Pediatricians should be active participants in the effort to reduce the negative consequences of adolescent sexual activity. Preventive measures include counseling teenagers and their families on responsible sexual decision-making, including abstinence, and providing contraceptive services for sexually active patients, when requested. In previous statements, the American Academy of Pediatrics has addressed the impact of adolescent pregnancy, counseling the pregnant adolescent, and management of sexually transmitted diseases. This statement provides information on adolescent sexual and contraceptive behavior, and it presents guidelines for counseling teenagers on sexual activity and contraceptive methods, including abstinence. Because of differences in the needs and circumstances of each adolescent, the practitioner should use these guidelines to develop an individualized approach suitable for young persons. Due to concern about acquired immunodeficiency syndrome, among other risks, a renewed emphasis on careful and informed decision-making regarding sexual activity is reflected in this revised statement.

ADOLESCENT SEXUAL AND CONTRACEPTIVE BEHAVIOR

Since 1970, there has been a distinct increase in the percentage of adolescents reporting nonmarital sexual activity. By 14 years of age, 10% to 20% of boys and 5% to 10% of girls report having had sexual intercourse. By 17 years of age, approximately half of all adolescents are reported to have had intercourse at least once. By 19 years of age, the majority are reported to have done so. The factors most strongly associated with age at first intercourse appear to be biology (age at onset of puberty), opportunity (dating behavior), peer group influences, personal expectations (academic achievement, educational goals, religiousness), and family characteristics (parental support and controls). In the United States, as in other Western countries, the average age at first intercourse among different cohorts of adolescents is between 15 and 17 years of age. Although there is variation in the frequency, regularity, and predictability of coitus among teenagers, it is important for health providers to recognize that middle to late adolescence is the time during which most young people become sexually active.

Although contraceptive use among sexually active teenagers has increased steadily since 1970, the majority of American adolescents are inconsistent users. Only 50% report using any method (withdrawal included) to prevent pregnancy at their first intercourse. Among sexually active girls, aged 15 to 17 years, surveyed in 1982, almost 15% said they “never use” contraception and 40% said they use contraception only “sometimes.” Teenaged girls tend to rely on their male partners for contraceptive methods (withdrawal, condoms) during early sexual intercourse experiences and later adopt prescription methods. The average delay between first intercourse and the first visit for medical consultation is about 1 year, and even then the first visit is often motivated by a pregnancy scare. Of teenagers who consistently use contraception, about 70% use birth control pills and 22% use condoms.

Among teenagers who do not want to be pregnant, reasons for nonuse of contraception or failure to seek medical consultation include real or perceived barriers to health care, fear of specific contraceptive methods or of the required pelvic examination, hesitancy to reveal or acknowledge sexual activity, and the sense of invulnerability characteristic of early and middle adolescence.

However, the finding that European and Canadian teenagers, at the same ages, use contraception more reliably than do United States youth suggests the problem may not be as much developmental age as social conditioning. Health care barriers may include the minor’s limited access to services, the
minors' limited resources to pay for services or supplies, and the health care provider's failure to offer contraceptive services as part of routine adolescent care. The latter may be related to the provider's belief that providing contraception will encourage sexual promiscuity or that withholding contraception will prevent sexual activity. Neither of these perceptions has been substantiated. Some clinicians may feel they lack the requisite skills to prescribe contraceptives. Others simply fail to include a sexual history as part of the routine office visit.

THE ROLE OF THE PEDIATRICIAN

Many teenagers will become sexually active while still under their pediatrician's care. Pediatric care givers are thus in a unique position to identify youth at risk and to assure that they receive needed services. All pediatricians who choose to see teenagers should be able to provide counseling about sexual behavior, education on contraceptive methods and prevention of sexually transmitted diseases, and assistance with access to family planning services, preferably in the office or, if necessary, by referral. Expansion of skills and office capabilities to provide routine reproductive health care for adolescents, including pelvic examinations, annual Pap tests, diagnoses of pregnancy, diagnoses and treatment of sexually transmitted diseases, and the prescription of contraceptives, is also encouraged. Pediatric care givers are encouraged especially to include adolescent males when discussing responsible sexual behavior. This issue warrants special attention, because boys often receive little or no sexual or reproductive health counseling.

COUNSELING ADOLESCENTS ABOUT CONTRACEPTION

Eliciting a sexual history should be a part of comprehensive care of adolescents. The physician can begin in the preteenage years by answering questions about puberty, providing anticipatory guidance, and offering booklets and sex education materials to the patient and family. After puberty, the history should include information on level of sexual interest, attitudes and knowledge about sexual behavior, degree of personal sexual activity, and use of contraception. These issues should be addressed with all adolescents, including those with chronic illnesses and/or physical and mental handicaps. By communicating honest, nonjudgmental interest, pediatricians can provide a safe, nonthreatening environment in which teenagers can acknowledge sexual concerns and experiences.

The following general principles should be considered by the health care provider for discussion with adolescents and with their families when appropriate.

Confidentiality and Consent

Care givers should be familiar with their own state laws, but in general, the adolescent's right to contraception has been upheld consistently in court either through specific statutes or the "mature minor" doctrine. Obtaining an accurate history about sexual behavior and health risks often requires assurance of confidentiality. A general policy guaranteeing confidentiality for the teenager except in life-threatening situations should be clearly stated to the parent and adolescent at the initiation of the professional relationship either verbally or in writing. This can prevent misunderstandings and promote acceptance of the teenager's rights.

The goal, however, from preteenage years on, should be to facilitate communication between the adolescent and the family and to enlist parental support for the adolescent's responsible sexual behavior (including contraceptive use) whenever possible.

Sexual Decision-Making

Fulfilling intimacy needs and becoming a sexually responsible individual is part of a normal developmental process beginning in adolescence. As teenagers become interested in dating, they need an opportunity to discuss sexual pressures, values, expectations, and options. Adolescents should be encouraged to postpone first intercourse until they are physiologically and psychosocially mature. The teenager who has decided to abstain from sexual intercourse should always be supported in this decision. The teenager who is contemplating or has initiated sexual intercourse should be actively educated about the inherent safety of abstinence, contraceptive methods, and protection against sexually transmitted diseases. Such discussions should also address the adolescent's reasons for initiating sexual activity and an exploration of the impact that such sexual activity might have on his/her relationships with partners and parents.

Sexual Responsibility

Without being morally judgmental, the pediatrician can help adolescents identify their own goals for safe and responsible sexual behavior (such as avoiding unintended pregnancy, sexually transmitted diseases, acquired immunodeficiency syndrome,
or psychological distress). Judgments based on health concerns are appropriate to the discussion between the pediatrician and the adolescent. Skillful counseling in this area is challenging, and the pediatrician must carefully weigh the desire to express personal opinion about "correct" behavior against the need to maintain a supportive, nonparental relationship in which the teenager feels accepted and safe from disapproval.

**Contraceptive Choices for Sexually Active Teens**

Although there is no ideal contraceptive method that is 100% effective in preventing both pregnancy and infection, free of any side effects, inexpensive, and unencumbered by forethought or planning, there are many methods suitable for use by teenagers. The best method for the adolescent and his or her partner is whichever effective method they will use correctly and consistently. The pediatrician should be familiar with standard contraceptive methods and be prepared to reevaluate the patient's needs as appropriate. Currently available contraceptives are medically safe and effective, especially when compared to the risks of early teenage pregnancy. However, myths and misinformation are common, and caregivers should be prepared to address these. The discussion of contraceptive choices should also include plans for prevention of sexually transmitted diseases.

**METHODS OF CONTRACEPTION**

Abstinence is the most effective means of birth control. In addition to abstinence and the use of noncoital forms of intimacy, the most recommended methods of contraception for teenagers are condoms used with spermicides and oral contraceptives. Pediatricians who provide contraceptive services, and all teenagers who are or may become sexually active, should understand the availability, correct use, risks, and benefits of the following methods. Recent reviews and protocols for prescribing and managing contraception are available.

The following comments focus on appropriateness of the various methods for adolescents.

**Nonprescription Methods**

**Condoms.** The condom is a mechanical barrier. The effectiveness of this birth control method is enhanced by use with a spermicide, as noted below. Condoms deserve special mention for several reasons. Latex condoms are the best way, short of abstinence, to prevent spread of sexually transmitted infections, including those caused by *Chlamydia trachomatis, Neisseria gonorrhoeae, Treponema pallidum* (syphilis), human immunodeficiency virus, herpes simplex virus, *Trichomonas vaginalis,* and human papilloma virus. Latex condoms should be recommended even when the female adolescent is using oral contraceptives, especially if there may be multiple sexual partners. Condoms are the only medical method available for use by the adolescent male, who should be encouraged to share responsibility for preventing adverse health consequences.

**Spermicides Plus Condoms.** The intravaginal spermicide Nonoxynol-9 is available in a wide range of forms, including foam, gel, cream, suppository, film, and the vaginal sponge. All forms need to be reapplied with each subsequent act of intercourse except for the sponge, which is effective for 24 hours. When spermicides are used alone, the birth control failure rate is relatively high, but when spermicides are used with a condom at every intercourse, the birth control effectiveness approaches that of oral contraceptives. In addition, the combination of spermicide plus condom provides protection against sexually transmitted diseases. This method deserves strong consideration for teenagers, especially those with infrequent sexual activity.

**Prescription Methods**

**Oral Contraceptives.** Oral contraceptives are the method chosen by most sexually active young women who seek medical consultation. Although the most effective in the prevention of pregnancy, oral contraceptives are not a protection against contracting sexually transmitted diseases. Physicians should perform a complete gynecological examination before prescribing the pill. A low-dose pill containing 30 to 35 μg of estrogen and 0.15 to 1.5 mg of progestin should be chosen. The standard pack containing 21 days of hormone pills and 7 days of placebo pills has been used widely and successfully with teenagers for many years. The newer triphasic packs with varying levels of hormone on different cycle days are also suitable. Minor side effects from birth control pills usually resolve spontaneously in two or three cycles. Caregivers should familiarize themselves with full prescribing information in the resources that are readily available.

**Diaphragm and Cervical Cap.** The diaphragm used with spermicide is an effective barrier method. Teenagers have been shown to be effective users if highly motivated and carefully instructed. However, long-term discontinuation rates are high. The technique of diaphragm fitting is easily learned, and excellent resources for clinical instruction are
available in most community and university family planning and adolescent clinics. The cervical cap is also a barrier method requiring fitting. However, the technique is more difficult, and it is not currently in wide use in this country. Use of these methods with a condom increases contraceptive effectiveness and prevention of sexually transmitted diseases.

Depo-Provera. An intramuscular injection of me-droxyprogesterone acetate (Depo-Provera) every 3 months, although used in many parts of the world, has had limited use in this country. Its primary use in the United States has been for sexually active or vulnerable mentally retarded young women unable to use other methods. When used in these patients, consultation with a gynecologist is recommended.

Other Methods

Most other methods of contraception have limited usefulness for teenagers but deserve some comment.

Most intrauterine devices were withdrawn from the market in 1985 to 1986 due to concerns about serious pelvic infections and subsequent liability issues. Although now reappearing, the revised contraindications exclude most teenagers from consideration.

"Natural" methods of periodic abstinence and fertility awareness are unreliable and too complicated for most adolescent couples, but they might be considered when religious convictions or other concerns preclude other choices.

Withdrawal, the male partner's attempt to withdraw before ejaculation, is widely used by teenagers for contraception, especially early in the sexual relationship. All adolescents should be informed that withdrawal has a high failure rate in the prevention of pregnancy and does not prevent transmission of infection.

Future developments and technology, such as long-acting subcutaneous progestin implants, are being tested and may have a substantial impact on adolescent contraception in the future.

Follow-up

Careful follow-up is important in maximizing compliance for all methods of contraception. Regardless of the method of contraception used, such follow-up should also include periodic assessment for the presence of a sexually transmitted disease and annual cervical cytology (Pap test). Frequent follow-up with the pediatrician or office staff should ensure that the adolescent receives the ongoing support, reinforcement, and personal guidance needed to enhance motivation and consistent use. Parental support, if present, is especially helpful.

RECOMMENDATIONS

1. Pediatric care givers should help prepare parents to be effective sex educators for their children, encouraging them to communicate factual knowledge, family values, and behavioral expectations throughout childhood and especially during the critical transition years into early adolescence.

2. By adolescence, families and health providers should ensure that all young people understand the health and social consequences of sexual activity and are well prepared to make responsible sexual decisions. This includes having the knowledge, skills, and resources to postpone sexual intercourse until they reach maturity and to use effective contraceptive methods to prevent pregnancy and sexually transmitted diseases when they do choose to become sexually active.

3. Pediatricians who take care of adolescents have the opportunity and responsibility to address this population's unmet needs for sexual counseling and contraception. Routine adolescent care includes taking a sexual history, identifying teenagers at risk, and assuring they receive necessary birth control services.

4. Office counseling skills, protocols, and policies of the pediatrician and staff should be developed to ensure to the teenager a supportive, nonthreatening, confidential relationship in which the care giver can convey goals of personal responsibility and the teenager can feel comfortable discussing sexual concerns and requesting birth control if needed.

5. Pediatricians, with specific training if necessary, should be competent and well suited to provide basic adolescent family planning services. When contraceptive methods are prescribed, close follow-up to enhance compliance is essential, with sufficient time allowed for counseling, education, problem-solving, and periodic reassessment either with the physician or support staff.

The consequences of teenage pregnancy, sexually transmitted diseases, and acquired immunodeficiency syndrome add urgency to the need to help teenagers make informed, responsible sexual decisions. Pediatricians are encouraged to update their skills and information about sexuality and contraception so they can develop an approach to adolescent patients and their families that is comfortable, realistic, and consistent with their professional obligations.
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