



CALIFORNIA  
HIV/AIDS POLICY  
RESEARCH CENTERS

## The Implementation of Culturally Appropriate Sexual and Reproductive Health Services for Cisgender Women of Color in California

### EXECUTIVE SUMMARY

The following key findings, based on a qualitative study conducted among healthcare providers and administrators, identify the facilitators and barriers to systematic implementation of culturally appropriate sexual and reproductive health (SRH) services for cisgender Black and Latina women in California.

### THEMES

The main themes across participant interviews included concerns with funding for SRH services, the role of intersectional stigma and its unique effects on women of color (WOC) with SRH needs and persistent gaps in sexual health education.

### Specified Barriers

#### Treatment guidelines

Current treatment guidelines for SRH screening and testing do not account for disproportionate STIs and/or HIV infection rates among women of color.

#### Patchwork funding

Funding is patchwork and programmatic requirements related to healthcare coverage drive gaps in services.

#### Intersectional stigma

Intersectional stigma (including sex-related stigma) facilitates marginalization and bias.

#### Systems failures

Systems failures are to blame for disparities in SRH outcomes for women of color.

### Potential Facilitators

#### Whole-woman care

Offer comprehensive health coverage, including supportive wraparound services, as part of SRH services.

#### Cultural humility

Create a culture that promotes cultural humility in healthcare services, starting with SRH services.

#### Comprehensive sex education

Provide comprehensive sex education including targeted efforts to educate young women of color.

### Policy Recommendations

**Bridge SRH needs with flexible funding sources.** Funding for SRH services and programmatic barriers related to funding serve as hurdles to access. An examination of funding streams to identify gaps is required. Further development and funding of low-burden, low-barrier programs that establish “no wrong door” access to SRH services is needed.

**Review treatment guidelines with an intersectional and health equity lens.** Gender, race/ethnicity and sex-related stigmas intersect, creating a challenging environment for to seek and access SRH care. Thus, treatment guidelines must consider gendered assumptions and sex-related stigma, when developing new tools for sexual risk-based assessments.

**Fund sexual health education efforts.** A lack of accurate SRH education and information only serves to exacerbate specified problems. Comprehensive sexual health education requires broad administrative support and funding that is not only concentrated in K-12 education but beyond.

## Background

Approximately a third of all women in the U.S. 16 years or older identify as Black (13.4%) and Latina (18.5%) (U.S. Census Bureau, 2019). They are at increased risk for poorer sexual and reproductive health (SRH) outcomes compared to their white counterparts. Black (57%) and Latina (18%) women together constitute no less than 75% of women diagnosed with HIV (Centers for Disease Control and Prevention, 2020a), with the overwhelming majority (85%) of transmissions due to heterosexual contact (Kaiser Family Foundation, 2020). The rate of new HIV infections for Black women was 15 times higher (Kaiser Family Foundation, 2020) and, for Latinas, it was 3 times higher than the rate for white women (Centers for Disease Control and Prevention, 2019a).

While HIV rates are declining among Black women, other trends related to sexually transmitted infections (STIs) are concerning (Centers for Disease Control and Prevention, 2020a). Young Black and Latina women continue to experience higher rates of chlamydia (1419.9 and 563.8 per 100,000) and gonorrhea (444.3 and 87.5 per 100,000) respectively. STIs are associated with increased risk for HIV transmission (Sexton, Garnett, & Røttingen, 2005). When left untreated, STIs carry long-term health consequences related to reproductive health (Centers for Disease Control and Prevention, 2020b). For these reasons, the need to address the sexual health and reproductive health issues of women of color<sup>1</sup> (WOC) remains critical.

## Organizing Women Centered Approaches to Trauma Related, HIV/STI and Reproductive Health Risk Reduction for Women of Color Study (WC4WC)

The WC4WC study sought to develop a framework for exploring opportunities for WOC to have agency over their sexual health decision-making processes and improve the healthcare service delivery models among clinics that offer women-centered health services. The goal of the policy research team within this study was to identify facilitators and barriers for systematically implementing culturally appropriate sexual and reproductive health (SRH) services for WOC in California.

The aims of this study were to:

1. Understand and identify barriers to implementing culturally appropriate SRH services for WOC in California, from multiple perspectives (administrators, providers and policy advocates).
2. Contextualize specified barriers within the current policy landscape.
3. Document potential facilitators at the individual, organizational and systemic level.

Through qualitative interviews, we explored perspectives of healthcare providers, organizational administrators and other front-line staff. We sought to understand how respondents, as individuals and as part of the organization/agency they represent, help facilitate the delivery of culturally appropriate SRH services. We also interviewed state- and federal-level policy advocates who work to address women's access to SRH services.

## Participants and Procedures

In May 2019, research staff identified potential respondents as those engaged in the delivery of and advocacy around implementing culturally appropriate SRH health services to WOC throughout California. Primary recruitment focused on funded partners of a California Wellness Foundation's Women of Color Health

<sup>1</sup> By women of color, we refer primarily to Black and Latina cisgender women. Some programs are more inclusive of services to transgender women. Given the differing reproductive health needs between cis- and transgender women, however, this policy brief addresses the specific needs of cisgender women.

Initiatives. Additional recruitment efforts were focused on achieving a diverse sample, factoring in individual characteristics of the participant (e.g. direct service, administration, policy), their level of experience (e.g. low to high), size of their respective organization/agency (e.g. eight to 800,000 employees) and geographic service area (e.g. Northern, Central and Southern California).

To be eligible for the study, respondents were required to identify as (1) over 18 years old; (2) serving WOC in California; (3) working to address SRH services in California (including policy advocacy); (4) familiar with HIV/STI and reproductive health services; and (5) a healthcare provider, administrator or policy advocate. In total, eighteen (N=18) participants were screened, deemed eligible and completed the interview. Of these, three (3) participants represented national policy advocacy organizations, one (1) represented a state-level policy advocacy organization, nine (9) were from Southern California, three (3) were from Northern California and two (2) were from Central California. Of those interviewed, eight (8) held policy advocate positions, seven (7) held positions as providers or front-line staff, and three (3) held managerial or administrator positions. Eligible respondents provided oral consent and completed a study interview via Zoom. Participants were offered a \$50 e-gift card.

### **Data Collection and Analysis**

Research staff audio-recorded individual semi-structured qualitative interviews that were transcribed verbatim using Otter.ai. Staff reviewed transcripts for accuracy. Members of the study team reviewed transcripts in full and then summarized data according to conceptual domains derived from the interview guide. Domains included service delivery, organizational capacity, best practices, and social and structural barriers to care. Based on a model of rapid qualitative analysis in health services research (Hamilton, 2013), the summary data were combined into a single, comprehensive matrix for analysis. The research team conducted matrix analyses, arriving at a consensus regarding the study findings.

### **Specified Barriers**

Interviews yielded three main themes regarding the implementation of culturally appropriate SRH health services for WOC in California. These themes reflected broad-based concerns described across nearly all participant interviews. They include (1) funding for SRH services; (2) intersectional stigma and its unique multi-level effects on WOC with SRH needs; and (3) gaps in sexual health education. Specified barriers included the following:

#### **Treatment guidelines**

Current treatment guidelines for SRH screening and testing do not account for disproportionate STIs and/or HIV infection rates among women of color.

#### **Patchwork funding**

Funding is patchwork and programmatic requirements related to healthcare coverage drive gaps in services.

#### **Intersectional stigma**

Intersectional stigma (including sex-related stigma) facilitates marginalization and bias.

#### **Systems failures**

Systems failures are to blame for disparities in SRH outcomes for WOC.

### **Current treatment guidelines for SRH screening and testing do not account for disproportionate STIs and/or HIV infection rates among women of color**

Funding for SRH services is influenced by STD screening and testing protocols set by federal administrative bodies which guide decision-making in the clinical milieu (Walensky & Paltiel, 2019). However, such guidelines constrain health care providers from offering their patients appropriate SRH care. One participant, representing a public health clinic, explained that their facility is unable to screen and test for certain

diseases if women are over a certain age (e.g. over 30) and without noted risk factors, regardless of a patient's independent request to be tested for all STIs. Additionally, a known gap with risk-based assessment is that accuracy depends upon factors such as the patient's understanding of their sexual partner(s)' risk factors and the patient's own perceived risks (Blumenthal et al., 2019; Bradley, Geter, Lima, Sutton, & Hubbard McCree, 2018; Villar-Loubet et al., 2016). One provider explained,

*[Y]ou don't want to stigmatize a race by saying, all, if you're this race, you should be tested for STDs because you inherently are going to have, more likely have STDs, but I also think...something with STDs in general, is that when you're talking to a person and the risk of getting an STD, it's not just about that person and their risk factors but it's also about their partner or partners and the risk factors of their partner[s] partners... And sometimes you just can't get that information because that woman or that patient ... doesn't know what the risk factors are, what that other [partner] is doing.*

- Participant 11

Treatment guidelines may also fail to identify risks due to gendered assumptions about the kind of sex women may be having. For example, despite indications that women are increasingly engaging in or report as engaging in anal sex (Reynolds, Fisher, & Rogala, 2015), they are not generally screened for rectal infections (Caragol, Voegeli, Mettenbrink, Wendel, & Rietmeijer, 2017; Reynolds, Fisher, Erlyana, & Otterloo, 2020).

### **Funding is patchwork and programmatic requirements related to healthcare coverage drive gaps in services**

Study participants, identifying as healthcare providers and frontline staff workers, described efforts to deliver comprehensive SRH services in the context of significant programmatic barriers. Because SRH care is constrained by funding limits, with each having its own established programmatic requirements, there remains a gap in delivering comprehensive services. In a public health setting, a participant explained that while the clinic offers STI services, they do not provide pre-exposure prophylaxis (PrEP) services (Participant 11). In the same clinic, pap smears and the human papillomavirus (HPV) vaccine is only available to uninsured women, despite the fact that it may be the recommended standard of care for insured women seen at the clinic.

SRH services are paid on a reimbursement basis and require providers to be authorized vendors prior to accessing various sources of funding. As a result, SRH services are often delivered in siloes. One participant described the inability to address high blood pressure in the context of delivering SRH services. Another described the limited role an OBGYN has in ensuring patients can address dental health needs, a known cause for pre-term labor among African American women.

Administrators further identified bureaucratic challenges with figuring out who is going to pay for the service. "We definitely offer the testing, but is it linked to an exam so can we bill for it?" (Participant 5). Even where local programs try to create flexible funding sources to be able to offer free, accessible and confidential STI testing, programmatic barriers can get in the way. One participant explained policies, such as "payer of last resort," erode confidentiality when the staff is required to check the patient's insurance first.

*[I]t defeats the whole purpose of confidentiality because they don't want you to check their insurance...we need to have funding that [...] is unrestricted to be able to meet our communities where they're at.*

- Participant 5

Policy solutions often center on comprehensive healthcare coverage. Low-income women in California enjoy higher rates of health coverage, supported by a diverse set of funding sources for SRH care. It is incorrect, however, to assume that increased health coverage results in increased access to health services. California

women reported minimal changes with regard to having a usual source of care, having the ability to obtain needed medical care, and getting prescription medication without delay despite a significant increase in healthcare coverage (Early et al., 2018). Others have documented that while affordability of care has increased (Johnston, Strahan, Joski, Dunlop, & Adams, 2018), especially in states like California where Medicaid was expanded, access to care has held steady rather than improved (Shartzler, Garro, Pellegrini, & Long, 2015). Thus, even where there is funding, they explained, access remains an issue.

*But I've also heard from young people, more so that they've been denied Family Pact, on things that they shouldn't have been denied on. Like, oh, you need to provide your parents' income, or you need to do these things and we're like, no, you don't have to provide that.*

- Participant 6

Another participant talked about how the minor consent process for accessing Medi-Cal benefits “felt broken.” She further explains,

*There are folks, especially in low income communities of color, that really rely on [Minor Consent Medi-Cal]...but [services in their given county] requires that you sign up in person at like a county Department of Public Health, every month in order to maintain coverage.*

- Participant 7

Prior studies have demonstrated that administrative rules, such as obtaining parental consent signatures and showing legal documentation, have often prevented young people from receiving much needed health and social services (Delany-Moretlwe et al., 2015).

### ***Intersectional stigma, including sex-related stigma, facilitates marginalization and bias***

Black and Latina women’s lived experiences require them to negotiate multiple forms of stigma and negative stereotypes on account of their gender, race/ethnicity and class (Demi, 1998; Melton, 2011). These intersecting points of stigma is compounded by a history of sexual exploitation (Berger, 2004; Castañeda, 2008; hooks, 1981; Melton, 2011). Throughout history, Black and Latina women have been stereotyped as promiscuous, hypersexual, and sexually immoral (Castañeda, 2008; Collins, 1990; Ghavami & Peplau, 2013). SRH issues bring to the surface stigma related to sexuality and STIs—where one’s STI and HIV status purportedly implicate one’s virtue and social class. Further, those who are living with HIV still risk being perceived as careless and oversexed (Collins, 1990; Melton, 2011). The awareness of being rebuffed or frowned upon by mainstream society can impact women’s self-perception, self-confidence, and may lead to feelings of alienation (Santana & Dancy, 2000).

As such, prior studies demonstrate that some women worry about being asked sexual health and prophylactics related questions by their provider as they might be seen as promiscuous (Williams & Mohammed, 2009). This is exacerbated by discriminatory health practices in the U.S. that have led to medical mistrust among women who do not feel safe speaking openly with their healthcare providers (Williams & Mohammed, 2009). A healthcare provider explains:

*[W]e are a modern society, in the wealthiest country on earth, at least now and yet, we can't change this...And I think ultimately, we have to address the social conditions in which people live to change this. I think there's still a lot of mistrust of government, And the last few years have only given people more reason to feel that way. That they shouldn't trust us.*

- Participant 15

Administrators acknowledge that WOC may not be receiving SRH care they need "...because they're a person of color, a woman of color," and that this could practically "affect the healthcare they receive." (Participant 5). Bias is illustrated by harmful stereotypes about women of color. One participant explains, "...there's a different perception, the way a woman of color is looked at, in regards to multiple pregnancies." (Participant 8). Rural young WOC may also face a unique set of obstacles in getting appropriate SRH care. Prior studies indicate that young people, from marginalized communities in particular, were found to be fearful of being stigmatized, discriminated against and victimized in health care settings (Delany-Moretlwe et al., 2015).

A participant from a remote rural area composed of largely immigrant Catholic households, described a young woman's challenging clinical experience while seeking STI testing.

***[The clinicians] grilling her with a lot of questions of why? Why does she even need to get tested? What makes you think she has an STI? Then she tried to explain herself, like, she's had multiple partners, and hasn't been using protection. They asked her if she's ever been pregnant, or has children? She mentioned she had an abortion. Then they started to question her about that, early on about her history with that as well. So that was a big turnoff for her to seek services there.***

**- Participant 6**

Coordinated campaigns by social and religious reformers have facilitated a view that STIs are a threat to families and societal values (Ford, Barnes, Rompalo, & Hook, 2013; Harris, 2010). In our domestic history, colonialism and Christianity have injected religion and spirituality into the cultural experiences of many Black and Latina women. This includes perceptions and approaches to health (Lujan & Campbell, 2006). STI-related stigma may be embedded in messaging that supports silence, shame and stigma around sex. The connection between sexuality and cultural and religious values is not limited to patients but also affects some healthcare providers. Some may feel discomfort discussing sexual health with patients. Others present patients with biased information based on their own beliefs.

***[O]ne of the things that I would hear is...the fact that, unfortunately, there are several medical providers, and I don't know if this is because of the region that we're in, being so conservative, is a lot of medical providers, regardless of if they made an oath to be able to provide, you know, all information as needed per patient, a lot of them will make that information based on their own personal and faith biases. And so the women won't get the information that they need, if this medical provider feels like hey, you know, there's no need for this.***

**- Participant 8**

Additionally, women may be reluctant to be seen in spaces that threaten how others perceive them. One participant explained:

***I think that, you know, if you feel you have an STD and you have to go to the doctor to get it checked out many, often times, women will be reluctant to go because they don't want to go. And...especially in this community here where everyone knows everybody, they may not want to go because they'll see, you know, "Susie" from down the block. And I saw her in there she had a STD that's why she's in there.***

**- Participant 2**

## ***Systems failures are to blame for disparities in SRH outcomes for women of color***

Existing literature demonstrates that poor SRH outcomes are better understood as a series of systems failures (Brawner, 2014). The fundamental issues of poverty and income inequality, education, housing instability, intimate partner violence, substance use, transportation, health coverage and access to comprehensive healthcare directly impact the SRH outcomes among WOC (August et al., 2016; Blackstock et al., 2015; Bradley et al., 2018; Smith & Larson, 2015; Tervalon & Murray-García, 1998). Yet, much of the focus has been placed on individual-level biological and behavioral factors, especially in the context of HIV prevention and treatment research (Baeten et al., 2012). Despite evidence that African Americans are more likely to engage in increased condom use and HIV testing, emphasis is placed on individual-level behavioral change (Pflieger, Cook, Niccolai, & Connell, 2013). Known SRH disparities by race/ethnicity simply cannot be accounted for by mere differences in their sexual risk behaviors (Laumann & Youm, 1999). A broader look at the prevalence of STIs among communities of color and the causes behind the rates, not just on individual sexual behavior, is warranted (Hallfors, Iritani, Miller, & Bauer, 2007). One participant explained:

***Well, it's not behavior. And it's been shown time and time again, that it's not that there's a difference in behavior among different racial, socioeconomic groups. It's more about prevalence, and there's, you know, increasing prevalence in certain populations. And we haven't done a good enough job to reduce the prevalence, so that the incidence is reduced as well.***

- Participant 17

Policy advocates described the disproportionate burden of STIs and HIV on Black and Latina women in terms of larger forces at play including systemic-level vulnerabilities that affect health. "One of our recommendations is that the risk factors that contribute to incidence and prevalence of STIs include emotional, economic, social and structural forces," Participant 18 explains. In regards to housing, one shared, "... [w]hen people don't have housing, you know, you can't really actualize your sexual and reproductive rights, including the right to safety." (Participant 10). As it relates to intimate partner violence, another policy advocate shared,

***"You know, violence is preventable. So that definitely also disproportionately impacts WOC and is probably impacting their HIV and STD rates. We know it is."***

- Participant 15

### ***Potential Facilitators***

#### **Whole-woman care**

Offer comprehensive health coverage, including supportive wraparound services, as part of SRH services.

#### **Cultural humility**

Create a culture that promotes cultural humility in healthcare services, starting with SRH services.

#### **Comprehensive sex education**

Provide comprehensive sex education including targeted efforts to educate young women of color.

### ***Offer comprehensive health coverage, including supportive wraparound services, for SRH services***

Perspectives on transformative action to address SRH disparities were influenced by the participants' respective position (e.g. policy advocate, administrator, healthcare provider). However, some insight can

be drawn from across these interviews on how to best serve women of color. On an individual level, WOC would benefit from increased access to comprehensive health care services that not only attend to their SRH health needs but also their physical, mental and even dental health. SRH services should be an access point to other needed health services. Increasing the time WOC have with their healthcare providers would also be beneficial in facilitating overall health in this population, as WOC often may not be receiving factual SRH information outside of their health facility.

These potential individual-level facilitators can only be implemented with sufficient local, state and federal funding support and with the guidance and leadership of community-based coalitions that are advocating for culturally appropriate SRH services. Additional resources have the potential to address funding gaps that deny insured and uninsured women comprehensive SRH care because of the type of healthcare setting they find themselves in (e.g. public health clinic, Title X family planning clinic or a primary care setting) and the type of funding that specific agency/entity receives. Participants underscored the missed opportunities to establish SRH service delivery that assures WOC that there is “no wrong door” to accessing comprehensive SRH care. Furthermore, healthcare facilities that are respectful, confidential and aware of women’s sexual and reproductive rights are important to ensuring equitable care (Braeken & Rondinelli, 2012). Additional funding would also help SRH clinics to become more women and family friendly by adding childcare services, transportation services and offering women-centered support services including clinic hours on the evening and weekend hours.

### **Create a culture in healthcare that promotes cultural humility, starting with SRH services**

Cultural humility training creates a space for healthcare and social service providers to check their personal bias and work more effectively with Black and Latina women who face ongoing stigma (Hook, Davis, Owen, Worthington Jr, & Utsey, 2013). This framework encourages providers to consider the patient’s narrative, by asking questions and having women explain their perspectives, choices, and history. As one participant states “...so being able to find a clinic that is going to serve you with whatever type of insurance you have. And that the individuals there are culturally competent or just you know, it’s not even cultural competence, it’s humility in treating and providing care.” (Participant 17). This approach allows women to be the expert in their own experiences and identities. Creating a space for women to share their story may counteract the power imbalance in the doctor patient relationship, reveal important information, and decrease medical mistrust (Hook et al., 2013; Tervalon & Murray-García, 1998).

A culturally humble provider in this context would make no assumptions about who patients are having sex with, what types of sex they are having or their SRH preferences.

***[I]f we’re talking about sex, I regularly ask what the gender of their sex partners are. So that’s something that’s helpful. And I usually ask them about history of STD testing. And if they have oral sex, anal sex, vaginal sex. So, I’ll talk to them about the type of sex that they have. And then I’ll talk with them if they’re HIV negative, I’ll talk with them about HIV prevention strategies, and also about whether or not they want to be pregnant or have a child, and if not, then if there’s any way that I can help them with pregnancy prevention. So yeah, I usually try to cover those bases.***

**- Participant 13**

This study participant in her work as a healthcare provider employs cultural humility to understand women’s unique experiences that inform their SRH decision making. Utilizing this approach minimizes assumptions and bias by providers based on their previous work with Black and Latina women. It requires ongoing effort by providers and administrators to support such learning to build awareness and work collaboratively with their patients in the clinical milieu (Hook et al., 2013; Mosher, 2017; Tervalon & Murray-García, 1998).

A systems-based approach is warranted to facilitate better SRH outcomes for women of color. Several participants noted that community-based interventions that focus on resilience factors (e.g. collaboration with faith-based communities) and increasing female health providers of color would be effective in reducing medical mistrust. This would help to improve confidence and comfort among WOC who often fear that their privacy and confidentiality are compromised as a result of accessing SRH services. Privacy and confidentiality was a frequently cited facilitator.

*I think also making sure that you know, people feel like this is anonymous or that they're not, that one they feel like they're in a comfortable space and like no one else can hear them or you know, it's, that they're in a private setting is important and that, you know, their information or what they say, they know that's not going to, you know, leak out anywhere is definitely a facilitator.*

- Participant 11

### ***Provide comprehensive sex education including targeted efforts to educate young women of color***

Reduced funding has been shown to limit administrators' ability to fully implement the California Healthy Youth Act (CHYA), the state's sex education law that requires school districts to deliver comprehensive sexual health education programming. As one participant who manages sexual health programs for youth indicated "Over time, we've seen some traction, and at the same time school districts are strapped, and one, whether they intend to, do this work, it's really tough given the fiscal constraints they're faced with," (Participant 9). While CHYA is viewed as model legislation, its failure has been in implementation as insufficient funding continues to plague its success. Similar problems have plagued sexual health programs across the country (Rubenstein, 2017).

Despite laws and policies addressing the integration of comprehensive sexual health education in the K-12 public schools, SRH education remains inadequate (The Bixby Center on Population and Reproductive Health, 2016). Study participants who are sexual health educators noted that they experienced resistance from local school districts in implementing comprehensive sexual health education. As one participant stated,

*I really want to show young people how to properly use a condom and I get a lot of pushback. So that's the biggest one [is that] comprehensive sex ed is not like on paper. The districts are not actually implementing what it encompasses and it's not being truly followed through*

- Participant 6

To fill gaps in SRH education, many obtain and share information among peers that can result in the spread of misinformation. Content may reflect personal beliefs rather than scientific facts (Dunlop, Logue, Thorne, & Badal, 2013; Flores, Acton, Arevalo-Flechas, Gill, & Mackert, 2019; Harris, 2010; Ross, Essien, & Torres, 2006). Value-based content on sexual information can exaggerate the risk of adverse outcomes for sexual activity.

*So, for example, here in the Central Valley, there are significant disparities in health care, we have a provider shortage. And so just basic access to information, medically accurate information about how to protect your health, what your rates are, I think those kinds of things are becoming more and more important.*

- Participant 7

Some women may turn to online material for clarity which presents its own challenges with health literacy (Kilfoyle, Vitko, O'Connor, & Bailey, 2016; Muvuka et al., 2020). The quality of content is not individualized nor vetted by medical professionals, and helpful accurate information may be too difficult for the average patient to comprehend. Women from immigrant communities may also come to the U.S. with limited SRH education

that can affect their use of SRH services. Similarly, to Black women, many Latinas turn to the internet for information (Yee & Simon, 2010). Although some Latinas report discomfort in discussing SRH issues with family members, friends and relatives, they may still share information that challenge traditionally western approaches to SRH care (Gilliam, Warden, Goldstein, & Tapia, 2004).

## Policy Recommendations

Specified barriers and potential facilitators as explored in this study offer insight into potential next steps.

### *Bridge SRH needs with flexible funding sources*

Funding for SRH services and programmatic barriers related to funding serve as hurdles to access. SRH providers must contend with the issue of cost, to what degree services are reimbursable, and determine the scope of available services based on this calculation. Because increased rates of health coverage have not necessarily translated to increased access, this issue of local, state and federal funding support for publicly funded SRH care remains salient. An examination of funding streams to identify gaps and further development of low-burden, low-barrier programs that facilitate access to SRH services is needed.

### *Review treatment guidelines with an intersectional/health equity lens*

For women of color, barriers to accessing culturally appropriate SRH care can be identified at the individual, provider and structural-levels. However, prior research and data herein suggest that addressing disproportionate rates of STIs requires implementing strategies that look beyond assessing individual-level sexual risk behaviors. Treatment guidelines and SRH providers implementing them may otherwise fail to identify risks. Risks may be underestimated by gendered assumptions and sex-related stigma. Thus, communities across California need the support to develop and implement data-driven treatment guidelines that are informed by an intersectional and equity-focused perspective.

### *Fund sexual health education*

A lack of access to accurate SRH education and information only serves to exacerbate these problems. Comprehensive sexual health education, especially for young women of color, was also identified as a vital resource to promoting a positive culture of sexual health from a young age. Thus, support to financially strapped school districts seeking to implement comprehensive sexual health education programs was indicated. Finally, the need for SRH education exceeds the jurisdiction of K-12 schools. Thus, funding and programmatic support for comprehensive sexual health education must also include additional resources to address the education needs of young WOC that are no longer engaged in the formal education system.

## Conclusion

A common sentiment expressed by many of our participants is that “people don’t think women of color are deserving of a special place or special services or special care” (Participant 14). It is supported by the understanding that WOC with SRH needs are left alone to grapple with social and structural manifestations of stigma at the intersection of race/ethnicity, gender, socio-economic status and STI status. WOC and young women of color, in particular, experience an inequitable burden with regard to STIs in the United States and face continued barriers to accessing comprehensive SRH care in California. This study describes specified barriers and potential facilitators to delivering much-needed culturally appropriate SRH services to women of color.

The current moment in history offers a unique opportunity for the lessons herein. For the first time in the U.S., the federal government is leading the charge to establish a national STI strategy, Sexually Transmitted Infections National Strategic Plan for the United States 2021-2025 (STI Plan; U.S. Department of Health & Human Services, 2020). The goal of this national strategy is to ensure that all people, regardless of age,

sex, gender, identity, sexual orientation, race, ethnicity, disability, geographic location, or socio-economic circumstance, are free of STIs or have equitable high quality STI health services. It directly addresses the issue of culturally appropriate service delivery and the importance of understanding disproportionate effects of STIs (Goal 4: Objectives 4.1, 4.2, and 4.3; U.S. Department of Health & Human Services, 2020). Key implications of this study are in alignment with this objective, such as the need to expand culturally appropriate SRH services targeting disproportionately impacted communities.

Simultaneously, California is making headway in its goal by developing a statewide plan to end the HIV, HCV, and STD epidemics in California (California HIV/AIDS Policy Research Centers (CHPRC), n.d.). It has set forth an ambitious goal to address these health conditions as a syndemic, viewed as a set of linked health conditions working synergistically resulting in poorer health outcomes (Singer, Bulled, Ostrach, & Mendenhall, 2017). In both domains, equity demands that the SRH needs of WOC move away from the margins to the center.

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