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Original Article

Sexual and Reproductive Health Care Receipt Among Young Males Aged 15–24

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A B S T R A C T

Purpose: This study aimed to describe young men's sexual and reproductive health care (SRHC) receipt by sexual behavior and factors associated with greater SRHC receipt.
Methods: There were 427 male patients aged 15–24 who were recruited from 3 primary care and 2 sexually transmitted disease (STD) clinics in 1 urban city. Immediately after the visit, the survey assessed receipt of 18 recommended SRHC services across four domains: screening history (sexual health, STD/HIV test, family planning); laboratories (STDs/HIV); condom products (condoms/lubrication); and counseling (STD/HIV risk reduction, family planning, condoms); in addition, demographic, sexual behavior, and visit characteristics were examined. Multivariable Poisson regressions examined factors associated with each SRHC subdomain adjusting for participant clustering within clinics.
Results: Of the participants, 90% were non-Hispanic black, 61% were aged 20–24, 90% were sexually active, 71% had female partners (FPs), and 20% had male or male and female partners (M/MFPs). Among sexually active males, 1 in 10 received all services. Half or more were asked about sexual health and STD/HIV tests, tested for STDs/HIV, and were counseled on STD/HIV risk reduction and correct condom use. Fewer were asked about family planning (23%), were provided condom products (32%), and were counseled about family planning (35%). Overall and for each subdomain, never sexually active males reported fewer services than sexually active males. Factors consistently associated with greater SRHC receipt across subdomains included having M/MFPs versus FPs, routine versus non–STD-acute visit, time alone with provider without parent, and seen at STD versus primary care clinic. Males having FPs versus M/MFPs reported greater family planning counseling.
Conclusions: Findings have implications for improving young men's SRHC delivery beyond the narrow scope of STD/HIV care.

IMPLICATIONS AND CONTRIBUTION

Despite new guidance recommending sexual/reproductive health-care delivery to young men, little is known about young men's sexual/reproductive health-care receipt. This study demonstrates that few young men aged 15–24 receive sexual/reproductive health-care services beyond the narrow scope of STD/HIV care.

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By age 19, the majority of males have initiated sexual intercourse, and young sexually active males aged 15–24 experience negative sexual health outcomes, including sexually transmitted diseases (STDs), human immunodeficiency virus (HIV), and unintended partner pregnancy [1,2]. National guidance recommends family planning and sexual and reproductive health care (SRHC) be delivered to young men [3,4]. Despite these recommendations, and *Healthy People* 2020's goal to improve reproductive care to young men, little is known about young men's receipt of core SRHC, including assessment about sexual health, past STD/HIV testing and family planning; STD/HIV laboratories; condom provision; and related counseling.

Past work examining males' SRHC receipt focuses on singular service receipt. Studies typically assess if patients ever had sex [5] rather than assess for the components of a complete sexual history, as recommended by the Centers for Disease Control and Prevention's Five P's approach (i.e., asking about Partners, Practices, Prevention of Pregnancy, Protection from STDs, and Past History of STDs) [6], or assess for STD/HIV testing only rather than in the context of other services (e.g., testing, condoms, and counseling). Overall, the literature indicates a concerning trend—less than one quarter of young men report receipt of any singular service [5,7–10]. Although studies examining care receipt among young men identified with higher sexual risks demonstrate slightly higher rates of singular services [10,11], these studies often use nonclinical samples that limit participants' recall of care and visit-specific service receipt, or conflate access to care with service receipt. One recent clinic-based study, which highlights clinicians' lack of attention to young men's SRHC, reports male adolescents were less likely than females to discuss sexuality during routine visits, and, when these discussions did occur, they lasted for 36 seconds or less and omitted key sexual health topics (e.g., discussions about sexual orientation, healthy relationships) [12,13]. One of the few clinic-based studies that examines males' SRHC counseling receipt across multiple topics reports that providers only ever discussed, on average, 3 of 11 topics; the most discussed topics were counseling on STD risk reduction (55%), correct condom use (38%), and relationships (36%) [14]. Other studies examining SRHC receipt across service domains mainly assess for HIV testing along with other singular services (e.g., HIV counseling [15], other STD testing [11], intimate partner violence assessment [16], vaccine receipt [17]) rather than across multiple SRHC domains.

For adolescents who have not yet initiated sex, the American Academy of Pediatrics (AAP) Bright Futures' guidance discusses that any clinical encounter is an opportunity to teach adolescents and their families about healthy sexuality, HIV infection and other STDs, and modes of infection transmission, and to provide information about contraception, including emergency contraception [4]. Centers for Disease Control and Prevention also recommends HIV testing start at age 13 regardless of sexual behavior [18]. One of the few studies to examine SRHC receipt by sexual experience used 1999 Youth Risk Behavior Surveillance data and showed that 19% of male students who had no sexual experience reported a past year preventive care visit that included discussions of pregnancy, STDs, or HIV prevention with their provider compared with 33% of sexually experienced male students [9].

Exploring factors associated with SRHC receipt is important to inform improvements in care delivery. For example, adolescents who report time alone with their clinician without a parent present during well-visits, as compared with those who did not, report substantially higher receipt of anticipatory guidance, including sexual health [19]. Female providers, compared with male providers, deliver preventive services at higher rates [20,21], but female providers report greater discomfort when taking sexual histories from opposite-sex patients [22,23]. Visit type may also influence care delivery; for example, experts in male health do not agree that key SRHC should be delivered to young men during acute visits [24]. Finally, not all clinical settings may be equipped to deliver the full-range of SRHC.

Addressing current gaps in the literature, this study's main goal was to describe young men's receipt of SRHC by sexual experience across four core SRHC service domains—assessment for sexual health, past STD/HIV tests, and family planning; STD/HIV laboratories; condom supply provision; and related counseling—among a clinical-based sample of young men aged 15–24. A secondary goal was to examine the demographic, sexual behavior, and visit characteristics associated with young men's greater SRHC receipt within each domain.

Methods

Procedures

From August 2014 to September 2016, cross-sectional surveys were conducted among nonprobability (convenience) clinical samples of males aged 15–24. Data were collected for approximately 2 weeks each at three primary care (one academic and two community-based primary care settings) and two public health STD clinics in a Mid-Atlantic city during four surveillance data collection rounds as part of a larger study, which trained nonclinical youth-serving professionals in community-based settings to engage young men they work with on SRHC and monitored young men's knowledge about this intervention. Round 1 (April 4, 2014 to July 9, 2014) was conducted before intervention initiation and Rounds 2 (October 27, 2014 to December 12, 2014), 3 (August 3, 2015 to September 16, 2015), and 4 (July 1, 2016 to September 30, 2016) after initiation. Inclusion criteria included identifying as a male, aged 15–24, and ability to speak, read, and understand English or Spanish. Immediately after the visit, participants completed an audio computer-assisted self-interview that took about 10–15 minutes to complete. Adult participants gave consent to participate in research, and minor participants gave consent if visits were SRHC-related; minors' assent and parent consent was given if visits were non–SRHC-related. Study protocols and procedures were approved by the human subjects review boards of the affiliated institutions. All participants received a US$5 gift certificate for their time. Study procedures necessitated clinicians to refer participants or male patients to approach the study recruitment table on their own volition. Of 786 males referred to/who approached the study team, 479 (61.0%) were determined to meet the study's inclusion criteria. Among eligible participants, 427 enrolled (89.1% participation rate) and 52 refused (10.9%) (e.g., due to time constraints).

Measures

SRHC receipt. Participants were assessed about receipt of 18 services representing four core SRHC service domains—screening history for sexual health, past STD/HIV tests, and family planning; STD/HIV-related laboratories; condom provision; and related counseling. Measures were developed based on core clinical preventive service recommendations for family planning and STDs/HIV [3,6,18,25] and prior work in this area [14,24]. Based on the