Access to and use of sexual health care services among young Canadians with and without a history of sexual coercion

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Abstract

Objective To determine access to and use of sexual health care services among adolescents and young adults with and without a history of sexual coercion, and to examine whether a history of sexual coercion was a barrier to using sexual health care services.

Design Online survey.

Setting Canada.

Participants A total of 405 adolescents and young adults aged 16 to 21.

Main outcome measures Participants' sexual histories, sexual coercion histories, current psychological functioning, and perceptions and use of health care services.

Results A history of sexual coercion was reported by 29.6% of participants; more female participants reported a history of sexual coercion than male participants did, and female participants reported more related distress than male participants did. Those with a history of sexual coercion reported more sexual health–related visits than those without a history of sexual coercion did. Among participants with and without sexual coercion histories, there were no differences in difficulty accessing care, perceived quality of care, or rates of unmet health needs. Among those who reported a history of sexual coercion, the odds of having a sexual health–related visit increased for those who had had a routine checkup in the previous year (odds ratio = 8.29) and those who believed it was not difficult to access care (odds ratio = 1.74).

Conclusion Having a history of sexual coercion was not a barrier to the use of health care services among adolescents and young adults. In fact, rates of health care service use were higher among those with a history of sexual coercion than those without such a history.

EDITOR'S KEY POINTS

- Little is known about how sexual coercion affects adolescents' and young adults' access to and use of health care services. This study explored the extent to which participants consulted providers, their perceptions of the quality of care, the topics discussed with providers, and whether a history of sexual coercion was a barrier to accessing sexual health–related care.
- A history of sexual coercion was not a barrier to accessing sexual health–related care. Few barriers were apparent overall: participants found relatively low levels of difficulty in accessing care, perceived the quality of care to be high, and reported few unmet health needs.
- Participants with a history of sexual coercion who reported having had a routine checkup in the past year were 8 times more likely to have had a sexual health–specific visit. Routine checkups clearly comprise a primary context for identifying sexual health–related issues and establishing rapport sufficient for continuity of care.

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L'accès et le recours aux services de santé sexuelle chez les jeunes Canadiens et l'utilisation qu'ils en font selon qu'ils ont été victimes ou non d'abus sexuels

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Résumé

Objectif Vérifier si les adolescents et les jeunes adultes qui ont subi des abus sexuel ont recours aux services de santé sexuelle et déterminer l'usage qu'ils en font; en outre, vérifier si le fait d'avoir été victime les empêchait de recourir à des soins de ce type.

Type d'étude Enquête en ligne.

Contexte Le Canada.

Participants Un total de 405 adolescents et jeunes adultes âgés de 16 à 21 ans.

Principaux paramètres à l'étude Les expériences sexuelles des participants, les abus sexuels dont ils ont été victimes, leur état psychologique actuel, et l'utilisation qu'ils font des services de santé sexuelle et ce qu'ils en pensent.

Résultats Une histoire d'abus sexuels a été rapportée par 29,6% des participants; ce groupe comprenait plus de femmes que d'hommes et ces dernières en avaient ressenti plus de détresse que les hommes. Les victimes d'abus mentionnaient avoir fait plus de visites en rapport avec la santé sexuelle que ceux qui n'en avaient pas subi. Il n'y avait pas de différence entre ceux qui avaient ou qui n'avaient pas été victimes d'abus pour ce qui est de la difficulté d'accès aux soins, de leur opinion sur la qualité des soins ou du taux de réponse à leurs besoins. Ceux qui disaient avoir été victimes d'abus et qui avaient eu un examen de santé de routine avaient plus de chances d'avoir fait une visite portant sur la santé sexuelle (rapport de cotes = 8,29) de même que ceux qui croyaient qu'il n'était pas difficile d'avoir accès aux soins (rapport de cotes = 1,74).

Conclusion Le fait d'avoir été victime d'abus sexuels n'empêchait pas les adolescents et le jeunes adultes de recourir aux services de santé. En réalité, le taux d'utilisation de ces services était plus élevé chez les victimes d'abus que chez les autres.

POINTS DE REPÈRE DU RÉDACTEUR

- On sait peu de choses sur l'effet des abus sexuels subis par les adolescents et les jeunes adultes, sur leur recours éventuel à des services de santé sexuelle et sur l'utilisation qu'ils en font. Cette étude voulait connaître dans quelle mesure les participants avaient rencontré un intervenant, ce qu'ils pensaient de la qualité des soins reçus et si le fait d'avoir été victime d'abus sexuels les empêchait de recourir à des soins liés à la santé sexuelle.

- Le fait d'avoir été victimes d'abus sexuels ne les empêchait pas de recourir aux soins de santé sexuelle. Il y avait apparemment peu d'obstacles : les participants pouvaient facilement obtenir ce type de soins et estimaient que ceux-ci étaient de très bonne qualité, et la plupart mentionnaient qu'on avait répondu à leur besoins.

- Les participants qui avait une histoire d'abus sexuels et qui disaient avoir eu un bilan de santé de routine au cours de l'année précédente avaient 8 fois plus de chances d'avoir eu une consultation axée spécifiquement sur des questions d'ordre sexuel. Il semble évident qu'un bilan de santé annuel est une bonne occasion pour discuter de questions liées à la santé sexuelle, tout en favorisant l'établissement de soins continus.

Cet article fait l'objet d'une révision par des pairs.
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Adolescents and young adults need to reduce reliance on parents for facilitating access to health providers and transition to self-initiated care. This transition is especially important for health care that is related to sensitive issues, such as sexual health issues, for which confidentiality is paramount.[1] Annual routine visits are the primary contexts for the provision of confidential care, establishing rapport necessary for patient disclosure and provider identification of health concerns.[2,3] Yet many youth report that they are unable or unwilling to talk to providers about sensitive issues.[4]

A history of sexual coercion (being the target of verbal pressure, threat, or use of physical force in an attempt to engage in sexual activity with an unwilling partner) might introduce even more barriers. Rates of sexual coercion remain high among adolescents and young adults (26% to 34%)[5-9] despite decades of research, public health interventions, and growing public and professional awareness. Few experiences of sexual coercion are reported to anyone, including health care providers.[10-13] Those who experience sexual coercion express fear, embarrassment, guilt, and privacy concerns as reasons for not using available health care resources.[14] Both male and female survivors report high levels of anxiety, depression, suicidal thoughts, sleep disturbances, chronic diseases, and other medical problems.[6,15-18] The result might be high rates of unmet health needs. But does a history of sexual coercion compound difficulties for adolescents and young adults transitioning to self-initiated primary health care?

Surprisingly little is known about how sexual coercion affects adolescents' and young adults' access to and use of health care services. We assessed the extent to which participants consulted providers, their perceptions of the quality of care, and the sexual health–related topics that participants discussed with providers. Among those with a history of sexual coercion, we examined whether their characteristics, their history of routine checkups, or their opinions about the difficulty of accessing care were associated with sexual health–related visits. Because females have higher rates of sexual coercion,[19] report more associated distress,[20,21] and use more health care services overall,[22] we also examined sex differences.

METHODS

Participants

We recruited 411 adolescents and young adults to participate in the study through online advertisements, public websites (eg, Kijiji), and an existing database from another youth study.[23] Eligibility requirements included age (16 to 21 years) and Canadian residency. **Table 1** presents demographic characteristics of participants.

Table 1. Demographic characteristics of participants: *N* = 405.

CHARACTERISTICS	N (%)*
Sex	
• Male	180 (44.4)
• Female	225 (55.6)
Race or ethnicity	
• European Canadian	365 (90.1)
• East or Southeast Asian	20 (4.9)
• South Asian	7 (1.7)
• African Canadian or black	5 (1.2)
• First Nations or aboriginal	4 (1.0)
• Other	4 (1.0)
Primary language	
• English	376 (92.8)
• French	8 (2.0)
• Other	21 (5.2)
Place of birth	
• Canada	369 (91.1)
• Other	36 (8.9)
Student status†	
• School part-time	47 (11.6)
• School full-time	296 (73.1)
• Employed part-time	131 (32.3)
• Employed full-time	34 (8.4)
Sexual orientation	
• Heterosexual	361 (89.1)
• Gay or lesbian	12 (3.0)
• Bisexual	16 (4.0)
• Other	16 (4.0)

*Percentages do not add to 100 owing to rounding.
†Respondents could have multiple answers for this category.

Measures

Background questionnaire. An investigator-derived questionnaire was used to assess demographic information including age, sex, race or ethnicity, sexual orientation, place of birth, education and employment status, and dating relationship status.

Sexual histories. Participants reported the lifetime number of sexual partners with whom they had had "oral sex, penile-vaginal intercourse, or anal sex." They also reported the age at which they first experienced oral sex, penile-vaginal intercourse, and anal sex (if ever).

Current psychological functioning. A brief item from the Youth Risk Behavior Survey[24] was used to assess depressed

mood. A parallel item was used to assess anxiety. Those who reported recent depressed mood (responded yes to "During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?") or anxiety (responded yes to "Over the past 12 months, did you ever feel so nervous or agitated every day for two weeks or more in a row that you stopped doing some usual activities?") were classified as experiencing a problem in current psychological functioning (α=.76).

Sexual coercion. To assess the experience of sexual coercion since age 14, we used the Sexual Experiences Survey,[25,26] modified to be sex neutral.[8] Three of the original 10 items were omitted because they assessed experiences of "sex play"; the remainder assessed sexual acts as a result of another person's use or threats of physical force, alcohol or drug use, verbal arguments and pressure, or misuse of authority. Participants could respond yes or no to each of the 7 items. Those who responded yes to any of the coercive sexual experience items were scored as having experienced sexual coercion. Current distress related to sexual coercion was rated from being not at all upset (score of 1) to being extremely upset (score of 7) (α=.79).

Sexual health care. Participants reported (yes or no) whether in the previous year they had had a routine sexual or reproductive health checkup; sought care from a provider about a sexual matter outside of a routine visit; considered seeking care from a provider about a sexual matter, regardless of whether they actually went; or had a serious health problem that had gone untreated. Participants also indicated which topics (ie, sexual orientation; sexually transmitted infections; sexual or physical abuse; sexual functioning; and pregnancy prevention or family planning) they had discussed with a provider. They rated the difficulty in accessing care (ie, "How much of a problem, if any, was it to get the care you or a doctor or other health provider believed necessary?") from being not a problem (score of 0) to being a big problem (score of 3); and rated the quality of care from worst health care possible (score of 1) to best health care possible (score of 10).

Procedure

Adolescents and young adults were directed to a website requesting their participation in a survey on "sexual relationships, health, and experiences." Those who met eligibility requirements first provided consent. All parents of minors provided consent using a passive consent procedure. Participants then linked to a secure survey, which took approximately 30 minutes to complete. All measures had been pilot-tested with a comparable sample. Participants received a $15 gift card as compensation. The study was approved by the University of New Brunswick Research Ethics Board.

Analysis

Chi-square analysis was used for comparisons of categorical data, and a 2×2 (sex × coercion history) ANOVA (analysis of variance) was used to examine continuous data. A Bonferroni correction controlled for inflated type 1 error rate from multiple analyses (an α level of .05 for 21 analyses resulted in $P=.002$). Logistic regression analysis identified factors associated with seeking care for sexual health matters (sexual health–related visits) among participants with coercion histories. Predictors tested were sex, age, sexual relationship status, number of past sexual partners, routine checkup, difficulty accessing care, current distress, and current psychological functioning. Analyses were computed using SPSS, version 19.0.

RESULTS

Two male and 4 female participants were dropped from the analyses because of incomplete data, resulting in a final sample of 180 male participants (mean [SD] age 19.3 [1.27] years) and 225 female participants (mean [SD] age 18.7 [1.41] years). Less than 5% of survey data were missing, and analyses indicated that data were missing at random. Therefore, mean substitution was used to address missing data.[27] Participants were predominantly European Canadian (90.1%) and English speaking (92.8%). Almost all (91.1%) were born in Canada. Most were in school full time (73.1%). Most participants identified as heterosexual (89.1%); the remainder identified as lesbian or gay (3.0%), bisexual (4.0%), or other (4.0%) (**Table 1**).

Categories

Current relationship status. More than half (53.3%) of participants indicated they were in a committed romantic relationship versus being single (33.6%) or dating but not exclusively (13.1%). The mean (SD) number of partners was 4.90 (5.73) among the 81.9% with sexual experience. Average age of first experience was 16.2 years for oral sex (n=317), 16.6 years for penile-vaginal intercourse (n=298), and 17.6 years for anal sex (n=110).

Sexual coercion history. Of 405 participants, 120 (29.6%) reported having a sexual coercion experience after age 14 (**Table 2**). More female participants than male participants reported a history of sexual coercion (38.2% vs 19.0%; $\chi^2_1=17.65$; $P<.001$); higher levels of current distress regarding their history of sexual coercion (mean scores of 4.5 vs 3.0; $F_{1,118}=15.67$; $P<.001$); and being very or extremely distressed by those events (27.6% vs 9.1%; $\chi^2_1=4.73$; $P<.05$).

Access to confidential health care. A 2×2 (sex × coercion history) ANOVA compared participants' reports of routine checkups in the previous year and the results were

Table 2. Comparison of health care histories of male and female participants and those with and without a history of sexual coercion

HEALTH CARE HISTORY	WITH HISTORY OF SEXUAL COERCION (N = 120), N (%)	WITHOUT HISTORY OF SEXUAL COERCION (N = 285), N (%)	MALE PARTICIPANTS (N = 180), N (%)	FEMALE PARTICIPANTS (N = 225), N (%)	ALL PARTICIPANTS (N = 405), N (%)
Routine checkup in the previous year	52 (43.3)	82 (28.8)	28 (15.6)*	106 (47.1)*	134 (33.1)
Sexual health checkup in the previous year	49 (40.8)†	58 (20.4)†	33 (18.3)	74 (32.9)	107 (26.4)
Considered a sexual health visit	79 (65.8)†	124 (43.5)†	80 (44.4)	123 (54.7)	203 (50.1)
Unmet health needs	11 (9.2)	15 (5.3)	9 (5.0)	17 (8.0)	26 (6.4)

*Results were significantly different between male and female participants ($P<.006$).

†Results were significantly different between those with a history of sexual coercion and those without a history of sexual coercion ($P<.006$).

significant ($F_{3,398}=17.82$; $P<.001$; $\eta_p^2=0.12$). The main effect for sex was significant ($F_{1,398}=35.35$; $P<.001$; $\eta_p^2=0.08$), with a higher proportion of female than male participants (47.1% vs 15.5%) reporting routine checkups (**Table 2**). The main effect for coercion history were not significant ($P=.21$), nor was the interaction of sex and coercion history ($P=.91$). Results of the analysis for sexual health–related visits were significant ($F_{3,399}=8.78$; $P<.001$; $\eta_p^2=0.06$) but revealed only significance for the main effect of sexual coercion history ($F_{1,399}=15.06$; $P<.001$; $\eta_p^2=0.04$). A higher proportion of participants with a history of sexual coercion (vs without) reported sexual health–related visits outside of routine checkups (40.8% vs 20.5%). The main effects for sex and the interaction term were not significant ($P=.111$ and $P=.266$, respectively). Results of the analysis for considering a visit were also significant ($F_{3,399}=6.03$; $P=.001$; $\eta_p^2=0.04$). Specifically, the main effect for sexual coercion history was significant ($F_{1,399}=12.20$; $P=.001$; $\eta_p^2=0.03$) but the interaction term was not ($P=.878$). A higher proportion of participants with a history of sexual coercion (vs without) reported having considered making an appointment. Neither the results of the analysis for unmet health needs ($F_{3,400}=0.99$; $P=.393$) nor those for difficulty accessing care ($F_{3,395}=3.11$; $P=.026$) were significant. The mean (SD) score for difficulty accessing care was 2.59 (0.79), indicating that participants typically experienced little or no difficulty accessing care.

Perceptions of quality of care and topics discussed with provider. A 2×2 (sex × coercion history) ANOVA compared participants' perceptions of quality of care, but the results were not significant ($F_{3,168}=1.48$; $P=.341$). Participants reported relatively high-quality care (mean score of 7.3). A higher proportion of those with a history of sexual coercion reported discussing abuse with a provider ($\chi_1^2=11.30$; $P<.001$) (**Table 3**). Only 1 sex difference was noted: more female participants than male participants reported discussing pregnancy prevention ($\chi_1^2=28.58$; $P<.001$). The topics discussed most often were pregnancy prevention or family planning (66.1%) and sexually transmitted infections (58.8%). Sexual orientation (7.1%) and abuse (8.9%) were discussed least frequently. Only 2 of the 14 participants who were currently very or extremely upset about their sexual coercion history reported talking to a provider about abuse.

Predicting sexual health visits among those with a history of sexual coercion. The logistic regression

Table 3. Comparison of sexual health topics discussed in the previous year with health care providers among the 169 (41.7%) participants who reported a routine health care visit

SEXUAL HEALTH TOPIC	WITH HISTORY OF SEXUAL COERCION (N = 67), N (%)	WITHOUT HISTORY OF SEXUAL COERCION (N = 102), N (%)	MALE PARTICIPANTS (N = 44), N (%)	FEMALE PARTICIPANTS (N = 125), N (%)
Sexual orientation	4 (6.0)	8 (7.9)	5 (11.4)	7 (5.6)
Sexually transmitted infections	39 (58.2)	60 (58.8)	23 (52.3)	76 (60.8)
Sexual or physical abuse	12 (17.9)*	3 (3.0)*	5 (11.4)	10 (8.0)
Sexual functioning	15 (22.4)	17 (16.7)	9 (20.5)	23 (18.4)
Pregnancy prevention or planning	47 (70.1)	63 (61.8)	14 (31.8)	96 (76.8)
Any topic	57 (85.1)	81 (79.4)	30 (68.2)	107 (85.6)

*Results were significantly different between those with a history of sexual coercion and those without a history of sexual coercion ($P<.001$).

analysis indicated that participants who had had a routine checkup in the previous year had more than 8 times the odds (odds ratio = 8.29) of having a sexual health–related appointment compared with those who had not gone for a checkup (**Table 4**). Perceived difficulty seeking care was also related: those who found it easier to access care had almost twice the odds (odds ratio = 1.74) of having a sexual health–related appointment compared with those who found accessing care more difficult. All other factors were unrelated to whether participants sought care for sexual health matters.

DISCUSSION

Only one-third of participants reported a routine checkup in the previous year and one-quarter reported a sexual health–related visit, similar to other studies.[28,29] Routine checkups are increasingly comprising a periodic health visit rather than an annual health examination in many provinces,[30-33] indicating that providers must rely on periodic visits for opportunities to complete assessments and to learn about adolescents and young adults' health care needs. Even so, few barriers were apparent overall: participants found relatively low levels of difficulty in accessing care, perceived the quality of care to be fairly high, and reported few unmet health needs.

Does a history of sexual coercion introduce barriers to health care? Coercive events, despite being fairly prevalent (29.6%), did not appear to hamper participants' access to sexual health services. In fact, those with a history of sexual coercion were more likely to have considered making an appointment for a visit and to have seen a provider about a sexual health matter in the preceding year. These participants might have greater need for care in line with their coercion histories. Those with coercive histories had higher (though still low) rates of discussing abuse with a provider.

This study reinforces past work documenting the value of periodic preventive visits as a means of ensuring adolescents and young adults do not experience unmet health needs.[2,3] Those who reported a routine checkup in the previous year were more than 8 times more likely to report a sexual health–specific visit. These appointments clearly comprise a primary context for identifying sexual health–related issues and establishing rapport sufficient for continuity of care. Lower perceived difficulty accessing care was related to sexual health visits, suggesting the need for provision of "youth-friendly" services[34] and outreach to those beginning their transition to adult care.[35,36]

Female participants reported more routine health visits than male participants did, as has been noted by other studies.[37,38] We found no sex differences in rates of sexual health–specific visits or other indices of access to care. Age, sexual relationship status, numbers of sexual partners, current distress, and psychological functioning were also unrelated to reports of sexual health–related visits. Sexual coercion histories appear more relevant to understanding sexual health care visits than any of these other standard variables.

Practical policy and practice changes include incorporating key information about transitions to adult care

Table 4. Predicting sexual health visits among participants with a history of sexual coercion (N = 120), using logistic regression analysis

PREDICTOR*	β COEFFICIENT	STANDARD ERROR	WALD STATISTIC	*P* VALUE	ODDS RATIO	95% CI
Sex	-1.108	0.583	3.610	.057	0.330	0.105 to 1.036
Age	-.036	0.191	0.036	.850	0.965	0.664 to 1.402
Sexual relationship status	0.396	0.490	0.654	.419	1.486	0.569 to 3.884
Number of past sexual partners	-.052	0.034	2.335	.127	0.949	0.887 to 1.015
Routine checkup	2.115	0.509	17.243	<.001†	8.286†	3.054 to 22.48
Difficulty accessing care	0.552	0.269	4.23	.040‡	1.737‡	1.026 to 2.940
Current distress	0.032	0.136	0.054	.816	1.032	0.791 to 1.346
Current psychological functioning	0.521	0.454	1.318	.251	1.684	0.692 to 4.103

*$\chi^2_8 = 29.74$, $P < .001$. Nagelkerke $R^2 = .31$.

†The odds of having a sexual health–specific appointment among participants who had a routine checkup increased more than 8 times compared with those who had not had a routine checkup; results are statistically significant.

‡The odds of having a sexual health–specific appointment among participants who believed it was not difficult to access care increased almost 2 times compared with those who believed it was difficult to access care; results are statistically significant.

into sexual education programs and provider training. Provider-youth communication is closely linked to health care transitions.[36] Adolescents and young adults who know more about how to navigate the adult health care system from their providers are likely to have their sexual health–related needs met best.

Limitations

These results need to be interpreted in light of some of the limitations of the study. First, our data rely on self-reporting, which are always subject to issues of social desirability and recall bias, especially for sensitive topics such as sexual coercion. An interview study would provide a more nuanced understanding of adolescents' and young adults' experiences and we are collecting qualitative data to that effect. Second, although our participants were fairly diverse in terms of sexual identity, they were all predominantly white and English speaking. Thus, the extent to which the results would be similar for adolescents and young adults from other ethnocultural communities is not known. In addition, participants were those who volunteered to be in a study addressing sexual matters, and thus we might have introduced a selection bias that perhaps excluded those who experienced greater (or lesser) levels of distress as a result of sexual coercion that they had experienced.

Conclusion

Adolescents and young adults with a history of sexual coercion manage to access health care and, in fact, appear to be using the health care system at higher rates than those without a history of sexual coercion. Those with a history of sexual coericon who had routine checkups in the previous year were far more likely to have had visits addressing sexual health–related issues. In place of routine checkups, periodic health visits might provide key opportunities to identify health issues and establish care for adolescent and young adult patients.

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Contributors
All authors contributed to the concept and design of the study; data gathering, analysis, and interpretation; and preparing the manuscript for submission.

Competing interests
None declared

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