



The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

ACOG COMMITTEE OPINION

Number 710 • August 2017

Committee on Adolescent Health Care

This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Adolescent Health Care in collaboration with committee member Karen R. Gerancher, MD.

Counseling Adolescents About Contraception

ABSTRACT: Modern contraceptives are very effective when used correctly and, thus, effective counseling regarding contraceptive options and provision of resources to increase access are key components of adolescent health care. Regardless of a patient's age or previous sexual activity, the obstetrician–gynecologist routinely should address her contraceptive needs, expectations, and concerns. Obstetrician–gynecologists should be aware of and be prepared to address the most common misperceptions about contraceptive methods in a way that is age appropriate and compatible with the patient's health literacy. The American College of Obstetricians and Gynecologists recommends that discussions about contraception begin with information on the most effective methods first. Emergency contraception routinely should be included in discussions about contraception, including access issues. Moreover, the American College of Obstetricians and Gynecologists recommends that obstetrician–gynecologists work with their office staff to establish office procedures and routines that safeguard the privacy of adolescent patients whenever possible. Adolescents' right of refusal for initiating or discontinuing a method should be addressed by obstetrician–gynecologists. At no time should an adolescent patient be forced to use a method chosen by someone other than herself, including a parent, guardian, partner, or health care provider. The initial encounter and follow-up visits should include continual reassessment of sexual concerns, behavior, relationships, prevention strategies, and testing and treatment for sexually transmitted infections per the Centers for Disease Control and Prevention's guidelines.

Recommendations and Conclusions

The American College of Obstetricians and Gynecologists (ACOG) makes the following recommendations and conclusions:

- Regardless of a patient's age or previous sexual activity, the obstetrician–gynecologist routinely should address her contraceptive needs, expectations, and concerns.
- Statutes on the rights of minors to consent to health care services vary by state, and obstetrician–gynecologists should be familiar with the regulations that apply to their practice.
- Emergency contraception routinely should be included in discussions about contraception, including access issues. The American College of Obstetricians and Gynecologists recommends that obstetrician–gynecologists write advance prescriptions for oral emergency contraception for their patients.
- Long-acting reversible contraceptive (LARC) methods have higher efficacy, higher continuation rates, and higher satisfaction rates compared with short-acting contraceptives. Because LARC methods are safe, they are excellent contraceptive choices for adolescents.
- Discussions about contraception should begin with information on the most effective methods first.
- Obstetrician–gynecologists should be aware of and be prepared to address the most common misperceptions about contraceptive methods in a way that is age appropriate and compatible with the patient's health literacy.
- The initial encounter and follow-up visits should include continual reassessment of sexual concerns, behavior, relationships, prevention strategies, and testing and treatment for sexually transmitted infections (STIs) per the Centers for Disease Control and Prevention's (CDC) guidelines.

Background

With a peak incidence of 117 per 1,000 women in 1990 (1), and despite significant decreases in recent years (2), the adolescent pregnancy rate in the United States is the highest among developed countries, according to available data, with a rate in 2010 of 57 per 1,000 girls aged 15–19 years (3). Three-quarters of adolescent pregnancies are unintended (2). Reproductive life planning, including delay of onset of sexual activity and childbirth, is an important element of counseling (4). When comparing the United States with Europe, adolescents have similar rates of sexual activity, but European adolescents are more likely to have access to sexuality education and contraception and are more likely to use the most effective methods, resulting in lower pregnancy rates (5). In the United States, approximately 4.3% of women aged 15–19 years who are currently using a method of contraception use a highly-effective LARC method (eg, intrauterine devices and the implant) (6). Long-acting reversible contraceptive methods have higher efficacy, higher continuation rates, and higher satisfaction rates compared with short-acting contraceptives. Because LARC methods are safe, they are excellent contraceptive choices for adolescents. Modern contraceptives are very effective when used correctly and, thus, effective counseling regarding contraceptive options and provision of resources to increase access are key components of adolescent health care.

The Contraceptive Health Visit

Regardless of a patient's age or previous sexual activity, the obstetrician–gynecologist should routinely address her contraceptive needs, expectations, and concerns. Virginal patients may not need contraception immediately, but contraceptive counseling conversations should take place before they are sexually active, and contraception should be made accessible. Ideally, the initial reproductive health visit should take place between ages 13 years and 15 years and should encompass a discussion about contraception and STIs in addition to preventive medicine services such as human papillomavirus vaccination (7). The CDC suggests taking a sexual history that encompasses the 5 Ps: Partners, Practices, Protection from STDs, Past history of STIs, and Prevention of pregnancy (8) (see [Box 1](#)). Such a history may elicit whether adolescents are engaged in noncoital activity (eg, oral or anal sex) (9). Guidance from the U.S. Office of Population Affairs and the CDC, [Providing Quality Family Planning Services](#), and the CDC's [U.S. Selected Practice Recommendations for Contraceptive Use](#) also offer important information on how best to provide reproductive health services (10, 11). By grade 12, more than one half of females report having had sexual intercourse (12), so speaking to young patients is an opportunity for obstetrician–gynecologists to provide anticipatory guidance. Sexual activity is not required before the discussion or offering of contraceptives. An adolescent-friendly environment is important,

as is adequate time for the adolescent patient who may need additional explanation and details compared with an adult patient.

Confidentiality

Confidentiality is an essential component of health care for all patients. It is even more crucial for adolescents because the lack of confidentiality can be a barrier to the delivery of reproductive health care services (13). The American College of Obstetricians and Gynecologists recommends that obstetrician–gynecologists work with their office staff to establish procedures and routines that safeguard the privacy of adolescent patients whenever possible. Obstetrician–gynecologists should discuss confidentiality with each adolescent and, as appropriate, with her parent(s) or guardians(s) during the initial visit, to help establish rapport and outline expectations (14). Other organizations, including the Society for Adolescent Health and Medicine and the American Academy of Pediatrics, provide useful guidance on confidentiality in the setting of adolescent health care, including the need to discuss the scope of and limits to confidentiality, while emphasizing its importance (15) and the need for confidentiality around a minor's consent to contraception (16). Statutes on the rights of minors to consent to health care services vary by state, and obstetrician–gynecologists should be familiar with the regulations that apply to their practice. Useful sources of information on state laws include the Guttmacher Institute (www.guttmacher.org/state-policy/explore/minors-access-contraceptive-services) and the Center for Adolescent Health and the Law (www.cahl.org/state-minor-consent-laws-a-summary-third-edition/).

When feasible, obstetrician–gynecologists should work with government agencies and legislative bodies to eliminate or mitigate the effect of laws that unduly restrict confidential health services for minor adolescents. Open communication between obstetrician–gynecologists and patients (this may include a parent or guardian) regarding the current laws and requirements is imperative, and confidentiality protection is consistent with the development of autonomy and maturity of the adolescent patient. Effective communication between adolescents and their parents should be supported and encouraged, but should not be required.

The billing and insurance claims process has a substantial effect on confidentiality (17). Although confidentiality for provision of contraceptive services may be allowed by state statute, violation of confidentiality may occur through insurance claim processes, such as explanation of benefits notifications. Implementation of the Affordable Care Act has increased coverage of some reproductive health services by mechanisms such as no additional cost-sharing for contraceptive methods for those with health insurance and expanded coverage options for young adults through parental policies. However, there has not been a concordant change

protecting health information from other individuals if the patient is not the primary insurance holder or is a minor. The American College of Obstetricians and Gynecologists endorses the Society for Adolescent Health

and Medicine and American Academy of Pediatrics recommendation that explanation of benefits notifications or other similar communications should not be sent when individuals insured as dependents obtain sensitive

Box 1. Sexual History Questions to Ask Patients ↩

1. Partners

- Are you currently sexually active? (Are you having sex?)
 - If no, have you ever been sexually active?
- In recent months, how many sex partners have you had?
- In the past 12 months, how many sex partners have you had?
- Are your sex partners men, women, or both?*
- If a patient answers “both” repeat first two questions for each specific gender.

2. Practices

- I am going to be more explicit here about the kind of sex you have had over the past 12 months to better understand if you are at risk of sexually transmitted infections (STIs).
- What kind of sexual contact do you have or have you had?
 - Genital (penis in the vagina)?
 - Anal (penis in the anus)?
 - Oral (mouth on penis, vagina, or anus)?

3. Protection from STIs

- Do you and your partner(s) use any protection against STIs?
 - If not, could you tell me the reason?
 - Are you comfortable asking your partner to use condoms?[†]
 - If so, what kind of protection do you use?
 - How often do you use this protection?
 - If “sometimes,” in what situations or with whom do you use protection?
- Do you have any other questions, or are there other forms of protection from STIs that you would like to discuss today?

4. History of STIs

- Have you ever been diagnosed with an STI?
 - When?
 - How were you treated?
 - Have you had any recurring symptoms or diagnoses?
- Have you ever been tested for human immunodeficiency virus (HIV) or other STIs?
 - Would you like to be tested?[‡]
 - Has your current partner or have any former partners ever been diagnosed or treated for an STI?

- Were you tested for the same STI(s)?
- If yes, when were you tested?
- What was the diagnosis?
- How was it treated?

5. Prevention of Pregnancy

- Are you currently trying to become pregnant?
- Are you concerned about getting pregnant?
- Are you using contraception or practicing any form of birth control?
- Is your partner supportive of your using birth control?[†]
- Do you need any information on birth control?

Completing the History

- What other things about your sexual health and sexual practices should we discuss to help ensure your good health?
- What other concerns or questions regarding your sexual health or sexual practices would you like to discuss?

*Health care for lesbians and bisexual women. Committee Opinion No. 525. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2012;119:1077–80 and Care for transgender adolescents. Committee Opinion No. 685. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2017;129:e11–6.

[†]If no, for more information on reproductive coercion see Chamberlain L, Levenson R. Addressing intimate partner violence, reproductive and sexual coercion: a guide for obstetric, gynecologic and reproductive health care settings. 2nd ed. Washington, DC: American College of Obstetricians and Gynecologists; San Francisco (CA): Futures Without Violence; 2012. Available at: https://www.futureswithoutviolence.org/userfiles/file/HealthCare/reproguidelines_low_res_FINAL.pdf. Retrieved April 7, 2017 and Reproductive and sexual coercion. Committee Opinion No. 554. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2013;121:411–5.

[‡]Ideally, opt-out HIV screening should be performed, in which the patient is notified that HIV testing will be performed as a routine part of gynecologic care unless the patient declines testing. See Routine human immunodeficiency virus screening. Committee Opinion No. 596. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2014;123:1137–9.

Data from Centers for Disease Control and Prevention. A guide to taking a sexual history. Atlanta (GA): CDC; 2011. Available at: <https://www.cdc.gov/std/treatment/SexualHistory.pdf>. Retrieved March 31, 2017.

services (18). Obstetricians–gynecologists should review such processes in their own practice to educate patients and policy holders on confidentiality implications, as well as potentially to revise processes that may increase adolescent confidentiality while maintaining compliance with all state and federal laws. When confidential services cannot be provided, referral to Title X Federal Family Planning program clinics (www.opa-fpclinicdb.com) should be considered.

Engagement of adolescents in their own health care through technology is another way to provide age-appropriate venues for confidential communication. As a core component of meaningful use requirements, the patient portal presents opportunities and challenges for the care of adolescents. When parents have access to adolescent health records, the practice of providing open-access to this information is often in direct conflict with best practices for confidential care of the adolescent patient. Institutionally-individualized electronic health record systems do not allow for easy implementation of technology modifications, such as control over parental access to records. Data demonstrate the ability of the patient portal or similar mobile health technology to advance adolescent health care (19); the challenge is to optimize its potential (20). When providing contraceptive services to adolescents, obstetrician–gynecologists should be aware of their own patient portal logistics and usage requirements and should discuss its limitations and opportunities for confidential communication with patients (21). In a large health care system, confidentiality may not be ensured when electronic health records are shared.

Coercion

Reproductive coercion is behavior that interferes with a woman’s decision making about any aspect of her reproductive health and can be associated with increased rates of physical, sexual, or psychological abuse in relationships. Adolescents may be more susceptible to such abuse than adult counterparts (22). See Committee Opinion No. 554, *Reproductive and Sexual Coercion*, for more information and resources (23). Health care provider bias is another form of coercion, and health care providers are encouraged to self-reflect on their own biases and how to provide patient-centered noncoercive care. Obstetrician–gynecologists have the duty to refer patients in a timely manner to other health care providers if they do not feel that they can provide the standard reproductive services that their patients request (24).

Adolescents’ right of refusal for initiating or discontinuing a method should be addressed by obstetrician–gynecologists. At no time should an adolescent patient be forced to use a method chosen by someone other than herself, including a parent, guardian, partner, or health care provider. A patient-centered approach is recommended by the U.S. Office of Population Affairs and the CDC’s Providing Quality Family Planning Services (10). Adolescents who are limited in their ability to

verbalize or give consent should not be seen as asexual. Obstetrician–gynecologists should provide them, or their caregivers, or both, with the same information on contraception as patients without disabilities, including the option of private time with the obstetrician–gynecologist, if appropriate. At age 18 years, an adolescent can autonomously give consent in most states; however, obstetrician–gynecologists should be aware of their state laws surrounding health care power of attorney documents and consent processes that may apply to patients living with disabilities. Adolescents with intellectual disabilities, or physical disabilities, or both, and special needs comprise a distinct population with unique considerations addressed later in the document (see “*Special Considerations*”).

Emergency Contraception

Emergency contraception can provide protection from pregnancy as many as 120 hours after unprotected or inadequately protected intercourse and should be made available to all adolescents (25). No physical examination or testing is indicated before the provision of oral emergency contraception. Notably, access to emergency contraception remains challenging for many women, particularly for adolescents, immigrants, non-English speaking women, survivors of sexual assault, those living in areas with few pharmacy choices, young women, and poor women (26). The Guttmacher Institute maintains an up-to-date listing of state policies on emergency contraception (www.guttmacher.org/state-policy/explore/emergency-contraception). The American College of Obstetricians and Gynecologists recommends that obstetrician–gynecologists write advance prescriptions for oral emergency contraception for their patients to increase awareness and remove barriers, especially for adolescents (26). Thus, emergency contraception routinely should be included in discussions about contraception, including access issues. Because of its efficacy and its advantage as an ongoing contraceptive method, a copper intrauterine device should be considered as an alternative to oral emergency contraception. Based on limited secondary data, obesity has been associated with reduced efficacy of oral emergency contraception; however, it should not be withheld from women who are overweight or obese (25).

Approach to Counseling

Provision of contraceptive services, including counseling and education, is enhanced using tools such as those provided by the U.S. Office of Population Affairs and the CDC (10). Contraceptive experiences and preferences, pregnancy intention and reproductive life plan, sexual health assessment, and medical history are key elements of the patient history. Obstetrician–gynecologists and other health care providers who treat adolescents should provide anticipatory guidance to patients and their parents or guardians, and they should individualize care to

the patient's developmental stage. Dual method use—the use of condoms for STI prevention in combination with more effective contraceptive methods to protect against unintended pregnancy—often is the ideal contraceptive practice for adolescents.

The counseling script, along with other factors such as cost, may influence contraceptive decisions, as demonstrated by the Contraceptive CHOICE Project (27). In this initiative, which provided access to all methods without cost, the counseling script described the effectiveness, advantages, and disadvantages of currently available reversible contraceptives in the order of method effectiveness. Choice of a LARC method, as well as continuation of the method, was exponentially higher in the CHOICE clinics compared with a cohort of surrounding clinics. The CHOICE Project demonstrated the efficacy of LARC methods. Women who used oral contraceptives, the patch, or ring were 20 times more likely to experience an unintended pregnancy compared with LARC users in the first year of the project (28). Based on the success of the CHOICE Project's structured counseling in order of method effectiveness (27), ACOG recommends that discussions about contraception begin with information on the most effective methods first. Obstetrician-gynecologists should be aware of potential barriers and the methods available to help guide the counseling process for their patients.

Counseling may be better received if the environment is adolescent friendly. This includes attention to details such as an adolescent-friendly waiting room, appointment scheduling at convenient times, and tools and visual aids used in the consultation room. See Committee Opinion No. 598, *The Initial Reproductive Health Visit*, for resources that are useful to create such an environment (7).

Special Considerations

Serving patients with certain medical conditions, such as a mental health issue or intellectual or physical disability, may require awareness of other barriers and issues and the implementation of additional counseling strategies. Some studies report higher rates of contraceptive non-use, misuse, and discontinuation among women with symptoms of mental health disorders (eg, depression and anxiety) compared with asymptomatic women (29). More information on contraception and mental health disorders is available in Committee Opinion No. 705, *Mental Health Disorders in Adolescents* (30). Young women with medical comorbidities that may influence their choice of contraceptive method should be counseled about the potential effect their condition could have on a pregnancy or that pregnancy could have on their condition. Obstetrician-gynecologists should consult the CDC's *U.S. Medical Eligibility Criteria for Contraceptive Use, 2016* for information on contraceptive counseling (31). Among adolescents with intellectual disabilities, or physical disabilities, or both, and other special needs,

reproductive health (eg, menstrual suppression) care may overlap with contraceptive choices (32). When working with a patient to choose an appropriate option, the need for menstrual management and anticipatory guidance in special caregiver situations should be considered (33).

Advantages and Common Misperceptions About Available Methods

Excellent tools exist to help the obstetrician-gynecologist guide a patient through selection and correct use of a contraceptive. Adolescents may have misperceptions and concerns about methods and an obstetrician-gynecologist should be prepared to elicit these concerns and counsel appropriately. Candidacy for use of individual methods is detailed in the U.S. Medical Eligibility Criteria for Contraceptive Use, 2016 (31). There are no restrictions on any method based on age alone. Additionally, evidence-based information regarding required testing and follow-up, initiation and timing, missed dosages, and adverse effect management is detailed in the CDC's U.S. Selected Practice Recommendations for Contraceptive Use, 2016 (11). The American College of Obstetricians and Gynecologists endorses and advocates the use of both documents.

Additionally, cultural, social, economic, and educational background can influence an adolescent's perceptions of birth control methods. Common areas of concern for each method, such as weight gain with depot medroxyprogesterone acetate use, are not unique to adolescent patients. However, young patients may not be effective in verbalizing their concerns and may experience intimidation and embarrassment in such discussions. Dialogue that includes open-ended and direct questions may provide an avenue for the patient to express her concerns or beliefs.

Data on unmarried young adults aged 18–29 years in the United States demonstrate that misperceptions are common regarding use of contraceptives—there is a gap between intent and actual behavior in preventing unplanned pregnancy (34). This gap stems from multiple issues, including awareness, fear, myths, underestimation of personal fertility, and access, as well as pregnancy ambivalence (34). Obstetrician-gynecologists should be aware of and be prepared to address the most common misperceptions about contraceptive methods in a way that is age-appropriate and compatible with the patient's health literacy (35).

Follow-Up Visit

Assessing adherence to and satisfaction with an adolescent's chosen method is important. An in-person visit, telephone call, or electronic communication gives her the opportunity to voice any concerns or problems. The availability of follow-up should be explained to the patient and documented in the record, and she should be provided with office phone numbers and email information

(if applicable) for ease of communication. The initial encounter and follow-up visits should include continual reassessment of sexual concerns, behavior, relationships, prevention strategies, and testing and treatment for STIs per CDC guidelines (36).

For More Information

The American College of Obstetricians and Gynecologists has identified additional resources on topics related to this document that may be helpful for ob-gyns, other health care providers, and patients. You may view these resources at [www.acog.org/More-Info/Adolescent Contraception](http://www.acog.org/More-Info/Adolescent-Contraception).

These resources are for information only and are not meant to be comprehensive. Referral to these resources does not imply the American College of Obstetricians and Gynecologists' endorsement of the organization, the organization's website, or the content of the resource.

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ISSN 1074-861X

The American College of Obstetricians and Gynecologists
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Counseling adolescents about contraception. Committee Opinion No. 710. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2017;130:e74–80.

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