CLINICAL REPORT Guidance for the Clinician in Rendering Pediatric Care

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Sexual and Reproductive Health Care Services in the Pediatric Setting

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Pediatricians are an important source of health care for adolescents and young adults and can play a significant role in addressing their patients' sexual and reproductive health needs, including preventing unintended pregnancies and sexually transmitted infections (STIs), including HIV, and promoting healthy relationships. STIs, HIV, and unintended pregnancy are all preventable health outcomes with potentially serious permanent sequelae; the highest rates of STIs, HIV, and unintended pregnancy are reported among adolescents and young adults. Office visits present opportunities to provide comprehensive education and health care services to adolescents and young adults to prevent STIs, HIV, and unintended pregnancies. The American Academy of Pediatrics, other professional medical organizations, and the government have guidelines and recommendations regarding the provision of sexual and reproductive health information and services. However, despite these recommendations, recent studies have revealed that there is substantial room for improvement in actually delivering the recommended services. The purpose of this clinical report is to assist pediatricians to operationalize the provision of various aspects of sexual and reproductive health care into their practices and to provide guidance on overcoming barriers to providing this care routinely while maximizing opportunities for confidential health services delivery in their offices.

abstract

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INTRODUCTION

Pediatricians are an important source of health care for adolescents and young adults, especially younger adolescents, and can play a significant role in continuously addressing sexual and reproductive health needs during adolescence and young adulthood, including preventing unintended pregnancies and sexually transmitted infections (STIs) and promoting healthy relationships.[1] The provision of needed sexual and reproductive health care services may not be feasible in a single visit; the services might need to be delivered over the course of several visits depending on the need(s) of the individual patient.

Primary care pediatricians care for sexually active adolescents and young adults who have sexual and reproductive health care needs. An estimated 45% of 15- to 19-year-old male and female youth in the United States report having had vaginal intercourse with an opposite-sex partner, 2.5% of 15- to 19-year-old male youth report having had oral or anal sex with another male, and 11% of 15- to 19-year-old female youth report having had a sexual experience (including oral sex) with another female.[2] Sixty-five percent of reported *Chlamydia* and 50% of reported gonorrhea cases occur among 15- to 24-year-olds.[3] Teen-aged birth rates in the United States have declined to the lowest rates seen in 7 decades yet still rank highest among industrialized countries. Pregnancy and birth are significant contributors to high school dropout rates among female youth; only approximately 50% of teen-aged mothers earn a high school diploma by 22 years of age versus approximately 90% of females who did not give birth during adolescence.[4] Child sex trafficking and commercial sexual exploitation of children (CSEC) is increasingly being identified as a public health problem in the United States, and victims of sex trafficking and CSEC may present for medical care for a variety of reasons related to infections, reproductive issues, and trauma and mental health.[5]

Pediatricians are an important source of information on sexuality and sexual and reproductive health for adolescents and young adults. Office visits present opportunities to educate adolescents on sexual health and development; to promote healthy relationships and to discuss prevention of STIs including HIV, unintended pregnancies, and reproductive health-related cancers; to discuss planning for the timing and spacing of children, planning for pregnancy, and delivering preconception health care, as appropriate; and to address issues or concerns related to sexual function and fertility.[6] Pediatricians can help adolescents sort out whether they feel safe in their relationships as well as how to avoid risky sexual situations. Pediatricians also can facilitate discussion between the parent and adolescent on sexual and reproductive health.[6] Pediatricians are in an important position to identify patients who are at risk for immediate harm (eg, abuse, sex trafficking, CSEC) and work collaboratively as part of a team of professionals from a number of disciplines to address these needs.

National guidelines and recommendations exist regarding the provision of sexual and reproductive health information and services for both male and female adolescents and young adults. The American Academy of Pediatrics (AAP) recommends that pediatricians provide confidential time during health maintenance visits to discuss sexuality, sexual health promotion, and risk reduction.[7,8] Both the AAP and the Society for Adolescent Health and Medicine support adolescents' universal access to the receipt of sexual and reproductive health care.[9] The Centers for Disease Control and Prevention (CDC) and the Office of Population Affairs (OPA) released national guidance on providing quality family planning services,[10,11] and the CDC has several guidance documents, including guidance on medical eligibility criteria for contraception use,[12] selected practice recommendations for contraception use,[13] STI treatment,[14] HIV testing and treatment,[15] and preconception health.[16] More than a dozen AAP clinical reports and policy statements provide guidance on sexual and reproductive health care services and counseling for adolescents and young adults (Table 1).[5,17–35] However, despite these recommendations, recent studies have revealed that there is substantial room for improvement in delivering the recommended services. In a sample of sexually experienced adolescents from the National Survey of Family Growth, only one-third reported receipt of information on contraception and STI and/or HIV prevention from their health care provider.[36] In an AAP survey of pediatricians, although most (86%) reported discussing puberty and reproductive health and two-thirds reported discussing abstinence, contraception, and condom use with their adolescent patients, only 18% reported discussing issues of sexual orientation and gender identity.[37] In addition, in an observational study, although 65% of adolescents had some discussion of sexual issues during an office visit, the average amount of time spent discussing sexuality was 36 seconds.[38] The purpose of this clinical report is to assist pediatricians to operationalize the provision of various aspects of sexual and reproductive health care into their practices and to provide guidance on overcoming barriers to providing this care routinely in their offices.

Sexual and reproductive health is defined by the 1994 Cairo United Nations International Conference on Population and Development and World Health Organization as being "a state of physical, mental, and social well-being and not merely the absence of disease, dysfunction, or infirmity, in all matters relating to the reproductive system, its functions, and its processes."[39,40] The definition also states that sexual health requires a positive, respectful approach to sexuality and sexual relationships that are free of coercion, discrimination, or violence. Achieving and maintaining healthy sexuality involves managing the many physical, social, and emotional changes experienced during adolescence and young adulthood. Successful navigation of this normal

TABLE 1 AAP Publications Related to Sexual and Reproductive Health Care

Addendum—adolescent pregnancy: current trends and issues	*Pediatrics*. 2014;133(5):954–957
Adolescents and HIV infection: the pediatrician's role in promoting routine testing	*Pediatrics*. 2011;128(5):1023–1029
The adolescent's right to confidential care when considering abortion	*Pediatrics*. 2017;139(2):e20163861
Care of adolescent parents and their children	*Pediatrics*. 2012;130(6):e1743–e1756
Care of the adolescent after an acute sexual assault	*Pediatrics*. 2017;139(3):e20164243
Child sex trafficking and commercial sexual exploitation: health care needs of victims	*Pediatrics*. 2015;135(3):566–574
Condom use by adolescents	*Pediatrics*. 2013;132(5):973–981
Contraception for adolescents (policy statement)	*Pediatrics*. 2014;134(4):e1244–e1256
Contraception for adolescents (technical report)	*Pediatrics*. 2014;134(4):e1257–e1281
Diagnosis of pregnancy and providing options counseling for the adolescent patient	*Pediatrics*. 2017;140(3):e20172273
Emergency contraception	*Pediatrics*. 2012;130(6):1174–1182
Confidentiality protections for adolescents and young adults in the health care billing and insurance claims process	*J Adolesc Health*. 2016; 58(3): 374–377
Expedited partner therapy for adolescents diagnosed with *Chlamydia* or gonorrhea: a position paper of the Society for Adolescent Medicine; (endorsed by the AAP)	*J Adolesc Health*. 2009;45(3):303–309; endorsement in *Pediatrics*. 2009;124(4):1264
AAP. Clinical report–gynecologic examination for adolescents in the pediatric office setting	*Pediatrics*. 2010;126(3):583–590
Male adolescent sexual and reproductive health	*Pediatrics*. 2011;128(6):1658–1676 (reaffirmed May 2015)
Office-based care for lesbian, gay, bisexual, transgender, and questioning youth: policy statement	*Pediatrics*. 2013;132(1):198–203
Office-based care for lesbian, gay, bisexual, transgender, and questioning youth: technical report	*Pediatrics*. 2013;132(1):e297–e313
Options counseling for the pregnant adolescent patient (policy statement)	*Pediatrics*. 2017;140(3):e20172274
Screening for nonviral sexually transmitted infections in adolescents and young adults	*Pediatrics*. 2014;134(1):e302–e311
Sexuality education for children and adolescents	*Pediatrics*. 2016;138(2):e20161348
Standards for health information technology to ensure adolescent privacy	*Pediatrics*. 2012;130(5):987–990
Use of chaperones during the physical examination of the pediatric patient	*Pediatrics*. 2011;127(5):991–993

developmental task involves the receipt of medically accurate, developmentally appropriate, and comprehensive sexual and reproductive health education and barrier-free access to related clinical services[41] that is declared by the United Nations to be a basic right for all people, including adolescents and young adults.[42]

CONFIDENTIALITY AND CONSENT TO SEXUAL AND REPRODUCTIVE HEALTH CARE

Providing the opportunity to address sexual and reproductive health topics confidentially is important in the pediatric office setting. When confidentiality is promoted, especially over multiple visits, adolescents are more likely to access health care; communicate about sensitive topics regarding behaviors, partners, or gender issues; and return for care.[43] Lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth may need multiple visits before they disclose their identity, so making the office more LGBTQ friendly may provide social signals that the pediatrician is a safe and sympathetic person to whom youth can make sensitive disclosures, especially because many transgender-identified people experience significant discrimination in health care settings.[44] The availability of confidential services does not disrupt communication between adolescents and their parents about their health.[6] The AAP recommends that pediatricians have an office policy that explicitly describes confidential services and that pediatricians discuss confidentiality with all parents and adolescents and post the policy in a visible location in the office.[34] As outlined in *Bright Futures*, beginning with the 11- to 14-year-old patient visits, the pediatrician should explain the office confidentiality policy to the adolescent and parent at the onset of the visit, which includes providing the adolescent time alone with the pediatrician. The pediatrician should also include examples of circumstances when confidentiality would be breached, such as concerns about sexual or physical abuse or disclosure of suicidal or homicidal thoughts.[7] This provides opportunity for confidential sexual and behavioral health risk history and counseling to help build the therapeutic alliance.

Consent and confidentiality laws vary from state to state, and providers should be familiar with laws in the states in which they practice.[45] The Guttmacher Institute and the Center for Adolescent Health and the Law provide resources summarizing the laws for each state.[46,47] All 50 states allow minors to consent for STI testing and treatment. Many states define conditions in which an adolescent is considered emancipated, such as service in the military or being married. It is also useful for health care professionals to be aware of the challenges new technologies present to providing confidentiality, as outlined in several recent publications,[9,22,48] including electronic health records (EHRs), mobile devices, patient portals, billing practices, and receipt of explanations of benefits from health plans, and should counsel adolescent and young adult patients about these risks. In many instances, EHRs provide more security than do paper charts, because they offer a separate section in which to place

sensitive information. The discussion regarding confidentiality can be a teachable moment to encourage adolescents and young adults to discuss sexuality and sexual health concerns with their parents, if possible. Increased awareness of community clinical resources will assist providers in referring patients who are not willing to risk potential disclosure of confidential services through EHRs or billing statements. Title X clinics, funded by the Office of Population Affairs of the US Department of Health and Human Services, provide high-quality, cost-effective family planning and preventive services for low-income women and men as well as for youth seeking confidential care (a search tool for clinics is available at: http://www.hhs.gov/opa/title-x-family-planning/initiatives-and-resources/title-x-grantees-list/).[49] The CDC offers a search tool for STI and HIV testing at: https://gettested.cdc.gov/.

THE OFFICE VISIT

Office Environment

It is important that the office culture reflects adolescents' and young adults' health needs to reduce barriers in accessing care and make the setting more youth friendly. Offering extended office hours that are convenient to adolescents and young adults improves access to care. Staff, including reception and nursing, should be trained to be friendly and welcoming to teen-aged patients, especially those who present to the office unaccompanied or with variations in gender presentation. Office brochures should address common concerns, such as normal puberty, sexual development, sexual orientation, or gender identity; male health; making healthy decisions about sex; STIs; and contraception and dealing with teen-aged pregnancy, in addition to other medical concerns such as acne and safety. A separate waiting area with age-appropriate magazines and other media can make adolescent and young adult patients more comfortable in a pediatric office. The office may consider making free condoms available in discrete areas. Condom distribution has been shown to increase condom use.[50] This can contribute to helping make offices more male friendly. All office staff should be aware of office confidentiality policies and procedures.

Making Offices LGBTQ Friendly

Stigmatization, ostracism, and parental rejection remain common experiences for sexual minority youth. Resilient sexual minority youth do well especially when they have supportive home and school environments. The AAP encourages pediatricians to have offices that are teenager friendly and welcoming to sexual minority youth (for example, by using clinical forms and/or questionnaires allowing patients to write in their own gender, allowing differentiation between sex assigned at birth and affirmed gender[25]). Sexually active LGBTQ youth are at higher risk for STIs, including HIV, because of behavioral factors and disease prevalence in their sexual networks. Specific information on sexual health care for LGBTQ youth can be found in the AAP policy statement "Office-Based Care for Lesbian, Gay, Bisexual, Transgender, and Questioning Youth."[25]

Introducing Confidentiality and Time Alone

During the visit, it is advised that the provider acknowledge the adolescent as the primary patient, which can be facilitated by the provider introducing himself or herself to the patient before the parent, making eye contact with the adolescent, and having the adolescent seated (in clothing) next to the seated provider, rather than on the examination table, for the interview. With parent(s) present, it is helpful for the provider to review office confidentiality policies and the office visit structure that includes time alone with the adolescent patient and reassure the parent that any serious or life-threatening concerns will be disclosed. Providers should normalize this practice as part of the routine clinic procedures starting at the early adolescent visit to help the adolescent begin taking responsibility for his or her own health care. Ideally, policies and visit structure around confidentiality and private time should be discussed at an earlier visit. The 11-year-old visit, when immunizations are administered, is an ideal time to introduce this new visit structure and discuss the need and/or limits of confidentiality.

Involving Families

While parent(s) or guardian(s) are present in the room, the provider may find it useful to ask about their concerns and review the past medical history and family history because the adolescent or young adult may not know the details of this history. Involving families in the care of adolescents and young adults as much as possible is highly encouraged; for example, the provider can "wrap up" the visit with the parent or guardian for nonconfidential issues and/or, if the adolescent or young adult wishes, to disclose anything with the provider present for support. Time alone with parents also can be instrumental to address concerns or to have discussions about sensitive topics.

History Taking

After reviewing the nonconfidential information with the parent in the examination room, the parent should be asked to step out of the room so the provider can spend time alone with the adolescent or young adult to review sensitive history questions and allow the adolescent to ask questions he or she might not feel

comfortable asking or answering in front of the parent. Another strategy is to have a "counseling room" in which the adolescent or young adult's confidential history can be taken; this may be an effective strategy if the parent or guardian has other children in attendance. It is important for providers to develop a rapport with an adolescent or young adult beginning with review of the confidentiality of the interview. Providers can accomplish this by first describing the structure of the visit, which includes the interview, the examination and what it will entail, and the developing and sharing of the assessment and plan that will take into account the patient's health concerns. Next, a psychosocial history can be taken, with less sensitive screening questions first, such as asking about home, education, and activities before discussing more sensitive questions about sexuality, mental health, violence, and substance use. Some adolescents may be more comfortable with questionnaires to raise sensitive subjects,[7] and these may be useful to focus counseling topics in busy practices. A private area in which the adolescent can complete the questionnaire confidentially is necessary.

The following are interviewing techniques that providers may find useful.

1. Use of open-ended questions that avoid a yes or no response, such as: "How often do you use condoms?" rather than "Do you use condoms all the time?"
2. Reflection responses that mirror the patient's feelings: "It sounds like you have a hard time getting your partner to use condoms. Tell me about that."
3. Restatement of the patient's feelings or summarizing the interview, such as: "You are worried about using birth control pills because you think you will gain weight, but you want to be protected against pregnancy."
4. Clarification of a statement, asking: "What did you mean by that?"
5. Use of questions that may give the provider insight into the patient, such as: "What do you do outside of school?"
6. Offering reassuring statements, such as: "You have made the decision to wait to have sex, even if it seems like most of your friends are having sex now. It sounds like you are making the decision that is right for you."
7. Presenting supportive statements, such as: "That must have been hard for you."[51,52]
8. The use of gender-neutral language is important when talking to the adolescent patient; offering a menu of sexual orientation questions is a good idea, such as: "What types of sexual experiences have you had?" or "Have you dated/had sex with someone? If so, what was that person's (first) name?"

Puberty

Assess comfort with bodily changes and ask whether the adolescent has questions. Early adolescents usually want to know whether they are normal, middle adolescents often are more comfortable with body image but are concerned about attractiveness, and late adolescents have fewer concerns in this domain. Asking, "Do you have any concerns about how your body is developing?" is a good way to start the discussion.

Sexuality

Adolescents may find it more comfortable to ask or answer questions about sexuality if a normative statement is made by the pediatrician first, such as: "Many people your age begin to have attractions physically or romantically. Have you thought about that? Are you attracted to boys, girls, or both?" It is advised that the pediatrician use gender-neutral language when talking with the adolescent and offer a menu of sexual orientation options. For example, by using questions such as: "Have you dated/had sex with someone? What was that person's (first) name?" Providers should appreciate the stage of an adolescent's cognitive development and recognize variation in knowledge and sexual experiences when asking patients such questions. For example, for early adolescents, providers may want to be more direct in how they ask a question, because early adolescents will be more concrete in their thinking than older adolescents or young adults.

Providers should be aware of the fluidity of sexual development. Same-sex sexual activity may be exploratory and not consistent with ultimate sexual identity as gay/lesbian, heterosexual, or bisexual. Gender expression also may not align with sexual orientation. For example, a transgender youth who was assigned as male at birth and now identifies as a transwoman may be attracted to males, females, or both. Masturbation may occur with or without sexual contact with another person. The middle adolescent may begin to have sexual contact, which may include same-sex experiences. Relationships generally are monogamous but may be short lived (that is, "serial monogamy"). Sexual behaviors may include touching or oral, vaginal, or anal sex. The late adolescent and young adult often forms more intense relationships, typically with 1 partner, and most late adolescents are sexually active.

Sexual Health Assessment

It is helpful to ask the adolescent directly what behaviors are practiced ("What types of sexual experiences have you had?") rather than, "Are you sexually active?" because this can be interpreted in different ways. For

TABLE 2 The 5 P's: Partners, Prevention of Pregnancy, Protection From STDs, Practices, and Past History of STDs

1. Partners
   - "Do you have sex with men, women, or both?"
   - "In the past 2 months, how many partners have you had sex with?"
   - "In the past 12 months, how many partners have you had sex with?"
   - "Is it possible that any of your sex partners in the past 12 months had sex with someone else while they were still in a sexual relationship with you?"
2. Prevention of pregnancy
   - "What are you doing to prevent pregnancy?"
3. Protection from STDs
   - "What do you do to protect yourself from STDs and HIV?"
4. Practices
   - "To understand your risks for STDs, I need to understand the kind of sex you have had recently."
   - "Have you had vaginal sex, meaning 'penis in vagina sex'?" If yes, "do you use condoms: never, sometimes, or always?"
   - "Have you had anal sex, meaning 'penis in rectum/anus sex'?" If yes, "do you use condoms: never, sometimes, or always?"
   - "Have you had oral sex, meaning 'mouth on penis/vagina'?"

   For condom answers
   - If "never:" "why don't you use condoms?"
   - If "sometimes:" "in what situations (or with whom) do you not use condoms?"
5. Past history of STDs
   - "Have you ever had an STD?"
   - "Have any of your partners had an STD?"

   Additional questions to identify HIV and viral hepatitis risk include
   - "Have you or any of your partners ever injected drugs?"
   - "Have any of your partners exchanged money or drugs for sex?"
   - "Is there anything else about your sexual practices that I need to know about?"

Adapted from Workowski KA, Bolan GA; Centers for Disease Control and Prevention. Sexually transmitted diseases treatment guidelines, 2015. *MMWR Recomm Rep.* 2015;64(RR-03):1–137.

example, the CDC suggests the 5 P's framework for a provider to obtain a sexual history (Table 2): Partners, Prevention of pregnancy, Protection from sexually transmitted diseases (STDs), Practices, and Past history of STDs.[53]

Reproductive Life Plan

Pediatricians can assess whether adolescents have a reproductive life plan[10] by asking questions such as: "Have you ever been/made someone pregnant/are you (your partner) currently pregnant? Do you want to have children (or more children)? How many children (or more children) would you like to have and when?"

Sexual Assault and Abuse

Adolescents and young adults 12 to 34 years of age have the highest rates of rape and sexual assault.[54] Questions for teenagers and young adults should include whether they were ever touched by anyone in a way that made them uncomfortable, whether they have ever been forced to engage in sexual contact and activities they did not want, or whether they have ever been "date raped." Providers must comply with state mandatory reporting guidelines regarding abuse, rape, and incest.[55]

Providers may choose to use evidence-based approaches for intimate partner abuse screening, such as using the Hurt, Insult, Threaten, Scream method.[56] Refer to the AAP statements "Care of the Adolescent Sexual Assault Victim" and "Child Sex Trafficking and Commercial Sexual Exploitation," as relevant, for additional information.[5,27]

Sexual Problems

Problems with sexual function are not uncommon, can be distressing, and are not necessarily shared with adolescents' health care providers. These problems can be related to substance use as well as certain classes of medications (eg, selective serotonin reuptake inhibitors). Any difficulty with intercourse or problems when having sex should be assessed among sexually active patients.[57]

Nicotine, Alcohol, and Other Drug Use

Assessing nicotine, alcohol, and other drug use may be important because use of tobacco and other substances can affect an individual's sexual and reproductive health.[10] Nicotine can lead to negative reproductive outcomes, and alcohol and other drug use before and during sex may lead to lack of condom use, risk for STI and/or HIV acquisition, and/or unintended pregnancy as well as problems with sexual function.

Mental Health

Assessing mental health may be important because certain adolescent populations may be at increased risk for depression, including those struggling with family rejection or other violence because of sexual orientation[44] or gender identity; experiencing stress during the coming-out process, such as loss of social support and homelessness; experiencing a relationship breakup; or struggling with self-esteem.[10] In addition, certain classes of antidepressants and illicit substance use may lead to problems with sexual function.

Physical Examination

The physical examination should be performed by the provider in the examination room with a chaperone present.[33] The adolescent can have the option of his or her parent or guardian remaining in the room or stepping out, which may depend on the extent of the examination, parental involvement, and nuances pertaining to appropriate chaperonage, applicable state laws and regulations, etc. Office policies on the use of chaperones should comport with existing AAP recommendations.[33] The provider should describe what areas of the body will be examined and that if, at any point, the patient is uncomfortable with the examination, he or she can tell the provider to stop. Ideally, the provider asks the adolescent to change into a gown with his or her underwear still on. Because some adolescents, both male and female, may not feel comfortable totally disrobing, the option to be partially clothed can also be offered, and the provider can disrobe each body part as needed to be examined.

Breast and Genital Examination

The breast examination should include documentation for sexual maturity rating.[58] Evaluation for masses should occur if there is clinical suspicion or patient concern. The genital examination should, likewise, include documentation of sexual maturity rating for hair and genitals, external lesions, vaginal or penile discharge, and masses. Teaching about normal and abnormal breast and genital findings can help an adolescent learn about his or her own body and changes through puberty. Additional information on the male genital examination is available in the AAP clinical report "Male Adolescent Sexual and Reproductive Health Care"[20] as well as the Society for Adolescent Health and Medicine position article on the male genital examination,[59] and information on the female pelvic examination is available in the AAP clinical report "Gynecologic Examination for Adolescents in the Pediatric Office Setting."[24]

Blood Pressure

Cardiovascular disease can lead to negative reproductive outcomes, so taking blood pressure is recommended before initiation of hormonal contraception.[10] Blood pressure should be assessed annually for adolescents.

BMI

Obesity can lead to negative reproductive outcomes.[10] BMI should be assessed annually for adolescents.

Laboratory Tests

STI Tests

The AAP recommends annual *Chlamydia* and gonorrhea screening of all sexually active females.[21] For heterosexual adolescent and young adult males, the AAP recommends considering annual *Chlamydia* and gonorrhea screening on the basis of individual and population-based risk factors, consistent with CDC guidance.[21] Specific AAP recommendations for nonviral STI screening are provided in the AAP policy statement "Screening for Nonviral Sexually Transmitted Infections in Adolescents and Young Adults."[21] Information about standard of care STI testing technologies are available from the CDC in its "STD Treatment Guidelines"[14] as well as "Recommendations for the Laboratory-Based Detection of *Chlamydia trachomatis* and *Neisseria gonorrhoeae*—2014" available at: www.cdc.gov/std/laboratory/2014labrec/default.htm. Adolescents can consent to STI testing and treatment in all 50 states without parental consent.

The routine screening of nonpregnant, heterosexual adolescents and young adults for other STIs, including syphilis (except in areas where there are high endemic rates), human papillomavirus (HPV), and genital herpes, is not recommended. Routine trichomonas screening of asymptomatic adolescents is not recommended. However, the AAP and the CDC advise that individual and population-based risk factors may put females at higher risk of infection that may warrant screening.[14,21] Routine screening for hepatitis B virus infection is recommended for adolescents and young adults at high risk, including those at high risk who have been previously vaccinated.[60] Males who have sex with males (MSM) are at high risk for urethral and rectal *Chlamydia*; oral, urethral, and rectal gonorrhea; syphilis; and hepatitis B and hepatitis C virus infections. Providers should consider screening young MSM reporting behaviors that can increase their risk of STIs or HIV (eg, multiple sexual partners, anonymous sex, frequent partner changes, or unprotected oral or anal sex) more frequently, such as every 3 to 6 months. LGBTQ youth should be tested for STIs and/or HIV according to the AAP guidance in "Office-Based Care for Lesbian, Gay, Bisexual, Transgender, and Questioning Youth" as well as CDC recommendations.[14,25]

The AAP recommends routinely offering HIV screening to all adolescents at least once according to CDC guidelines. Youth at increased risk, such as MSM or teenagers having unprotected vaginal or anal sex, should be tested for HIV annually, and preexposure prophylaxis should be offered according to CDC guidelines.[61] Specific HIV screening recommendations are provided in the AAP policy statement "Adolescents and HIV Infection: The Pediatrician's Role in Promoting Routine Testing."[26] Some state laws mandate HIV screening at a certain age or require specific consent procedures.

Pediatricians can inquire with their state or local health department about these laws.

When possible, single-dose treatment and directly observed therapy for simple STIs (eg, urethritis, cervicitis) is recommended to promote compliance but is not recommended for more complicated STIs (eg, pelvic inflammatory disease, epididymitis). Patients should inform their partners about their infection and the need for full STI evaluation. In some states, expedited partner therapy (EPT), the clinical practice of treating the sex partners of patients diagnosed with an STI by providing prescriptions or medications to the patient to provide to his or her partner without the health care provider first examining the partner, is legally permissible. Information on which states allow, permit, or prohibit EPT can be obtained from the CDC Web site.[62] As part of an EPT program, it is recommended that providers seeing adolescents include educational and STI counseling materials detailing partner medication indication, instructions, and warnings; referral to a local testing center for complete STI evaluation; and instructions to abstain from intercourse for 7 days after treatment.[35,62]

Cytologic screening for cervical cancer is recommended to begin at 21 years of age and continue every 3 years among 21- to 29-year-olds.[63] For immunocompromised female patients, including female patients infected with HIV, the CDC recommends cytologic screening should begin within 1 year of the onset of sexual activity but no later than 21 years of age and be conducted annually.[64]

Pregnancy Test

Providers should be able to provide pregnancy testing for adolescents, preferably on-site. Guidance for pregnancy testing and follow-up care based on results can be found in AAP statements[23,28] and in the CDC/OPA providing quality family planning services recommendations.[10]

Immunizations

The AAP and the Advisory Committee on Immunization Practices of the CDC recommend routine HPV immunization for all 11- and 12-year-olds and catch-up vaccination for adolescents and young adults 13 through 26 years; immunization to protect young people against hepatitis A and B viruses; and completion of the measles, mumps, and rubella vaccine series, especially for reproductive-aged females. Specific information on the HPV, hepatitis A and B virus, and measles, mumps, and rubella immunization schedules are available in the "Recommended Childhood and Adolescent Immunization Schedule" at http://redbook.solutions.aap.org/SS/Immunization_Schedules.aspx.

Counseling

Comprehensive education about abstinence and contraception delays the onset of sexual behavior, decreases the number of sexual partners, and improves the use of contraception.[9,30,65] When seeing an adolescent who is not contemplating sexual behavior in the near future, providers should reinforce the adolescent's decision to be abstinent as a healthy choice. If the adolescent is sexually active or contemplating sexual behavior, it is important to provide counseling on safe sexual behavior, including use of condoms and contraception (preferably highly effective long-acting reversible contraceptive [LARC] methods), and recommended routine sexual and reproductive health care services, including recommended STI and HIV screening. Pediatricians can counsel their patients on good partner choices, such as choosing a partner who respects their personhood, capacity for consent, and desire for condom or other contraceptive use. Patient-centered counseling, such as motivational interviewing, is the most effective approach to provide individual counseling about sexual and reproductive health topics. Information about motivational interviewing for sexual health counseling is described in the AAP technical report "Contraception for Adolescents."[32] Pediatricians also can encourage parents and guardians to have age-appropriate, nonjudgmental discussions about sexual and reproductive health with their adolescents.

STI Risk Reduction

Moderate- to high-intensity behavioral counseling about STI prevention is recommended annually for all sexually active adolescents and young adults who are at increased risk.[66] For example, this can consist of 2 separate 20-minute clinical sessions, 1 week apart. During the first session, a patient is assessed for personal risk and barriers to risk reduction, and a small risk-reduction step is identified to minimize this risk within 1 week. During the second session, the previous week's behavioral change successes and barriers are reviewed, support for changes made is provided, barriers and facilitators to change are identified, and a long-term plan for risk-reduction is developed. Coding and local reimbursement practices allow for preventive health care counseling to be included within problem-focused visits. The CDC offers STI informational brochures, infographics, and fact sheets in multiple languages that are free to download at www.cdc.gov/std/products/default.htm.

Contraception, Including Condoms

It is important to continually assess all patients' need for contraceptive services, including patients identifying as LGBTQ. Regarding contraception counseling, providers can refer to detailed AAP reports on contraception,[32] condoms,[19] and emergency contraception[18]

as well as guidance from the CDC/OPA on family planning services,[10] the CDC "US Medical Eligibility Criteria for Contraceptive Use,"[12] and CDC "US Selected Practice Recommendations for Contraceptive Use."[13] Pediatricians should counsel about and ensure access to a broad range of contraceptive services for their adolescent patients. This includes educating patients about all contraceptive methods that are safe and appropriate for them and describing the most effective methods first. Pediatricians should be able to educate adolescent patients about LARC methods, including the progestin implant and intrauterine devices. Given the efficacy, safety, and ease of use, LARC methods should be considered first-line contraceptive choices for adolescents.[17] Encouraging the adolescent or young adult to involve a parent can be helpful for contraceptive compliance; however, many adolescents will desire to obtain contraceptive services confidentially. Many adolescents are able to share information about contraception with parents and, likewise, parents with children. For those who cannot, discussion should include what the teenager would do if the parent were to find out. Parents may be distressed by discovery of their teenager's use of contraception. It is important to express empathy while also reinforcing that their daughter's or son's decision to use contraception is a healthy one. If contraceptive counseling and prescribing is not a part of the primary care clinician's practice, he or she needs to refer adolescent and young adult patients to alternative sites where these services are available, such as a family medicine physician, obstetrics-gynecology office, school health service, local health department, Planned Parenthood, or Title X family planning clinic.

Pregnancy Desire

If patients are considering pregnancy, refer to the AAP clinical report "Care of Adolescent Parents and Their Children"[35] as well as guidance from the CDC on providing quality family planning services for recommendations on achieving a healthy pregnancy.[10]

Hygiene

It is prudent that female adolescents be advised against douching because it alters vaginal flora and increases the risk of bacterial vaginosis or hypersensitivity reactions. Male adolescents who are not circumcised should be instructed about ways in which they can clean under the foreskin. It is common practice for both male and female adolescents to shave pubic hair. For teenagers who shave, provide anticipatory guidance about how to prevent local inflammation and folliculitis, including trimming hair before shaving, using shaving cream or gel, and shaving with a new razor blade.[67] Guidance to teenagers on other pubic hair removal methods can be provided, including over-the-counter creams, waxing, laser hair removal, and electrolysis.

MINIMIZING BREACHES IN CONFIDENTIALITY

When providing confidential sexual and reproductive health care, it is useful for providers to be aware that explanations of benefits and other mechanisms for health plans to communicate billing and insurance claim information to policyholders have the potential to inadvertently violate confidentiality for minors or young adults insured as dependents on a parent's or guardian's health insurance policy.[68,69] Providers may consider taking steps to minimize such breaches (eg, use of confidential coding practices) or refer the individual to providers who have more experience in this area or who can provide confidential care (eg, Title X or health department clinics).[31]

The Health Insurance Portability and Accountability Act of 1996 (Pub L No. 104–191, 110 Stat, 1996) "Privacy Rule" provides standards to protect the privacy of protected health information (PHI). When a minor can consent to care under state or other laws, such as care for STIs or contraception, and when state law is silent on parental access to that portion of the minor's record, the minor's privacy is protected. When and to the extent that the parent agrees that the minor may have a confidential relationship with the pediatrician, the pediatrician may deny the parent access to the minor's PHI. However, the parent may revoke this agreement if state or other law requires or permits parental access.

The Health Insurance Portability and Accountability Act of 1996 also states that if there is no applicable state law about the parent's rights to access their children's PHI, pediatricians or other licensed health care providers may exercise professional judgment to provide or deny parental access to the records. Parental access to a minor's PHI is denied when a minor obtains health care services at the direction of a judge or a person directed by the court (ie, the mature minor doctrine). When the provider's professional judgment leads him or her to reasonably believe that the minor may be subjected to abuse or neglect or domestic violence or be otherwise endangered by the parent, the provider may deny the parent access to the minor's medical records.

Careful documentation of the provider's professional judgment regarding protecting the privacy of the minor's health information is important. The AAP recommends that pediatricians have an office policy about confidential services that includes PHI disclosures to parents or guardians and that pediatricians discuss and document

confidentiality with all parents and adolescent patients.[32] EHRs can assist in delineating parts of the medical records that are confidential from those that are not. It will be useful for providers to be aware of how to flag portions of the medical record that are confidential, especially when parents or other bodies request medical records that contain services and conversations that may be protected by state adolescent consent and confidentiality provisions. This is a challenging area that may require review by each practice and developing protocols that depend on state law.

CONCLUSIONS

Provision of sexual and reproductive health care is an essential part of well-rounded health care for adolescents and young adults. Pediatricians should be prepared to educate adolescents and young adults on sexual development and promote healthy behaviors in relationships and prevention of STIs and unintended pregnancies. Pediatricians should be prepared to address these issues with preventive counseling for adolescents and young adults and their parent(s) or guardian(s) and provide sexual and reproductive health services or a referral to a provider who can provide the services (eg, adolescent medicine specialists in-person or via telemedicine). Several relevant AAP documents (Table 1) provide extensive information about the topics summarized in this report and are recommended for review to facilitate sexual and reproductive health care delivery in office settings. Whether sexual and reproductive health care services are delivered across several visits or as part of a visit dedicated to addressing core sexual and reproductive health issues will depend on the need(s) of the individual patient. Tools are available for pediatricians to be up-to-date on coding and local reimbursement practices that allow for preventive health care counseling to be included within problem-focused visits (https://www.aap.org/en-us/professional-resources/practice-support/Pages/achieving-bright.aspx and https://www.aap.org/en-us/professional-resources/practice-support/Coding-at-the-AAP/Pages/Coding-Fact-Sheets.aspx).

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ABBREVIATIONS

AAP: American Academy of Pediatrics
CDC: Centers for Disease Control and Prevention
CSEC: commercial sexual exploitation of children
EHR: electronic health record
EPT: expedited partner therapy
HPV: human papillomavirus
LARC: long-acting reversible contraceptive
LGBTQ: lesbian, gay, bisexual, transgender, and questioning
MSM: males who have sex with males
OPA: Office of Population Affairs
PHI: protected health information
STD: sexually transmitted disease
STI: sexually transmitted infection

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