Honors Thesis Proposal

For

Health Care Providers’ Perspectives on Male Involvement in their and their Partner’s Sexual and Reproductive Health Care Needs

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I. INTRODUCTION

Almost 13 million (30% of) young adults aged 20–29 years did not have health insurance coverage in 2008. Young men aged 20–29 years were 36% more likely than young women of the same age to be uninsured (R.A. Cohen, 2010). Most of the time when the words sexual and reproductive health come to mind, it is referred to women, however there is a huge disparity of men who do not have access, or use, sexual and reproductive health services. Young men are at the greatest risk of contracting STIs within the U.S. male populations, yet are the least likely to make a sexual and reproductive health (SRH) care visit.

There are many reasons and studies done questioning why there is such a gap between men and women’s use of sexual and reproductive services. 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 knowing where to go for sexual and reproductive health care. On the other hand, there are also barriers from the health care provider perspective, these include the lack of national guideline knowledge, agreement, perceived effectiveness and/or implementation, in addition to personal self-efficacy to perform certain clinical tasks and external factors all impact service delivery (Marcell et. al. 2010).

In this study I hope to further understand these questions via qualitative anthropological research with SRH care providers by unraveling what approaches are used by providers at the University of Central Florida Health Center to educate and involve men (between the ages of 18-30) and male partners of female patients in their SRH needs. In order to narrow this study, I will focus on SRH services for human papilloma virus (HPV), herpes and chlamydia. I am focusing on these three diagnostic areas for the following reasons:
a. HPV because there is a healthcare disparity for men in that there is currently no test to determine if they have HPV, although the Gardasil vaccine does prevent against two strand of this virus;
b. Herpes because the outbreaks are controllable if the proper education and treatment are provided, and
c. Chlamydia because it is the most treatable and prevalent amongst the STIs although the symptoms are often silent, similarly to HPV.

Therefore, clinical approaches in these areas that include the outreach to and the involvement of male partners of female patients (as well as male involvement in general) can prove particularly useful in expanding SRH care to men and can also improve health outcomes for women who have sex with men. Thus, this study aims to examine perspectives of providers at the Student Clinic on the inclusion of men in SRH care on the UCF campus.

II. LITERATURE REVIEW

The University of Central Florida is currently the second largest university in all of the United States of America, with a total of over 56,000 students enrolled in this university (undergraduate, graduate, and medical students) (UCF OIR 2011). The diversity profile of this university is as follows 63.51% White, 15.7% Latino, 9.6% Black, 5.38% Asian, 2.47% Non-resident Alien, 0.81% Multi-racial, 0.35% Native American/Alaska Native, 0.12% Native Hawaiian/Other Pacific Islander, 2.06% Not specified (UCF OIR 2011). With regards to the breakdown of biological sex, there are a total of 25,348 men (44.99%) and 30,989 females (55.0%) 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 23% (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, involving both a woman and a man (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, stigma, denial, lack of social support and the need for confidential service; as well as lack of health insurance and knowing where to go for sexual and reproductive health care. On the other hand, there are also barriers from the health care provider perspective, these include the lack of national guideline knowledge, agreement, perceived effectiveness and/or implementation, in addition to personal self-efficacy to perform certain clinical tasks and external factors all impact service delivery (Marcell et. al. 2010). The four key themes surrounding this argument involved the cost of care, continuity of care, quality of care and the fear of care.

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, thus they are denied the right to health. Even those who are lucky enough to get their hands on some type of insurance, often times find themselves with holes in their insurance policies because their plans seem to not to cover services when one is in dire need of them. 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 as well. For example, many women having abortions are trying hard to avoid unintended pregnancy, but are having trouble doing so, thus to improve contraceptive use a woman needs good counseling, easy and affordable access to her chosen method and the necessary services to support her choice over time; a woman’s ability to lead a reproductively healthy life is closely connected to her ability to overcome other social and economic barriers (Cohen 2008). Men however are even more at risk for financial burdens preventing them from accessing their SRH.

In a study done within focus groups amongst Latino and black men in northern Manhattan, 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 (Kalmuss 2010). 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 intensive marketing strategies that highlight not only availability and location of SRH clinics serving men, but also their affordability (Kalmuss 2010).
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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 the SRH care people do receive is neither comprehensive nor integrated (Cohen 2007). For men particularly, there is a system deficiency in the lack of formal screening or service guidelines (Kalmuss 2007). 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 a study based on the data sample of the 2002 National Survey of Family Growth, 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 (Kalmuss 2007). A large majority of men are receiving testicular exams, when evidence does not support its effectiveness in reducing mortality and morbidity from testicular cancer (Kalmuss 2007). 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 (Kalmuss 2007). This lack of professional consensus regarding standards of care, is one way to identify the unmet need for services which suggests a 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). 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, STI 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).

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, this 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, comparisons of sexual behavior by country of origin 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. As noted above, to improve contraceptive use a woman needs good counseling, easy and affordable access to her chosen method and the necessary services to support her choice over time (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
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Fear is a major issue that torments many minority communities, especially among undocumented immigrant communities. 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). However, 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.

III. RESEARCH DESIGN AND METHODOLOGY

With the permission of the University of Central Florida Health Services Clinic, health care providers will be invited to be interviewed with regards to men’s sexual and reproductive health needs and healthcare utilization. Health care providers will be recruited through flyers distributed to the different departments within the clinic, as well as word of mouth. The content of the flyers will include the description of the study, research questions and objectives, and the description of confidential data collection and handling. Interested providers will be able to contact the PI of this study, via e-mail or phone, to schedule a thirty minute to one hour interview. The aim of this study is to recruit at least 25 providers.
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The target participants of this study are health care providers who work (as employees or volunteers) for the University of Central Florida Health Center, which could be health care professionals, allied health professions and community health workers. This includes but is not limited to physicians, physicians' assistants, registered nurses, licensed practical nurses, certified nursing assistants, case management workers, and community health advocates. This study, however, would not include non-healthcare providers at the clinic, including phlebotomists, student workers, receptionists, and the like, as well as health care providers who are not affiliated with the University of Central Florida Health Center.

No clinical procedures will be done in this study. The research in this study will be based on face to face interviews with willing health care providers in their office. The office must be a location that offers the privacy needed for confidential exchange of information, in order for these interviews to be conducted efficiently.

The questions that are being proposed to ask during these semi-structured interviews include, but at not limited to the following:

1. Does one have to be a UCF student to receive the services of the health center?
2. What types of services do men need (ages and intervals in which they should receive these services)?
3. What is the training for health care providers regarding services for men?
4. 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)?
5. 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?
5. 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?
6. Why not make HIV AND STI testing a mandatory part of a physical exam (help to remove the stigma of HIV testing)?
7. Professional consensus involving standards of care (i.e. types of services men should receive and how often)?
8. Determinants of comprehensiveness of the nontesticular sexual and reproductive health services men receive?
9. If requiring testing for HIV, why not also other STI’s at the same time?
10. 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?
11. Demographics of men recommended to get HIV or STI testing?
12. What is considered sexual risk behavior? Characteristics?
13. 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?)
14. 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?
15. Is there a rescreening of patients who have been infected with an STI?
16. What is your response to the need of “breaking the cycle” (the cycle of reinfection; screening & treatment of the original patient)?
17. Solutions: Home based testing kits, educational & communication-skills-training efforts, expedited partner therapy (EPT) (Sonfield 2009), herbal treatments (Breitbart et al 2010).
18. Do you think there is a feeling of mistrust for the health system amongst minorities?

Interviews will be recorded through a voice recorder with the permission of the interviewee, such that only the audio portion of the interview will be documented. After each interview takes place, all the interactions will be transcribed. In addition the recordings of the interviews will be destroyed once transcribed. No identifying information will be collected (unless otherwise requested by the health care provider), interviewees will be identified through a number and that number will be used for their consent forms, recordings and transcriptions. Consent forms and transcriptions will be kept in a locked storage unit in the PI’s home and the electronic files will
be 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 has the authority to withdraw from the research study. Especially if the health care provider feels that their job is at jeopardy for discussing the health care policies of their employers.

IV. 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 would give 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 this university (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 attaining directly from health care providers at the UCF Health Center, we would be 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 there currently is still no consensus as to what should be standard SRH care services men should receive, this study would also help to inform future studies of some of the issues that might come about from the side of health care service providers.

V. BIBLIOGRAPHY


Milanes, Lilian


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Moore, Ann M, Lori Frohwirth, and Elizabeth Miller. Social Science and Medicine. Male reproductive control of women who have experienced intimate partner violence in the United States.


Taylor, Janelle S. Academic Medicine, Vol. 78, No. 6, Pg. 555-559, June 2003. Confronting "Culture" in Medicine's "Culture of No Culture."

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<http://www.iroffice.ucf.edu/character/current.html#Head>

