

# Health care providers' perspectives on male involvement in their sexual and reproductive health care needs

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Lilian Milanes  
*University of Central Florida*

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**HEALTH CARE PROVIDERS' PERSPECTIVES ON MALE  
INVOLVEMENT IN THEIR SEXUAL AND REPRODUCTIVE HEALTH  
CARE NEEDS**

by

LILIAN MILANES

A thesis submitted in partial fulfillment of the requirements  
For the Honors in the Major Program in Anthropology  
In the College of Sciences  
and in the Burnett Honors College  
at the University of Central Florida  
Orlando, FL

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Thesis Chair: Dr. Joanna Mishtal

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## **ABSTRACT**

Young men are at the greatest risk of contracting sexually transmitted infections (STIs) within the U.S. male populations, yet are the least likely to make a sexual and reproductive health (SRH) care visit. Clinical approaches in these areas that include the outreach to and the involvement of male partners of female patients can prove particularly useful in expanding SRH care to men and can also improve health outcomes for women who have sex with men. In this study I examined UCF's healthcare provider's approaches to educate and involve men (between the ages of 18 and 30) and male partners of female patients in their SRH needs. I conducted qualitative semi-structured interviews with 18 health care providers at the Student Health Center; including physicians, physician assistants, and registered nurses. This study found that there were significant differences in perception of men's SRH risk behaviors among the providers. In addition, this study revealed issues that might deter male students from accessing care, specifically how patients are required to state to the operator (who is also an undergraduate student) their name, PID and exactly why they are scheduling a visit to the clinic, thus many men say they have cold symptoms instead of issues with SRH. This study is significant because it can contribute to improvements in the delivery of SRH care to male students on campus.

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## INTRODUCTION

Almost 13 million young adults (30%) aged 20–29 years did not have health insurance coverage in 2008 (Cohen, 2010). American men die more often as a result of having an STI, yet more cases are reported in American women (Shahul, 2005). In the U.S., the rates of early death and disability that can be attributed to sexual behavior are three times higher than in any other so-called developed nation (Shahul, 2005). In 2010, there were 1,307,893 cases of chlamydia, an increase of 5.1% from 2009. The overall rate of chlamydia infection among women in the US was over 2.5 times higher than the rate of this infection among men. Males, however, are increasingly being tested for chlamydia; from 2006 to 2010 the chlamydia rate in men increased 36.4%, whereas in women it increased 19.5%. The chlamydia rate among African Americans was over eight times that of whites. The prevalence of infection was greater among economically disadvantaged women aged 16-24 (STD Surveillance, 2010).

Barriers men face with regards to accessing SRH include fear, stigma, denial, lack of social support and the need for confidential services; as well as lack of health insurance and low knowledge about where to go for sexual and reproductive health care. There are also barriers for health care providers, including the lack of national guidelines about best practices in men's SRH<sup>1</sup> as well as lack of, -agreement about-, perceived effectiveness and/or implementation of services, in addition to external factors, all impact service delivery (Marcell et al., 2010). The research question used to guide this study is: what approaches are used by providers at the UCF

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<sup>1</sup>in the same way that the American Council of Obstetricians and Gynecologists set such guidelines for women's SRH care

Health Center to educate and involve men (between the ages of 18-30) and male partners of female patients in their SRH needs? This study found that there were significant differences in perception of men's SRH risk behaviors among the providers. In addition, this study revealed issues that might deter male students from accessing care, specifically how patients are required to state to the operator (who is also an undergraduate student) their name, PID and exactly why they are scheduling a visit to the clinic, thus many men say they have cold symptoms instead of issues with SRH. This study argues for greater efforts to educate college men on what the essential services are to ensure the best SRH care.

## **LITERATURE REVIEW**

According to a 2011 report by the UCF Office of Institutional Research, UCF is currently the second largest university in all of the United States of America, with a total of over 58,000 students enrolled in this university (undergraduate, graduate, and medical students). The diversity profile of this university is as follows: 60.75% White, 17.65% Latino, 9.83% Black, 5.38% Asian, 2.40% Non-resident Alien, 1.52% Multi-racial, 0.32% Native American/Alaska Native, 0.18% Native Hawaiian/Other Pacific Islander, 1.97% Not specified (UCF OIR, 2011). With regards to the breakdown of biological sex, there are a total of 26, 498 men (45.14%) and 32, 200 females (54.85%) enrolled within UCF (UCF OIR, 2011). Of all the students enrolled at UCF, the overall average age is twenty-four, and the percent of students who are over the age of twenty-five is 24% (UCF OIR, 2011).

While historically services have targeted women, providing sexual and reproductive health (SRH) care services to men is particularly important because sexual health outcomes are rooted in sexual relationships. The sex, gender or orientation of the relationship does not matter, the importance lies in the fact that reproduction is the responsibility of both parties involved (Kalmuss, 2010). Men who have sex with women are not receiving adequate levels of sexual and reproductive health care that they need. While reviewing the literature, I identified many themes surrounding the obstacles men face in accessing their sexual and reproductive health, these include but are not limited to fear (Kalmuss, 2010; Marcell et al., 2010), stigma (Fortenberry et al., 2002), denial (Marcell et al., 2009), lack of social support (Lowery, 2005; Marcell et al., 2009) and the need for confidential service (Ford et al., 2001); as well as lack of health insurance

and knowing where to go for sexual and reproductive health care (Marcell et al., 2009; Kalmuss, 2010). In a study done on services accessed by adolescent males, Marcell et al. identified barriers from the health care provider perspective, including the lack of national guidelines, agreement, perceived effectiveness and implementation, and personal self-efficacy to complete clinical tasks and external factors, all impact service delivery (Marcell et al., 2010). The five key themes I identified within the literature discussing barriers faced by men to access their optimal SRH care, include issues with the cost of care, continuity of care, quality of care, fear of care, and notions of masculinity.

The research question guiding this study is: what approaches are used by providers at the UCF Health Center to educate and involve men (between the ages of 18-30) and male partners of female patients in their SRH needs? This research question is anthropological because it seeks to involve the perspective of medical professionals within the process of evaluating health from a holistic perspective. With this study, one is able to view the SRH care of men from the essential viewpoint of these health care providers, an important part of the equation in the delivery of health care. By discussing with these providers the various factors involved with providing adequate SRH care to college aged men, we are able to see that the disparities for providing SRH care to men is not just based on access to health care.

Anthropological scholarship provides theories of structural violence and stigma that can be used to analyze the literature revolving around men's involvement in their SRH care. The anthropological concept of structural violence is an inherent action that is unintentional or intentional that causes harm by not allowing others to exceed their full potentials (Galtung, 1969; Farmer, 2004; 2005; 2006). Structural violence can be physical, mental, emotional, economic,

political or even the denial of knowledge (Galtung, 1969; Farmer, 2004; 2005; 2006). This theory of structural violence relates to this topic because of the simple fact that access to the U.S. health care system requires health insurance and an exorbitant amount of money, both elements that the structure of the U.S. health care system prohibit those with less socioeconomic status from accessing. Furthermore, anthropological scholarship have focused studies on the culture of biomedicine, that is the culture of health care providers and their environment, is one that is reported to contribute to the institutionalization of power that protects White privilege through exclusionary practices that perpetuate hierarchies of domination (Chapman, 2005). Stigma is a label given, that does not have a positive connotation to it (Herek et al., 2009; Fortenberry, 2002). When a stigma is related to STIs and more specifically AIDS has been related to prejudice, discounting, discrediting and discrimination directed towards those who are thought to be diagnosed (Herek et al., 2009; Fortenberry, 2002).

The cost of health care is something that continuously plagues the United States, a country rooted in independence and freedom, yet many underserved citizens do not have the resources to access a healthy lifestyle and are thus denied the right to health (CMS, 2012; RWJF, 2008). Even those who are lucky enough to get their hands on some type of insurance, often times find themselves within holes in their insurance policies because their plans seem to not cover services when one is in dire need of them (RWJF, 2008). Granted, there are various services and programs that play significant roles in the access of care for disadvantage communities (e.g. Medicaid, free/affordable local clinics) however, even with these programs and services, people slip through the cracks. As noted previously, SRH has to do with relationships, and although this study is focused on men's involvement in their SRH, it is also important to identify the

similarities in how this relates to women; because women's SRH is parallel to that of men's SRH (Kalmuss, 2010). Just as a woman's ability to lead a reproductively healthy life is closely connected to her ability to overcome other social and economic barriers, these same social and economic barriers are ones that men face as well (Cohen, 2008). Men however, are even more at risk for financial burdens preventing them from accessing their SRH (Marcell et al., 2009).

There is evidence that cost might not play as significant a role with involvement of SRH care, as displayed in a study done with focus groups amongst Latino and black men in northern Manhattan. Within this study participants were very vocal about the high cost of seeing a doctor, and repeatedly discussed not having medical insurance and not being able to afford out of pocket health care costs (Kalmuss, 2010). While the men in this study overwhelmingly identified financial barriers as a major impediment to seeking care, in each of the communities where the study was conducted had clinics offering low-cost comprehensive SRH services. These men also reported feeling confused and overwhelmed by the financial aspects of health care (223). This data shows that economic barriers to care might not play as significant a role as other factors, such as the gap between perception and reality, suggesting the need for better marketing strategies that highlight not only availability and location of SRH clinics serving men, but also their affordability (226).

When it comes to SRH there are various problems with the links between health care services and health care providers, revealing the issue with continuity of care. Even when SRH care is accessed, it is neither comprehensive nor integrated (Cohen, 2007, p. 9). For men particularly, there is a system deficiency in the lack of formal screening or service guidelines (Kalmuss, 2007, p. 74). There is a lack of consensus varying from health care document to health care document,

meaning that neither health care providers nor their clients are informed about what services men should receive and when they should receive them (Kalmuss, 2007). Routine screening of chlamydia and gonorrhea among women under 26 is considered a cost-effective, yet underutilized, form of preventive health care because of its ability to reduce rates of pelvic inflammatory disease (PID) (Sonfield, 2009). In 1999 the first efforts to understand male SRH care began when the Male Advisory Committee established the Region II Male Involvement Advisory Committee (MAC, 2009). When this committee first began, they identified issues related to men's SRH care including the fact that not many providers male inquiries relating to SRH care unless specifically asked by the patient and that men rarely seek care (MAC, 2009). Having determined some of the basic issues the MAC, in 2009 established the first effort to develop a uniform document to be used as a resource for the development of clinical services for male patients (MAC, 2009).

In 2007, Kalmuss conducted a study based on the data sample of the 2002 National Survey of Family Growth. For this study, when comparing men who had private or no insurance, respondents with public insurance were significantly more likely to have received nontesticular care and significantly less likely to have received a testicular exam only (Kalmuss, 2007). However men with private insurance were no more likely than those without insurance to have received either form of care (79). A large majority of men are receiving testicular exams, when evidence does not support its effectiveness in reducing mortality and morbidity from testicular cancer (79). None of the proposed standards for routine SRH care for men endorses a model that prioritizes a testicular exam over other SRH services for men aged 20-44 (79). This lack of professional consensus regarding standards of care, is one way to identify the unmet need for

services which suggests a unified consensus document that establishes guidelines of care for men (both adolescent and nonadolescent), insurance coverage for the recommended services and plans for communicating these standards of care to providers and the public (Kalmuss, 2007).

Another issue that comes about is quality of care. There is a critical importance of quality of care as it affects health-seeking behavior and outcomes (Cohen, 2008). Providers are doing the same thing for every patient and not accounting for individual needs, which is a concern because the one-size-fits-all approach may leave minority patients with needs that aren't met (Cohen, 2008). The most consistent feature of wider research into health inequalities is that social class is the most significant determinant of health expectations (Crawshaw et al., 2009). However, given that the United States is so diverse in its racial and ethnic backgrounds, cross-cultural comparisons of sexual behavior may be helpful in attempts to deliver large-scale programs for the prevention of STIs (Nyitray et al., 2009). All these characteristics need to be taken into account by health care providers because a simple solution for one patient could mean something completely different for another patient's beliefs (Cohen, 2007). To act safely and responsibly men need screening, clinical care, counseling, education about SRH and safer-sex behaviors, and shared responsibility for contraception and parenting (Kalmuss, 2007). A comprehensive service would include at minimum HIV, STD and birth control services (counseling and advice about these topics, testing and treatment) and testicular exam for sexually active men (Kalmuss, 2007). However there is a concern that with the integration of HIV testing into routine physical exams it could mean less and less pre and post-test counseling for the HIV test, a crucial opportunity to educate (Kalmuss, 2007).

The most reliable source of continued, qualified SRH care is a consistent primary care physician. And with that comes the relationship between this consistent primary care physician and the patient. Current recommendations are advocating for a more patient-centered approach to providing health care, in which the provider should be “responsive to the patients’ wants, needs and preferences,” (Laine and Davidoff, 1996; Institute of Medicine, 2001). By using a patient-centered approach to health care, it can improve health outcomes to both access to, and effectiveness of, care; all of which are critical components in establishing quality healthcare (Campbell et al., 2000). However if there is no continuity of health care with a primary care physician, there is no way for patients to build that relationship, this is a significant impediment to men’s access to SRH care.

Fear is a major issue that torments many minority communities, especially among African American and Latino communities, particularly undocumented immigrant communities. This fear can be traced back to decades of oppression, but to the most infamous and devastating of cases was the Tuskegee syphilis study in which African American populations were infected with syphilis purposefully to conduct experiments on the long term effects of syphilis (Reverby, 2009). This study is now the reason why we have such a thing as the Institutional Review Board for all research studies involving human subjects. Given that UCF has over 30% of the study population being considered minority students, and the majority of that minority being Latinos, this culture of fear is something that is very eminent and real within Latino communities, no matter what generation they immigrated. This fear also translates to a fear of health care in the United States. Mistrust for the health system in minority communities causes a patient to refuse

treatment and/or comply with medical advice which can cause providers to become less engaged (Cohen, 2008).

Men of color are more likely than white men to received nontesticular SRH care (even after race, ethnicity, income, relationship status, sexual risk behavior and connectedness to the health care system have been controlled for) (Kalmuss, 2007). As a result of these findings, Kalmuss proposed two hypotheses: (1) health care providers may consciously or unconsciously use race and ethnicity in assessing whether to offer nontesticular SRH services to men (the provider's assessments about the need for SRH screening and care may be based more on a man's group risk profile than on his individual risk behavior; and (2) men raised in communities with higher levels of sexual risk behavior may be more willing than others to access services and report their SRH concerns to providers, also accessing services may be more stigmatizing and thus less likely for men from lower-risk communities where exposure to SRH care may be uncommon (Kalmuss, 2007). If equal proportions of male students are accessing their SRH care services, then communities with higher levels of sexual risk behavior and higher prevalence of cases of STIs and HIV (i.e. African-Americans and Latinos) should be easily identified and treated by providers within the health center. However, in a qualitative study done by Kalmuss in 2010, men of color connected the stigma of having an STI with their disinclination to be seen anywhere near a sexual health or STI clinic and frequently talked about a fear of finding out that they had an STI, with some mentioning the inability to deal with hearing bad news (Kalmuss, 2010).

In 2010 Vicki Breitbart and many other colleagues did a study comparing Dominican women from the island to those who moved to New York City, and their perceptions of SRH;

there were many interesting findings that highlight new ways to address the disparity amongst SRH for not only Dominican Latinos in the U.S., but can have some similarities for other Latino communities. Vicki Breitbart found that women from the Dominican Republic talk to their female relatives about their health, as well as some male relatives because ‘men know more things than women’; however this requires us to question, where are men going for these same consultations? Despite the conventional wisdom that women are major facilitators of men’s health care seeking, women’s influences were a minor theme in the qualitative study amongst men in communities of color (Kalmuss, 2010). Participants also made frequent references to the fact that men didn’t talk to their friends about SRH; however men in seven out of the ten focus groups mentioned conversations that they had had with male peers or relatives, or the fact that they should be encouraging men in their social network to get a SRH care checkup (Kalmuss, 2010). While concepts of masculinity continue to play a huge role in gender studies, especially in the United States, the object of this study is to shed light on the other problems that health care providers see which prevent men from attaining their optimal SRH.

Anthropological scholarship explains notions of masculinity for centuries and cross-culturally. When discussing notions of masculinity, Wright came up with five different categories to explain the different forms of masculinity, specifically among African American communities; (1) men whose sexual activities are completely homosexual, (2) men who are mostly homosexual and partly heterosexual, (3) men whose sexual activities are mostly heterosexual but partly homosexual, (4) men whose sexual activities are equally homosexual and heterosexual (bisexual); and (5) men whose sexual activities are solely heterosexual (Whitehead, 1997; Wright, 1993). Yet with all these various forms of masculinity, the gender identity is kept

by continuing sexual relationships with women, and in homosexual encounters, being the passive person when it comes to oral sex and the active person when it comes to anal sex (Whitehead, 1997; Wright, 1993). In a qualitative study with Mexican immigrants regarding SRH and gender roles, it was found that stereotypes were less based on daily experiences, but rather still deeply rooted by cultural and societal roles (Maternowska, 2012).

## **RESEARCH DESIGN AND METHODOLOGY**

This was a qualitative study using semi-structured interviews with key informants at the UCF Health Center. The sample size was 18 key informants. Consisting of 5 physicians, 2 physicians' assistants, 10 registered nurses, and 1 community health advocate.

The definition of key informants is research subjects in ethnographic studies who have a disproportionate weight and role within the community that the researcher is studying. These informants are 'key' in that they facilitate access in acting as gatekeepers, within their social networks, and can provide particularly important understandings to the researcher on aspects of their collectivity, for reasons such as their rich knowledge of the collectivity through their seniority or through their specialist roles in the setting (Bernard 2006). Key informants have 5 main characteristics: occupy a role in the community that exposes information being sought, knowledge on information being observed, willingness to share this information, intelligible communicability, and ability to remain objective (Marshall 1996). Clinic providers at the UCF Health Center fit this category because they serve as authoritative and professional figures within the field of health care, specifically within the science of medicine, and also provide healthcare services and therefore have experiences in dealing with patients, especially within the age group of 18 to 30, since the clinic is based on a population of college students.

With the permission of the UCF Health Services Clinic, health care providers were invited to be interviewed with regards to men's sexual and reproductive health needs and healthcare utilization. Health care providers were recruited through inter-departmental e-mails sent by Dr. Mary Schmidt-Owens, the Coordinator of Management Analysis. The content of e-mails sent

out included a description of the study, research questions and objectives, the description of confidential data collection and handling, and the consent process (since no consent form was required). Participants were also recruited through Dr. Schmidt-Owens' connections with administration and employees within the clinic and also through word of mouth. Often times once one interview was conducted with a provider within one of the offices, once the interview was complete, the provider gathered up more participants within their offices. Interested providers were able to contact the PI of this study, via e-mail or phone, to schedule a thirty minute to one hour face-to-face interview. There were also two focus group sessions with three R.N.'s each in which the same questions were asked and all of the members within the focus group would have the opportunity to respond how they pleased.

The target participants of this study were health care providers who work (as employees or volunteers) for the Student Health Center, which could be health care professionals, allied health professions and community health workers. This included physicians, physicians' assistants, registered nurses, licensed practical nurses, certified nursing assistants, case management workers, and community health advocates. This study, however, does not include non-healthcare providers at the clinic, including phlebotomists, student workers, receptionists, and the like, as well as health care providers who were not affiliated with the UCF Health Center.

**Table 1: The following Table 1 shows the sample characteristics:**

<b>Characteristics of Key Informants</b>	
<b>Sample Characteristics<sup>a</sup></b>	<b>Sample n</b>
	<b>(N=18)</b>
<i>Sex</i>	
Men	5
Women	13
<i>Type of Provider</i>	
Physicians	5
Physician Assistants	2
Registered Nurses	10
Health Educators	1
<i>Office Type</i>	
Primary Care (Blue Pod)	4
Primary Care (Green Pod)	6
Acute Care (Gold Pod)	5
Women's Clinic (Purple Pod)	1
Administration	1
ANNEX Center	1

The research in this study utilized face-to-face interviews with health care providers in their office or in a medical examining room, within the health center. The location of the interview was a place that offered the privacy needed for confidential exchange of information, in order for these interviews to be conducted efficiently.

Interviews followed the same basic five questions, however as is customary in semi-structured interviewing, the PI encouraged full narrative answers, even if expanded or departed from the questions, and probed deeper after the initial responses were offered. The main five questions that were used during these semi-structured interviews were:

1. What types of basic services do men need (ages and intervals in which they should receive these services) in order to access the best SRH care?
2. How do you assess the need for sexual and reproductive health screening and care? (based on a man's group risk profile or his individual risk behavior?)
3. Patient's level of acceptance of their need for and receipt of sexual health care?
  - a. Men's willingness to access services?
  - b. Men's willingness to report their sexual and reproductive health concerns to providers?
4. Do you think that the patient population that you treat here at the health center is representative of the UCF student body population when it comes to demographics [e.g. 60.75% White, 17.65% Latino, 9.83% Black, 5.38% Asian, 2.40% Non-resident Alien, 1.52% Multi-racial, 0.32% Native American/Alaska Native, 0.18% Native Hawaiian/Other Pacific Islander, 1.97% Not specified (UCF OIR 2011)]?
  - a. Do you think there is a feeling of mistrust for the health system amongst minorities?

5. What are some solutions that could be done to involve and get men more access for their SRH care: [e.g. Home based testing kits, educational & communication-skills-training efforts, expedited partner therapy (EPT) (Sonfield 2009), herbal treatments (Breitbart et al 2010).]

Other sample questions also used in the course of probing or following up on responses included

6. I noticed that many universities around the country have a Men's Clinic in addition to a Women's Clinic, but UCF doesn't. How do you feel about not having a Men's Clinic here – is that something that's not really needed?
  - a. Do you think men on campus would be eager to utilize the clinic?
  - b. What do you think might prevent men from utilizing the clinic?
  - c. Do you think that some men on campus would not want to come to a Men's Clinic?
7. If there was a Men's Clinic, what type of services would be offered for men?
  - a. Testicular exam?
  - b. Nontesticular exam (HIV & STI testing, birth control, sterilization advice)?
8. Offer counseling and/or education about sexual health? Info about safer-sex behaviors, shared responsibility for contraception and parenting, and the rights of both men and women to have volitional and pleasurable sexual experiences?
9. How is the service of HIV or STI testing conducted?
  - a. Where do men get tested?

b. Is there pre- and/or post-counseling involved?

Interviews were recorded through a voice recorder with the permission of the interviewee, such that only the audio portion of the interview was documented. Notes from the interviews were also taken by hand. After each interview took place, all the audio files were transcribed. No identifying information was collected; interviewees are identified through a provider number (e.g. P1, P2, etc.) and that number is used for their recordings and transcriptions. Transcribed interview narratives were then coded and analyzed to establish major themes and subthemes in the providers' responses.

Consent forms and transcriptions were kept in a locked storage unit in the PI's home and the electronic files are stored on the PI's personal computer within folders and files that are all password protected. At any moment during, before or after the interview participants had the authority to withdraw from the research study; especially if the health care provider felt that their job was at jeopardy because of discussing the health care policies of their employers.

## **FINDINGS**

The results of this study have been grouped into three main sections; (1) providers' understanding of what services should be offered to men and which populations they serve, (2) providers' perspectives and experiences regarding barriers to men's utilization of SRH care, and (3) providers' perspectives and experiences regarding encouragement of utilization.

SECTION 1-Providers' understanding of what services should be offered to men and which populations they serve:

These findings display providers' understanding of what services should be offered to men and which populations they serve. Three main findings that emerge in this area of inquiry are: (a) most providers had similar responses to what type of services men should receive; (b) providers were relatively consistent with their definition of risk behavior; and (c) providers estimated that the patients they saw were a good representation of the student body but there was overall low awareness of patients' demographics.

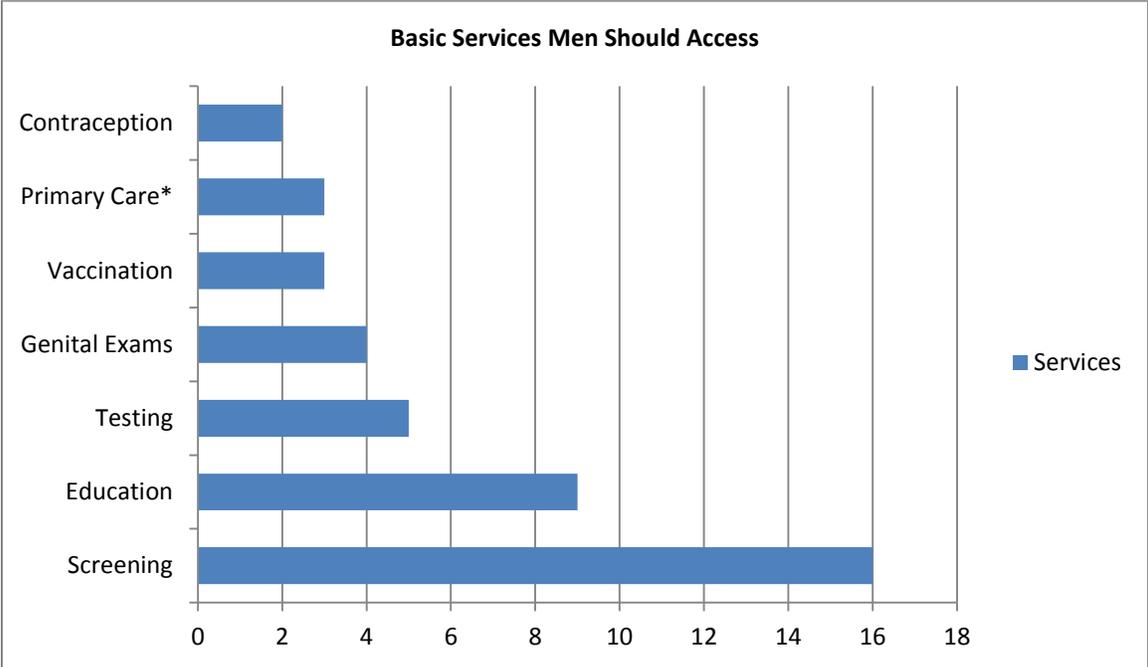
**(a) Providers' Responses to what type of services men should receive**

One of the questions directed to all providers was: "What type of basic services would you suggest in order for men to access the best sexual and reproductive health?" The majority of the providers' responses demonstrated many similarities and common responses based around seven key elements, those include STI/HIV screening, education, testing, genital examinations, vaccinations, primary care and access to contraception. This finding also indicated that providers saw a need for comprehensive men's healthcare services. The following is a representative quote about the ideal services:

"They [men] should have access to a primary care provider, I mean I don't know how basic of services we're talking about, but certainly access to the adequate providers so that they can ask questions, if they're having questions, be treated, etc. There should be

some wellness services to provide education. And then all of your basic testing services, treatment of any conditions that are caused by any sexual behavior, and then there certainly should be condoms, access to vaccines, education.” –P8

**Table 2: Below is a chart that demonstrates each of the services providers reported should be accessed by men to ensure their optimal SRH care.**



\*What is meant by primary care is patients having access to a consistent primary care physician such that patients can have annual checkups to supervise their overall health and wellness.

### *Services Types: STI Screenings*

Sixteen out of 17 providers stated that it is very important to conduct STI screenings, whether it be for preventative measures or if the patient is at risk, for example if the patient or the patient's partner had been diagnosed with an STI/HIV. Providers also saw an important opportunity for men to come in to be tested at the time of a change in their relationship status. Below are examples of the three "classic" times for male patients to come in to get screened at the health center for STIs or HIV:

"Probably at the beginning of the new relationship with an individual, probably would be a good time to do an evaluation. And also if you have had a one night stand encounter, that might be another opportunity to do an evaluation. If you've noticed anything different, say for instance a lot of guys, they'll have symptoms of urinary frequency, or symptoms like that so that would be a time to be evaluated"-P12

"And as she said if they're entering in a new relationship, and both partners decided to be tested and that's a way to come in and be tested. Or sometimes it's a long term relationship or sometimes they're going to get back together, those are like the three classics of coming in to be tested."-P13

Another important aspect of STI and HIV screening that the researcher pursued in the interviews is the use of pre-counseling and post-counseling. Pre-counseling and post-counseling involves conducting the STI or HIV screening that is more time intensive with the patient. Pre

counseling consists of asking more in depth questions with regards to why the patient decided to take the risk of engaging in unsafe sex and other aspects of behavior involved in risk-taking. Post counseling involves going over any questions the patient might have about their test results and helping the patient through any concerns regardless of what the results of the test were. In most cases, especially regarding testing for HIV, pre-counseling and post-counseling are the most important aspects to educating an individual about risk behavior. When providers in this study were asked questions whether or not there was pre- and post-counseling provided with any of the HIV and STI screening they described their strategies to take a sexual history of the patient, or offering the counseling services of a nurse on staff , or even referred the patient to the UCF counseling center. Therefore pre-counseling and post-counseling were not routinely performed, and were generally inconvenient because the patient would need to see another provider or would have to walk to another office (e.g. the counseling center), thereby potentially making the follow up uncertain. The following were some sample responses that reflect this finding.

“Yes but it’s not very involved. The provider who orders it [HIV/STI screening] and then they give the results. Of course it's if it's negative they can get them over the phone. So there's no post counseling much there.”-P16

“Pre-counseling? I mean, when I do a sexual history, I ask, are you sexually active, how many partners, do you use condoms, what types of birth control do you use or barriers . And I find out from them, and then I go from there, based on what their answers are.”-

P5

“Yes, we take a sexual history. That’s how you determine low risk and high risk. I usually ask, the number of partners in the past 90 days, then I ask the gender of those partners, I ask about condom use, I ask about the association of alcohol and do they engage in sex while intoxicated, and does it affect their ability to make safe decisions. So that’s what I assess pre-testing, then I make the determination of high risk or low risk and who to test and at that point, after testing I decide either bring them back for second visit, if they’re high risk.”-P1

The response from Provider number 5 suggests that pre- and post-counseling might be considered to be similar to taking a patient’s sexual history or that sexual history can be performed in lieu of counseling, yet the two are not the same. A pre and post counseling session for getting an HIV test is not limited to how many partners an individual has had within a certain time period, sex of partners, condom and contraceptive use, or the influence of alcohol. A typical STI/HIV counseling session would ideally involve detailed follow-up questions to an individual as to why that person decided to make unsafe decisions such as not using a condom, or what they were thinking at the time, or if they considered what the consequences were if they were to contract an STI or HIV. If an individual is at risk of contracting HIV, that person is just as much at risk of contracting any other STI, and if these opportunities to educate and allow an individual to reflect and really think about the consequences of their behavior are not utilized, then these STI and HIV screenings are counterproductive or at least not fully utilized. Thus, the post-test counseling is just as important as the pre-test counseling, both are opportunities to educate patients and alter risk behavior. As one provider very well put it:

“Whether they have had multiple partners, not many partners, that really is insignificant because all it takes is one time. And so it’s just having that discussion on what is going on in their life, past or present, that we have to address.” –P4

Furthermore, once an individual contracts HIV, they become even more susceptible to contracting other STIs because HIV, suppresses one’s immune system, thus making it easier to contact any type of bacteria, infection, illness, virus, etc., including STIs

### ***Services Types: Education***

While 9 out of 17 providers stated that general sex education needed to be part of the basic services provided to men who come to the clinic, all providers stressed the importance of education overall. The narratives of the providers reveal that education of the patients should include topics such bodily functions, consequences of risk behavior and how STIs are spread, and education should be evidenced-based. The following are examples of the various aspects of education that should be involved in men’s utilization of sexual and reproductive health services:

“I think a lot of these younger guys need to be educated more as to the core temperature as it correlates to the sperm and the scrotum and clothing and the way that affects, you know the effects of the body temperature, why the scrotum is outside of the body and not inside the body because of the body temperature; I don’t think they understand that. I don’t think they understand that concept. So I think, education, more education about the body and why things are where would help them a lot. I think some of the clothing they wear, the things they do, and when you mention it to them they’re like, ‘Oh for

real?’ So that’s one. I think more education, about everything, themselves, more of a familiarity with women, would help.” –P7

The regulation of the core body temperature is of concern for this provider because it has to do with promoting the optimal reproductive health, and if the sperm are not performing at their potential, then that is inhibiting a man’s reproductive capabilities and overall SRH.

### *Services Types: Testing*

Testing differentiates from screening in that testing is done to check if a patient has chronic conditions, such as cancer. When it comes to men’s SRH care, providers believed in the importance of the prevention for prostate cancer, and services like Prostate-Specific Antigen (PSA) testing for risk populations, typically this testing is done at the age of fifty or older.

“Well I would think that men’s health would include STI screening as well as testicular cancer awareness and testing. Also general physicals, sports physicals, so that they know about their health.” –P3

One provider reported new recommendations with regards to PSA testing and limiting it to the ‘high risk group’:

“The taskforce and the CDC just came out and recommended against pre-teen PSA testing. Even in men over 50 and to limit it to the high risk group, again the risk and

high risk, the high risk group being a family history of prostate cancer, or actually the African American population is a high risk for prostate cancer, so you might want to limit your PSA testing to that group, and then they recommend having a discussion of the implications of the testing because there's a fairly high false positive rate, or the fact that it may indeed uncover the cancer, or the cancer is maybe not an invasive cancer that may lead to decreased mortality.” –P1

### *Services Types: Genital Examinations*

Although genital examinations were brought up as being important in a few interviews, one provider who mentioned this service discussed the controversy with conducting genital exams because exams of the genital area have not shown to provide significant preventative services.

“And then in terms of just a general physical in a male is somewhat aged vented, if they're young, no one says the standard of care is to do an examination of the genital area, but I think it's very helpful. A very common thing for a young male is an ingrown hernia, so I think part of the examination should be an ingrown hernia. The preventive services taskforce [USPSTF] does not recommend doing testicular exams, or teaching the patient testicular self-exam. But I believe it's helpful and also a very important part in a physical of a young male, so I'll tend to do an examination of the testes looking for

possible cancer or any other abnormality, particularly if there's a complaint to that area, testicular pain, or some other complaint.” –P1

Given that this health care center is based around the student population, typically between the ages of 18 and 30, many providers did not differentiate between types of services offered to specific age groups. This might be so because the interview questions did not include many topics regarding pediatrics. The above provider was one of the few that pointed out the importance of treatment and services being age specific, suggesting that generally age-specific is not of high priority with the care provided at the clinic.

### *Services Types: Vaccinations*

Vaccinations were one of the services recommended less within the interviews by providers, however inquiries made to providers about the use of the HPV vaccine were very revealing, especially now that the Gardasil vaccine is recommended for both men and women. Providers observed that very few, if any, men request information about the HPV vaccine. Other barriers include issues with insurance companies to pay for vaccines, and negative aspects of getting the HPV vaccine. Some of these drawbacks to getting the HPV vaccine is the influence of pain and men not being able to experience the direct benefit of the vaccine. Below is an example of one of the provider's response:

“It’s [HPV vaccine] been approved and insurances, I don’t know exactly if they cover it but it should be covered now for the HPV vaccine. So yes the awareness for men to get it, although they’re not as motivated because they don’t have a risk of cancer that we know of at this time and there’s no test for them to see if they have HPV, so getting them to decide to have the vaccine is a big educational measure. It should start probably before middle school so they understand and involve their parents, with the HPV vaccine.” –P3

When the researcher asked a follow up question about where men would seek the HPV vaccine, providers were not certain where they could access this vaccine, thus demonstrating that of the few men who asked about the HPV vaccine, even less actually received the vaccine. This can be fueled in part by provider’s relatively low awareness and knowledge of this vaccine for men’s use.

### ***Services Types: Access to Primary Care***

With regards to access to primary care, providers believed that it is important for men to have general wellness in order for that to translate to good SRH. Providers described the importance of patients having access to a primary care provider, such that there is a consistent delivery of care to the patient, that the patient lead an overall healthy lifestyle from the sleep they get each day, to the nutrition they get through the food they eat, to the activities and behaviors they do throughout their lives. Below is an example:

“As far as any other screening or health screening that can be done other than the regular STD testing if necessary, I’m not sure what else can be done, other than just basically trying to have a healthy lifestyle as much as possible, respecting one’s body, getting good sleep, getting a good nutrition (which can be controversial now a days, what is a good nutrition), having emotional health is a pretty good foundation of general health which also carries down to sexual health as well, being part of regular health.”-

P10

### ***Services Types: Access to Contraception***

Access to contraception was another important element of SRH wellness that many providers mentioned, specifically access to condoms. The following are examples of provider’s responses to the importance of accessible contraception:

“...access to condoms that are free or discount, because you know these kids...tuition has gone up, fees have gone up, we’ve got food banks here at UCF that made the national news one evening with that. I mean, I know money is an issue, and if they can’t afford food, they won’t be buy condoms. You know so it needs to be [available].” –P2

**(b) Providers were relatively consistent with their definition of risk behavior**

One of the five questions that was asked to each of the providers was “How do you assess the need for risk behavior?” Overall providers use the CDC’s definition of risk behavior to then take action. Below one provider went into detail of the CDC’s definition of risk.

“They [CDC] define high risk and low risk, [someone] who is low risk and says “I have been sexually active, I am monogamous, I have heterosexual sex, and I do use condoms.” That is a low risk person. I would say that person should have a screening for gonorrhea and Chlamydia, and that counts for safe sex practices. Then a more high risk person, that would be MSM, men having sex with men, someone who has multiple sex partners, who doesn’t use condoms consistently, that’s a high risk person, we would add screening for syphilis to that person, according to the CDC.”-P1

It should be noted here that there should be a better description of “heterosexual sex” because the only form of sexual activity that a man and a woman can perform, that a man and a man, nor a woman and a woman cannot perform, is vaginal intercourse. If providers are describing low risk behavior as having “heterosexual sex”, this can be a misconceiving concept because risk of contracting HIV and STIs is increased through any form of unprotected intercourse, whether it is between a man and a man, a woman and a man, or a woman and a woman. Furthermore, another concept that should be considered is sex on the down low; if men are having sex with men but do not consider themselves having “homosexual sex,” this is also an issue because these men might hear these categories of low risk and high risk and place themselves in categories that would not apply to them.

In a focus group providers listed a variety of things that factor into the way that they assess risk behavior; such as multiple partners, unprotected sex, influence of alcohol, influence of peers, involvement in certain extracurricular activities, being away from home for the first time and the perception of freedom. Below are some other responses that providers gave as to how they responded to and treated risk behavior:

“We obviously have our few higher risk (we say higher risk populations), the African Americans, the LGBT, or more the men that have sex with men more specifically. So we definitely like to make sure that we get those folks tested.”-P4

“Like I said I would go through the sexual history, if I see any risk at all, I offer the test. If they are sexually active I just offer it, I see what they say, if they are higher risk, if they have multiple partners, then I really recommend it [STI/HIV screening]. If they’ve been in the same relationship for the past 5 years I’ll ask if they want to, but I don’t push the need, at all.” –P5

“It depends on the history of the patient, if somebody tells me that they may have had a risk factor for HIV or some other type of potential infection, then of course the recommendation would change. But for the average heterosexual male (that’s usually the vast majority of our patients) I would recommend gonorrhea or Chlamydia test. If the patient was not heterosexual, then I would recommend something else, be it the HIV or the syphilis test, or both. So it really depends on the history of the patient, of each patient individually.” –P10

When providers were asked follow up questions about which STIs they have frequently seen in the Health Center most said that Chlamydia and Gonorrhea were the top two, others also mentioned herpes and syphilis.

**(c) Providers estimated that the patients they saw were a good representation of the student body but there was overall low awareness of patients' demographics.**

Based on the studies that show that there is a mistrust of the health care system, especially amongst minority populations (Cohen 2008), there were some questions structured into the interviews to examine to what extent providers' were aware of mistrust as a potential barrier for minority men to access care. The extent of their awareness of this problem would, in turn, have implication for how to best assuage potential mistrust with some patients. The first question that was asked to prompt providers to think about different patients' ethnicities was, "Do you feel that the patients that you see are a good representation of the UCF student body, in particular with regards ethnic demographics?" Often times this question was followed with an example of the different ethnic groups along with percentages displayed within the university campus. Most providers said that the patient populations was a good representation of the student population on campus, although there were some additional insights revealed, namely that awareness of minority patients' potential concerns was usually low:

"... [That is a] good question. I hadn't really thought about that... but, it is an excellent question. I think, we have a pretty good mix, the patients are very diverse, even down to

the international students, they come in as well. So I think it's [patient demographics] a good representation.”- P7

“I would say so. I guess I never really cogitatively measured it but yeah I can't say that the demographic is any different than the normal demographic that I see in women, and everybody else.” –P8

“I can't say for sure if these are the percentages I'm seeing but roughly I would say the majority of the patients are Caucasian men, and then probably next group would be Hispanic or Latino men, and then the last group would be African Americans or other groups.” –P10

“Yeah I think so, the only thing that I haven't seen as much is the Asians ...I've seen Latinos, African Americans, and Caucasians. I've seen more of that population, but the Asians, and well the Indians, the Indus (Hindus), they're considered Asian also, but I still haven't seen those two populations. But the population that comes in frequently is the Caucasian, Hispanic and African Americans.” –P13

There were a few times that the providers were left to disclose whatever ethnic groups they perceived they were treating; and the following results show that ethnic differences among patients was not something providers were very aware of, or took into account, when going through their daily routines of providing care:

“...mostly Caucasian, Black American, Spanish, and the Asians are a little more hesitant to be checking for that... The Asian people , even female or male, they're

bashful due to their background to be checked about all that because some of them still have the belief that they're not behaving, it's not good that's why they catch this problem . They don't know that it's very common.”-P11

“We do see our fair share of Caucasian or African American but we do see the Asians, we do see some of the Middle Eastern -which sometimes, this is where you give your own specific, when you start talking about different religious faiths. I thought that certain religious faiths don’t have sex, that they actually have a bride or a wife or what have you, no that’s not the case, they have sex like everyone will have sex, and that’s for a lot of different people.”-P15

Following the general opening question about demographics, the researcher followed up with the specific issue of mistrust by asking, “There have been studies that suggest that there is a mistrust of the health care system amongst specifically minority populations (African-Americans and Latinos), have you observed that in any of your experiences here at the Health Center?” Most providers quickly argued that there are no issues with mistrust among their patients, regardless of their ethnicities. Many believed that they did not have issues with mistrust because it has been their understanding that those individuals who do not trust the health care system would not seek care to begin with. Below are some examples:

“Not that I have been aware of no. No because it might be my suspicion that, that patient may not come in the first place, so no I haven’t felt that anyone didn’t trust what we were doing.” –P8

“No. I think the education level brings them here. ... If they’re here there's not a mistrust. I mean, yeah, if they’re here there’s not a mistrust.” –P12

“Not to my knowledge. I haven’t had anybody at least verbalize anything like that. Usually if somebody seeks care for an important issue of such, of sexual health that is, usually they come in with a willingness to at least listen and I think even if they do not take action that day. So I think for the most part people that come in to see us are prepared to have some level of interest or some level of trust perhaps on what’s discussed during the visit.” –P10

A couple of providers, it seems as though, tried to show knowledge of different demographics, and began discussing other recent data surrounding various demographics:

“No I haven’t seen here. I looked at some data, and it was rather surprising. Age at first sex, have you seen that data? ... So there are major racial differences between age of first sexual activity. Whether those same differences are in sexually transmitted illnesses, I can’t say, I don’t know the latest data, and then willingness to be tested, and the trust of the healthcare, I believe there may be differences, but I have not observed that, just in terms of our university population.” – P1

“Oh isn’t that a shame? The answer is, I would love to believe that’s not true but I’m absolutely certain it’s true. ... It just breaks your heart to understand that even with equal incomes; Caucasians who are treated for asthma have better treatment and better

outcomes than African Americans who have the exact same economic strata, and they have worse outcomes. You can't get away from the data. So the answer is, I am so dumb I don't even know my own prejudice, but I'm sure it's there, because the statistics are overwhelming . Now, do I think that transfers to sexually transmitted diseases , does that transfer to treatment of hyper tension, well I know it transfers to treatment of hyper tension, I know it transfers to diabetes, I know it transfers to a number of other chronic diseases, does it transfer to sexual health and the answer is, you tell me. I bet it does but I don't know, because I haven't read those statistics but I bet it does. I'm almost sure of it. And I'm so bad that I don't even know my own prejudice, but I bet you I do behave that way (in a prejudice way), I'm just too dumb to know it.” – P9

Only a few providers, based on their experiences, observed that there might be mistrust amongst minority patients, below are more responses.

“I think so; I don't know that it's in one particular culture or another. I think that across the board people have a fear of needles or blood drawing, fear of shots, so that in itself. Although, even in giving out the flu vaccines, we have the nasal one but it was costing a little more so nobody wanted to pay that so, but there is a general consensus, ‘oh I don't need that,’ even with the flu vaccine.” – P3

“Yes, I mean I do see that in some of the patients. They'll think that with some tests. But some people think that with some tests, if it comes back negative, it's negative, when that's not always true either. And minority patients, a lot of them they'll do the

herbal remedies, but I feel like a lot of the ones that are at UCF are a little bit more modernized. They'll say, 'My parents never did any of that but if I need antibiotics, I'll take antibiotics,' that's what I have seen. I never had any of my patients, in my short time period say, 'I won't take them.' Every patient that I've had, that needs them, will agree to take them, I haven't had an issue."- P5

"I do unfortunately [think that there is a mistrust of the health care system amongst minority patients] . I know that there was some hesitation with the health center on campus. I think the main issue with that that needs to be addressed is being culturally competent. And I know that that's a term that's not so widely used but it's extremely important. When you have a lesbian couple coming in and getting a screening done or getting their pap smears done and you have a provider trying to force birth control down their throat to use on a regular basis when it's not needed, it's just things like that. I think providers need to be culturally competent, know who their patients are and work with them on that. Be aware that we've got diversity issues, we've got different cultures out there, we have different beliefs, whether it is religious, etc. that you have to be aware of and respect, and I think that's the biggest thing."-P4

This issue of cultural competency as it manifests in awareness of evidence about multi-ethnic patient body also showed up in a couple of other interviews.

"Most of the time the providers don't think that it is a problem. You know you have insurance and everything else, but I know that there's been a hesitancy to go to the

health center on campus. Because well first, people didn't think that they were real doctors, which is a myth, they are real doctors, but on the other hand, it was the issue of not having a good experience because of whatever the issue may be, or whatever the case may be . And so being culturally competent, being aware of who you're talking to, and respecting that, and making decisions based on that is important.”-P4

One provider was asked if he felt that there might be a need for more cultural competency programs where all health care providers in general could learn more about the diverse populations that they serve and after having to explain exactly what cultural competency was, he quickly responded that culture really does not have anything to do with how often people have sex. This is the response:

“No having done this for some many years now, I think it's just, people have sex. ... I think it's just more of a common thing at this point in time that people are having sex. And not, 'does he have a ring on,' no they're just having sex. And I think it's across all cultures. I don't see any more, you know I don't see Blacks vs. Whites, vs. Middle Eastern, vs.... I don't see any one of those groups having sex more, they all have sex. It's just my own personal...I don't want to say prejudice, my own personal thoughts, that that's what I thought<sup>2</sup>. But that's not the case, they all, it doesn't matter religious wise.”-P15

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<sup>2</sup> Here the provider was referring to their misconception that people of Middle Eastern descent waiting to engage in sexual relations until they were married

Overall providers were consistent with regards to what type of basic services men should access to have the best sexual and reproductive health care, what the definition of risk behaviors were and how to respond to those risk behaviors. Their awareness of the patient population that they were serving was also the same, in that they did not really notice any obscure pattern for men who seek more help for SRH care. On the other hand there were many telling responses that suggested that as much as education needs to be part of the solution in involving men more in their sexual and reproductive health, there also needs to be education among health care providers, whether it be physicians, PAs, RNs, health insurance companies and health care system administration overall in order to promote culturally competent healthcare provision and harmonize knowledge and services across different aspects of SRH.

## SECTION 2-Provider's perspectives and experiences regarding barriers to utilization

This section describes provider's perspectives and experiences regarding barriers to SRH care utilization among male patients. Most providers reported three main barriers for men's utilization of SRH care and those include (a) influence of knowledge, (b) influence of cost, and (c) ways in which the patient negatively perceives SRH care.

### **a.) Influence of knowledge**

The influence of knowledge and education was a very significant factor when it comes to men's involvement in their and their partner's SRH care. This influence of knowledge comes into effect whether there is a lack of knowledge or an influx of knowledge; for the most part there is an overall lack of education among patients with regards to STIs and their SRH care, with regards to an influx of knowledge, it has to do with patients utilizing the internet or peer sources to get incorrect information. Providers discussed a need for better education not only for the patients they see, but also the populations of men that are not accessing care at all. Providers recommended education on SRH overall, about both the male and female body regarding the anatomy and physiology, about STIs/HIV, how STIs/HIV are spread and consequences of risk behavior. The following are responses regarding the importance of education:

“...they're [men are] not as motivated because they don't have a risk of cancer that we know of at this time and there's no test for them to see if they have HPV , so getting them to decide to have the vaccine is a big educational measure . It should start probably before middle school so they understand and involve their parents, with the HPV vaccine. Same with awareness for STIs...”-P3

“Well truly educated, I don't know how educated they are. I mean they know of them but they are not truly educated. You know they'll come in and ask for chlamydia or HIV but I think it's just what they've heard I don't think that they are truly educated.” –P17

Provider number 3 sheds light on the importance of providing education on SRH care at an earlier age, such that services such as the HPV vaccine would be most effective. Involving SRH care education at an earlier age, such as during middle school or even elementary school, would mean involving parents. Providing education at younger stages of an individuals' life is especially difficult among public schools systems that have adopted an abstinence only SRH education, however with programs like the YMCA and Planned Parenthood, it is not impossible .

Others discussed other sources of knowledge that patients use to guide them to have the best SRH care. Some of these sources include the use of internet as a method of knowledge and how that affects the patient's knowledge of their body into thinking that they might have a specific STI when they might be mis-treating themselves and thus either delay scheduling a visit because they think they know what is wrong with them, or when they do schedule a visit they immediately tell the provider exactly how they want to get treated or what kinds of tests they want, thinking that they know what is the best option for them. Below are examples:

“So yes they are aware of any minor changes, yes they are aware it they can't have sex, yes they are aware if it burns when they urinate, yes they are aware if they can't have an ejaculation. They do, and they tell you that.”-P15

This quote demonstrates that the internet often serves as a way to self-diagnose with a potential problem because it teaches the patient about their own normal bodily functions. Therefore, when there is an issue, they are quick to respond.

“To my experience here most of them request [specific STI screening], [they] come in to see me for testing, they already have in mind, and they already looked at the Internet, and have in mind what they want. I just want to elaborate more as a medical provider, explain to them more, because the Internet is not too detailed, or too detailed and it scares them.”- P11

Provider 11 observes that the internet might actually have too much information and can translate into an information overload or cause undue stress. What might be a reassuring source of information for some, can actually create a sense of being overwhelmed and scared.

#### **b.)Influence of cost**

The cost factor is another theme that was prevalent in many of the interview narratives. Specifically providers believed that having or not having health insurance coverage, cost of each STI test, and overall cost of care pose serious barriers to the utilization of SRH services offered at the clinic. Many providers revealed that often time’s patients had to “pick and choose” between which STI screenings to get tested for because of the influence of cost, in that either insurance would not cover the costs for all tests, or because they had to pay on their own account for the screenings. Situations in which a patient might incur the cost of testing include wanting to

protect their privacy thus not involving insurance companies, or not having insurance at all. And in addition, providers discussed that perhaps not all patients had risk factors for specific STIs, for example if a patient just wanted to get a regular checkup to make sure they did not contract an STI, the patient and the provider would go through the list of what STIs are the most likely that they are at risk for and “pick and choose” which screenings they decide to get done under the insurance and financial constraints of the patient. Below are various aspects of this problem discussed by providers:

“Obviously if someone has to come in, and spend a good amount of dollars to get screening, they will allocate those dollars as best possible in their perspective. If they feel threatened, that the HIV is the most important thing that they need to do today, that’s what they will do. If I recommend something else, even though it may be well received and understood, they may not go forward, in terms of having that tests done for financial reasons.” –P10

“...again money is a big issue with the kids, they may want to do it [get the HPV vaccine] but they don’t have the money to do it. College isn’t like it used to be, kids take a full load of classes and they have to work and that’s just to be able to have their car and their gas, and to eat. So when you start throwing in, \$135 times three, that’s a lot of money to a kid that’s making \$10 an hour. How long do you have to work to pay for that shot?”-P2

Thus providers show that as much as the patient’s intent to utilize and access their optimal SRH care, the cost factors weigh more on their abilities to make better health decisions. A report in Ireland on the uptake of Gardasil shows that a very high percentage (82%) of girls sought the

vaccine in this setting where it was given at no charge. This is important because Ireland is a predominantly Catholic nation, however when cost is not an issue the opposition of the church against Gardasil was less important for parents/families than obtaining the vaccine for health protection (O'Brien 2012).

**c.) Ways in which the patient negatively perceives SRH care**

When providers reported what their perceptions were of barriers involved in men's access to their SRH care, many stated the patient's individual attitudes towards their SRH care mostly involving a "cavalier" attitude towards their health, meaning that patients did not think that anything was going to happen to them, or they would continue their risk behavior because nothing had happened to them yet. This "cavalier" attitude also plays into patients' sense of denial that their risk behaviors would have no consequences to their health. In addition, there was also a sense of fear, where once patients reached that point that they or their partners were experiencing symptoms of STIs, that they just wanted to get screened for anything that they were at risk for in order to ensure that they were "safe".

Embarrassment as a barrier was also discussed by several providers with regards to patients feeling embarrassed to discuss with anyone, except a physician, their SRH issues or patients feeling embarrassed because they have a health issue and they did not want to admit that they have a SRH issue. This issue of embarrassment also deals with honesty in that the patient might go to the extent of lying about their reasons for making a visit to the Student Health Center and some even to the nurse, and it is not until they are face to face with the physician that they

admit that they have an SRH care problem. Embarrassment also reveals the stigma that is linked to STIs and HIV.

The question of comfort is also influential with men's perception of SRH care because providers discussed the need to make the patient feel comfortable in order for them to disclose to the provider what exactly was going on with them, and to feel comfortable enough to be able to return to the health center and visit providers if there ever was the need in the future. Another important aspect was the individuality of the patient, and being able to acknowledge that not one patient is the same as the next, thus being able to adapt to each patient's character and respond to their SRH care needs.

Below is an example of the provider's concern about awareness of the individuality of patients:

"I think providers need to ... know who their patients are and work with them on that.

Be aware that we've got diversity issues, we've got different cultures out there, we have different beliefs, whether it is religious, etc. that you have to be aware of and respect, and I think that's the biggest thing."-P4

This quote suggests the importance of cultural competency; of taking into account each individual patient's culture whether it be through ethnicity, race, religion, sex, gender, sexual orientation, etc. each aspect is significant into how each individual perceives care.

Another important aspect of patients' problematic attitudes toward healthcare was the providers' overall perception that many male patients had a "cavalier" attitude with regards to their SRH.

Below are some statements that exemplify this concern:

“Well I think why I see an awful lot of guys that have STIs, it’s because they’ll approach it as, ‘I have no problem right now.’”-P15

“Sometimes, their attitude will display a lack of concern for what they’re here for...And sometimes they’ll have this real cavalier attitude , and then other times they’re really concerned...”-P7

“At that age they think nothing is going to happen to them. And basically until something happens then they think I'm going to take all the risks that they have, I don’t know how many partners, and if something happened to them and that's when they take reality face to face and they start taking action . So that's the big one, that is a barrier.”-P14

These standpoints where the patient is waiting until the last minute to change risk behavior or get treatment is an issue that providers have been very frequently exposed to and have been able to treat and deal with patients who only seek treatment once there is an issue with their SRH. This “cavalier” attitude can be explained as demonstrating the influence of normative ideas of masculinity within the U,S, and how these ideas translate into a toughness and over confidence that leads to this “cavalier” attitude. On the other hand, this attitude might be used by men to mask what they might consider a weakness, such as inadequate education or knowledge about STIs. This attitude could even be a response to feelings of vulnerability, which can be difficult to navigate.

Another aspect of male patients’ negative perceptions of SRH care was the fear that their sexual lifestyle would be affected as the result of any current issues they were having. Thus as a

result of patients fearing that their sexual lifestyle would be affected by an STI concern, they would schedule visits with the provider, but only after there was an STI issue.

Here are some sample aspects relating to fear:

“Frequently they have symptoms before they come [into the Health Center]. Some come because they're concerned they might have an encounter with something [an STI], that jeopardizes their [sexual] health. Frequently they have a sore, they have discharge or burning [in the genital area]. They'll see if it goes away. And when it doesn't, then it becomes panic.”-P16

Regarding to patient honesty, there were several instances that providers pointed out that at times patients would not be honest to the technicians or even nurses for their reasons for visiting the health center, but that instead the patient only was comfortable to be honest with the provider. Providers described that patients knew that the people scheduling their appointment were fellow students and they did not want to have their private health information exposed.

“One of the issues that we see is that a lot of the men don't tell the truth when they make the appointments. They call in, and they're too embarrassed to say they think that they have an STI. So they say, you know, 'I have a cold'. And they will actually lie about the reason for the appointment but then when the nurse gets them in the room and they start talking with the nurse, they may or may not be truthful with the nurse.” -P2

“I think they just don't want to call and say, 'Hey I have to get tested for STDs or I have this issue down there.' And I think they only want to confront that with their provider. And they don't tell nursing that at all either. Sometimes they will, but most of the time they won't, they'll just tell them the cold stuff and then they'll tell you everything.”-P5

These aspects were very telling in that the patient not only is uncomfortable being honest with the health care facility's staff, but also in some cases even the medical professional staff such as the RNs.

Another important aspect that providers acknowledged was the patient's comfort level with accessing and utilizing their SRH care. Providers described the need to make the patient feel comfortable and reassuring them.

“And in some cases, patients may be uncomfortable, from a personality standpoint to discuss sexual health issues, or they feel shy, or in general, not up to, or willing to discuss any of those issues.”-P10

“And so I think the biggest barrier that I say is people that just don't want to come in and say I have a problem because sometimes you do have to bring it out of them. And that's not a bad thing, because my job is if you have enough respect to come in to see me, to say I have a problem, and I'm going to be looking at all your private areas and I'm going to be asking you some very sensitive questions, that as a health care professional is my job to make you feel comfortable , and not necessarily to thank you for coming in, but make you feel at ease to say, I've got a problem, this is what it is.” – P15

These also display the importance of the patient and provider relationship in hopes of establishing that comfort and trust, specifically dealing with tapping into the patient's mind set in how he is feeling about any SRH issues how patients not only need a medical provider that will

treat them, but also a provider that will be able to listen to them and respond to any feelings of uncertainty, fear, denial, embarrassment, or anything else of concern.

### SECTION 3-Providers' perspectives and experiences regarding encouragement of utilization

This last section describes providers' perspectives and experiences to encourage men to utilize their SRH care. Overall findings from this portion show the following: (a) the importance of establishing the patient-provider relationship and the different components of it for encouraging greater utilization of SRH care among male students; and (b) solutions for involving men more in their SRH care.

#### **a.) The importance of establishing the patient-provider relationship and the different components of it for encouraging greater utilization of SRH care among male students:**

There were various components that the providers believed influence the establishment of a good patient-provider relationship including male patient and provider interaction with each other, the many roles of the provider (providers are more than a medical provider but also an educator, opportunist (taking advantage of any chance to treat and teach patients about their SRH care), source of guidance and a professional) and restrictions the overall health care system has put on providers. This included influences to the atmosphere providers work in, attainment of resources to provide to patients, and misinformation and miscommunication among providers themselves.

Male patient and provider interaction is influenced by communication, both verbal and non-verbal. For example, some providers conveyed that they could notice that the patient has yet to divulge more information because they appeared to be hiding something. Providers also felt it was important to be receptive to the patients' reasons for visiting the Health Center.

“Sometimes...there was a young man one time and I remember he lied about what his appointment was, so I’m trying to check him in. And I looked at him, and I remember thinking, ‘this is not right’ and I remember saying to him, ‘You know it’s okay to tell me the truth.’ And I remember him going, ‘Oh. What the hell!’ he goes, ‘You’re an adult! I know you’ve heard this stuff before.’ And then he was honest with me and it was an STI issue, but it was like he was like he was embarrassed.”- P2

“I feel off of the patient to see if I think they’re being honest, because even in a relationship, anything could be happening.” –P5

“So what I routinely do for screening is to assess their risk based on their sexual behavior. Even in terms of a sports physician, standpoint, that’s very easily done, you just have to be friendly and open with patients and ask honestly and review their history.”- P9

“You need to relax, we’re all humans, we all have sexual organs, we do the same thing. Yes I appreciate the being candid or the modesty, but you need to relax, they’re professionals. I’m a professional; tell me what’s on your mind so I can help you.”-P15

Male patient and provider interaction is also influenced by the amount of time spent with a patient, this has to do with time constraints being placed on the visit because of the patient himself or even the provider. Although there were no responses with direct evidence that providers cut the visit short because of time limitations, it could also mean that providers did not

admit to spending enough time with these patients or providers do not notice how much time they take with patients.

“If it's [HIV or STI test] negative then they're [the patient is] going ‘shew’...” –P16

“They're gone.” –P17 “They don't want to hear much of anything.” –P16

Provider interaction with male patients also involves the methods used to follow-up with patients who have sought care at the Health Center. Some providers discussed how they wished there was more follow up and more in-depth inquiry when it comes to taking the overall health history of the patient, while others described being able to follow-up through the use of the telephone.

“As part of that, part of our screening here is to dispassionately ask them to complete a questionnaire, we have a healthy knights form, and it would be nice if we could actually asses them as part of that, which would be reasonable, it's a real opportunity for young adults.” –P9

“...I usually tell the patient, ‘We'll call you have you back in [after their initial SRH care visit].’ But then when I call them it's mostly negative and I'll just say, ‘Your results are negative you don't need to come back in,’ that's how I do it. And then sometimes some patients might be going home, because you know we have the college population and they're going back home for break or something, or even if they aren't able to get in I just want to get them antibiotics or something. So I'll call and say, ‘Hey I'm calling in these antibiotics for you at the pharmacy, they're there for you to come pick it up,’ and they're fine with it.” –P5

Within the patient-provider relationship there are many roles that the health care provider should assume, ranging from an educator, opportunist, professional and a source of guidance.

While lack or limited sex education among men can contribute to procrastination in seeking care at the clinic, at the same time education offered by providers, be it to correct misunderstandings or offer new information, can serve as an important encouragement to greater utilization of care.

The role of an opportunities with providing healthcare can be explained as a provider who utilizes any opportunity a patient comes to seek care in order to treat and ask the patient if they are would like to access specific SRH care services, such as STI or HIV testing. Here is an example of the provider embracing the role of an opportunist with regards to offering SRH care to men:

“Or I think a lot of them, like say the male physicals, I always ask about sexual history and they weren’t going to bring it up, but then when I ask, I’ll always ask, ‘Do you want to get screened for Chlamydia, gonorrhea, etc.’ And they’ll say yes, they’re just usually happy someone said anything, but they wouldn’t say it themselves.”-P5

Another important role of the provider is to serve not only as a professional medical provider, but also to explain to the patient how they are remaining updated with recent research within the field, use of terminology within the field, and also their ability to remain neutral and objective when providing SRH care regardless of sex of the patient and the provider. Several providers sited recent studies with regards to SRH care including studies on the specific college

aged populations (e.g. freshmen vs. seniors) that were the most at risk for contracting STIs, the age of first sex among different ethnic groups, and the effects of disparities on health among different ethnic groups. Throughout each of the interviews, most of the providers did not use too much medical jargon and those that did, made sure to explain any unclear terminology throughout the interview, for example:

“The difference between a test and a screening, is that the screening is accurate for the most part but if we do have a reactive, it’s called reactive vs. non-active , if we have a reactive test we’re going to follow up it up with a confirmatory test. So something like the OraSure.” –P4

The above quote is discussing testing and screening methods used for testing for HIV. It is especially important to note that this provider did not use medical jargon with the researcher because it shows that if this provider is careful not to use jargon with an ‘up-and-coming expert’ within the same field, then this means that they would also be speaking in the same terms with patients, thus making the SRH care visit more understandable from the patient’s perspective.

Another aspect throughout the interviews that was revealed was the adaptation of the term sexually transmitted infections (STIs) vs. sexually transmitted diseases (STDs). There were only a handful of providers who used the term STIs, and some even changed their use of the word from STD to STI mid-interview when a question was asked from the interviewer using the correct term STI. Most providers are still using the term STDs, this could be evidence of the

providers speaking out of habit, trying to speak in terms that their patients will understand, or because they have yet to be updated on the proper terminology.

There were also references within interviews with many female providers and one male provider regarding situations in which men were feeling uncomfortable discussing SRH care with a provider of the opposite sex. Female providers discussed male patients being less inclined to scheduled visits with them as female providers. Below is an example:

“Well I would say, if you asked a male counterpart it would be different, but I would say that with me, probably just their...I don't want to say unwillingness...but maybe embarrassment on their part of confronting a female provider about their issues. Now if some of them, and mostly the ones that I end up seeing are specifically requesting a female, which is why I only see so few, I think most want to see male providers, they usually know what kinds of services they want.” –P8 (female provider)

Here one can see male patient's embarrassment to be treated for their SRH care by a provider of the opposite sex. If a male patient does not want to see a female provider that can also mean that his ideas about masculinity suggest that he should not be vulnerable, which can also be argued for women patients whom only want to see women providers.

A few providers stated the importance of serving as a medical guide, but also as an adult source of guidance to help the patient make decisions, even when the decisions did not directly have to do with physical health. Regarding providers as a source of guidance, below is an example of some of the overall aspects roles of guidance should include:

“And some of them, just need, not a medical provider in all cases, they just need a male figure to say, ‘you are normal.’ If they have ejaculatory problems ‘you’re fine.’ ... people just don’t want to come in and say I have a problem, because sometimes you do have to bring it out of them. And that’s not a bad thing, because my job is if you have enough respect to come in to see me, to say I have a problem, and I’m going to be looking at all your private areas and I’m going to be asking you some very sensitive questions, that as a health care professional is my job to make you feel comfortable, and not necessarily to thank you for coming in, but make you feel at ease to say, I’ve got a problem, this is what it is. This is my job and I’m going to say, ‘you need to relax, take a deep breath, there’s nothing you’re going to tell me that’s going to surprise me,’ because I’ve heard a lot of stories, and I’ve seen a lot of things. And it is my job then to make your feel comfortable so you can open up and tell me what your most personal problem is.” –P15 (male provider)

In general providers in this study supported their perspectives on screenings by citing guidelines established by professional organization, evidence-based medicine and authoritative departments within the field, thus reinforcing their role as a health care professional. The use of recommendations and guidelines from authoritative programs such as the CDC or the U.S. Preventative Services Taskforce is what is called evidence based medicine; using research to support the types of services provided to patients. Some examples of the use of evidence based medicine within the UCF Health Center include screening for things that cause harm, involving testicular exams with men’s SRH care, and tracking STIs within the Health Center.

Another issue with providing the optimal SRH care to men involves the role of the overall health care system; such as the type of environment promoted within the UCF Health Center, lack of resources within the health center, and discrepancies of information distributed among employees of the health center. This is related to encouraging care because if the overall health system is limiting access to healthcare, then that is a significant barrier that prevents patients from even having the option of attaining care. In addition, if the provider does not agree with the environment in which they are providing care, then they are less likely to encourage patients to return to the Health Center for care. A couple providers alluded to the UCF Health Center taking a proactive approach to providing health care, one provider discussed a negative environment that is not necessarily seen by patients but is experienced by providers.

“The current social and political environment makes it virtually impossible for any women to actually be routinely screened by me. I understand, I’m old, gray, overweight, bald, all that kind of stuff, so I’m sure that I project a paternal image, and I would imagine that a lot of young women, have some concerns about that projection and would prefer to see someone who is female and younger and that has been co-opted by women’s health as something that would be their exclusive purview. And that makes it difficult as a primary care physician to actually open that door. It makes it a matter of whether I’m being intrusive, or people are actually taking offense. I have to be quite cautious as a primary care physician in my certain, in my stage of life, to simply say that I should open that door. A lot of times, what happens is, that closes the therapeutic relationship that I have on many other levels, so I’m pretty cautious about that. That’s a

problem. So I address it as carefully as I can, and a lot of times the door slams shut, in which case we could try to direct them in health maintenance. We'll usually back off and go to health maintenance there.” –P9

This provider shows that the environment in which these medical professionals are working in, is not always a pleasant one. And when there is a hostile working environment, chances are the employees, the customers and the services will not be at its best.

On another note, providers discussed having problems with being able to provide men of all the SRH care services they might need. Specifically noted they were not always able to supply the proper tools for STI screening and testing because the Health Center decided not to offer those specific testing resources, the quality of the testing results were not on par with other forms of testing. They also felt like there was not enough condoms available for distribution, although one provider mentioned that condoms were ‘rampantly free’ at the Health Center.

“And syphilis testing, which is the other thing we will commonly do is inexpensive to screen, so if they’re already doing the chlamydia, that one is such a small cost to add on, that I think most of the time they will easily add that on. And again it could just be, if there are not any symptoms, the testing isn’t very good so often I wouldn’t even recommend that. Usually if we can get past Chlamydia and gonorrhea being the most costly, the other ones aren’t as much of an issue.” –P8

“...unfortunately you can also get Condyloma up inside your urethra, and we can’t tell anything. Unless you have something called a Cystoscopy, a little scope where they actually go in [the urethra] and take a sample. Yes when they do come in and ask, [can]

they have a blood test for Condyloma, and I have to tell them, ‘No we don’t really don’t have that .’”-P15

Here the provider explains his frustration with the limited amount of condoms the Health Center provides, but also the limited access to free condoms the overall student body has. Below is the quote regarding accessibility of contraception, in particularly condoms:

“Okay, I go to wellness, wellness has some, but by the same token, we’re limited as to what we can get, because these aren’t free. So the university needs to partner up with Trojan or whatever, Lifestyle, who makes the condoms. Get some kind of program going on campus where they are just inundating us with condoms to help... .I mean how many people know that they can come to me and get a free condom ? I have a bunch. I mean I know wellness has some, I know you can go over to wellness and get some free condoms. But you’re talking about a campus of 50,000 people; I know that 50,000 people aren’t going to give a dime [to purchase condoms]. But two places, come on.”-P15

This also brings up another issue in that there has been evidence within the interviews of miscommunication among the employees of the health center and even on a wide scale with regards to the acceptance of the HPV vaccine being used on men. When providers were asked if they recommended the HPV vaccine for men most agreed that this vaccine would be a good preventative measure, however there was still some lack of clarity among providers if the HPV vaccine was recommended for men as well as women.

In a question with regards to the popularity of the HPV vaccine among men, the provider displayed the obscurity of the acceptance of the HPV vaccine for male patients. This was one of the responses to the question of HPV vaccine for men:

“I’ve had a few men ask about it and right now it’s recommended in women to get it. Males, if they are [asking about the HPV vaccine], I’ve talked to some of the staff and, they do recommend that males get it too and that that’s a good thing. I don’t know, do you know if that’s the recommendation for males to get it?” –P5

One group interview with three providers revealed this miscommunication first hand while a question was asked about men’s access to condoms.

“Well they’re (condoms) free here. I mean they’re rampantly free here.” -P16

“Yeah but, we can’t get them (condoms). I mean we have a high time getting them to give out. We don’t ever get them.” -P17

“Not here?” -P16

“No.”-P17

“Not anymore?” -P16

“Nope. Dr. Bob has got to pay.”-P17

Although the below provider mentions that among the health center staff they spoke with, the HPV vaccine was recommended for them, this provider still seemed uneasy as to the accuracy of

this recommendation and asked me as a researcher within the subject, if the HPV vaccine is recommended for men.

There are also problems with third party providers, specifically with health insurance providers and their lack willingness to cover certain preventative health services and protecting patient's privacy. Below a provider discussed the importance of protection of privacy:

“Another thing that I want to mention that is very important, is with insurance reinforcement, a lot of patients lose their privacy when they have companies reimburse them for STD screening, in other words, they have no true privacy as to the results of their tests so in other words, many of them would prefer to get tested paying cash or out of pocket however they can pay out of pocket, to reserve that privacy that is lost. When a third party is involved in a reimbursement process, the way the legal system works right now, they have access to those results, now whether that is appropriate or not, that's a whole different conversation, but it's certainly a factor as to whether patients utilize insurance and whether they don't. And that of course can affect, how many tests you can get done, how many recommendations you go along with, in terms of spending money out of pocket to do those tests-wanting absolute privacy, that can affect your ability or your decision making as to what kind of tests you have done, what kind of recommendations you want to follow, when there's money involved.” –P10

The above provider is concerned about the privacy of the patient and how that privacy is automatically lost once a third party is involved, e.g. insurance companies. This provider went out of their way to report this problem of privacy within the interview and described the extent to

which some patients go to protect their privacy, by paying out of their own pockets for services just so that insurance companies cannot see what SRH care services they are accessing. Other providers also mentioned their battles with insurance companies to even cover the costs of STI screening and vaccinations such as the HPV vaccine.

**b.) Solutions for involving men more in their SRH care.**

Among the providers that were interviewed, when asked what could be some solutions and recommendations that can be implemented to involve men more in their SRH care, they recommended establishing some sort of Men's Clinic and reaching out more to the UCF community in general.

“I think that one thing that we can do here, and I wished we would do, I'm retiring so it's just one of those things ...But I wished we had certain hours of every day where we'd have one provider that would be a men's clinic provider. And so when the kids call in, they could just say, 'I want to make an appointment in the men's clinic.' And they don't have to say, 'it burns when I pee,' 'I have discharge,' they don't have to do all of that, and you know, that would give them some coverage. And then maybe, through the men's clinic, there could be some education that goes on.” –P2

“So I don't know if in the future they'll have like a man's clinic, as like Planned Parenthood. Planned Parenthood they have a male's clinic where all the males will come in and they'll teach sexual health, or how to check their genitals, you know teach them, and hand out pamphlets and stuff like that. And they'll come in and they'll have a

full night of just guys night only. And I don't know about this health center, but that would be another way of reaching out for males, just to come in and just be tested. Just like the female comes in and they have their own services just for the females.”- P13

Towards the end of provider thirteen’s response, she sheds light on the idea of promoting a culture of equity among men and women, especially when it comes to providing equal amount of care and services to each person. This culture of equity is important because in order for health disparities to cease and desist, we must give everyone the same access to health care resources in order for everyone to have the equal quality of health and life.

In some instances if the idea of a Men’s clinic was not brought up by the provider themselves, they gave positive feedback to establishing some type of office specifically for men when the researcher approached the topic. One provider on the other hand mentioned that there would not be a need for a men’s clinic because there are enough health care providers who are men, which can provide the necessary treatment to that patient population.

Another solution proposed by providers is an improvement in reaching out to the UCF community, particularly those who are still not aware of the health center and those who are not accessing health care services at all.

“Every semester, like in the last several weeks, we’ve been seeing a lot of 22 year olds who are graduating or have just graduated and they came for their very first visit. So that tells me that, in four years, they didn’t have an awareness that they could come here

or maybe that they were procrastinators. But in general it's that they've been getting their care somewhere else, or not getting care at all. So I think a lot of it is awareness of the health." –P3

"...we still get students that have been here from time to time, and we'll say, 'Have you ever been in here [health center] before?' and they'll say, 'No we didn't even know you were over here.'" –P7

In response to this low awareness, many providers mentioned focusing on advertising not only promoting the Student Health Center and the services they provide, but also distributing more information on SRH care whether it is through collaborations, or putting up posters throughout the campus and education.

## CONCLUSIONS

Male patients come to the health center when either they themselves or their partners show symptoms or have issues with STIs or HIV, this is especially problematic because most STIs are asymptomatic. Given that most cases of STIs do not show symptoms, it is very concerning that the students that are being treated at the Health Center might be the worst case scenario of STI symptoms because they may be the ones that have more developed forms of each respective STI.

Because so many male patients only seek care when there is anything out of the ordinary with their SRH, there is a lack of education with regards to how frequent and what services men should access to achieve their optimal SRH care. It is no coincidence that 17 out of 18 providers interviewed stated that educating patients and the community about their health, especially SRH, is factor in providing any type of health care. If patients had the knowledge that they are at risk of having an STI without even showing symptoms, they would be more prone to get annual checkups specifically dealing with STI/HIV screening.

There needs to be more information distributed among the UCF population about the services the UCF Health Center provides, although there is information provided within each students' orientation, this information needs to be reintroduced in another way. More community outreach can be done through hanging up posters advertising for the Health Center, flyers among the student dorms on and off campus, social media such as twitter or Facebook, or even collaborating with student organizations to spread awareness about the student clinic. There also needs to be more distribution of knowledge on what the essential services are to ensure the best SRH care (for men and women) throughout campus, because now such information is only found

within the health center. Furthermore, energy should be focused on raising awareness towards ways to prevent contracting and spreading STIs/HIV. Currently, when a student enters college at UCF the only mandatory “course” that all students are required to take is a drug and alcohol awareness course, which is website with various videos and modules to test students’ knowledge on drug and alcohol wellness. However there is no mandated course pertaining to SRH, the only actual course that truly educates students about the consequences of risk behavior is Sharon Douglas’ course all about HIV/AIDS, HIV Disease: A Human Concern. By simply requiring each student at UCF to take a course on SRH before they graduate (preferably before they finish their first year at UCF) would not only teach students about their own wellness, but would also provide them with information on services offered on campus and within the Central Florida community.

Limitations of this study that need to be considered include the fact that this study was only conducted at one health care facility, and as one of the providers stated, not all of the UCF student population accesses the services of the Health Center, some students are using their own providers, going off campus or none at all, most of the time because there is no knowledge of the Health Center’s existence. In future studies I would like to interview key informants at other health care facility within the Central Florida community, specifically offices such as primary care facilities, private practices, free clinics, and Planned Parenthood. I would also want to conduct studies with male students at UCF to get a better understanding of what the barriers are for men’s involvement in their SRH care.

## **SIGNIFICANCES**

As mentioned previously, not only is there an unequal distribution of knowledge with regards to men accessing health care in general, but more specifically their sexual and reproductive health. Furthermore, there is even less studies from the perspective of the health care providers who offer services to men. This study gives the opportunity to hear directly from the health care providers, the providers that one would assume to be the most accessible for UCF students. Based on the diversity profile of UCF (over 15% Latinos and 9% Black), it is also of great concern that minority communities are being considered when it comes to inclusion, accessibility and utilization of SRH care at the UCF Health Center. By observing directly from health care providers at the UCF Health Center, we are able to understand what health care providers themselves believe to be some of the most important aspects of men's involvement in their SRH care needs. Since currently there are limitations on the standard of care for men's SRH care, this study helps to inform future studies of some of the issues that might come about from the side of health care service providers.

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