Overcoming Disparities in Women’s Sexual Health

By Ann Kelly [1]
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African-American women are hardest hit by HIV/AIDS and sexually transmitted infections, and many are unaware of their infections. The highest teen birth rates occur among Hispanics. This 12-page brief examines the causes and impact of these disparities, and describes evidence-based policy solutions that states have implemented.

The Florida Department of Health statistics tell a grim story. More than half of Floridians affected by AIDS are African-American, even though only 15 percent of the population is black. Among black women, AIDS case rates in 2008 were 20 times greater compared to white women and seven times greater compared to Hispanic women. In fact, HIV/AIDS has been the leading cause of death among Florida’s black women ages 25 to 44 for the last 16 years. In 1999, Florida developed the We Make The Change campaign to educate African-American, Hispanic and Haitian/Caribbean communities through television, radio, outdoor advertising and print communications about prevention services to help fight the spread of HIV. In 2008, the department created Sistas Organizing to Survive, SOS for short, to mobilize black women in the fight against HIV and AIDS.

An Orlando SOS conference encouraged black women to not only get tested for HIV/AIDS themselves but to also persuade other black women to do so. Sessions informed the nearly 600 consumers, health providers and community leaders who attended how other sexually transmitted diseases and substance abuse increase HIV risk and connected black women to testing and treatment resources. With a goal of testing 100,000 black women each year by 2010, the conference and an ongoing Web-based campaign encourage women to take a pledge to be tested for HIV and to educate others. To recognize the one-year anniversary of the SOS conference, black women were encouraged to be tested on June 20, 2009. Women could find HIV testing sites on the campaign Web site [3] or by texting their zip code to 477493.

The Florida HIV/AIDS experience is the same across the country. After 25 years of the U.S. epidemic,
HIV and AIDS have hit African-Americans the hardest of all racial and ethnic groups, according to the Centers for Disease Control and Prevention. Contributing causes to this disparity include poverty, inadequate medical care, stigma of the disease, and negative stereotypes of people living with HIV/AIDS or those whose behavior might put them at risk for HIV. These factors also result in increased rates of other sexually transmitted diseases; infections that in turn facilitate the transmission of HIV.

**Florida Policy Guide**

The Florida Department of Health has also recommended state policies to combat the disparity in *Silence is Death: The Crisis of HIV/AIDS in Florida's Black Communities*. The guide outlines how communities and public health officials can work together to strengthen prevention, testing and treatment programs, and specifically recommends:

- Community coordination to help more people get tested and treated for HIV/AIDS through political and religious leaders, civic organizations, businesses, schools, parents, cultural leaders, medical and other service providers, and people living with HIV/AIDS.
- More youth involvement in HIV community planning and prevention programs, and culturally relevant programs for each at-risk language group, racial and ethnic population in the community to reduce transmission among youth.
- Increased access to HIV testing using mobile testing units, health fairs, county jails, community events, emergency rooms and extended hours in existing clinics.
- HIV prevention and education in medical treatment settings, to overcome HIV/AIDS conspiracy beliefs and mistrust of the health care system, to address issues related to discrimination, homophobia and stigma, and to encourage safe sexual and needle-sharing behaviors.
- Testing for other sexually transmitted diseases, which also disproportionately affect blacks, because having certain STDs can increase the chances of contracting HIV infection three to five times.
- Local media campaigns for the general population to make HIV prevention, testing and treatment both accepted and part of routine medical care, to help overcome the stigma associated with HIV testing. These public messages educate on the health benefits of abstinence until marriage and fidelity thereafter, the benefits of condom use and other risk reduction methods. Also, by encouraging individuals to get tested for HIV and know their status, the diagnosis of HIV infections in the treatable early stages can be increased.

For more information, see:

- Florida Department of Health. "Silence is Death [5]."
- Florida Department of Health: "We Make the Change [6]."
- Centers for Disease Control: "HIV Among African-Americans [7]."

“Perhaps the single most important preventive measure is for people to know their own HIV status. If they are uninfected, this knowledge helps them protect themselves; if they are infected, the information helps them to protect their partners and to seek care and treatment for themselves. If communities support these recommendations, it will help to significantly reduce HIV/AIDS cases and deaths.” — Thomas Liberti, chief of the Bureau of HIV/AIDS, Florida Department of Health

**Talking Points**

**Who is Affected by STDs, HIV/AIDS and Teen Pregnancy? What are the Disparities?**

- Approximately 19 million new STD infections occur each year—nearly half of them among young
people ages 15 to 24, and in addition to the burden on youth, women are disproportionately affected. Racial disparities also persist across all reportable STDs. Blacks represent only 12 percent of the U.S. population, but make up about 70 percent of gonorrhea cases and nearly half of all chlamydia and syphilis cases. Similar disparities among Hispanics exist for chlamydia infections; Hispanics comprise 15 percent of the population, but experience 19 percent of reported cases.1

• More than 1 million Americans are infected with HIV and one in five is unaware of the infection.2 An estimated 56,300 people are newly diagnosed with HIV every year. The populations most affected are men who have sex with men, African-Americans and Hispanics/Latinos.4 The total number of people living with HIV/AIDS has grown in recent years due to earlier diagnosis and availability of effective treatments.4 Among women, HIV/AIDS disproportionately affects racial and ethnic populations, particularly African-American women. Youth are also increasingly affected, with 34 percent of new HIV infections occurring among individuals between the ages of 13 and 29. Young men who have sex with other men, especially those of minority races or ethnicities, are particularly at high risk for HIV infection.4

• Nearly 40 percent of sexually active high school students did not use a condom the last time they had sex.4 Teen birth rates, which declined from 1991 to 2005, rose in 2006 and 2007. In fact, one in 10 babies is born to mothers between the ages of 15 and 19, and teen birth rates are highest among African-American, Hispanic and Native American teens.4

What Legislators Can Do

• Consider legislation and policies to support routine medical testing for HIV and STD infections.
  ○ Support the CDC’s recommendation that all patients ages 13 to 64 in medical care settings be tested for HIV as part of routine medical care. State requirements for separate consent for HIV testing and prevention counseling may need modification so general medical care consent is considered sufficient to encompass consent for HIV testing.
  ○ Assure that HIV and other STD tests are covered through state and private insurance plans to reduce financial barriers to routine testing.
  ○ Support education programs for health care providers on incorporating HIV testing into routine medical care, the benefits of coupling chlamydia screening with a Pap test, and more frequent screening for gonorrhea and syphilis.
  ○ Support the CDC’s recommendation that all sexually-active women 25 years of age or younger be screened annually for chlamydia, as well as those older than 25 with risk factors for acquiring the infection. Even though symptoms of chlamydia are usually mild or absent, serious complications that can cause infertility can occur.2
  ○ Support public education campaigns to encourage women to get tested for HIV and other STDs when they see their doctors, such as annual chlamydia testing for sexually active women.
  ○ Remove state legal and regulatory barriers to implementing expedited partner therapy, which allows health providers to give patients diagnosed with chlamydia or gonorrhea medication or a prescription and prevention information for the patient’s sexual partner to prevent re-infection.8

• Encourage state departments of education and health, local health departments and community organizations that provide STD, HIV and teen pregnancy prevention programs to coordinate their services.
  ○ Work with state health and education experts to identify those most in need of services, and to coordinate education, testing, and treatment of HIV and STDs. Prevention programs for teens should be evidence-based and the teachers delivering the programs should receive adequate training to achieve success.
  ○ Encourage new community-based testing sites to extend services to people with inadequate
access to medical care, those who are uninsured or underinsured, or those who don’t have a trusted medical provider. Testing can also be initiated in non-medical facilities such as juvenile detention centers, jails, prisons and homeless shelters.

- Support culturally and age-appropriate public information and education programs that encourage women to avoid behaviors that put them at risk, and identify local services where they can be tested for HIV and other STDs and receive treatment if needed.

**Policy Examples**

**Routine HIV Testing For Pregnant Women in Philadelphia**

In Philadelphia, a community-based partnership offers HIV testing as part of an in-home prenatal and postpartum care program in an urban high-risk neighborhood. The agency partners included a community maternal health services organization, an HIV medical clinic, and a faith-based community organization. HIV counselors attended the home visits with the maternal care advocates, providing HIV education, rapid testing and prevention counseling to women, their partners and families.

The program found that infected women were more likely to agree to treatment during pregnancy. Bringing the HIV testing and counseling services to the home not only increased the women’s willingness to be tested, it also reached other family members without access to medical care and HIV services. Over five years of the partnership, there was no mother-to-child HIV transmission among more than 130 pregnant women who were treated for HIV infection. The comprehensive services offered at the treatment clinic also included screening and treatment for other sexually transmitted diseases.

Widespread testing for HIV infection is cost-effective when infected individuals are diagnosed early and treatment is provided in a timely manner because testing is relatively inexpensive and HIV treatment can result in fewer AIDS cases and deaths.³ Plans to implement HIV testing widely in medical care settings must include efforts by public health and health care providers to quickly link HIV-infected individuals to quality health care, and encourage them to take their medications.

For more information see:

- "Cost-Effectiveness of HIV Testing and Treatment in the United States" [8].

**Georgia’s Insurance Coverage for Chlamydia Testing**

Georgia’s Chlamydia Screening Act (House Bill 1565), enacted in 1998, requires health insurers to cover chlamydia testing annually for women under age 30. A strong educational effort by the legislature’s women’s caucus built support for the bill in the legislature. Legislators learned about strong evidence from other states’ routine testing programs that medical treatment costs can be avoided through reduced chlamydia infection and its severe complications that lead to infertility. The availability of a convenient one-time antibiotic treatment strengthened the likelihood of the program’s success. The state public health department provided detailed information to legislators on communities that were disproportionately affected by chlamydia infections, including teens and women of color. In addition, public health officials worked with the state Medicaid agency to allow payment to physicians who administered the convenient single dose antibiotic to patients immediately upon diagnosis.
Today, Georgia remains one of only a few states that mandate chlamydia testing coverage. However, testing has increased in states without mandates because chlamydia screening is included in the Healthcare Effectiveness Data and Information Set, information used by most health plans nationally to measure quality of care. In addition to testing, continued success in the reduction of chlamydia infection in Georgia includes efforts to encourage physicians to perform the tests and patients to seek medical exams and testing, as well as to provide access to coverage and services for the uninsured.

For more information see:

- Council of State Governments. "Chlamydia Screening and Treatment."[11]

**New Mexico Involves Patients to Control Chlamydia Infection**

Under New Mexico’s Clinical Prevention Initiative, the New Mexico Medical Society and the state Department of Health work together to educate private physicians on how to incorporate evidence-based disease prevention activities into their clinical practices. In 2006, New Mexico’s rate of chlamydia infection was 503 per 100,000 population, which was nearly 50 percent higher than the national average and one of the highest rates in the country. New Mexico responded with an initiative to increase routine chlamydia screening and treatment in four groups of patients: sexually active women aged 25 or younger; men and women with more than one sexual partner; anyone with a recently diagnosed STD; and all pregnant women. By distributing educational materials to physicians and including handouts for their patients, the initiative has helped to change medical practices.

New Mexico’s initiative also recommends that physicians treat the partners of patients diagnosed with chlamydia to prevent re-infection. Rather than using traditional approaches where partners would be contacted by the doctor, the patients or public health officials about treatment, physicians were encouraged to use a more direct approach to get the partners treated—known as expedited partner therapy.

Expedited partner therapy is an approach that allows physicians to give patients diagnosed with chlamydia either medications or prescriptions for their partners. Patients are counseled about STDs and ways to reduce re-infection, and the patients are encouraged to pass the information along to their partners. In some cases, the patient contacts his or her partner by cell phone and the doctor talks to the partner directly before writing a prescription for the partner. Studies have shown expedited partner therapy to be cost effective due to reduced rates of re-infection and the medical complications that are avoided.[4]

Some states and health care providers have concerns about the approach because the provider doesn’t examine the partner, speak to the partner about drug allergies or provide counseling to the partner. In some states, doctors would risk losing their licenses for such action if practice standards are not modified. In New Mexico, the Medical Licensing Board changed the medical practice regulations in 2007 to specifically allow physicians to use expedited partner therapy. The Clinical Prevention Initiative Task Force requested the changes with the support of both the state medical society and state department of public health. The licensing board was willing to make the changes based on the research evidence documenting the success of the approach, as well as the broad support of the state’s public health and medical practitioners.

For more information see:

- Council of State Governments. "Chlamydia Screening and Treatment."

**California School-Based Health Services Reach High-Risk Youth**
California school-based health centers implemented a chlamydia screening program at seven high
schools in rural and urban California where family planning services were provided. The program
funded and trained staff to provide chlamydia screening services to at-risk teens. The direct medical
care reached a student population that might not otherwise have accessed a health care setting, and
offered a confidential and low-cost screening site as well as prevention counseling that was youth-
focused and integrated with other reproductive health services.

More than 1,300 sexually active girls sought services from the school-based health centers during the
2006-07 school year, and nearly 90 percent were screened for chlamydia. Of those tested, about 7
percent tested positive for chlamydia. Young black women, Asian women and women identifying as
"other race" were more likely to test positive than white women. Because it was integrated with other
reproductive health services, this program efficiently brought screening services to a hard to reach,
high risk youth population.

For more information see:

- California Family Health Council. "To Screen or Not to Screen—Maximizing Chlamydia Screening of
  Adolescent Females in School Based Health Centers in California [12]."

**Successful Texas Campaign Targets African-American Teens**

The Texas Department of State Health Services launched a media campaign to increase awareness of
STDs and the need for testing among sexually active African-American girls ages 15 to 19. The state
Bureau of HIV and STD Prevention’s successful campaign received the National Public Health
Information Coalition’s Bronze Award for Excellence in Public Health Communication.

The STD Awareness Media Campaign, developed by the bureau with a public relations agency, used
targeted television, radio and billboard advertisements to bring STD awareness and prevention
messages to African-American adolescent girls in the cities of Tyler and Longview. The campaign’s
tools included an interactive CD-ROM-based tool developed by the CDC that provides practical, step-
by-step assistance to public health professionals in designing public health educational campaigns.

Surveys of adolescents after the pilot campaign indicated that awareness of chlamydia as an STD
more than doubled. Of those who saw the campaign ads, 69 percent said the ads made them think
more about STDs than they had before, 28 percent said they talked to someone about STDs because
of the ads, and 19 percent said they got tested for an STD other than HIV because of the ads. The ads
continue to be used by public health departments throughout Texas for public information campaigns.

For more information see:


**Illinois Public Health and Corrections Access Community Services**

Beginning in the late 1990s, the Illinois Public Health and Corrections Task Force brought together the
corrections and public health communities with the Chicago agencies taking the lead. More than 160
organizations including local health departments, county jails, faith-based organizations,
policymakers, community-based organizations and five of Chicago’s top universities participated in
the task force. From 1999 to 2004, a task force initiative integrated health resources to improve the
health status of inmates either in correctional institutions or recently released from one. Cook County
Department of Corrections inmates received services during and after incarceration. Those services
included coordinated primary care and links to referrals; prevention counseling and treatment
services for HIV/AIDS, other STDs, hepatitis and tuberculosis; and mental health and substance abuse
assessments and treatment services.

Managing the health care and assimilation of inmates into the community after release took on new urgency as the number of HIV/AIDS cases identified in correctional facilities increased. The relationships between drug use, disease and cycles of incarceration in jails and prison highlighted the opportunity for corrections and public health officials to join forces.

Through voluntary testing of more than 2,000 inmates, HIV positive inmates were identified and then referred to medical services and intensive case management services prior to release. About one-fifth of the inmates who received case management services were women. Offering a high level of case management, the program provided clients with individualized treatment plans for health and social services, access to the services, and frequent contacts with case managers both inside the correctional facility and after release. Additional education programs were provided to more than 1,000 adolescent females in juvenile detention centers focusing on HIV and hepatitis prevention, and providing hepatitis vaccinations. In addition to the direct benefits to inmates, the program benefited communities of color throughout Chicago, where many of the clients returned to live. Based on the program’s success, Illinois funded additional continuity of care programs throughout the state modeled after the Chicago initiative.

For more information see:

- University of Illinois at Chicago School of Public Health. "Public Health and Corrections [14]."
- Health Resources and Services Administration, U.S. Dept. of Health and Human Services. "Opening Doors [15]."

Key Facts

- **Millions of Americans are diagnosed each year with STDs.**
  - Women, especially young women and women of color, are hit hardest by chlamydia. The reported chlamydia case rate in females was almost three times higher than for males in 2007. Young females ages 15 to 19 had the highest chlamydia rate, followed by females ages 20 to 24 years. Chlamydia symptoms are usually mild or absent, but serious complications that cause irreversible damage, including infertility, can occur.¹
  - Primary and secondary syphilis rates among females have increased each year since 2004, following more than a decade of declines. From 2006 to 2007, the syphilis rate for females increased 10 percent. Untreated syphilis in pregnant women can result in congenital syphilis (syphilis among infants), which can cause stillbirth, death soon after birth, and physical deformity and neurological complications in children who survive.¹
  - Reported cases of gonorrhea reached nearly 360,000 in 2007. Gonorrhea occurs twice as often in young women as in young men, and four times more often in young people (ages 15 to 24) than among the general population. Among women, gonorrhea is a major cause of pelvic inflammatory disease, which can lead to chronic pelvic pain, ectopic pregnancy and infertility.¹ ¹²

- **Sustained prevention and treatment over the past 20 years reduced the total number of AIDS cases and deaths, but HIV and AIDS are still major problems in the United States.**
  - The CDC estimates that more than 1 million Americans are infected with HIV, and one-fifth of them are unaware of the infection and can unknowingly spread it to others. Someone in the U.S. is infected with HIV every 9½ minutes.¹¹
  - Of the people newly diagnosed with HIV, 27 percent are women and nearly half are African-American.¹¹
  - About 14,000 people die from AIDS each year. Although this number has decreased due to new
drug therapies, an estimated 56,300 people in the U.S. are still diagnosed yearly with HIV. The number of new cases in the U.S. has remained relatively stable for more than a decade despite expanded prevention efforts.\textsuperscript{11}

- **Racial and ethnic minority communities are the hardest hit by HIV/AIDS and other STDs.**
  - HIV/AIDS affects African-American populations disproportionately. African-Americans accounted for 45 percent of all new HIV/AIDS diagnoses in 2006, with African-American women and youth increasingly at risk of infection compared to women and youth of other races.\textsuperscript{3}
  - There are persistent racial disparities in STD rates, with African-Americans bearing a particularly heavy burden. Blacks represent only 12 percent of the total U.S. population, but made up about 70 percent of gonorrhea cases and almost half of all chlamydia and syphilis cases in 2007. While Hispanics account for 15 percent of the U.S. population, they account for 19 percent of all reported chlamydia cases. Syphilis increased in all racial and ethnic groups except Asian/Pacific Islanders and among men who have sex with men. Racial disparities in gonorrhea rates are the most severe of all reportable STDs.\textsuperscript{1}

- **Teen birth rates increased in 2006 and 2007 after 14 years of steady decline.**
  - Birth rates among Hispanic adolescents (ages 15 to 19) in 2006 were three times higher than rates among whites. African-American and American Indian/Alaska Native adolescents gave birth more than twice as often as whites.
  - Teen mothers don’t complete high school and live in poverty more often than other teens. Pregnant teens (ages 15 to 19) don’t receive prenatal care or gain appropriate weight as often, and are more likely to smoke, compared to women older than 19. These behaviors are associated with premature or low birth weight births and may lead to infant death, blindness, chronic respiratory disease, mental retardation and learning disabilities.\textsuperscript{13,14,15,16}

- **What causes racial and ethnic disparities in STDs, HIV/AIDS and teen pregnancy?**
  - Individual risk behavior does not fully explain why STD disparities exist. For example, even when individual risk behavior is similar, an African-American is still more likely to contract STDs than a white person because the prevalence of disease is much higher in African-American communities.
  - In addition to risk behaviors such as unprotected sexual activity, other contributors include low socioeconomic status, social environment, lack of testing due to stigma associated with diseases, access and availability of health care and homelessness. Reporting bias is also possible because minority patients are more likely to seek care in public health clinics that more completely report STDs to the CDC compared to private health care providers.\textsuperscript{1}
  - Key barriers to STD screening and treatment in racial and ethnic minority communities include lack of access to care, high numbers of uninsured, inadequate funds for payment for services, and lack of education about the diseases and their potential effects.

**Using Research to Address Disparities**

- **Consider supplemental state funding for state and local agencies to address disparities.** Establish priority funding for communities with the highest reported incidence of HIV/AIDS, other STDs and teen pregnancy. Use state data on HIV/AIDS cases by sex, mode of exposure, race and ethnicity to target specific actions for communities.

- **Encourage routine testing for HIV infection.** Research shows that once people are aware of their HIV infection, they take steps to reduce spreading it to others. The CDC recommends HIV testing of all patients ages 13 to 64 in health care settings in an effort to reduce the stigma surrounding HIV. The CDC also recommends states allow the general consent for medical care to be sufficient to encompass consent for HIV testing, and to allow opt-out screening for HIV testing, which means after a patient is notified that HIV testing will be performed, the patient may decline testing.
To prevent mother-to-child transmission during delivery, HIV testing is recommended as part of routine prenatal testing unless the woman declines. Testing of pregnant women is especially important in jurisdictions with elevated HIV or AIDS incidence (at least one diagnosed HIV case per 1,000 pregnant women per year), and a rapid HIV test should be used during labor for all pregnant women whose HIV infection status is unknown.

**Support chlamydia screening, an effective and cost-saving approach.** Although annual chlamydia screening is recommended for all sexually active women age 25 and younger and more frequently for those at high risk of infection, less than half receive screening tests. Ongoing health provider education is needed on the benefits of reduced complications and cost-savings from chlamydia screening and treatment. Community education on preventing chlamydia should be culturally appropriate and encourage behaviors that reduce risk, such as practicing abstinence, using condoms and limiting the number of sex partners. Successful prevention efforts rely on sustained outreach and education.

**Support services for partners of chlamydia and gonorrhea patients, including expedited partner therapy.** Expedited partner therapy allows health providers to give patients medication or a prescription and prevention information to pass on to the patient’s sexual partner to prevent re-infection. The approach is an effective treatment option for chlamydia or gonorrhea, proved to increase treatment rates and decrease the number of re-infections. Providers instruct their patients on proper use of the medicine, and recommend that patients encourage their partners to be tested. Barriers to expedited partner therapy implementation include state legal restrictions on medical providers that don’t allow them to dispense medication for an individual they have not examined. Potential risks for the partner include allergic reactions, medication taken improperly and undiagnosed medical conditions contradicting use of a specific antibiotic. The approach is legally permissible in 18 states and Baltimore. It is prohibited by law in nine states, and it may be legally possible in 23 states, Puerto Rico and the District of Columbia. (For an assessment of each state’s status, see [http://www.cdc.gov/std/ept/legal/default.htm](http://www.cdc.gov/std/ept/legal/default.htm).)

**Provide resources for schools to address disparities through school health education programs.**
- Encourage school districts to develop health education curricula that are evidence-based, take into account local preferences, and are culturally appropriate and medically accurate.
- Provide professional development for school staff on effective implementation of curricula, and policies and laws regarding nondiscrimination and confidentiality related to HIV.
- Support programs that seek to improve the social environment for lesbian, gay, bisexual, transgender and HIV-affected students at school and that seek involvement of parents and family in the lives of these students.
- Make confidential STD screening and treatment, and reproductive health services easily accessible to teenagers, along with culturally sensitive counseling and education involving teenagers and their parents.

**Encourage faith-based and community-based initiatives to reach people without access to medical care.** Faith-based efforts have successfully reached minority communities—particularly African-American communities. Faith-based organizations can provide highly tailored programs to meet the specific needs of their community. Examples include:
- **Balm in Gilead** brings together more than 17 major church denominations, coalitions and independent churches to respond to the AIDS crisis in African-American communities. It provides educational and training programs to African-American churches that strive to become centers for AIDS ministry, education and compassion.
- The **National Latina Health Network** has six regional offices and more than 1,500 members, including health professionals, educators and the media. Several of the programs to promote
HIV/AIDS awareness involve peer educators and storytelling—a tradition in Hispanic communities—to spread awareness. A youth advisory group made up of young women ages 16 to 24 reviews all materials for age appropriateness.

**Resources**

**Centers for Disease Control and Prevention:**

**HIV:**

- [Effective HIV Prevention, HIV/AIDS Prevention Research Synthesis Project](#)[18]
- [HIV Incidence System—U.S., 2006](#)[19]
- [HIV and AIDS in the U.S., 2007](#)[20]

**STDs:**

- [Information on STDs, links to programs and technology based education](#)[21]
- [State statistics on STDs and prevention programs](#)[22]
- [Trends in Reportable STDs in the U.S., 2007](#)[23]

**Youth:**

- [State statistics on youth sexual risk behaviors](#)[24]
- [State and local education agencies funded for HIV prevention](#)[25]

**The Council of State Governments:**

- [Chlamydia Screening and Treatment Policy Brief](#)[11]
- [Confronting Disparities in Sexually Transmitted Diseases Talking Points](#)[26]
- [Making HIV Testing Routine Talking Points; Brief](#)[27; 28]
- [Expedited Partner Therapy for Sexually Transmitted Diseases Talking Points](#)[29]
- [HIV/AIDS & STD Prevention Tool Kit](#)[30]

**U.S. Department of Health and Human Services:**

- [Office of HIV/AIDS Policy](#)[31]
- [Leadership Campaign on AIDS](#)[32]
- [Office of Minority Health](#)[33]

**National Prevention Information Network**[34]

**Kaiser Family Foundation**[35]

**Association of State and Territorial Health Officials**[36]

**National Coalition of STD Directors**[37]

**National Alliance of State & Territorial AIDS Directors**[38]

**National Association of County & City Health Officials**[39]

**American Social Health Association**[40]

**Arc of Refuge: HIV/AIDS Ministry**[41]
The Balm in Gilead

Black AIDS Institute

National Minorities AIDS Council

References:


7. CDC. “Sexually Transmitted Diseases, Infertility and STDs.”


11. Act Against AIDS. “Nine And A Half Minutes, Get the Facts.”


14. CDC. “Adolescent Reproductive Health: Preventing Teen Pregnancy.”


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