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## The socio-ecology of sexual and reproductive health care use among young urban minority males

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### Abstract

**Purpose**—To explore perceptions of facilitators/barriers to sexual and reproductive health (SRH) care use among an urban sample of African American and Hispanic young men aged 15–24, including sexual minorities.

**Methods**—Focus groups were conducted between April 2013 and May 2014 in one mid-Atlantic U.S. city. Young men aged 15–24 were recruited from 8 community settings to participate in 12 groups. Moderator guide explored facilitators/barriers to SRH care use. A brief pre-group self-administered survey assessed participants' sociodemographics and SRH information sources. Content analysis was conducted and three investigators independently verified the themes that emerged.

**Results**—Participants included 70 males: 70% were aged 15–19, 66% African American, 34% Hispanic, 83% heterosexual and 16% gay/bisexual. Results indicated young men's perceptions of facilitators/barriers to their SRH care use come from multiple levels of their socio-ecology, including cultural, structural, social and personal contexts, and dynamic interrelationships existed across contexts. A healthcare culture focused on women's health and traditional masculinity scripts provided an overall background. Structural level concerns included cost, long visits, and confidentiality; social level concerns included stigma of being seen by community members and needs regarding healthcare provider interactions; and personal level concerns included self-risk assessments on decisions to seek care and fears/anxieties about STI/HIV testing. Young men also discussed SRH care help-seeking sometimes involved family and/or other social network members and needs related to patient-provider interactions about SRH care.

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**Conclusions**—Study findings provide a foundation for better understanding young men’s SRH care use and considering ways to engage them in care.

### Keywords

male adolescents; young adult men; sexual and reproductive health care use; access to care; barriers to care

## Introduction

U.S. racial/ethnic and sexual minority male youth aged 15–24 have substantial sexual and reproductive health (SRH) needs and are disproportionately impacted by sexually transmitted infections (STIs) and human immunodeficiency virus (HIV) [1–3]. Despite these needs, few young men get SRH care [4] and healthcare use patterns decline during adolescence [5, 6]. *Healthy People’s 2020* objectives outline the need to increase sexually active males’ receipt of HIV testing and reproductive health [7] as recommended by national professional and Federal organizations [8–10]. Gaining a better understanding of young men’s perspectives about SRH care is needed to develop more effective strategies to engage this population in SRH.

Past work that examines young men’s perspectives of SRH care use typically separate care access from service receipt. Although informative, this literature does not provide a complete picture of young men’s care path from SRH information seeking to care use. Studies examining young men’s SRH care access are mainly exploratory in nature and discuss barriers to care involving personal factors (such as fear about STI test results, stigma in being seen, traditional masculinity beliefs preventing care seeking, lack of perceived need) [11–14] and access factors (such as accessibility, cost) [11, 13–16]. The few studies that explore facilitators of young men’s SRH care use indicate young men discuss seeking care when: they are symptomatic for STIs, their partner has an STI, they perceive STI risk among a recent partner, or after a sexual encounter outside their ‘normal’ behavior (e.g., ‘one-night stands’ combined with alcohol/drugs) [12, 13]. Exploratory studies of care experiences indicate that young men want respectful and personal provider-patient interactions, confidential and private care, and short wait times [11, 13–15]. Analyses of large datasets that examine factors associated with young men’s greater receipt of SRH-specific services (e.g., STI/HIV counseling, HIV testing, routine examinations) also indicate the importance of personal factors (e.g., knowledge about testing location) and access factors (e.g., having a usual source of care, insurance, social support) [17–21]. However, these analyses do not account for males’ direct perspectives and make inferences about the factors that influence young men’s care receipt based on analyses of secondary data that use a limited set of variables. Finally, past studies on SRH care typically focus on heterosexual or non-heterosexual males; common or unique perspectives across populations of young men are not well-assessed or reported.

Andersen’s Behavioral Model of Health Care Use (BMHCU) is a common conceptual framework that has been used to inform past studies when considering the factors that facilitate or hinder young men’s SRH care use. This model describes that a young man’s

care use is influenced by his personal resources (enabling factors), motivation (predisposing factors), and actual stimulus to engage in care (health needs) [22]. However, other factors have also been shown to shape young men's STI testing experiences. For example, Shoeffler et al (2010), exploring young men's STI testing experiences, discuss how structural level factors related to STI testing procedures act together with cultural level factors (e.g., perceptions of masculinities) to shape young men's STI testing experiences [12]. Thus, when considering young men's perspectives of their SRH care use, cultural and clinical structures may also need to be considered alongside personal and access factors that may be more aligned with socio-ecological frameworks such as Bronfenbrenner's Social Ecological Model (SEM) [23].

Addressing gaps in the current literature, the goal of this study, conducted among a diverse urban minority sample of young men aged 15–24 including sexual minorities, was to broadly explore young men's perceptions of the facilitators and barriers to their SRH care use, using a moderator guide informed by Andersen's BMCHU. Study findings will help to inform further research in this area and ways in which to engage young men in SRH care.

## Methods

Focus groups were conducted between April 2013 and May 2014 with young males recruited from community settings. A total of 12 age-stratified groups were conducted: 7 groups were conducted with heterosexual adolescents aged 15–19 (3 groups of African Americans; 2 of Hispanics) and 5 groups with young adults aged 20–24 (3 groups of heterosexual African Americans; 2 of African American sexual minorities). Focus group methodology was chosen to maximally explore participants' cognitions in a domain such as SRH care in which they may have more limited experience.

Participants were recruited using flyers at 8 community settings (recreation centers; faith-based; lesbian, gay, bisexual, and transgender (LGBT); and Hispanic organizations) in neighborhoods with high STI rates in one mid-Atlantic U.S. city. Consented participants completed a brief 5-minute self-administered questionnaire before the group to collect sociodemographic and SRH information. The 60–90 minute focus group discussion was moderated by trained male staff matched by race/ethnicity and was audio-recorded. Eight groups were conducted in English and 4 in Spanish. Groups ranged from 3 to 10 participants to facilitate participant involvement. Study protocols and procedures were approved by the University Institutional Review Boards.

## Sample

The sample consisted of young men aged 15–24. Inclusion criteria were: ages 15–24; African American or Hispanic; and ever engaged in sexual behavior regardless of sex partners' gender. Participants received \$15 stipend for time and transportation, and food during the group.

## Measures

Descriptive quantitative sociodemographic and SRH information source data were collected via a brief survey. Participants were assessed on their age (categorized as 15–19 or 20–24);

race and ethnicity (categorized as African American or Latino); sexual orientation (heterosexual, gay or bisexual); last grade completed in school (coded as less than 12<sup>th</sup> grade or 12<sup>th</sup> grade or higher); whether they had health insurance (coded as yes or no/don't know), a regular source of health care, and a physical examination in the last year; whether they went in the last year to get an HIV test, an STI test other than for HIV, and free condoms from a clinic; whether at last health visit, they spent time alone with their healthcare provider; and person who usually makes their doctors appointment (self, mother, other). Participants were also asked if each of 13 sources were "very helpful," "somewhat helpful," or "not at all helpful" for SRH information (coded as being "very helpful" or "somewhat/not at all helpful"), adapted from prior work [24] (Table 1).

Discussion questions were designed to explore participants' general SRH care knowledge, beliefs, behaviors, and barriers/facilitators to care and informed by Andersen's BMHCU (1995). Moderator guide question examples are presented in Table 2.

## Analysis

Quantitative descriptive analyses included percentages for nominal data (Table 1). Qualitative data were transcribed (and translated from Spanish as appropriate) verbatim from the discussions and NVIVO Version 10 (QSR International Pty Ltd) was used for data management. Data were analyzed using conventional content analysis. Data were verified against original audio-recordings and then organized. Investigators then twice read each transcript for general tone, patterns, and meanings in context. An initial coding scheme was developed and code meanings were discussed and clarified with two other analysts. While conducting the content analysis, the investigators identified that the coding scheme's categories regarding young men's barriers/facilitators to care derived from multiple levels of their socio-ecology and that the strategy for coding and theme development better aligned with contexts as described by Bronfenbrenner's Social Ecological Model (SEM) [23] rather than Andersen's BMHCU which emphasizes mainly personal contexts. In the SEM, individuals are nested within multiple levels of their socio-ecology, and personal behaviors are influenced by social (e.g., family, peers, intimate-partners), structural (e.g., clinical settings), and cultural (e.g., socialization) contexts in addition to the personal context. Thus, overall categories were organized using SEM contexts (i.e. culture, structure, social, personal). The coding scheme was reviewed continuously to verify data and coding procedures, and frequency tables were generated for identified categories and sub-categories allowing for further content analysis and theme development [25]. Investigators pre-determined that salient themes needed to be discussed across five or more groups and by at least two groups within a strata (age, race/ethnicity, sexual orientation). Salient themes were also compared by age, race/ethnicity, and sexual orientation, and selected quotes represent illustrations of salient themes. Steps were taken to corroborate study findings [25] including: 1) coding transcripts by one investigator; 2) verification of coding and themes by another investigator; and 3) review by a third investigator of transcripts, categories, frequency tables, and themes.

To examine whether SRH information sources perceived as very helpful and background characteristics varied by participants' age, Fisher's exact test analyses were performed

(Table 1). To minimize Type 1 error, comparisons with associated probabilities 0.01 were considered statistically significant.

## Results

### Demographic characteristics

The final sample consisted of 70 young men with the majority aged 15–19; African American; self-identified as heterosexual; and with less than a 12<sup>th</sup> grade education (Table 1). Just over half reported a regular source of care and health insurance. In the last year, the majority reported a physical examination, only half were HIV tested, and fewer STI tested. At the last health visit, the majority reported spending time alone with their healthcare provider and cited their mother as the person who typically made their appointment. The majority perceived their mother and healthcare provider as very helpful SRH information sources.

### Qualitative analysis

Themes about young men's perceptions of facilitators and barriers to their SRH care use emerged for their personal context as well as for their social, structural, and cultural contexts (see Table 3 for illustrative quotations). Unless specified, themes emerged across all strata of young men assessed.

### Personal context

**Self-risk assessment on decisions to seek care:** Participants discussed decisions to seek care that were based on self-assessments of sexual risk behavior. For example, some perceived condom use protected them from STIs and thus saw no benefit in STI screening, whereas others made decisions to get tested based on risk (e.g., partner numbers). Some participants made decisions to seek care if they had physical signs/symptoms after sex, whereas others denied symptoms and did not seek care or varied in their threshold for “*wait[ing] out*” symptom resolution.

**STI testing anxiety:** Participants discussed their anxiety and fear surrounding STI testing. Fears were discussed regarding testing procedures and associated pain of older tests (e.g., urethral swab) not reflecting availability of newer, non-painful urine-based methods. Anxiety in seeking testing locations was discussed by participants related to stigma in being seen by others at STI clinics, assumptions that others might make about their presence, and impact on their reputation (see also Stigmatized settings). Fears about testing positive were also discussed as major barriers to testing. These are compounded when communicating positive results with one's partner and fidelity concerns are raised. Heterosexual young adults reflected how these testing anxieties may partially explain why some males avoid testing by denying symptoms or risk behavior involvement (see also Self-risk assessment).

## Social level

### Social network context

**Having credible SRH information sources:** Participants discussed wanting people in their lives to talk about SRH, and needing “*credible*” or “*expert*” SRH information sources or at least good role models. Participants’ discussions about mothers and healthcare providers as being very helpful SRH information sources were consistent with self-administered survey responses (Table 1). Participants discussed the importance of having personal interactions rather than relying solely on the Internet, and older participants described fact-checking information received regardless of the SRH information source (e.g., friend, healthcare provider).

**Needing help finding a healthcare provider:** Adolescent participants described using friends to identify providers and locations for SRH care. They discussed wanting to learn from friends about known reputable clinics and knowing that they were satisfied with services received (e.g., received right diagnosis, medications).

### Healthcare provider context

**Choice in provider:** Participants discussed wanting to be involved in choosing a healthcare provider they can relate to and be comfortable with (see also Providers’ interpersonal communication style). Preferences for the provider’s gender varied by participants’ sexual orientation. Whereas provider gender “*didn’t matter*” among gay/bisexual young adults, heterosexual and adolescent participants preferred female providers, especially if the examination involved private parts (see also Discomfort in being touched). Finally, Hispanic participants discussed wanting Spanish-speaking providers who can help them better understand care content and be understood as a patient, thus conferring competency and skill.

**Providers’ interpersonal communication style:** Participants discussed wanting compassionate, respectful, and empathetic providers who maintain confidentiality. Confidentiality discussions extended to other clinic staff (see also Confidentiality concerns) based on prior experiences with staff and providers who “*talked loudly*” about private matters in common areas.

Some participants, especially adolescents, discussed wanting providers to “*Tell me what you’re going to do [before you do it]*” including before a general examination and especially before examining private parts (“*Don’t just start touching my testicles*”). Young adult gay/bisexual participants did not want providers to make assumptions or generalizations about risk behavior solely based on sexual orientation and would rather they, for example, tailor assessment and counseling based on need.

**Discomfort in being touched:** Participants, especially heterosexuals, described discomfort when providers touched them during examinations in general, but especially when it involved private parts regardless of the providers’ gender. Most adolescents had negative opinions about male providers touching private parts (“*No man should have a male doctor*”), and discussed rescheduling appointments when female providers were not available.

Participants described their discomfort in being touched was related to anticipated anxiety of getting an erection during the examination and what this would mean to them, especially if the provider was male (see also STI testing anxiety). Participants questioned male providers' intentions when performing genital examinations, and wanted to know why the examination is necessary and what it entails (see also Providers' interpersonal communication style). Young adults were able to reconcile the importance of having a genital examination versus anticipated discomfort, discussing that providers need to be "*professional*" and avoid lengthy discussions ("*Don't say anything while touching me*") during the examination.

**Content to learn from the provider:** Participants, especially Hispanic adolescents, described wanting providers to teach them about specific SRH content such as "*knowing more about your body*", "*being offered HIV/STI testing*", and "*why you need to use condom.*" Participants discussed wanting to help choose content covered and be an active participant in their care.

**Self-confidence in asking/answering questions:** Adolescents described needing greater self-confidence when interacting with healthcare providers, especially when asking/answering questions about their health, in general, and about sexual health specifically (e.g., not knowing what questions to ask, talking about uncomfortable topics). They indicated that having greater self-confidence in these types of interactions with their providers would help them improve their own health and, ultimately, develop into healthy and successful adults.

## Structural context

### Clinical operation context

**Time to be seen:** Participants discussed their experiences with long waits including the time to complete paperwork before and after the visit. Reflecting from these personal experiences, participants discussed how their peers would not find long waits acceptable.

**Confidentiality concerns:** Participants discussed the importance of, and need for, all clinic staff maintaining confidentiality and that all clinic spaces (e.g., registration, triage) are private and free from onlookers or eavesdropping.

**Cost of care:** Participants described healthcare costs serving as a major barrier in accessing care, especially for uninsured individuals. Cost concerns were also raised for insured individuals because of high copays (or deductibles) or misperceptions about how insurance works.

### Clinical space context

**Stigmatized settings:** Participants discussed not using certain clinical settings because of patients served or appearance. Participants discussed anxiety and associated stigma of being seen at clinics associated with STIs (e.g., STI clinics; see also STI testing anxiety). Participants shared that they would not go to settings located in old and decaying buildings, discussing how these settings were not welcoming and did not engender trust of care.



## Cultural context

**Young men’s lack of socialization into healthcare:** Participants discussed how it was more typical for females than males to use healthcare or be seen for SRH-related care. They described females having better relationships with their doctors because they use services more frequently. Young adults had greater insight than adolescents into the role that the healthcare system plays in engaging females in care.

Males discussed how they lacked clear messages about reasons to access SRH care, and that care use typically involved unplanned visits (e.g., tipping points, such as having active STI symptoms or discovering a recent sex partner has an STI) rather than adoption of health promotion and prevention strategies. Tipping points were filtered through participants’ experiences, and thresholds for tipping into care varied based on participants’ ability to manage discomfort/pain. Whereas some males were willing to wait, others discussed taking more immediate action.

## Discussion

This study demonstrates young men’s perceptions of facilitators and barriers to their SRH care use come from multiple levels of their socio-ecology, including personal as well as cultural, structural, and social contexts, and highlights the dynamic interrelationships that exist across contexts. A healthcare culture that young men perceive as focusing on women’s health, and traditional masculinity scripts that reinforce young men’s decisions to “wait it out” provide an overall background to understanding care use. Young men discussed accessing SRH care involved navigating structural clinical barriers, interactions with their social network and healthcare provider, and personal anxieties. Young men’s SRH help-seeking also involved their family and/or other key social network members. Study findings provide a foundation for better understanding young men’s SRH care use and can inform future research and intervention work to engage this population in care.

Cultural context shapes young men’s overall SRH care use and experience. Specifically, a healthcare system that young men perceive to be designed and routinized for females limits their engagement in SRH care, healthcare provider relationships, and settings for care. Although participants discussed delays in seeking care when “waiting out” symptoms [26] due to traditional cultural scripts about what it means to be a man, these beliefs were not pervasive across all socio-ecological contexts. Young men in this study described needing social support including wanting to talk with others to get credible SRH information [26]. One of the few intervention studies to address inequitable community-level gender norms as part of a multi-level intervention found that addressing this cultural norm was a key element of males’ individual HIV behavior change [27]. Use of a multi-level approach that also accounts for cultural influences is otherwise missing from past prevention intervention work related to young men’s SRH care use [28] and is also relevant to support sexual minority youth [29]. These findings, along with findings from this exploratory study, support the need for future work that targets multiple contexts of young men’s socio-ecology when considering approaches to address their SRH care.



In this study young men discussed mainly common barriers and facilitators to their SRH care use and this is consistent with findings from past studies. The current study extends this past work by employing a broader framework. Common factors at the structural level included concerns about costs, long visits, and confidentiality [11, 13]; at the social level included concerns about the stigma of being seen by community members and resultant impact on their reputation [30]; and at the personal level included fears/anxieties about testing [20, 21] and conducting self-risk assessments [12, 13]. A few unique concerns were discussed by adolescents, Spanish-speaking male adolescents and older sexual minority males that clinical services and providers may need to take into account when serving this population. Adolescents described wanting a choice in the provider they see, wanting the provider to respect their body during examinations, and needing greater self-confidence in asking/answering questions. These needs are most probably attributed to their developmental stage and traditional masculinity scripts about seeing same gender providers [31], that may not be as heightened among older males in the sample. Further, the cultural context of SRH historically does not prepare males for SRH-related visits that may contribute to their lack of self-confidence in talking about sexual health. Above and beyond common descriptors of providers' interpersonal communication style that included compassionate, respectful, and empathetic providers who maintain confidentiality, Spanish-speaking male adolescents discussed needing to see same language-speaking providers, highlighting unique language needs related to culturally competent care. Finally, older sexual minority young men's concerns that providers make assumptions about their health based solely on sexual orientation [16, 32] may not be as heightened among non-sexual minority males in the sample who are not typically targeted as being at "high risk." Past work suggests that males occupying multiple social identities, including race/ethnic, gender, age and sexual orientation, may experience stress when care seeking and the impact of implicit bias by providers that contributes to stigma, discrimination, and confidentiality concerns [33]. These findings need to be considered in the context of young men residing in communities with high STI/HIV prevalence that may influence their experiences with the health care system. Other factors may also be relevant for younger sexual minority and older Spanish-speaking males since these views were not assessed in the current study. Future work is needed to understand how factors discussed in this study change over time (e.g., from one developmental stage to another, during transition to sexual activity, from one partner to another) within and across diverse populations of young men, especially young racial/ethnic and sexual minority men, and to prospectively examine who is successful in accessing care and which of these factors influence actual care use.

Social networks, including parents, play an important role as SRH information and care sources. Past work demonstrates that social network size, content, and structure influence the help-seeking process [34]. However, males may have less support with the help-seeking process since males typically have smaller social and SRH information networks [35, 36] and receive more limited general SRH information [37]. This may explain why young men in this study discussed wanting to have more credible SRH information sources, especially from male role models. Consistent with these findings, a recent study of heterosexual African Americans aged 15–17 indicated that males reported high SRH information utility from family, healthcare providers, and sex education but lower utility from friends and the

Internet [36]. In contrast, a study among sexual minority youth found that these youth cited healthcare providers and the Internet as important SRH information sources over parents [38], possibly due to more challenging parent interactions about sexuality or to desires to view sexually explicit material to learn about the mechanics of same-gender sex [39]. Further work is needed to better understand how and why young men value SRH information from one source more than another and the role social networks play in the SRH help-seeking process.

Overall study findings contribute to a better understanding of potential pathways of SRH help-seeking to care use for young men – an area of research that is underdeveloped in the realm of young men’s SRH. Although this study did not focus specifically on identifying pathways, from the participants’ discussions it became clear that traditional masculinity scripts were not the only pathway to care seeking (waiting it out and then eventually tipping into care), they also considered making personal decisions, involving one’s social network, accessing care, and then evaluating care experiences to inform subsequent help-seeking for oneself and potentially other peers (e.g., sharing positive or negative provider/clinic experiences). Although Andersen’s BMHCU informed the study’s moderator guide and the SEM assisted in organizing the current study’s findings, neither fully explicate the process of young men’s SRH help-seeking to care use. A useful framework from the mental health care literature [40] acknowledges formal care use is the last stage of the help-seeking pathway, if it happens at all; prior stages include symptom perception, evaluation and information seeking, information sharing with significant others, possible lay system referral, and possible care use. This framework may be useful in understanding young men’s SRH help-seeking given shared perceived stigmas associated with mental health and non-curable STIs/HIV. Future work should more closely examine young men’s pathways of SRH help-seeking, how they make decisions to seek care, and points along the pathways that can be leveraged to engage them in care.

This study has several limitations. First, this study was exploratory and does not test associations of identified factors with actual SRH care use. It is possible that the issues young men perceived to be important to their SRH care use may affect future care use but it is also possible that prior SRH care use shaped shared opinions/views. Although focus group methodology allowed for participants to discuss perceived facilitators and barriers to SRH care use, discussed topics may only highlight issues perceived to be interesting to peers and not necessarily what is most important. However, this study demonstrates that a diverse sample of urban young men think about common facilitators/barriers to SRH care. Although study findings may not be generalizable to young urban men from other racial/ethnic groups or socioeconomic backgrounds, overall findings are consistent with past work in this area including an exploratory study that used participant interviews rather than focus group methodology [12]. Participants represent a convenience sample, and not all actively participated in group discussions. However, findings from the self-administered pre-group survey about SRH information sources were consistent with discussions within and across groups. Finally, despite a diverse sample in terms of age, race/ethnicity, and sexual orientation, only older gay/bisexual and younger Hispanic males were represented. Older gay/bisexual males may have more experiences with the healthcare system and younger males may underreport same sex sexual experiences or not be comfortable disclosing their

sexual orientation. Offsetting these limitations is that this study extends past literature by comprehensively exploring SRH care use among a diverse community-based sample of young men.

This study highlights young men's perceptions of facilitators and barriers to their SRH care use that come from multiple levels of their socio-ecology and the dynamic interrelationships that exist across contexts. Researchers and providers will need to take into account young men's socio-ecology to better understand their SRH care use and inform future research and interventions needed to engage this population in SRH care.

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Preliminary findings from this work were presented as a platform presentation at the 2014 Society for Adolescent Health and Medicine annual meeting in Austin, Texas.

## Acronyms

|              |   |
|--------------|---|
| <b>BMHCU</b> | Behavioral Model of Health Care Use     |
| <b>HIV</b>   | human immunodeficiency virus            |
| <b>LGBT</b>  | lesbian, gay, bisexual, and transgender |
| <b>SEM</b>   | Social Ecological Model                 |
| <b>SRH</b>   | sexual and reproductive health          |
| <b>STI</b>   | sexually transmitted infection          |

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### **Implications and Contribution**

Understanding young men's perspectives about sexual and reproductive health (SRH) care use is needed for researchers and providers to more effectively engage them in care. Young men perceive facilitators and barriers to SRH care use come from multiple contexts of their socio-ecology, including cultural, structural, social and personal contexts, and dynamic interrelationships exist across contexts.

**Table 1**

Participants' background characteristics and perceived very helpful sexual and reproductive health (SRH) information sources overall and by age group (N=70)

|   | Total |    | Age group <sup>I</sup> |         |
|---|-------|----|------------------------|---------|
|   | N     | %  | % 15–19                | % 20–24 |
| <b>Background characteristics</b>                               |       |    |                        |         |
| Age   |       |    |                        |         |
| 15–19   | 49    | 70 | -                      | -       |
| 20–24   | 21    | 30 | -                      | -       |
| Race/ethnicity  |       |    |                        |         |
| Non-Hispanic African American                                   | 46    | 66 | 51                     | 100***  |
| Hispanic  | 24    | 34 | 49                     | -       |
| Sexual orientation  |       |    |                        |         |
| Heterosexual  | 59    | 84 | 98                     | 52***   |
| Gay or bisexual <sup>2</sup>                                    | 11    | 16 | 2                      | 48      |
| Last grade completed  |       |    |                        |         |
| <12 <sup>th</sup> grade   | 49    | 70 | 88                     | 29***   |
| 12 <sup>th</sup> grade, equivalency or more                     | 21    | 30 | 12                     | 71      |
| Health insurance  | 36    | 51 | 41                     | 76**    |
| Regular source of care  | 38    | 54 | 45                     | 76      |
| Physical exam in last 12 months                                 | 47    | 67 | 69                     | 62      |
| In past year, went to get...                                    |       |    |                        |         |
| HIV test  | 35    | 50 | 31                     | 95***   |
| STI test other than HIV   | 27    | 39 | 25                     | 71***   |
| Free condoms from health clinic                                 | 30    | 43 | 37                     | 57      |
| At last health visit, spent time alone with healthcare provider | 41    | 59 | 57                     | 62      |
| Person who usually makes doctor's appointment                   |       |    |                        |         |
| Self  | 25    | 36 | 20                     | 71***   |
| Mother  | 37    | 53 | 65                     | 24      |
| <b>Perceived very helpful SRH information sources</b>           |       |    |                        |         |
| Mother (woman who raised you)                                   | 46    | 66 | 59                     | 81      |
| Father (man who raised you)                                     | 30    | 43 | 37                     | 57      |
| Sibling(s)  | 25    | 36 | 35                     | 38      |
| Other relative(s)   | 23    | 33 | 31                     | 38      |
| Girlfriend/boyfriend/spouse                                     | 20    | 29 | 29                     | 29      |
| Other friends/peers   | 20    | 29 | 27                     | 33      |
| Coach/sports team   | 14    | 20 | 20                     | 19      |
| School/teacher  | 27    | 39 | 35                     | 48      |
| Healthcare provider/doctor/clinic                               | 41    | 59 | 57                     | 62      |
| Church/religion   | 15    | 21 | 16                     | 33      |



|                               | Total |    | Age group <sup>1</sup> |         |
|-------------------------------|-------|----|------------------------|---------|
|                               | N     | %  | % 15–19                | % 20–24 |
| Community organization        | 14    | 20 | 20                     | 19      |
| Media (TV/radio/music/movies) | 17    | 24 | 22                     | 29      |
| Internet                      | 20    | 29 | 29                     | 29      |

AA=Non-Hispanic African American; HIV=human immunodeficiency virus; STI=sexually transmitted infection

<sup>1</sup>Fisher's exact test compared participants' background characteristics and perceived very helpful SRH information sources by age group

<sup>2</sup>Comprised of 9 gay and 2 bisexual youth

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p<.01;

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p<.001

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**Table 2**

## Focus group questions

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When I say sexual and reproductive health, what does it mean to you?

What kinds of health services do you consider to be important to help males your age for their sexual and reproductive health?

Instruction: For the remaining discussion, when we say sexual and reproductive health we mean

- promoting sexual health, development and healthy relationships and communication;
- preventing STIs/HIV, unintended pregnancy and infertility;
- appropriately planning to have children and best spacing between children;
- family planning including use of birth control and emergency contraception;
- preventing reproductive health-related cancers, such as testicular and prostate cancer;
- addressing issues related to problems with sexual enjoyment or desire.

How important is your sexual and reproductive health to you as compared to other aspects of your life?

Can you talk about your most trusted sources for sexual and reproductive health and why they are helpful?

Where do males your age go for sexual and reproductive health? What about for STI testing? HIV testing?

Which places would you not go for sexual and reproductive health services?

What kind of information do males your age need to know where to get to such places?

What kinds of things have your doctors or health care providers done during a health visit that you (or male friends your age) liked or did not like?

What makes it easy or helps you go to a doctor to seek health care services? What makes it difficult or prevents you from going to a doctor for seeking health care services?

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HIV=human immunodeficiency virus; STI=sexually transmitted infection

**Table 3**

Illustrative quotations from young men regarding influences of sexual and reproductive health care use

| Contexts & Themes                              | Illustrative quotations   | Group                       |
|--|---|-----------------------------|
| <b>Personal context</b>                        |   |                             |
| Self-risk assessment on decisions to seek care | “If you’re using a condom, there’s no need for a clinic.”   | 20–24 gay/bisexual AA       |
|  | “I mean...if you know you are going to have a whole bunch of females running around the clock...you might wanna get yourself checked out.”  | 15–19 heterosexual AA       |
|  | “If it’s not an emergency...you don’t want to go, or maybe you don’t have time...., very simply you don’t need to...”   | 15–19 heterosexual Hispanic |
| STI testing anxiety                            | “If I get gonorrhea I’m just going to wait until the symptoms arrive, because I’m not getting that test no more. I’ll take the HIV test...the blood test. But that rod thing, no. You’ve got to find a better way.”   | 15–19 heterosexual AA       |
|  | “...If you know you got an STI but you don’t want to hear you got one, you just hoping it’s something else. But you know for a fact that you were not with a clean woman and...did not use a condom then you go to the free clinic and you get an answer you don’t want to hear. That’s what keeps some people from going ‘cause they already know the answer.” | 15–19 heterosexual AA       |
| <b>Social context</b>                          |   |                             |
| Social network context                         |   |                             |
| Having credible SRH information sources        | “Some people don’t have a good role model or male role model at that. Your mother don’t tell you everything... It’s good for a male to explain to you, or somebody that had been through something, to sit down and talk to you: ‘Like, it ain’t good, to just be out and having sex with everybody...’”  | 15–19 heterosexual AA       |
|  | “I’d rather learn from somebody that experienced it than somebody that just threw it up on the Internet.”   | 15–19 heterosexual AA       |
| Fact checking                                  | “I like to get [my] sexual health counseling from [named clinic]. But, also I want to check up on it. You know...ask them about...‘Was this true that I read on the Internet? ...Is that true?’”  | 20–24 gay/bisexual AA       |
|  | “...The doctor...cause he went to school for this, ...he know what he talking about. ...I’m goin[g] to listen to him first...even though I might check up on what he told me...”  | 20–24 heterosexual AA       |
| Needing help finding a healthcare provider     | “I wouldn’t go...any place that’s unknown, that no one has told me that that’s a good place to seek information because no one recommended them to me and you don’t know what you will find in that place.”   | 15–19 heterosexual Hispanic |
| Healthcare provider context                    |   |                             |
| Choice in provider                             | “Listen, if I go in there and I straight tell them that I do not want a male [doctor], you feel me, like I can have a request.”   | 15–19 heterosexual AA       |
| Being understood                               | “If they spoke to us in Spanish, they’d understand us better there.”  | 15–19 heterosexual Hispanic |
|  | “We feel more comfortable with someone from the same race...that speaks your own language. And we feel like...they are a good person.”  | 15–19 heterosexual Hispanic |
| Providers’ interpersonal communication style   | “They’re supposed to tell you before they do that. Like my doctor she [says] ‘I’m about to check your testicles. Is that okay?’. Then I say ‘Yes.’ They’re supposed to ask.”  | 15–19 heterosexual AA       |
| Non-judgmental                                 | “I got so pissed off at my...doctor! All of a sudden I say, ‘I’m bi-.’ And then [provider] is like ‘oh, you gotta do this, ...you high risk, because this and that’. This [provider] won’t shut up. So...I really can’t stand when they automatically, if you say you’re gay or bisexual...going to say: ‘this is what you do’...I just hate that.”             | 20–24 gay/bisexual AA       |
| Discomfort in being touched                    | “During a check-up, truthfully, I don’t like it when they have to touch [me] and examine your genital parts and all that. I know it’s part of the job, but...it makes you feel a little...let’s say, abused.”   | 15–19 heterosexual AA       |
| Content to learn from the provider             | “...It would be good to know about your body so you can understand it better. Like about sexuality, it would be good to learn about...how to control yourself and how to be prepared...to be an adult.”   | 15–19 heterosexual Hispanic |

| Contexts & Themes                                 | Illustrative quotations   | Group                       |
|---|---|-----------------------------|
|   | "...To know the right moment to have sex, the best time to do it and to know what precautions to take to prevent an unwanted pregnancy or a disease."   | 15–19 heterosexual Hispanic |
| Self-confidence in answering/asking questions     | "Yeah, I don't feel right. ...I'm not going to lie. When they start talking to you by yourself you don't feel sure...how to answer the question[s]. [The doctor] be asking questions like 'have you ever had sex before?'"  | 15–19 heterosexual AA       |
| <b>Structural context</b>                         |   |                             |
| Clinical operations                               |   |                             |
| Time to be seen                                   | "When you're done and they got to sign you out you wait like an hour. An hour just to leave! Like, 'I can't leave?' 'No, you got [to] wait for this paper'. I'm like 'look, I'm about to leave, f--k this. I don't even care what this paper is for.'"  | 20–24 heterosexual AA       |
| Confidentiality concerns                          | "...I don't want it to be announced. You go, and like, "Well, he's walking in here to get tested." Nobody wants that to happen. You look around. I like the system [clinic name] do. Nobody knows or says your name in there. They just call you by the number they give you."  | 15–19 heterosexual AA       |
| Cost of care                                      | "Sometimes when you don't have insurance...that is necessary. And sometimes that's why...you pay more. Sometimes you can't go for the check-ups."   | 15–19 heterosexual Hispanic |
|   | "You can't go to the doctor all the time, because it would be costing money out of my insurance."   | 15–19 heterosexual AA       |
| Clinical spaces                                   |   |                             |
| Stigmatized settings                              | "A lot of times...someone is going to get their checkup, someone else finds out, and that person goes and tells. Like if they see someone coming into the clinic...the one that is like about diseases, a person...that likes to gossip...they spread [gossip] among a lot of people and the same people discriminate or they say things that can, well not hurt, but make you uncomfortable when they say things like that." | 15–19 heterosexual Hispanic |
|   | "First of all, it's an old building, and the lights are off, and there will be some people in the back with some problems. Some of them could have diseases, and some of them don't. ...If I got AIDS, I'm going to go here. I'm going to just look, and walk on out. Who wants to sit there in a depression? ...They need to do something about these clinics."  | 15–19 heterosexual AA       |
| <b>Cultural context</b>                           |   |                             |
| Young men's lack of socialization into healthcare | "If I was a female or whatever I'd be [expected to be] in the clinic...I ain't that though..."  | 20–24 heterosexual AA       |
|   | "Yeah...it's females that go. Most likely females got a good relationship with the[ir] doctor. They talk to the[ir] doctor about anything."   | 15–19 heterosexual AA       |
| Tipping points into care                          | "Cause I had sex with this girl last night and everybody told me about a day later about what was going on...Like is she a freak? Now y'all tell me...I gotta go to the free clinic and get checked up."  | 20–24 heterosexual AA       |
| Waiting it out                                    | "Alright, I might got that. It ain't like...that can kill me so I can ride this out for a minute"   | 15–19 heterosexual AA       |
| Taking more immediate action                      | "No...you go to the Internet...see what's wrong with you. It pops up, and if it's what you thought it was, that's when you go to the doctor without your mother. You just walk out the door and don't say anything."  | 15–19 heterosexual AA       |

AA=African American