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VIEWPOINT

Paediatricians should do more to address male adolescent sexual health

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Young people have the right to be informed and access appropriate health-care services about their health, including sexual matters. They also have the right to be treated in a confidential, culturally appropriate, positive and respectful manner. While components of a sexual history and health discussion vary and are tailored to the individual and their own circumstances, it is paediatricians who are failing our young people by not providing them with the opportunity for sexual health discussion, with males missing out the most.

A recent study by Alexander *et al*.[1] found that 35% of annual adolescent health visits made no mention at all of sex. When such 'discussions' took place, they lasted an average of 36 seconds and rarely involved any input from the young person. None of the 253 adolescents (aged between 12 and 17 years and just over half being female) initiated discussions on sex. Half of all conversations were responses to yes or no (close-ended) questions. Females were twice more likely to spend time talking about sex than males.

Unfortunately, these are not new or surprising findings. Sexual health is raised more often with females and older youth. American primary care providers are three times more likely to take sexual health histories from female than male patients and twice as likely to counsel female patients on the use of condoms.[2,3] There appears to be greater ease in covering issues of menstruation, sexually transmitted illnesses (STIs) and contraception than male sexual health issues.

While the 'physiological agenda' of doctors is to provide information on contraception and screen and treat STIs, adolescents are more interested in the course of normal pubertal progression, making sense of relationships and countering sexual misinformation. Ignoring their concerns leads to disengagement, so it is vital to meld the two, like in any good conversation. It is important to raise the issue of *dating violence*, which occurs in approximately 10% of adolescents and males may be perpetrators, victims or both. A significant concern is that a quarter of adolescent sexual encounters involve alcohol (in up to 34% of Australian male reports)[4] or drug use and that 50% of new STI cases occur among young men and women.[5] All sexual experiences should be free of coercion, discrimination and violence.

Many Australian teenagers perceive the age of sexual consent of 16 years as a barrier to be overcome. After all, many teenagers will drink and smoke before they can legally purchase and use these substances at age 18. The thrill of an illicit action is lost when it is made legal. Loss of virginity is occasionally seen as a milestone akin to attaining a driver's licence (with similarly perceived attached kudos), and some teenagers will initiate sex to 'get it out of the way' or as practice and experience for a future partner. A generational culture of YOLO ('You Only Live Once') does not help. In 2008 in Australia, 70% of Year 10 and 88% of Year 12 students had experienced some form of sexual activity,[4] 40% had experienced sexual intercourse and 44% had experienced oral sex. Thirty-two per cent had reported ever having unwanted sex.[6] The majority of male adolescents practice *serial monogamy*, averaging one sexual partner per year,[1] and male Australian Year 12 students are more likely to have three or more sexual partners than females (43% and 34%, respectively).[4]

Pubertal initiation is trending earlier, particularly among non-Hispanic white boys,[7,8] at approximately 10 years of age. While there is no evidence to suggest cognitive development and maturation are occurring at a similar earlier time, exposure to social and peer influences tends to support the need for education. Viewing videos of sex predicts adolescent initiation of sexual behaviour.[9] Increasingly, because of access, children learn about sex online via the use of pornography.[10] Pornography as sex educator skews the young person's view of sex and sexual roles. It is known that earlier maturing boys engage in more risk-taking behaviours and late developers (associated with obesity) experience teasing, bullying, mental health issues (poor self-esteem, anxiety and depression) and substance use.[11,12] This emphasises the need for dialogue about quality sex education and parental discussion. In Australia, the most popular source of sexual information among males was school programmes (49%) and among females was their mother (62%).[6] Many secondary school teachers feel unsupported in teaching sex education to their students, with few receiving formal training in the area.[6]

Counselling of the normalcy of pubertal progression and velocity is indicated by paediatricians to counter misinformation, investigate pathology (folliculitis from currently 'fashionable' pubic hair shaving, trauma, *tinea cruris*, varicocoeles, etc) and allay fears (such as gynaecomastia and pearly penile papules). Klinefelter syndrome affects approximately 1 in 600 males and may have gone undetected. Testicular cancer

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increases in incidence from 13 years of age and may be misdiagnosed as epididymitis or a hydrocele.[13] Testicular self-examination[14] screening recommendations are unclear.[13,15] The anti-androgenic effect of cannabis on pubertal development should not be discounted.

From a prospective cohort study[16] of males aged 12–18 years, 9.2% of respondents reported high concerns with muscularity and 7.6% of males would use potentially unhealthy products monthly (including supplements, growth hormone derivatives or anabolic steroids in 2.4%) to improve their physique. These males are twice more likely to start binge drinking frequently and use other drugs. Males with high concerns about thinness but not muscularity were two to five times more likely to develop highly depressive symptoms.

The decline in the practice of circumcision (currently 10–20% in Australia and less than 10% in New Zealand)[17] means that the male adolescent and paediatrician are increasingly confronted with issues of phimosis and its treatment. Uncircumcised males are more likely to have gonorrhoea and syphilis than circumcised males[18] (92 cases per 100 000 young people and 8 per 100 000 young people, respectively, in 2011 Australia),[4] although the prevalence of these conditions is 10- to a 100-fold less common than that of chlamydia,[6] which may be asymptomatic. Two-thirds of all chlamydia cases in Australia occur among youth (945 per 100 000 young people).[4] Uncircumcised males are also less likely to have visible genital warts.[18] Access to STI screening tests and appropriate antibiotics are paramount for every young person in Australia and forms part of all routine adolescent medicine clinical practice. Potential complications following STI non-treatment include urethritis, epididymitis and infertility.

The widespread use of selective serotonin reuptake inhibitors in adolescents means that health-care providers have an obligation to screen for sexual dysfunction from an iatrogenic cause. Medications used to treat attention-deficit hyperactivity disorder, such as methylphenidate and atomoxetine, may rarely induce priapism (median age 12.5 years).[19]

In the USA, there is a medical culture of annual 'physicals' and health checks for insurance cover purposes and for clearance to participate in sports. In Australia, a teenager will see a general practitioner on average on only two occasions over a 3-year period.[4] Less than one in five males aged 10–19 years has private health insurance cover, which is half the rate of their female counterparts.[6] Indigenous youth access health-care services even less often. Australia does provide subsidised human papillomavirus immunisation for adolescent males and provides financial support for basic dental services from 2–17 years of age (Child Benefits Dental Schedule).[20]

Should Paediatricians Give 'The Talk'?

Not all parents choose to talk about sex with their children. They may rely on others to do so, including the family paediatrician. The role of health educator falls under the remit of being a paediatrician, although we should be wary of acting as a surrogate parent. Many may argue that paediatricians already advise about diet, exercise, child-rearing (positive parenting) practices, behavioural modification and mental health matters, educational support and contraception; so sex education is just another aspect of their role. Others may hold the view that sex education is the domain and responsibility of the parents and is comparable with their choice on whether to immunise their child or not, administer corporal punishment, introduce a religion, teach and model values or adopt a life-style choice (e.g. vegetarianism or consuming alcohol with meals).

At all stages, paediatricians should encourage parental–child dialogue about sex. There may be many reasons why this does not occur. In our society, fathers may be distant or absent from the home or not lead such a discourse with their sons.[21] In 2012, 73.4% of Australian families were intact, 15.4% involved a single mother and by comparison 2.3% a lone father.[6] While more mothers than fathers talk about sex with their sons, they are less comfortable doing so than with their daughters.[22,23] Male adolescents cite doctors and other health-care providers as one of their top four sources of sexual health information inclusive of parents, health classes and television.[24] School sex education results in fewer sexual partners, acts and more consistent condom use.[25] Sometimes paediatricians need to give 'the talk' to parents.

How can we improve?

- Set the scene – make your practice 'adolescent friendly' (complete the checklist)[26]
- Display everyday virtues of honesty, privacy and service without judgement
- Adopt a positive approach to eliminate shame and stigma
- Explain patient confidentiality – Alexander *et al*.[1] found that adolescents were up to four times more likely to discuss sexual issues when this occurred
- Take time – every additional minute alone yields a 6% increase in engaged discussion on sexual health.[1] (This is difficult to achieve in practice and calls for a separate Medicare Benefit item number for adolescent consultations. The subspecialty of adolescent medicine is yet to be accredited by the Royal Australasian College of Physicians)
- Use open-ended questions
- Be comfortable – address your own attitudes to sex first
- Raise sexual health during each adolescent consultation so that it is seen as a matter of course and not taboo. Physicians initiating such a conversation send a clear message that sexuality is an appropriate and normal discussion topic at health maintenance visits[1]
- Be alert for sexual abuse – sexual health discussion can raise negative experiences
- Provide trustworthy online and local resources (e.g. sexual health clinic details)
- Welcome parents as partners – offer materials and resources to guide them how to have important conversations with their teenagers at home
- Offer discrete STI testing to the young person
- Provide condoms (see below)

The Case for Condom Provision

'Paediatricians are encouraged to provide condoms within their offices and to support availability within their communities, such as schools', as stated in 2013 American Academy of Pediatrics (AAP) policy.[27,28] (The caveat is that policies and procedures that address the provision of such services should be developed

and explained to families *before* the provision of such services is ever needed).[29] Condom availability does not increase the onset or frequency of adolescent sexual activity: 42% of studies reviewed found that sexual initiation was actually *delayed* for at least 6 months and 55% of studies found that education had no effect at all on the timing of initiation of sex.[27] However, adolescents who do not receive formal sex education are half as likely to use a condom at the time of first intercourse as those who do.[30]

Sexually active Australian Year 10 and 12 students almost universally (99.8%) used some form of contraception at their last sexual encounter, with condoms (68%) being the most favoured form.[4] While 9 out of 10 adolescents in one study said that using condoms was a sign of respect, caring and responsibility, about half of those surveyed also said that bringing up the subject of condoms can raise suspicions about their own or their partner's sexual history. More than a third of adolescents find buying condoms embarrassing and an equal number find it hard to raise the subject.[25]

Approximately 10% of Australian and American male adolescents use withdrawal as their contraception method of choice,[4,31] which does not protect against STIs (and to a lesser extent unplanned pregnancy!).

Physicians are encouraged to counsel adolescents about dual contraceptive (such as combined condom and contraceptive pill) use, which only 24% of male American adolescents reported using,[31] and emergency contraception methods, which alarmingly 8% of Australian adolescents used after their last sexual encounter.[4]

The AAP recommends that adolescents be encouraged to abstain from sexual intercourse or be counselled to postpone future sexual relationships.[27,28] Virginity pledges (not endorsed by the AAP) and abstaining from sex until marriage have not been found to have long-term effectiveness in preventing STIs and other adverse outcomes. They might actually place pledge-takers at *greater* risk of STIs and unintended pregnancy. Although pledge-takers delayed initiation of sex for a longer period of time, when pledge-takers initiated sex, they were *less* likely to use condoms and seek reproductive health care compared with their peers who did not sign pledges. One prospective study found that adolescents who signed abstinence pledges experienced *similar* STI rates as did adolescents who did not sign pledges.[32]

In the words of Alexander *et al.*, 'it's always better to have the conversation two years too soon than one day too late'.[1] This is particularly sobering when more than 40% of children have intercourse before discussions of STI symptoms and contraceptive use (including partner refusal) take place.[33] So there is an imperative that we should be holding discussions about sexual health *earlier* and *better* than we currently do.

As paediatricians, we are missing opportunities to educate and counsel the next generation of Australian men. Many will become fathers and raise sons. Today's male teenagers do deserve better, especially in the area of sexual health service provision. They need it but will not ask for it.

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