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Deficits in Young Men's Knowledge About Accessing Sexual and Reproductive Health Services

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Abstract

Objective—The current study aimed to examine (1) gender differences in college students' knowledge of sexual and reproductive health care (K-SRHC) service access points, and (2) the relationship between demographic and psychosocial factors and college students' overall K-SRHC service access points.

Methods and Participants—Self-report online surveys were administered to 18- and 19-year-old college students from a northern California public university ($N = 183$; 39.9% men; 32.2% Latino).

Results—Women reported higher overall K-SRHC service access point scores than men. Findings indicated that gender and family planning self-efficacy were the strongest correlates of K-SRHC service access points. Men with a regular source of health care had higher K-SRHC service access points than men without.

Conclusions—Results suggest that college men need additional education about how to access sexual and reproductive health services to support their own and their partner's health.

Keywords

Sexual and reproductive health care access; gender; men; health care knowledge

Young adults are at increased risk for negative sexual and reproductive health (SRH) outcomes. A recent national study found that 77% of pregnancies among 18- to 19-year-olds are unintended¹, and risks for sexually transmitted diseases (STDs) that may affect later fertility increase during young adulthood.² To mitigate these negative outcomes, *Healthy Campus 2020* calls for increasing the proportion of college students who receive SRH

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services, including contraceptive, pregnancy, STD, and other preventative health services.³ Importantly, this recommendation applies to both men and women as research has shown that gender differences exist in the receipt of SRH care, with men using health care services substantially less than women.^{4, 5} Further, studies suggest men and women face different barriers to discussing or receiving SRH services with health care providers.^{6, 7}

Knowledge about SRH care (K-SRHC) service access points and the scope of services available is a first step in removing the barriers that constrain young adults from accessing SRH care and utilizing effective prevention methods which may positively impact current and future health. Available data indicate that only 54% of adolescents and young adults had knowledge of where to access confidential health services and a significant proportion did not know where to access SRH care.⁸ Further, when youth do see a provider, they often do not receive the recommended SRH services.⁹ Given that unique developmental challenges and transitions associated with this developmental period, exploring young adult college students' knowledge of SRH services is particularly timely.

Although research has demonstrated gender differences in the receipt of SRH care and that young people need education on where to access care, less is known about the individual factors that influence this knowledge. As such, this study aims to fill this gap in the current literature. Specifically, the goals of the current study are to (1) examine gender differences in college students' K-SRHC service access points and (2) assess the relationship between demographic and psychosocial factors and college students' K-SRHC service access points. Study findings will help to identify knowledge gaps that can be narrowed and ultimately increase the proportion of sexually experienced men and women who receive SRH services; a critical step in promoting the health of individuals and their partners.

Methods

Participants & Procedure

Students who attended a northern California public university were asked to participate in a study on SRH care in October, 2014. The Office of Institutional Research provided e-mail addresses for a subset of 18- to 19-year-old students who had completed at least 30 credits. This subset of students was examined at the request of the university to ensure no overlap with a concurrent study with a similar population. An invitational e-mail described the study and informed consent. Because the focus of the study was on pregnancy prevention, only individuals who identified as heterosexual were invited to participate. Data were collected via a self-report web survey hosted on SurveyMonkey. The Institutional Review Board of the Prevention Research Center approved all procedures. Though 251 participants began the survey, only 183 completed items relevant to the current analyses. Participants with and without missing data did not differ on key demographic variables including gender, GPA, maternal education, Latino ethnicity, or sexual intercourse experience. Therefore, only those with complete data were included in analyses. The response rate was 25%, which is similar to other college web-based surveys.¹⁰ The study took approximately 40 minutes to complete and participants were compensated \$10.00 for their time.

This sample included 39.9% men and the following racial/ethnic groups were reported: 32.2% Hispanic/Latino, 29.5% Non-Hispanic White, 25.7% Asian, and 12.6% other. The average Grade Point Average (GPA) was $M = 3.09$ ($SD = 0.53$) and 58.5% of students reported having a mother with more than a high school education.

Measures

Survey items were both drawn from existing measures¹¹ and developed in consultation with two researchers in the field of adolescent reproductive health. Further, a focus group was conducted to ensure that young adults a) interpreted the questions consistent with what was intended by the researchers, b) questions were worded clearly, and c) items and response categories accurately represented students' behaviors and perceptions of their experiences.

K-SRHC service access points—Individuals' perceived knowledge of places to access SRH care services/resources was assessed by asking, "Do you know of at least one place in your community where X is available to people your age?" Knowledge about where to obtain the following nine services was assessed: condoms, prescriptions for birth control methods, counseling for birth control, emergency contraception, pregnancy test, pap smear, testicular exam, prenatal care, and an STD test. Dichotomous response options included 0 (*No*) and 1 (*Yes*). Affirmative answers were summed across 8-items (pap smears for women/testicular exam for men) to create a single construct, such that greater scores indicated greater knowledge of service access points.

Family planning self-efficacy—Family planning self-efficacy was assessed with 8-items addressing individuals' beliefs in their ability to make, communicate, and enact decisions about pregnancy prevention. Representative items included, "I am often too embarrassed to tell my health care provider everything he/she asks about my sexual and reproductive history," and "I am confident in my ability to prevent pregnancy if I was having vaginal intercourse." Items were coded such that higher scores represent higher family planning self-efficacy. Response options ranged from 1 (*Strongly Disagree*) to 4 (*Strongly Agree*). A mean score was generated ($\alpha = .74$) for analyses.

Regular source of care—Respondents were asked, "Do you have a place you usually go to when you are sick or in need of medical advice?" Dichotomous responses were coded 0 (*No regular source of care*) and 1 (*Regular source of care*).

Sexual experience—Respondents were asked if they had ever had vaginal intercourse with dichotomous responses including 0 (*No sexual experience*) and 1 (*Sexual experience*).

Demographic characteristics—Respondents reported on their gender (women served as the reference group), race/ethnicity (Non-Hispanic White students served as the reference group), highest level of education completed by mother, and current GPA.

Analysis Plan

Descriptive statistics and bivariate correlations were examined first. Next, chi-square and *t*-tests analyses were used examine gender differences across in K-SRHC service access

points. Finally, multiple linear regression analysis was used to explore associations among demographic and psychosocial factors and K-SRHC service access points. The following equation demonstrates the model examined:

$$\begin{aligned} \text{K-SRHC service access points} = & B_0 + B_1(\text{Gender}) \\ & + B_2(\text{Maternal Education}) \\ & + B_3(\text{GPA}) \\ & + B_4(\text{Race/Ethnicity}) \\ & + B_5(\text{Family Planning Self Efficacy}) \\ & + B_6(\text{Regular Source of Care}) \\ & + B_7(\text{Sexual Experience}) + e \end{aligned}$$

where K-SRHC service access points is a function of gender, maternal education, GPA, race/ethnicity, family planning self-efficacy, having a regular source of care, and sexual experience.

Results

On average, students reported knowledge of more than five locations to obtain SRH services ($M = 5.56$, $SD = 2.43$). Participants also reported high family planning self-efficacy, with the average score above the mid-point ($M = 3.27$, $SD = .46$). Most students reported having a regular source of care and sexual experience (81.4% and 61.2%, respectively). Bivariate correlations among continuous variables were examined. K-SRHC was positively correlated with maternal education ($r = .15$, $p < .05$) and family planning self-efficacy ($r = .46$, $p < .001$). GPA was positively correlated with maternal education ($r = .19$, $p < .01$).

Chi-square and *t*-test analyses revealed gender differences in K-SRHC service access points across the various individual services/resources and overall (see Table 1). Findings indicated that a significantly higher proportion of women than men reported knowing where to access all individual SRH services except condoms. The overall difference in men's and women's K-SRHC service access points was a statistically significant, large effect ($d = .89$ [95% CI = .59–1.194]), with women having knowledge of approximately two more SRH services than men. Both among women and among men, the most reported service/resource students knew where to access was condoms (94.6% and 78.1%, respectively) and pregnancy tests (90.9%, and 78.1%, respectively). Similarly, knowledge of prenatal care access points was lowest among women and men (55.5% and 31.5%, respectively), which may reflect young people's emphasis on preventing pregnancy.

A linear regression analysis was used to examine associations between demographic and psychosocial factors and K-SRHC service access points (see Table 2). Results suggested that women and those with greater family planning self-efficacy reported significantly higher levels of K-SRHC service access points than men ($b = -1.67$, $p < .001$ and $b = 2.16$, $p < .001$, respectively). Having a regular source of care and sexual intercourse experience were also significantly and positively associated with overall access point knowledge ($b = 1.37$, p

$< .001$ and $b = .82$, $p < .01$, respectively). Maternal education level, GPA and ethnicity were not significantly associated with K-SRHC.

Given gender differences in K-SRHC service access point were observed, a second set of regression analyses was conducted to examine whether gender moderated the associations between the psychosocial correlates and K-SRHC service access point, controlling for demographic characteristics (not shown in Table 2). Having a regular source of care interacted with gender ($b = 2.33$, $p < .01$). Follow-up analyses to examine this interaction suggested that men without a regular source of care had significantly lower K-SRHC service access points than men with a regular source of care ($b = 2.46$, $p < .001$). The effect was not observed for women (see Figure 1). Significant interaction effects with gender were not observed for sexual experience or family planning self-efficacy.

Comment

The purpose of this study was to investigate demographic and psychosocial correlates of young adult college men's and women's knowledge of where to access sexual and reproductive health care services. Findings suggested that compared to same-aged women, college men were substantially less knowledgeable about SRH care service access points. Among men but not women, having a regular source of care was associated with greater knowledge. These patterns of findings are consistent with past research on gender-related health disparities. For example, data on general health care visits indicate that as youth move from childhood into adolescence, men begin a trajectory of disengagement from the health care system with considerably lower levels of care utilization.¹² With men interacting less with health providers, it is not surprising that by young adulthood, they report a relative lack of knowledge and misinformation about available health services as a barrier for obtaining care.¹³ This lack of knowledge may also exist because unlike women, who often need to seek out health care services when they become sexually active and need prescription contraception methods, men's primary form of protection is condoms, which can be obtained without a visit to a health care provider. Thus, sexually active men using protection may have no more exposure to SRH care providers than those who are not sexually experienced.

Results also indicated that across all students, greater family planning self-efficacy was associated with increased knowledge about where SRH services are available. This relationship may exist due to exposure (e.g., provision of SRH information by a provider) or because youth who have more contact with health providers are more confident and proactive in seeking out SRH information. It is likely that both processes are at work.

Conclusions

Current study findings draw attention to deficits in young people's, particularly men's, knowledge about where they can obtain SRH services. Strategies to enhance this knowledge gap can include a multifaceted approach. For example, in addition to parents fostering youths' contacts and comfort level with their health care provider, sex education programs could emphasize messages about locating services and the range of services available. Further, health care providers could provide information to adolescent and young adult

patients during annual visits through discussions and literature. These contacts and information will offer opportunities for education about services and development of young people's confidence around seeking health care. It is also critical to develop gender-specific messages to increase young men's willingness to engage with SRH services. Preliminary findings from a large-scale national evaluation suggest that recruitment efforts directed at men through clinic outreach and in-reach, restructuring clinic environments, and training clinic staff on the delivery of services for men resulted in an increase in patients who were young men.¹⁴ Perhaps, colleges and universities can use similar techniques to engage college men to positively influence their SRH.

Lastly, the study results highlight the need for SRH service access point education to continue into college and the young adult years. Many universities have health and wellness centers that could engage in informational and outreach efforts by distributing information at freshmen orientation/seminars and in an ongoing fashion via social media and text messages. Relatedly, following recent examples¹⁵, SRH service agencies may want to include young adults in their outreach efforts. Again, it is important to ensure that messages are crafted to resonate with young adult men.

Limitations

This study's findings are limited by its cross-sectional design and low response rate. Further, this study was limited given the sample was drawn from a single university using non-probability based sampling procedures. Although the sample was diverse, future research should use probability sampling would ensure the target population is represented. Relatedly, future studies should use varied methods, such as interview or focus groups, to address the limitations of survey research and gain insights into factors which influence college students SRH. Nonetheless, the findings underscore the fact that college-educated young men are under-informed about where to access key SRH services, information that could assist them and their partners to avoid serious social and physical SRH problems. Future research should identify effective strategies that increase college students' knowledge about SRH services and resources to increase service utilization rates.

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Figure 1. Estimated knowledge of sexual and reproductive health care (K-SRHC) access points for men and women college students with and without a regular source of care.

Table 1

Knowledge of sexual and reproductive health care (K-SRHC) service access points, gender differences

Variable	Men (n = 73)	Women (n = 110)	Test Statistic
Pregnancy test, %	78.1	94.6	$\chi^2 = 11.24, p < .01$
Condoms, %	83.6	90.9	$\chi^2 = 2.24, p = .12$
Birth control prescription, %	58.3	87.3	$\chi^2 = 19.88, p < .001$
Emergency contraception, %	57.5	83.6	$\chi^2 = 15.25, p < .001$
STD testing, %	61.6	80.0	$\chi^2 = 7.45, p < .01$
Birth control counseling, %	49.3	74.6	$\chi^2 = 12.20, p < .001$
Prenatal care, %	31.5	55.5	$\chi^2 = 10.13, p < .01$
Pap smear, %	–	69.1	<i>na</i>
Testicular exam, %	43.8	–	<i>na</i>
K-SRHC service access points, (<i>Mean, SD</i>)	4.37 (2.50)	6.35 (2.03)	$t = 5.90, p < .001$

Note. The knowledge of sexual and reproductive health care (K-SRHC) service access point score ranged from 0 to 8 and was based on 8-items used for all subjects and one gender-specific service: Pap smear for women/testicular exam for men.

Table 2

Correlates of knowledge of sexual and reproductive health care (K-SRHC) service access points

Variable	Full Model		Reduced Model	
	<i>b</i> (<i>SE</i>)	β	<i>b</i> (<i>SE</i>)	β
Maternal Education	0.10(0.06)	0.11		
Grade Point Average	−0.02(0.28)	−0.01		
Ethnicity				
Hispanic/Latino	0.52(0.37)	0.1		
Asian	−0.08(0.40)	−0.01		
Other	0.34(0.47)	0.05		
Gender	−1.67(0.29)	−.34 ***	−1.60(0.29)	−0.32 ***
Family Planning Self-Efficacy	2.16(0.32)	.41 ***	2.21(0.31)	0.42 ***
Regular Source of Care	1.37(0.37)	.22 ***	1.52(0.36)	0.24 **
Sexual Experience	0.82(0.29)	.17 **	0.83(0.28)	0.17 ***
<i>F</i>	15.34 ***		32.63 ***	
<i>R</i> ²	0.44		0.42	

Note. Non-Hispanic White students served as the comparison group for the various ethnic groups and women served as the reference group for gender (*N* = 183).

**
p < .01,

p < .001