs, and interventions that target risk behavior.
- ***STIs, including HIV.*** All inmates should be provided with voluntary STI, including HIV, risk assessments, screening, and prevention counseling as part of routine medical care in correctional facilities. This should include STI and HIV testing upon entry and before release, as well as periodically during incarceration. The reluctance of some inmates to test for fear of a positive result and the stigma and fear associated should be addressed and medical confidentiality should be assured. Women should specifically receive routine screening for cervical cancer, chlamydia, and trichomoniasis.
- ***HIV-Positive Inmates.*** Like all inmates, those who are HIV-positive must have their confidentiality assured and should not have to live in fear that the correctional facility will involuntarily disclose their HIV status or that they will be assigned to higher security prisons where segregated HIV units are housed. The vast majority of states now integrate HIV-positive inmates into the general inmate population. Alabama and South Carolina, which still institute segregation policies and force HIV testing of all inmates upon entry, should discontinue the segregation and physical marking of inmates who are HIV positive.
- ***Contraception, Pregnancy, and Abortion.*** Incarcerated women and adolescent females should be provided sexual health care as are women and adolescent females who are not incarcerated, with

attention to the increased risk of infectious diseases and mental health problems common to incarcerated populations. They should be provided with access to adequate contraception, pre- and post-natal care, abortion services, pap tests and appropriate follow-up, health education, and adequate planning before release from correctional facilities. The use of restraints during labor and delivery should be eliminated and breastfeeding should be encouraged and allowed.

- ***Adolescents.*** Like all young people, youth in correctional facilities need sexual health care services that are confidential, youth friendly, and culturally competent. Whether housed in juvenile or adult facilities, youth should have access to health services tailored to their specific needs. Youth in state custody should be given screenings that address both their physical and mental health, as well as examinations that include their sexual histories. They should be provided behavioral prevention counseling, testing, and treatment, as needed for STIs, including HIV, pregnancy, and sexual abuse. They should also receive age-appropriate vaccinations as part of their preventative sexual health care services, including for HPV and hepatitis A and B.





Sexuality Information and Education  
Council of the United States

At the Nexus of Policy and Implementation

## **THE SEXUAL HEALTH CARE NEEDS OF OLDER ADULTS**

**A SPECIAL FOLLOW-UP REPORT TO  
ENSURING EQUITABLE ACCESS TO HIGH-QUALITY SEXUAL HEALTH CARE SERVICES**

**BY THE  
SEXUALITY INFORMATION AND EDUCATION COUNCIL OF THE UNITED STATES**

SIECUS recognizes the importance of looking at sexual health across the lifespan and the affordability and accessibility of high-quality sexual health care services for all populations. We also recognize the importance of highlighting the specific needs of marginalized populations, those that are often invisible in conversations about health care and who often lack the access and resources necessary to avail themselves of services. It is important to continue to prioritize the health of those that often face discrimination in health care settings. In this vein, we have chosen five subgroups, including older adults, to address their unique sexual health care needs.

### **THE SEXUAL HEALTH CARE NEEDS OF OLDER ADULTS**

By the year 2030, 19 percent of the U.S. population will be over the age of 65.<sup>312</sup> This represents a significant demographic shift with far reaching social and economic impacts as people live longer. Human beings are sexual beings from birth until death. However, sex is typically associated with youth and there is a general perception, also far too common among health care providers, that older adults are not interested in sex or sexual expression--that they are asexual beings without sexual thoughts, feelings, or desires—and that they are not sexually active. Certainly, there are physiological changes and various medical conditions, disabilities, surgeries, or medications that may affect older adults' ability to have and enjoy sex.<sup>313</sup> However, according to the University of Chicago's National Social Life, Health and Aging Project, many older people engage in sexual intercourse and have active sex lives well into their seventh or eighth decades.<sup>314</sup>

Health care providers and caregivers should work toward a new vision of sexuality for the older people in their care. Sexuality can mean different things to different people and encompasses the need for physical touch and desire but also to convey love, care, and tenderness. This is particularly true for older people. As noted by Michael Bauer, et al, for older adults sexuality can be “just as much about intimate kissing, cuddling, masturbation or intercourse as it can be about companionship, look and feeling one’s best, talking ‘dirty’ and enjoying explicit magazines and movies.”<sup>315</sup> However, health care providers often view sexual expression and behavior as being “problem behaviors,” particularly when those older adults live in institutionalized settings such as nursing homes or retirement facilities.<sup>316</sup>

Research has shown that ageism is rampant within the health care field and this is particularly true for the very old and for those in residential care facilities or nursing homes. The way sexual health concerns of older patients are addressed—or not—by health care providers can be a significant barrier to sexual health care and can have a substantial impact on the attitudes and behaviors of patients as well as their decisions to disclose details about their sexual health to physicians and other health care providers. Older people have reported that they are often reluctant to discuss sexual concerns with health care providers because they are embarrassed, believe that “sexual problems” are the result of normal aging, feel shame, or fear how their provider will react to their sexuality.<sup>317</sup>

There is growing concern about STIs, including HIV, among older adults and our cultural reluctance to talk about sex with older adults is revealing itself in increasing rates of STIs and HIV. According to the U.S. Centers for Disease Control and Prevention, the rate of chlamydia infection among 45- to 64-year-olds nearly doubled among women between 2000 and 2010 and tripled among men.<sup>318</sup> In addition, 15 percent of all new HIV cases are among adults over the age of 50<sup>319</sup> and by 2015, over half of people living with HIV and AIDS in the U.S. will be over the age of 50. One major reason for the “greying” of HIV in the United States is that as people living with HIV and AIDS have benefited from highly effective treatment, HIV-related illness and death have decreased significantly, allowing people with HIV/AIDS to stay healthier longer.<sup>320</sup> However, as the population of people living with HIV and AIDS gets older, this places older adults at greater risk of transmission because individuals are more likely to engage in sexual activity with people in their age cohort.

While people with HIV and AIDS are living longer, growing older with HIV or being diagnosed further into progression of the disease also presents medical challenges specific to aging. The immune systems of people living with HIV are constantly fighting infection, making HIV-positive individuals more susceptible to ongoing inflammation that is associated with comorbidities associated with aging, including diabetes, heart disease, hypertension, and cancer.<sup>321</sup> Symptoms of HIV can also be confused with other age-related declines in physical and mental functioning.<sup>322</sup>

More than 30 years since the beginning of the HIV epidemic in the United States, continued education is needed to debunk the myth that older adults are not at risk – especially older women. For many years, women were not considered a significant risk group for HIV infection, let alone older women beyond their reproductive years. In women over the age of 50, heterosexual transmission is the most commonly reported exposure category. Among older women, normal biological changes can also put them at greater risk for HIV infection including decreased vaginal lubrication and thinning vaginal mucosa as a result of diminished estrogen levels.<sup>323</sup>

While some health care providers may find it difficult to address sexuality topics in general, some physicians feel that it is even more difficult to discuss these sensitive issues with older populations.<sup>324</sup> Physicians are less inclined to address older patients’ sexual histories, screen for STIs or discuss HIV in comparison to young patients. For providers who do not discuss sexual health or take a sexual history, older people may also be reluctant to reveal their sexual histories or current practices. They may not be accustomed to frank dialogue about number of sexual partners, sexual practices and STIs, including HIV. In addition, because pregnancy is no longer an issue for women over 50, the conversation about sexual health may have stopped with menopause. The development of medications to alleviate erectile dysfunction, in contrast, may have positively contributed to conversations that older men have with medical professionals about sex, but may fall short in the context of disease prevention.

Beyond health care providers not adequately addressing sexual behaviors, older people generally know less about STIs, including the risk factors for HIV and how to prevent it,<sup>325</sup> and reportedly know “little or nothing about AIDS” or use condoms in comparison to younger people. As a result, they are more likely to practice unsafe sex. Because older adults are less likely to understand how HIV is transmitted, know prevention strategies, and do not receive prevention messages targeting their demographic, they are less likely to see themselves at risk for contracting HIV or other STIs. This also means they are less likely to seek testing or disclose sexual behavior that may be putting them at risk for HIV with their health care providers.<sup>326</sup> Deterrents to condom use among seniors are similar to those among the younger population. They are embarrassed to purchase them or ask their partner to use them, they do not know how to approach the topic with their partners, know how to put one on their partner, or other basic information about types of condoms and lubricants.

Research on older people and non-heterosexuality is notably sparse. As noted by the Institute of Medicine, “If being old is rarely equated with sexuality, then being old, sexual and gay, or lesbian, bisexual, or transgender, it would seem, is even more remote in the minds of many people.”<sup>327</sup> Older gay men may be more open about their sexual identity; however an assumption of heterosexuality by others, including health care providers, is frequently made. Regardless of age, this is often a significant barrier to the care for LGBT individuals who do not feel comfortable coming out and may, therefore, not be receiving the specific care and counseling they need to be sexual healthy. For older adults, this assumption of heterosexuality can a significant barrier to care, particularly if they reside in institutional facilities, rendering them all but invisible. Clinicians need to take into account the full spectrum of sexualities when their patients are older.

### ***Conclusion and Recommendations***

As our nation ages, it will become increasingly important to address sexuality and sexual health among older adults. Although sexuality and sexual behavior can mean different things to different people, the perception that older adults are not sexual beings with sexual feeling or desires and that they do not participate in sexual behavior could not be further from the truth. The ageist attitude of health care providers is a significant barrier to sexual health care for older adults as is older adults’ own attitudes about their sexuality and their fears about how their health care providers may perceive it.

- ***Provider Training.*** Health care providers need to shift their attitudes about sexuality and older adults and the general perception that older adults are not interested in sex, sexual expression, or sexual activity. They should increase their level of awareness of sexual issues in older age and view the topic as a relevant discussion for older patients. Health care providers should discontinue viewing sexual expression and behavior as being “problem behaviors,” and sexuality and sexual behavior should be addressed by nursing homes or retirement facilities. In addition, the assumption of heterosexuality and freedom from STIs needs to be challenged.
- ***Sexual Health Discussion.*** Health care providers should address older patients’ sexual histories and current behaviors in order to facilitate conversations that will support older adults’ sexual health and well-being and will encourage patients to seek care and address all health related matters openly. Lack of discussion by physicians about sexuality and sexual health can have a substantial impact on the attitudes and behaviors of patients as well as their decisions to disclose details about their sexual health to physicians and other health care providers.

- ***STIs, including HIV.*** Older adults should receive behavioral counseling to prevent STIs, including HIV, and should be counseled by their health care provider to use barrier methods, including condoms. HIV counseling and testing is central to prevention and treatment efforts and it should be part of routine sexual health care services for older adults and readily available and affordable for any older adult who wants to be tested, in a confidential manner.
- ***Education Campaigns.*** Older adults need to receive messages about sexual health and well-being and prevention targeting their demographic. Education campaigns should, at minimum, inform older adults about the normal changes that occur in a person's sexuality as they age; address the importance of honest discussions with intimate partners and health care providers about sexual health problems and/or sexual behavior that may be inhibiting their ability to be intimate and have pleasurable sexual activity; and address older adults' risk for contracting HIV or other STIs and the importance of accessing testing and treatment services.
- ***Research.*** Additional research on sexuality and aging, particularly on LGBT older adults, should be undertaken in order to better inform health care providers and better address the health care needs of adults as they age.

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