Interventions in Sexual Health Care–Seeking and Provision at Multiple Levels of the U.S. Health Care System

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Much of the time, the popular construction of health care is reactive—a woman is hit by a car, the ambulance arrives within a certain time, the medics have suitable training, and the hospital has the staff with the necessary skills and the best equipment for them to use. But, as the old proverb reminds us, an ounce of prevention is worth a pound of cure. Routine health care–seeking and provision is part of that ounce, and sexual health care, here, mainly for disease or infection control, is part of high-quality comprehensive health care (1,2).

For this chapter, we will focus on sexual health care–seeking and provision both in the sense of a recommended routine event (e.g., a yearly check-up) and as a reaction to suspicion of a sexually transmitted infection or disease, including human immunodeficiency virus (HIV) infection. HIV transmission presents perhaps the most critical rationale for improved health care–seeking and provision because unrecognized HIV infection persists in part due to lack of routine testing (3) and, in turn, increases the risk of complications and further transmission. We also include studies from the perspectives of the provider and system, as well as the patient, so some interventions covered herein optimized health care–seeking through improving access and availability.

We have left questions about the quality of health care for STD aside, except as perceptions about getting appropriate care pertain to actual health care–seeking. Care may entail screening and treatment—screening is the topic of another chapter in this volume; treatment falls outside the scope of this chapter. This chapter examines the factors that lead to provision of sexual health care, with interventions using patients and providers as intervention targets, and both groups and system-level changes as the agents of change.

Defining a Framework for Sexual Health Care–Seeking and Provision

The principal organizing framework for this chapter is drawn from Aral and Wasserheit’s (4) Person-Time of Infectiousness (PTI) model. The full model explains delays in health care–seeking and service delivery between STD
onset and secondary prevention and how delays affect the proportion of people affected and the duration of infectiousness. Health care-seeking delays comprise the second component of this model—the first is loss to detection, the subsequent three (diagnostic, treatment, and prevention delays) pertain to delays that follow actual entry into the health care system and therefore fall outside the scope of this chapter. Each of the components contains references to various potential targets of intervention and agents of change: pathogen, individual (both characteristics and behaviors), provider, and health system/societal parameters. The topic material of the interventions we discuss can be classified into these parameters; this constitutes the organization of our sections on interventions, but also on correlates of health care-seeking and provision. To the extent the data permit, we also discuss the interactions among these parameters, although there is little true multilevel research on sexual health care-seeking or provision.

A separate chapter in this volume examines screening interventions as a stand-alone topic. However, screening for STD is typically an integral part of systemic and provider-level interventions promoting health care provision; for example, a provider who eschews STD screening as part of sexual health care can hardly be said to be contributing to a patient’s health care-seeking. Consequently, we have included studies with screening as an outcome variable, but only when this outcome is presented in the context of overall improved sexual health care.

**Extent and Common Correlates of Health Care-Seeking and Provision**

To guide intervention efforts, one would like to know what proportion of a given target population actually receives routine health care and which variables are related to health care-seeking and provision. Numerous surveys and cohort studies have yielded many more calls for interventions to improve sexual health care-seeking and provision than there are actual interventions. However, such studies are helpful to intervention research in that they reveal important variables to consider as subject matter for intervention. They comprise, in effect, the broadest type of formative research (but we are not suggesting they replace formative research for any given intervention!). Table 1 provides a summary of factors found in this section of the chapter.

**Extent of Sexual Health Care-Seeking**

Estimating the extent of sexual health care-seeking relies on two sources of information: estimates of how many people seek care and which providers include appropriate sexual health care as part of health care provision (which can occur without health care-seeking). In 2002, 84.1% of the general population (75.2% of 18–24 year olds; 78.2% of 25–44 year olds) made at least one health care visit to a doctor’s office or emergency department, or received a home visit from a doctor, but causes and content of such visits were not broken down (5). Uninsured persons were substantially less likely to seek care and Hispanic or Latino persons were the least likely of any race or ethnicity to have a regular source of health care (5). Compared with their insured peers, adolescents who lack health insurance are more likely to have health...