Adolescents' Discussion of Sexual and Reproductive Health Care Topics with Providers: Findings From a Nationally Representative Probability Sample of U.S. Adolescents

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Abstract

Purpose

National practice guidelines encourage providers address sexual and reproductive health (SRH) as part of all clinical encounters with adolescents. Yet, no studies provide nationally representative estimates of how frequently adolescents are screened.

Methods

Data were adolescent participants (aged 14–17 years; N = 826) in the 2018 National Survey of Sexual Health and Behavior, an online, nationally representative study of sexual health experiences of people in the U.S. SRH variables were: (all no/yes) pregnancy prevention, sexual identity, STD/HIV prevention, sexual difficulties, sexually transmitted infections testing, and sexual activity. We used descriptive statistics and weighted logistic regression (Stata 16.0; all $p < .05$) to examine differences in the odds of SRH discussion with provider by sexual identity, age, gender, and race/ethnicity.

Results

The coverage of SRH topics was poor. The most common topic was asking about sexual activity (52.9%), and the least common was being offered a sexually transmitted infection test (21.7%). An adolescent's sexual identity, race/ethnicity, and age affected the odds of topic screening.

Conclusions

Health care providers appear to both infrequently and inconsistently address key SRH topics during encounters with young people. Targeted interventions should focus on strengthening the regularity and depth of clinicians' SRH conversations regardless of adolescent demographic or history.

Keywords: Adolescent, Sexual and reproductive health, Health care

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Implications and Conclusions: Our nationally representative data suggest that providers do not fully adhere to national guidelines that recommend addressing sexual and reproductive health topics in all clinical encounters with adolescent patients.

Background

Increased interest in sexuality and participation in solo and partnered sexual behaviors is a normative and healthy aspect of adolescent development.[1] While most young people navigate this transition without issue, some do experience adverse outcomes such as sexually transmitted infections (STI) and unintended pregnancy.[2] Because these outcomes are readily preventable – but can contribute to lifelong fertility, economic and physical health challenges if left unchecked[3] – it is imperative that adolescents have ongoing access to sexual and reproductive health (SRH) care. Several health and professional organizations recommend that all encounters with adolescents – whether as part of annual preventative care or as part of other clinical services (e.g. acute care, school-based clinic or emergency department) – be utilized as an opportunity to address SRH.[4,5]

Current literature demonstrates wide variation in the SRH topics providers address with adolescents, and the number of adolescents who receive information.[6] Nationally representative studies (e.g. NSFG or YRBS) assess only a narrow range of SRH topics – including condom/contraceptive use, STI/HIV counseling or testing – and typically show that somewhere between one-fifth and thirds of teens have talked to a care provider about SRH (supplemental references 1-3). More pediatricians (86%) self-report discussing general issues of puberty and development than they do abstinence, contraception, and condom use (66%) or sexual orientation and gender identity (18%) (supplemental references 4-5). Some studies suggests that younger adolescents (supplemental reference 1), female adolescents (supplemental references 4-5) and those sexually experienced (supplemental reference 2) are more likely to receive SRH counseling. It is also currently unknown the extent to which sexuality minority youth receive SRH services in ways that are different from heterosexual youth.

The objective of the current study was to – using data from the 2018 NSSHB – examine the prevalence of adolescents who reported discussing SRH topics with their health care provider during a clinical encounter with a provider. Our study expands on existing literature in two ways. We widen the scope of typically assessed SRH topics (e.g. condom/contraceptive use, STI/HIV prevention and testing, current sexual activity) to include other developmentally important sexual health topics, including sexual identity and sexual difficulties.

We also provide a comparison by key demographic categories, rather than limiting the sample to only those who have reported sex, or only to heterosexual adolescents.

Methods

Study Design and Participants

The 2018 NSSHB – a multi-wave, online, cross-sectional probability survey – provided data for this study. Data collection was facilitated by Ipsos Research (Menlo Park, CA, USA) using their Knowledge Panel, a nationally representative probability-based research panel using the U.S. Postal Service's Delivery Sequence File (DSF). The 2018 NSSHB examines sexual experiences among individuals 14-79 years of age in the United States (all 50 states and District of Columbia). Households randomly selected to participate from the panel received a description of the study; those who agreed self-administered online screening, informed consent and survey completion. Ipsos provided survey weights to adjust the sample for sampling design and non-response. Additional methodology details are available in the online supplement. The larger study was approved by the Indiana University Bloomington IRB.

In total, 2581 panel members with adolescent children (14- to 17-years-old) were contacted about the study's availability. About half of these (N=1441; 56%) provided consent for their children to participate. Teens whose parents provided research permission were sent an email that the study was open, and all completed surveys were accepted until the end of the day on which the *apriori* contracted adolescent sample size (N=800) was reached. In total, 826 adolescents provided data and provide the analytic sample for the current study (Supplemental Table). This is an *incidence rate* of 57% (826/1441).

Measures

All adolescent participants indicated whether they had seen a healthcare provider in the last year for a well-exam and/or for other reason (e.g., illness/injury, allergies, etc.). Those who answered affirmatively to either and/or both reasons were subsequently asked whether or not they had discussed ("Did you and your healthcare provider discuss…?": no/yes) each of six ***SRH topics*** (full definitions in Table 1), including pregnancy prevention, sexual identity, STI/HIV prevention, sexual difficulties, STI testing and being sexually active). These topics were our outcome variables.

Demographic predictors included: ***sexual identity*** (heterosexual/sexual minority [ref: lesbian, gay, bisexual, asexual or something else]), ***age*** (14-15 years vs. 16-17 years [ref]), ***gender*** (male/female [ref]) and **race/ethnicity** (White/Min [ref]).

Statistical Procedure

Weighted frequencies were used to estimate the prevalence of adolescents addressing each SRH topic during a clinical encounter in the last 12 months. Weighted logistic regression (Stata 15.0; all $p<.05$) examined the impact of four demographic predictors on the odds of each of the six SRH topic discussion – each in a separate model.

Results

Over 90% (749/826) of adolescents reported at least one visit with a health care provider in the last year; two-thirds (511/757) reported both a preventative well-check and other type of visit (e.g., sick care A). Slightly more than half (52.1%) of adolescents were asked about being sexually active, while 31.6% were counseled about pregnancy or STI/HIV prevention. Fewer discussed sexual identity (12.6%) or sexual difficulties (7.6%). The least common was being offered an STI test (7.25%). A median of one SRH topics was discussed; one-third (268/749) discussed no SRH topics with their provider and only 2.2% percent discussed all topics (data not shown; available from first author).

As shown in Table 1, there were no gender differences in SRH discussions. Sexual minority adolescents were less likely than heterosexual adolescents (OR=0.25) of being asked about sexual identity. In addition, 16-17 year olds had about twice the odds of discussing pregnancy prevention, STI/HIV prevention or being sexually active (OR=1.67-2.17) compared to 14-15 year olds. Racial/ethnic minority adolescents were nearly two-to-three times more likely to be asked about pregnancy prevention, sexual identity, STI/HIV prevention, sexual difficulties and being sexually active (OR=1.59-2.58) as compared to White peers.

Discussion

Despite national recommendations that health care providers use all clinical encounters with adolescents as opportunities to address SRH,[4,5] our nationally representative data align with existing studies (Supplemental references 1-5) to show that there is poor adherence to those recommendations. Although

some adolescents receive SRH information and services during preventative and/or acute care, our data suggest this is the exception rather than the rule. Our observed SRH discussion levels were far below Healthy People 2020 (HP2020) objectives for pregnancy prevention (31.6% vs. 66.9%-77.6% HP2020) and STI- (7.25% vs. 74.6% HP2020) or HIV- (31.6% vs. 73.6% HP2020) screening.[7] Further, other topics important to healthy sexual development – including sexual function and sexual identity[8] – were also inconsistently discussed. We demonstrated that receipt of SRH counseling could be linked to adolescent sexual identity, age and race/ethnicity, meaning that some young people do not receive the SRH information that is needed at this age. Such barriers – particularly for marginalized and disenfranchised youth – is incongruent with global models of sexual health as a fundamental human right.[9] Study limitations are provided in the Supplement.

Brief practice-based interventions could be implemented to help providers increase their SRH skill set. In particular, efforts could standardize SRH screening across adolescent encounters, both in terms of clinicians' addressing a complete set of SRH topics, as well as ensuring that all young people receive the same counseling.

Table 1. Adolescent Sexual and Reproductive Health Discussion with Provider (N=826) – Logistic Regression Results Overall and by Gender, Sexual Identity, Age and Race/Ethnicity.

Sexual and Reproductive Health Topics Discussed	Gender			Sexual Identity			Age (years)			Race/ethnicity		
	Male	Female (ref)	OR (95% CI)	Heterosexual	Sexual Minority (ref)	OR (95% CI)	14-15	16-17 (ref)	OR (95% CI)	White	Minority (ref)	OR (95% CI)
	%			%			%			%		
Preventing pregnancy, including birth control or condom	29.0	38.0	1.00 (0.99 - .00)	33.4	37.0	0.86 (0.38 – 1.95)	25.0	41.6.	**2.17 (1.44 – 3.27)*** **	29.9	38.2	**1.59 (1.06 – 2.39)***
Sexual identity	16.2	11.6	0.99 (0.98 – 1.00)	14.4	6.8	**0.25 (0.08 – 0.83)***	11.9	15.7	1.54 (0.86 – 2.67)	9.3	19.7	**2.50 (1.44 – 4.36)****
Preventing STIs and HIV	35.9	35.3	0.99 (.99 – 1.01)	35.9	30.2	0.61 (0.26 – 1.52)	30.4	40.3	**1.67 (1.11 – 2.48)***	28.5	43.7	**2.09 (1.39 – 3.12)*** **
Sexual difficulties, such as painful sex, erectile function or vaginal lubrication	8.4	7.5	0.98 (0.97 – 1.00)	8.0	6.5	0.44 (0.06 – 3.27)	6.1	9.4	1.82 (0.91 – 3.67)	6.2	9.8	1.73 (0.91 – 3.28)
Test you for sexually transmitted infections (STI)	9.2	7.0	0.99 (0.98 – 1.01)	7.4	15.6	2.18 (0.54 – 8.80)	7.4	8.9	1.21 (0.60 – 2.43)	5.2	11.4	**2.58 (1.32 – 5.00)****
Being sexually active	51.6	57.7	1.01 (0.99 – 1.02)	53.5	70.5	1.90 (0.81 – 4.44)	48.2	60.7	**1.71 (1.17 – 2.49)****	49.9	60.3	**1.63 (1.11 – 2.39)***

*$p<.05$; **$p<.01$; ***$p<.001$

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