

# Too Little, Too Late?

## The Challenges of Providing Sexual and Reproductive Healthcare to Men on College Campuses

*Lilian Milanés and Joanna Mishtal*

**ABSTRACT:** Scholarship and advocacy work regarding reproductive health have often focused on women's experiences. Concerns about men's sexual and reproductive healthcare (SRH) have historically been on the margins in this context. In the United States, young men are at the greatest risk for sexually transmitted infections (STIs), yet are the least likely to seek SRH. Based on research with 18 healthcare providers in a large public Florida university clinic, we examined providers' perspectives about expanding men's SRH provision and utilisation. Research findings demonstrate inconsistent provider strategies in treating men's SRH needs and a clinical environment that has low expectations of men receiving preventive care, further perpetuating the placement of SRH responsibility upon women. This article contributes to applied and medical anthropology scholarship on health inequalities through its discussion of the challenges and barriers that contribute to poor SRH for young men and the critical role of providers in this context.

**KEYWORDS:** health inequalities, healthcare providers, men, reproductive health, sexual health, United States

This article contributes to the anthropological scholarship on men's sexual and reproductive healthcare (SRH) through the narratives of healthcare providers in their experience providing SRH in a university setting. Focusing on men's health has been a rather marginalised area within the vast scholarship on SRH access. In particular, we write to contribute towards anthropologies of institutions by examining professionals – in this case healthcare providers – and by taking the 'vertical slice' (Nader 1972) approach in order 'to study not only power elites but also their relationships and interconnections with people and institutions of subordinate socioeconomic strata' (Stryker and González 2014: 11). Understanding providers' perspectives on the provision of care to men offers insight into one of the many influences within reproductive practices through the lens of providers' own experiences.

Within the field of sexual and reproductive health, men are an important yet far less visible part of the conversation. Concerns about SRH needs have historically focused on women, while men's needs for health and well-being in SRH have not garnered the same attention. Anthropologist Matthew Gutmann (2007: 11; 2011: 54) has observed this institutional bias excluding men from matters of reproduction, sexuality and family planning. This bias is evident in governmental, international health agency and non-governmental organisation (NGO) initiatives alike. With the exception of HIV/AIDS and attention geared towards gay, bisexual or transgender communities, the absence of men's health concerns in resources generated by the state and academia might seem like 'a conspiracy of silence with respect to men and reproductive health' (Gutmann 2011: 57). In 1999, the first US efforts in New York to include men in



more comprehensive provisions of SRH began when public health scholars, advocates and healthcare providers in the northeastern United States established the Male Involvement Advisory Committee, which pursued discussion of ‘best practices’ regarding family planning for men (MAC 2005). The impetus for the committee was the recognition that men rarely sought SRH and that few providers offered SRH or counselling unless specifically requested to do so by patients.

Despite these efforts, poor SRH outcomes continue to characterise men’s health. Overall, while advanced healthcare knowledge and services in the United States do exist, American youth continue to be vulnerable to one of the highest rates of unintended pregnancies in the industrialised, more ‘developed’ world (Guttmacher Institute 2016; Weinstock et al. 2004). Significantly, a disparity between young men and women is also evident: 65% of young women who are sexually active and using contraceptives have also been offered counselling about sexually transmitted infection (STI) prevention and testing (Marcell et al. 2010), while young men, due to receiving fewer con-

traceptive services, receive even fewer STI prevention services than young women (Arrington-Sanders and Ellen 2008; CDC 2010b; Marcell et al. 2010; Porter and Ku 2000). Even though the rate of chlamydia infection was over two-and-a-half times higher amongst American women than amongst American men, infections amongst the latter increased sharply for chlamydia, gonorrhoea and syphilis (see Figure 1 below) (CDC 2016; KFF 2017).

Our analysis of SRH utilisation in the context of men’s health rests on the two-fold assumption that health is a human right and that provision of, and access to, healthcare is fundamental to social justice and equitably structured public services (Farmer 2003). While anthropologists and feminist scholars have critiqued biomedical assumptions about the necessity of treatment as a form of medicalisation (Scheper-Hughes and Lock 1987), others have also shown that individuals make pragmatic decisions and often seek healthcare when treatment options become available (Lock and Kaufert 1998). The availability of SRH, including a wide range of options for STI testing and pregnancy prevention, has been the

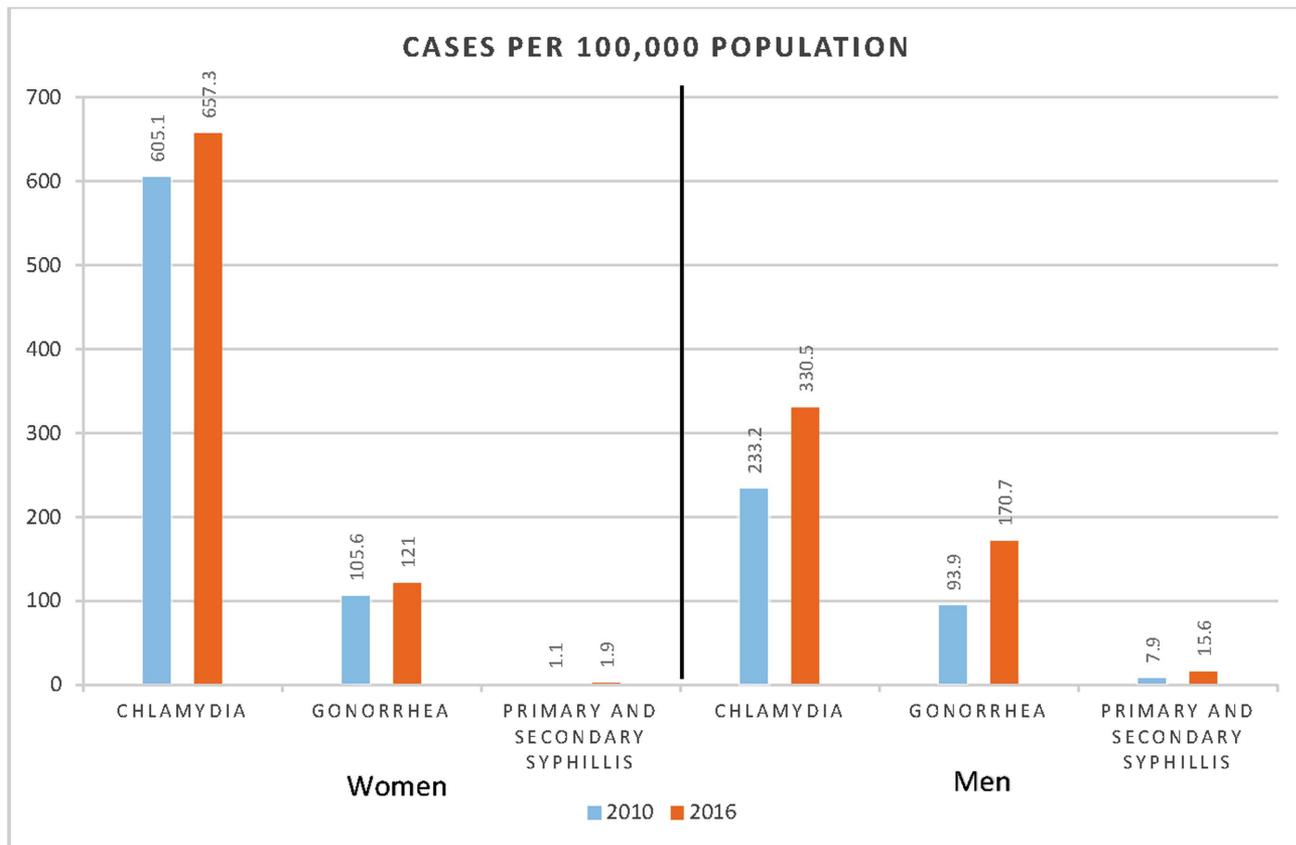


Figure 1: Rising Rates of Sexually Transmitted Infections. Sources: CDC 2016 and KFF 2017

norm for women's healthcare and highly utilised by women; however, far fewer SRH services have been systematically offered to men (Gutmann 2011). This has created a highly stratified context for SRH, placing disproportionate responsibility for the prevention of pregnancy and STIs on women. Therefore, we suggest that addressing these imbalances through making comprehensive SRH available and accessible in an equitable manner across axes of difference – including gender, racial, ethnic and socio-economic classes – constitutes a form of 'good medicalization' (Parens 2013). Moreover, this article also rests on the assumption that an anthropologically informed analysis is valuable in advancing our knowledge of public health concerns, that it can provide a deeper understanding of the practices of SRH provision (Butler 2012: 30–43) as well as providers' subjective understandings (Fineman 1991) and providers' own non-compliance, a particularly relevant consideration for addressing STIs in the college campus context.

Social science and public health scholarship have identified a number of obstacles that men face in accessing SRH services, including fear of learning their STI status, the stigma of seeking care, and the denial that anything is wrong, all of which lead to significant delays in seeking help (Fortenberry et al. 2002; Kalmuss and Austrian 2010; Marcell et al. 2010). Other obstacles that men face include low or inconsistent social support in pursuing care (Lowery et al. 2005) and the fear that confidentiality might be breached due to insurance billing practices (Ford et al. 2001). Although Florida is one of 13 states with provisions that serve to protect the confidentiality of individuals insured as dependents (Gutmacher Institute 2017), this fear was also relevant in our research, as will be demonstrated in the sections below. Notions of masculinity are particularly important in influencing sexual behaviour and SRH-seeking behaviour. Social and cultural constructions of masculinities (and femininities) are complex and may depend on one's race, ethnicity, class, socio-economic status, religion, sexual orientation and life position. Gender constructs are always fluid, and similarly fluid analytical approaches such as the concept of 'emergent masculinities' (Inhorn and Wentzell 2011) can help us account for more dynamic understandings of maleness.

In the context of SRH, anthropologist Tony Whitehead (1997: 419) argued that a fragmented sense of masculinity tends to lead to an exaggerated assertion of sexual capacity that can result in greater sexual risk-taking and exposure to, and spread of, STIs. This

simultaneously contributes to delayed healthcare-seeking behaviour. Merrill Singer (2006) has demonstrated how factors such as substance use, violence and HIV/AIDS often interact to worsen the health of an individual, a finding that is important for understanding the cumulative effect of these conditions. However, anthropologists have agreed that we must not merely focus on the reduction of risk but rather the social and economic inequalities that are underpinning vulnerability to HIV/AIDS and other STIs (Parker 2001).

Significantly, barriers for men in the ability and opportunity to access care are also related to healthcare providers and the biomedical institutional setting. This is due mostly to the lack of national guidelines in men's SRH as well as to the lack of agreement about how the perceived effectiveness and implementation of services impacts who gets health services and when (Kalmuss and Tatum 2007; Marcell et al. 2010). Critical medical anthropology suggests that the asymmetrical power structure restricts patients' choices based on the provider's expertise and preferences, which can negatively affect the potential health benefits to the patient (Chapman and Berggren 2005; Kleinman 1980). By highlighting healthcare providers' narratives, this article provides a window into the patient–physician relationship from the physician's point of view in treating men for their SRH needs, and it offers an anthropological critique of providers' assumptions and expectations as a cultural system (Scheper-Hughes 1990).

Larger politico-economic factors also contribute to poor SRH outcomes for American men. Lack of health insurance and inadequate knowledge about where and how to pursue care are significant barriers, as almost 13 million young adults (30%) aged 20 to 29 did not have health insurance coverage in 2008, amongst which young men were 36% more likely than young women to be uninsured (Cohen and Bloom 2010; Kalmuss and Austrian 2010). Following the implementation of the Affordable Care Act (ACA) in 2010, access to healthcare coverage was expanded to most uninsured populations in the United States. Despite implementation of the ACA, young adults (aged 20 to 24) are amongst the highest uninsured populations in the country. Furthermore, STI rates continue to increase, with young adults, people of colour and men who have sex with men (MSM) disproportionately affected by these inequalities (KFF 2017).

Poor access to healthcare has been identified as a form of structural violence not only on the level of physical and emotional health but also in terms of

economic and political injustices (Farmer 2004). Access to the US healthcare system requires health insurance coverage or substantial financial resources, as growing out-of-pocket costs, inadequate preventive care, and exorbitant costs for the uninsured prohibit those with limited resources from accessing the full range of services when needed. Furthermore, having insurance does not mean elimination of all barriers, as anthropologists have pointed out that disparities exist between the insured and the underinsured, or those who have inadequate coverage (Fletcher 2014). The ability to lead reproductively healthy lives is closely connected to the ability to overcome several socio-economic barriers (Cohen 2008).

The disproportionate impact of HIV/AIDS on African American communities throughout the country is well documented, and this holds true for the state of Florida as well. According to the Florida Department of Health, more Blacks are living with HIV or have died from AIDS than any other racial or ethnic group. For over 15 years HIV/AIDS has been the leading cause of death amongst Black women aged 25 to 44 in Florida (DOH 2017). The college-age population, while typically under 25 years of age, is especially relevant here as this age group is more at risk for STIs, including HIV/AIDS (CDC 2014c). Furthermore, in a recent nationwide comparison of all 50 states Florida ranked 47th in terms of sexual health (Phillips 2015). Recently, Florida recorded its first sexually transmitted Zika case, showing an additional health risk for sexually active people in a state that already has a poor record of addressing SRH needs (Chang 2016).

Since minority men are at a higher risk of contracting STIs than White men (CDC 2010b), providers who offer the same SRH services to every patient may not be adequately addressing individual needs, especially in the hopes of addressing SRH disparities (Cohen 2008). Fear of the healthcare system is another obstacle in seeking services in many minority communities, especially in African American and Latino, and undocumented immigrant communities. This issue can be in part traced back historically to decades of marginalisation and the devastating effects of the Tuskegee syphilis study (Reverby 2009). Therefore, while minority men have greater SRH needs, the common mistrust of the health system amongst minority communities may simultaneously lead to delayed care, future developed illnesses, refusal of treatment, and/or non-compliance, which in turn affect health providers' engagement with patients' needs (Cohen 2008). As anthropologist Carolyn Rouse argues, the 'need to blame health dispari-

ties on noncompliance emerges out of an inability to confront the fact that our health care system rations by cost and effectiveness, and that medical science is in many ways still in its early adolescence' (2010: 196). Thus further health inequality research must complicate 'if and how noncompliance leads to poorer health outcomes' (197).

Through Laura Nader's (1972) 'vertical slice' approach of looking at each phenomenon and the linkages of the phenomenon with bureaucratic structures along with the entities and actors within institutions, we can better understand the processes of power inherent in the provision of care through an analysis of providers' perspectives and through consideration of how these perspectives might affect men's access to and experience of SRH. This article contributes to studying 'up, down and sideways' (Stryker and González 2014) by looking at one of the various aspects that influence reproductive practice: clinician-patient interaction within a large Florida public university campus clinic. Specifically, the research question was as follows: 'To what extent do providers encourage the involvement of male students in their SRH needs?' This university campus provides an ideal setting in which to examine a research question about men's SRH because it has a large ethnically diverse population of young men, which is representative of Florida's overall demographics. Furthermore, in a three-tier ranking of US states by rate of STI infection, Florida ranks in the highest category for every STI, including chlamydia, gonorrhea and syphilis, with most infections occurring in the under-age-24 population (CDC 2010a; CDC 2011).

The social context of our research is within a large public university with an enrolment of approximately 50,000 students. Over 90% of students are Florida residents, and over 70% of undergraduate students receive some form of financial aid. The clinic setting itself is estimated to care for 6,000 patients each day. In 2016, ethno-racial demographics within the state of Florida were as follows: 54.9% White, 16.8% African American, 24.9% Latino, 2.9% Asian and 0.5% Native American (US Census Bureau 2016). The demographics at the university where our research was conducted closely parallel the state demographics with a slightly lower proportion of African Americans and a higher proportion of Asian students attending.

Within the state of Florida, those who hold a bachelor's degree or higher consist of 27.3% of the overall state population, compared to 29.8% nationally (US Census Bureau 2016). Furthermore, Florida has a relatively high level of poverty: those living below

the poverty line make up 15.7% of the population, compared to 13.5% nationally (US Census Bureau 2016). When it comes to HIV diagnoses alone, Florida ranks fourth highest in the country with a rate of 30.8% (CDC 2014a). While the incidence of sexual infection is associated with socio-economic status, overall this project is situated in a context in which students are ethnically diverse, predominately from a lower socio-economic background, and reside in a state with one of the highest rates of HIV infections; therefore, they constitute an important population for this inquiry regarding university-based health-care provision.

### Methodology

This research in this article is based primarily on data derived from 16 semi-structured interviews and two focus groups conducted with campus healthcare providers in 2012. The providers were in charge of general care, which included SRH, at a student clinic in a major public university in Florida. Providers interviewed included five physicians, two physician assistants (PAs), ten registered nurses (RNs), and one community health advocate (Table 1). The focus groups were conducted with three RNs in each group. All participants within individual interviews and focus groups were asked the same set of questions using the Interview Guide. Each provider was assigned the letter P and a number (e.g. P7) as a pseudonym. The sensitive nature of sexual and reproductive care provided to men made participant observation limited to time spent in the clinic’s waiting rooms due to the protection of patients’ privacy. Thus, this article focuses on the providers’ perspectives as key informants, perspectives collected via ‘appointment anthropology’ (Luhmann 1996: vii), an approach more common for ‘studying up’ (Nader 1972) and research carried out in institutional settings. Given that this article focuses on the clinical setting, participant observation is limited due to the 1996 Health Insurance Portability and Accountability Act to protect patients’ privacy. Such research that focuses its gaze ‘up’ on the healthcare providers may rely on appointments, but nevertheless offers significant insights into providers’ understandings of SRH provision to men.

These healthcare providers served as key informants in that they have a significant role within the college health community and can provide important insight due to their seniority or specialist roles (Marshall 1996). Clinic providers simultaneously

understand the institutional setting and draw on experiences treating individual patients. Interviews focused on providers’ perspectives on men’s SRH needs and healthcare utilisation, and potential ways of improving care. Participants were initially recruited through inter-departmental e-mails sent by the clinic’s management, and subsequently through a snow-ball (respondent-driven) sampling method (Bernard 2006: 192–193). Interviews were audio-recorded with permission, and fieldnotes were taken by hand. The audio files were transcribed, coded and analysed to establish major themes and subthemes in the narratives (see Table 1).

### ‘I Have No Problem Right Now’: Providers’ Perceptions of Treating Men on Campus

Based on their experiences at the campus clinic, the providers who participated in this research observed that the incidence of STIs amongst men on campus is on the rise. In 2015, this trend was especially evident with chlamydia: Floridians between the ages of 15 and 24 represented only 13% of the Florida population yet accounted for 64% of reported cases of chlamydia infections (DOH 2015). However, providers also noted an increase in cases of gonorrhoea, genital warts, herpes and syphilis. Providers reported that men typically do not receive preventive, routine

**Table 1:** Participant Demographics

Occupation	Number in Research	Number in Clinic
Physician		
Physician Assistant	4	6
Nurse Practitioners	3	5
Registered Nurse	1	8
Health Educator	9	25*
	1	3
<b>Clinic Specialty**</b>		
Primary Care	11	15***
Acute Care	5	8***
Women’s Clinic	1	10***
Public Health Outreach	1	3
<b>Gender</b>		
Male	5	6
Female	13	–

\*This number is an estimate, as this data was not available.

\*\*For the purpose of this research, this chart excludes providers within departments of mental health, clinical dietitians, and dentists.

\*\*\*This number was calculated by estimating five registered nurses per specialty section.

screenings, and instead delay seeking care at the clinic until they have already developed symptoms of infection. One of the acute care physicians who had the chance to ‘see an awful lot of guys with STIs’ explained that the common approach of men on campus regarding their SRH is to say, ‘I have no problem right now’, indicating little concern with prevention or routine care (P15). Providers offered three distinct but also interconnected explanations of delayed SRH-seeking behaviour by male patients: embarrassment, cost and low level of SRH knowledge. Each of these themes is discussed below.

#### *‘That’s a Penis Problem’: Embarrassment*

Almost uniformly, providers believed that young men who came to the clinic were embarrassed and apprehensive to discuss SRH issues, which made it challenging for the patients to both come to the clinic and to comfortably explain their problem once there. As the providers observed: ‘Patients may be uncomfortable ... to discuss sexual health issues or they feel shy’ (P10); and ‘they’re bashful ... because some of them still have the belief that they’re not behaving’ (P11). Providers noted that some patients scheduled appointments at the clinic under the pretense of another ailment, such as a cold or the flu, and that they revealed their true concerns once they were one-on-one with them (the providers). One of the providers explained:

[A] lot of the men don’t tell the truth when they make appointments. They call in, and they’re too embarrassed to say they have an STI; they say “I have a cold.” And they will actually lie about the reason for the [appointment] and they may or may not be truthful with the nurse. Yeah, they have issues being upfront about their symptoms; they’re too embarrassed. (P2)

Both male and female providers have observed that male patients generally prefer to be treated by, and often request, male providers as a way to deal with embarrassment. For example, one of the women PAs (P5) noted that ‘male providers here get more male patients for sexually transmitted disease issues or just general male exams, because a lot of times patients say, “If I have a female provider, I don’t want an exam”. ... I think they [male patients] only want to confront that with their provider, and they don’t tell nursing [staff] that at all either’. The pattern of declaring a non-sexual ailment or being reluctant to disclose the problem altogether is particularly evident as a way to bypass the often female-staffed front-line personnel who might schedule appointments or

take health history or vital signs before the patient sees the male doctor he requested. An explanation by the following male provider is emblematic of this phenomenon:

We do have a lot of guys that will come in, the nurses will log them in [and say], ‘What are you here for?’ and they’ll say, ‘I’ll talk to the provider’. I’ll tell you what, that’s a key flag to the nurses; that’s a penis problem. Okay, so they’ll come in, and they’ll talk to you, the provider, and typically it’s because they’re embarrassed. That’s why they’ll see a guy: they don’t want to tell a female that they have a problem, and that’s just a cultural thing too, that’s a male thing that sometimes they just don’t want to open up. (P15)

This provider believed that the main barrier in accessing SRH was the young men themselves because of their own reluctance, perceived here as a ‘cultural thing’ or a ‘male thing’, to admit they have a problem and seek care. This research participant did note that providers have a role in helping ‘to bring it out of them’, to assist patients in overcoming potential reluctance or embarrassment (P15). These providers’ narratives also show that anonymity and privacy in SRH are of paramount importance, and doubts about the protection of the patient’s privacy can lead to hesitancy in seeking care at the clinic. On the other hand, embarrassment amongst patients can also be understood as a form of internalisation of neoliberal expectations of self-care. Healthcare providers who assume or expect embarrassment from their patients may also be reflecting this public health model in which the burden of seeking care and the responsibility for reducing infection-related harm to oneself and others is placed on the individual (Petersen and Lupton 1996).

#### *‘How Long Do You Have to Work to Pay for That Shot?’: Cost of Care*

Intertwined with concerns of privacy is also cost of care, a general barrier and dilemma for both students with and without health insurance. Those who have insurance face out-of-pocket co-pays as well as the cost of tests that are not completely or only partially covered by their policy. Some providers observed the priority that privacy takes, as even some patients with health insurance coverage prefer not to use insurance in order to protect their privacy. This is particularly true when coverage is dependent on one’s parents’ insurance policy. Choosing to pay for clinic services entirely out of pocket creates an added financial strain. As one of the physicians emphasised, privacy is ‘certainly a factor as to whether

patients utilise insurance and whether they don't, and that of course can affect how many tests you can get done, how many recommendations you go along with' (P10). The same provider added that 'wanting absolute privacy', which necessitates paying out of pocket, inevitably leads to selective healthcare in that patients decide only on those services that are most urgent (P10). Another physician reiterated that 'a lot of the time they will kind of pick and choose; if there's a lot of tests it's hard for them, and I help them in that decision' (P1). Therefore, while almost all providers find that young men are receptive to STI testing, they are frequently unable to follow through with all recommended services for financial reasons. One of the experienced nurses pointed out the challenge of recommending the human papillomavirus (HPV) vaccine to men, which post-ACA should be covered by most health insurance policies:

[M]oney is a big issue with the kids; they may want to do it but they don't have the money to do it. College isn't like it used to be: kids take a full load of classes, and they have to work, and that's just to be able to have their car and their gas, and to eat. So when you start throwing in, \$135 times three, that's a lot of money to a kid that's making ten dollars an hour. How long do you have to work to pay for that shot? (P2)?

In contrast, free or very inexpensive SRH tests are readily used. One PA noted that when there was a fee for human immunodeficiency virus (HIV) tests, 'a lot of them say, 'How much are the tests?,' but now we have free HIV testing so anyone can get that done, especially when you say something is free to college students, they're like, "Oh sure! Might as well!"' (P5). Overall, providers' experiences revealed that the provision of free and reduced-cost SRH (be it HIV or other STI screenings, or condoms), constitutes an important avenue to expand these services to young men, especially in a university clinic setting, in spite of embarrassment as a potential factor delaying care.

*'It's Never Gonna Happen to Me':  
Limited SRH Knowledge and Education*

Providers reported that men on campus were generally sexually active, but possessed low levels of SRH knowledge, an observation evident even with senior students. Of the 20 million new cases of STIs each year in the United States, half of these cases are people between the ages of 15 and 24 (CDC 2014b). Within the state of Florida, more cases of syphilis were reported amongst women between the ages of 20 and 29 than amongst any other group (DOH 2015).

Three out of four reported STI cases in Florida were between the ages of 15 to 29 (DOH 2015). Therefore, college-age youth populations are of particular concern in terms of STIs and SRH.

One physician noted that patients' embarrassment was sometimes linked to the belief that they had 'misbehaved' and 'that's why they had caught this problem' (P11), suggesting that some patients had low awareness of the widespread prevalence of STIs on campus. Moreover, providers perceive men to be poorly educated about how their bodies work in terms of sexual and reproductive physiology. They observed that male patients tend to deny or ignore existing problems because of a poor understanding of symptoms and risks, which can lead to delayed care. This is exemplified in the following excerpts: 'a lot of guys, they'll have symptoms of urinary frequency or symptoms like that, so that would be a time to be evaluated. But of course they would have to be aware of what some of those things are' (P12); 'a lot of them, they don't know, they're not aware of that, "Oh you know, I didn't know I could get something like that"' (P13); 'they don't think that anything is wrong or that they need any screening' (P3). Some providers also linked men's low awareness of risks and manifestations of STIs to feeling invincible or displaying a cavalier attitude about their SRH. Patients with a cavalier attitude about their health problem, even as they came to the clinic to seek treatment, typically did not take the proper precautions. One health educator explained:

I really don't want to sound negative about this, but for me the frustration with talking with students is the invincibility. They hear about these situations happening, but they think 'it's never gonna happen to me' and so for me it's a matter of breaking down that wall, breaking down that barrier, before it's too late. [...] It's like, what can I do to get to them and get them that education in the manner that they're going to take it in and it's going to sink in (P4).

Since the majority of this university's students come from the state of Florida, these provider observations might be reflective of Florida's inadequate sex education where Abstinence-Only-Until-Marriage programmes, promoted by the Reagan and Bush administrations, continue to fail youth in educating them about basic SRH and safe sexual practices. Unlike in other states where such programmes were phasing out, these programmes, or no sex education, were common in Florida at the time of our research. While comprehensive sex education has been identified as vital in promoting SRH (Santelli et al. 2017), the focus

on patient education should also be understood as a potential tool of the neoliberal shift of responsibility from states onto individuals. In this health model, the self-management of health and risk built on patients' own motivation and self-improvement creates a neoliberal 'subject who is self-regulated, "health"-conscious, middle-class, rational, civilized' in present-day public health discourses (Lupton 1995: 131). Therefore, as this research suggests, health education should be considered in the wider sociocultural, economic and political context in conjunction with such interlocking elements as access to healthcare, social constructions of masculinity, and promotion of health and well-being as a collective public good.

## Discussion and Conclusions

This research has limitations. We have focused on the healthcare provision in a university setting as one perspective from which to examine SRH services offered to men and potential barriers to comprehensive care in this context. The role of men's experiences related to socio-economic status and SRH care-seeking is an area of concern that has surfaced in this research, but it would benefit from further investigation in future research with men.

Nonetheless, based on our findings we argue that the perspectives and experiences of healthcare providers at the clinic reflect the scarce opportunities for male students to become involved in their SRH because of two major factors that are viewed by healthcare providers as patient-related: embarrassment in seeking care for concerns related to sexuality and the inadequate awareness of SRH needs resulting from poor sex education. However, as this study shows, assumptions and expectations about patients' own self-care are also driven by providers' own clinical culture, and, from a critical medical anthropology perspective, this should be understood as a structural concern (Scheper-Hughes 1990). A third factor that constrains access to SRH is the cost of services and the pervasive lack of sufficient insurance coverage for many preventive and diagnostic services. In fact, providers' concerns about patients' inability to pay for services contributes to their reluctance to offer care, follow up or counsel, which in turn might further contribute to inadequate use of services by men. Significantly, providers' experiences with men delaying and selectively using care contributes to a sense of low expectations that men on campus can receive preventive services and that providers can offer consistent care to this patient population. The

simple acceptance of a patient-based behavioural explanation is congruent with and perpetuates culture of poverty theories, which posit that poverty is 'learnt' and passed down between generations as a set of cultural practices (Rouse 2010). Anthropologies of public health are in the position to trace the social constructions of non-compliance as a 'subjective, provider-created category' (Fineman 1991) and of providers' own non-compliant behaviour within clinical settings and, more specifically, within the clinician-patient relationship (Rouse 2010). Moreover, while some providers noted the growing incidence of STIs on campus, in general few recognised a college campus as a site with an inherently higher STI risk.

Indeed, providers reported that the male patients treated at this clinic tended to present specific concerns, rather than seek care for preventive reasons. The main reason providers noted that male patients were seeking care is because patients and/or their partners experienced STI symptoms; patients were starting or rekindling a new relationship and wanted to make sure they were healthy; or they wanted to be tested before becoming intimate. None of the providers reported that patients were visiting the clinic for a routine annual SRH exam, as is done with the Pap smear for women.

Although this research did not question providers' definitions of compliance directly, the narratives offered below demonstrate how providers subjectively constructed and interpreted their patients' compliant or non-compliant behaviour. The majority of the time, these male patients were considered 'compliant', since they sought out the clinic specifically for treatment. The issue of 'non-compliance' emerged when patients lacked the necessary resources to cover the expenses for all STI screening or medications for treatment. However, there are various levels of compliance to consider beyond financial constraints including whether advice is rejected outright, or whether there are concerns about the safety and effectiveness of the treatment, as well as an inability to access care (Rouse 2010). Furthermore, non-compliance 'has as much to do with the values, attitudes, and beliefs underlying providers' expectations and assessments as it does with their clients' behaviors' (Fineman 1991: 372-373).

If the patient had health insurance, the insurance sometimes would not cover the full cost of each screening, if it offered compensation for screening at all. Alternatively, as one provider noted, patients wanted to protect their privacy by not submitting a claim to their third-party insurance provider, thus they paid out of pocket for whatever screenings they could afford. Providers perceived that there was a sizeable

student population that was still not using healthcare services, and that improved outreach would help improve healthcare utilisation. However, few providers made the effort to propose STI screening if male patients were not seeking SRH directly. The majority of providers were more 'strategic' or conservative about offering STI screening, thereby perhaps foreclosing on the full range of options that could otherwise be offered to patients.

Each of the providers interviewed were asked to suggest some solutions to resolving the issues discussed above. Overall, providers offered solutions such as more specialised care for patients (e.g. Men's Clinic), better advertising and communication about clinic services, increased education about SRH for men and the overall campus population, reduced-cost services and resources, and normalised testing and preventive SRH services for men.

This research was conducted while the ACA was at the beginning of its implementation. The question of cost for care remains a concern, given that (while the ACA remains in effect) younger generations with lower incomes have been found to opt out of health insurance and instead pay the penalties for lack of coverage. Should the ACA be repealed and subsequently be replaced by the (currently) proposed Senate bill, the cost of care may worsen for low-income groups, given that health insurance coverage levels would decrease, increasing the number of uninsured people by 24 million in 2026 due to Medicaid changes under the new law (CBO 2017).

From an applied anthropology perspective, these findings highlight the potential importance of expanding clinical environments and spaces to offer men an opportunity to attend to their SRH needs. This is significant in light of ongoing political debates about how healthcare services should be structured and delivered. Notably, models such as those that exist at some US university campuses, where Men's Clinics have been launched in recent years (e.g. Tulane University, Columbia University, University of Maryland) and where weekly Planned Parenthood clinics are offered, are encouraging examples of expanding SRH for men.

Rather than promoting a generalised biomedical and public health approach to men's SRH, we seek to add to the scholarship that brings 'men back into the reproductive imagery, as reproductive partners, progenitors, fathers, nurturers, and decision makers' (Inhorn et al. 2009: 3). Opening the conversation, within the clinical setting, about SRH to include men, providing more opportunities where men can access SRH, and making SRH more routine in primary care

should be a top priority in light of the continued poor outcomes in this area of health. We hope that this article also encourages policymakers to take a more inclusive approach in structuring healthcare provision, in this case focusing on the importance of SRH offered to young men.

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**LILIAN MILANÉS** completed her PhD in anthropology from the University of Kentucky in May 2018, and is now an Assistant Professor of anthropology at William Paterson University. Her research is driven by engaged anthropology, and her interests include access to healthcare, health inequities and US Latinx communities. Email: milanesl@wpunj.edu

**JOANNA MISHTAL** is an Associate Professor of anthropology in the Department of Anthropology at the University of Central Florida. Her work focuses on reproductive health and policies in Poland, Ireland and the European Union, and access to healthcare for sexual minority adolescents in Florida. Email: joanna.mishtal@ucf.edu

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