

# SEXUAL AND REPRODUCTIVE HEALTH CARE BEST PRACTICES FOR ADOLESCENTS AND ADULTS

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Focusing on  
contraception care  
and preventing,  
screening and testing  
for STIs and HIV







This guide sets forth best practices for sexual and reproductive health. It focuses on contraceptive care and the prevention, screening and testing of sexually transmitted infections (STIs) and HIV. It is intended as a reference tool for health care providers in settings such as Primary Care, Internal Medicine, Urgent/Emergency Care, Family Medicine, Pediatrics, Adolescent Health, Family Planning, Abortion Care, Gynecology, Labor and Delivery, Obstetrics/Maternal-Fetal Medicine and Pre/Postpartum Care. Providers are encouraged to meet these best practices while creating their own innovative health care quality improvement strategies that place patients' unique cultures, experiences and preferences at the center of care.

### **The following resources are useful supplements to this guide:**

- The Centers for Disease Control and Prevention (CDC)'s 2015 Sexually Transmitted Diseases Treatment Guidelines
- The CDC's United States Medical Eligibility Criteria (US MEC) for Contraceptive Use, 2010
- The U.S. Selected Practice Recommendations for Contraceptive Use, 2013

Find these and other reference materials under "Tools and Resources."



# Advancing Sexual and Reproductive Justice

The New York City Health Department envisions a city where all New Yorkers can safely express their sexuality and gender identity with dignity, possessing the knowledge, skills and resources to support healthy and fulfilling lives.

**Leading with a Sexual and Reproductive Justice approach means promoting every individual's human right to:**

- Decide if and when to have a child and the conditions under which to give birth
- Decide if and when to not have a child and the options for preventing or ending a pregnancy
- Parent the children they have with the necessary social supports in safe environments and healthy communities, and without threat of violence from individuals, organizations or the government
- Bodily autonomy or self-expression and agency free from any form of sexual or reproductive oppression

In addition to promoting evidence-based clinical practices, this guidance stresses a commitment to the above values.

*The Sexual and Reproductive Health Care Best Practices for Adolescents and Adults* were developed by the New York City Health Department and have been endorsed by:

- Association of Reproductive Health Professionals (ARHP)
- Heilbrunn Department of Population and Family Health, Mailman School of Public Health at Columbia University
- National Abortion Federation (NAF)
- New York Civil Liberties Union
- New York State American Academy of Pediatrics, Chapters 2 & 3
- NYC Health + Hospitals
- Physicians for Reproductive Health



# Policy and Practice Recommendations

## 1 Provide **patient-centered** and **culturally sensitive** care to assess and meet patients' sexual and reproductive health needs.

- A. Individuals and families make decisions about contraception, pregnancy, childbirth, breastfeeding and birth spacing in the context of many personal and cultural factors. Conduct **patient-centered care**—care guided by patients' unique circumstances and preferences—while offering unbiased, evidence-based information.
- B. Refrain from making assumptions about patients' sexual orientation and gender identity and expression based on external appearances. This information should come only from the patient. Recognize that self-identification and behaviors do not always align.
- C. Use culturally responsive language, including self-designated pronouns, to affirm patients' gender identity and expression. This applies to paper and electronic forms and medical records, to the fullest extent possible.

### Contraception Terms in this Guide:

Throughout this document, “hormonal IUDs” refers to any of the device trade names Mirena®, Skyla® and Liletta™. The term “non-hormonal IUD” refers to ParaGard®, also known as the copper IUD. Unless otherwise specified, “IUD” or “IUDs” refers to both hormonal and non-hormonal devices. “Implant” refers to Nexplanon®. Oral contraceptives (either combined hormonal or progestin-only types) refer to “the pill” or “pills,” and “the patch” refers to Ortho Evra®. The term “vaginal ring” refers to NuvaRing®, and “the shot” refers to the trade name Depo-Provera®, also known as the contraceptive injection, depo or DMPA.



- D. Ensure a private setting is made available for discussing patients' **sexual history** and sexual and reproductive health needs.
  - i. Robust, sensitive and inclusive sexual history-taking is crucial to determining the sexual and reproductive health needs of patients, particularly LGBTQ (lesbian, gay, bisexual, transgender, queer or questioning) patients, who may not volunteer relevant information as readily as heterosexual and cisgender patients.<sup>1-4</sup>
- E. Take a brief sexual history at every visit, beginning at age 12, to identify needs for education, counseling, contraception, STI and HIV screening and testing, and similar services.
- F. Take a comprehensive sexual history at least annually.<sup>5-10</sup>
- G. Use patient-centered, **trauma-informed counseling strategies** that support patients in making decisions free of **provider bias**, pressure or coercion.<sup>7, 8, 11, 12</sup>
- H. Routinely **assess** adolescent and adult female and male patients, including LGBTQ patients, for intimate partner violence, sexual abuse and assault. If a patient discloses these experiences, offer resources and treat the patient or refer for prompt treatment.
- I. Screen patients for **reproductive coercion** in their intimate relationships, and refer patients to appropriate resources.<sup>13-18</sup>
- J. Regardless of the initial reason for the visit, address any identified sexual and reproductive health needs on the day of service, without delaying until a follow-up visit.



## 2 Ensure the **confidentiality** of sexual and reproductive health care, including contraception provision.

- A. Provide **sexual and reproductive health services to adolescent patients** who are capable of consenting independently for such care without parental permission, in accordance with applicable laws and regulations.<sup>a</sup>
  - i. NY Pub. Health Law: § 2305(2); § 2504(3); § 2780(5); § 2781

<sup>a</sup> *NY Pub. Health Law § 2305(2)*: A licensed physician, or in a hospital, a staff physician, may diagnose, treat or prescribe for a person under the age of twenty-one years without the consent or knowledge of the parents or guardian of said person, where such person is infected with a sexually transmitted disease, or has been exposed to infection with a sexually transmitted disease.

*NY Pub. Health Law § 2504(3)*: Any person who is pregnant may give effective consent for medical, dental, health and hospital services relating to prenatal care.

*NY Pub. Health Law § 2780(5)*: "Capacity to consent" means an individual's ability, determined without regard to the individual's age, to understand and appreciate the nature and consequences of a proposed health care service, treatment, or procedure, or of a proposed disclosure of confidential HIV related information, as the case may be, and to make an informed decision concerning the service, treatment, procedure or disclosure.

*NY Soc. Serv. Law §350(1)(e)*: Any inconsistent provisions of this title notwithstanding, so long as federal law and regulations require, family planning services and supplies shall be offered and promptly furnished to eligible persons of childbearing age, including children who can be considered sexually active, who desire such services and supplies, in accordance with the regulations of the department. In order to maximize federal financial participation, the department may require that such services shall be furnished under title eleven of article five. No person shall be compelled or coerced to accept such services or supplies.

*NY Soc. Serv. Law 365-a(3)(d)*: Any inconsistent provisions of this section notwithstanding, medical assistance shall include: [...] (d) family planning services and supplies for eligible persons of childbearing age, including children under twenty-one years of age who can be considered sexually active, who desire such services and supplies, in accordance with the requirements of federal law and regulations and the regulations of the department. No person shall be compelled or coerced to accept such services or supplies.

See also, e.g., *42 USCA §1396d(a)(4)(C)*; *18 NYCRR §§463.1, 463.6 and 505.13*-applicants for or recipients of public assistance, recipients of Medicaid, and recipients of supplemental security income. See also *42 CFR §59.5(a)*- Title X family planning projects.

- ii. U.S. Code Title 42: §1396d(a)(4)(C)
  - iii. NY Soc. Serv. Law: 350(1)(e); 365-a(3)(d)
  - iv. NY Codes, Rules and Regulations Title 18: 463.1; 463.6; 505.13
  - v. Code of Federal Regulations Title 42: 59.5(a)
- B. Provide sexual and reproductive health services to all patients in accordance with applicable laws and regulations.<sup>19-21</sup>
- C. Protect all patients' confidentiality in administrative, (e.g., billing, appointment reminders, lab results reporting), registration and other front desk procedures.
- D. Routinely collect confidential contact information from patients.<sup>19, 20, 22</sup>
- E. Provide consenting patients with adequate time alone to discuss sexual and reproductive health and other potentially sensitive health topics.

### 3 Adhere to evidence-based guidance on **contraceptive counseling, provision and follow-up care.**

- A. Provide patient-centered counseling and education materials about the full range of FDA-approved contraceptive methods and STI and HIV **prevention** methods.



- B. Recommend dual method use—condoms for STI and HIV prevention and an additional contraceptive method that the patient determines is best for them.<sup>7,8</sup>
- C. Dispense or prescribe the full range of FDA-approved contraceptive methods (including condoms, oral contraceptive pills, the patch, the ring, the shot, IUDs and implants), and offer referrals for methods not available on site.<sup>7, 8, 23-26</sup>
- i. Provide on-site access to ample condoms that patients can take privately and without having to ask. Prescribe additional condoms to patients whose insurance will cover the cost.
  - ii. **Order** free male and female condoms from the New York City Health Department for dispensing in health care settings.
- D. Do not require pelvic examinations as a condition of contraception provision unless clinically indicated; **see also** recommendations regarding urine-based STI testing.<sup>7,8</sup>
- E. For patients who request an IUD and need STI testing, the IUD insertion should not be delayed while waiting for test results. The STI testing specimens can be collected during the IUD insertion.
- i. If the patient has elected to receive an IUD and the cervix shows signs of acute infection (e.g., purulent cervical discharge), treat the infection and delay IUD insertion.<sup>23, 25</sup> Offer alternative contraceptive methods until the infection is fully treated and the IUD can be safely inserted.
  - ii. IUDs may be safely used in patients with a history of ectopic pregnancy and/or STIs.<sup>23</sup>
- F. All methods of contraception, including IUDs and the implant, may be initiated the same day as the patient's visit ("Quick Start"), unless delaying insertion is clinically indicated or the patient does not want the method initiated the same day as the visit. Same-day contraception initiation is safe at any point during the menstrual cycle, as long as the provider is reasonably sure the patient is not pregnant.<sup>7,8, 25</sup>





- G. When prescribing contraceptives, offer the maximum supply as dictated by patient's third-party payer. Additionally, prescribe refills to last at least 12 months.<sup>25</sup> For Depo-Provera, an annual prescription includes one unit and three refills. For patients without insurance, see **Best Practice #5**.
- H. Recommend patients who initiate a contraceptive method to return for follow-up visits as indicated. Work with front desk/administrative staff to ensure that patients have the opportunity to schedule future follow-up appointments before they leave the office.<sup>25</sup>
- i. For adolescent patients who initiate any form of contraception, schedule a follow-up visit within one to three months, and schedule regular follow-up visits thereafter to discuss patients' satisfaction with method, adherence, side effects and complications.<sup>27</sup>
  - ii. For patients who initiate the IUD or implant, schedule post-insertion follow-up visits with a provider if indicated (e.g., if they encounter problems or side effects, have questions about the method or wish to change methods). Encourage patients to contact their provider if they have questions or concerns about side effects prior to the scheduled follow-up visit.
  - iii. For patients requesting an IUD or implant, ensure that they have information about device removal, including whether your facility offers removal appointments.
  - iv. For adult patients who initiate any method, recommend that they return if they encounter problems or side effects, have questions or wish to change methods. Unless otherwise indicated, no routine follow-up visit is necessary.<sup>25, 26</sup>
  - v. For patients who initiate the shot, schedule a follow-up visit within 12 to 14 weeks for the next injection.<sup>25</sup>
- I. Adhere to current guidance on providing emergency contraception (EC).
- i. As indicated, offer advance provision of EC, including a prescription for ulipristal acetate (brand name ella®) to all patients.<sup>7, 8</sup>
  - ii. The copper IUD has been found to be the most effective form of emergency contraception if inserted within five days of unprotected sex.<sup>28</sup>
- J. Provide pregnancy testing as indicated and if requested by patient, regardless of last menstrual period.<sup>25</sup>



## 4 Adhere to evidence-based guidance on STI prevention, testing and treatment.

- A. Follow **current clinical guidelines** on STI prevention, testing and treatment for patients based on age, pregnancy status, sexual history and other risk factors.<sup>7, 8, 29, 30</sup>
- Annual screening for *C. trachomatis* (chlamydia) and *N. gonorrhoeae* (gonorrhea) is recommended for all sexually active females ages <25.
  - Use urine-based testing when possible to avoid unnecessary pelvic exams or urethral swab collection.<sup>29</sup>
  - As indicated, counsel patients on partner notification, and discuss notification options that protect the safety and well-being of both the patient and their partner(s).<sup>31, 32</sup>
  - Offer **expedited partner therapy** for chlamydia when appropriate.<sup>29, 33b</sup>
    - As of May 2016, New York State Department of Health **has waived** the electronic prescribing **mandate** for expedited partner therapy treatment. The waiver will remain in effect until March 26, 2017.
    - See also: NY Public Health Law §2312; §281(3); §3334 and §3337
    - See also: NY Education Law §6810
    - See also: NY Codes, Rules and Regulations Title 10: §23.5

- B. Adhere to **current guidance** on HIV prevention, testing and treatment.<sup>7, 8, 29, 34, 35, c</sup>
- Offer HIV testing to all patients ages 13 to 64 per NY Public Health Law §2781-a.
    - Offer testing annually or more frequently to patients determined to be at ongoing risk of infection.<sup>7, 8, 29</sup>
  - Offer HIV testing via **oral consent** process; informed consent may now be obtained verbally when ordering any HIV test.<sup>35, 36</sup>
  - For patients at ongoing behavioral or epidemiologic risk for HIV, offer **pre-exposure prophylaxis** (PrEP) antiretroviral medication or referral to a PrEP-experienced site.



<sup>b</sup> NY Pub. Health Law §2312: Expedited partner therapy for chlamydia trachomatis infection.

NY Pub. Health Law §281(3): Article 2-A –Prescription forms, electronic prescribing and language assistance.

NY Pub. Health Law §3334: Emergency oral prescriptions for schedule II drugs and certain other controlled substances.

NY Pub. Health Law §3337: Oral prescriptions schedule III, IV and V substances.

NY Education Law §6810: Prescriptions.

NY Codes, Rules and Regulations Title 10: §23.5:

<sup>c</sup> NY Pub. Health Law § 2781: HIV related testing.

NY Pub. Health Law § 2781-a: Required offering of HIV related testing. 1. Every individual between the ages of thirteen and sixty-four years (or younger or older if there is evidence or indication of risk activity) who receives health services as an inpatient or in the emergency department of a general hospital defined in subdivision ten of section twenty-eight hundred one of this chapter or who receives primary care services in an outpatient department of such hospital or in a diagnostic and treatment center licensed under article twenty-eight of this chapter or from a physician, physician assistant, nurse practitioner, or midwife providing primary care shall be offered an HIV related test unless the health care practitioner providing such services reasonably believes that (a) the individual is being treated for a life threatening emergency; or (b) the individual has previously been offered or has been the subject of an HIV related test (except that a test shall be offered if otherwise indicated); or (c) the individual lacks capacity to consent to an HIV related test. 2. As used in this section, "primary care" means the medical fields of family medicine, general pediatrics, primary care gynecology, without regard to board certification. 3. The offering of HIV related testing under this section shall be culturally and linguistically appropriate in accordance with rules and regulations promulgated by the commissioner. 4. This section shall not affect the scope of practice of any health care practitioner or diminish any authority or legal or professional obligation of any health care practitioner to offer an HIV related test or to provide services or care for the subject of an HIV related test.



- iv. For HIV-negative patients who report recent exposure to HIV, offer **post-exposure prophylaxis** medication (PEP) or referral to a PEP-experienced site.
- v. As indicated, counsel patients on partner notification, and discuss notification options that protect the safety and well-being of both the patient and their partner(s).<sup>31, 34, 37</sup>

C. Offer **age-and population-appropriate vaccines**.<sup>38</sup>

- i. The HPV vaccine is recommended for:
  - All youth<sup>d</sup> aged 11-12 years
  - Females aged 13 to 26
  - Males aged 13 to 21 who haven't previously been vaccinated
  - High-risk males (including men who have sex with men and patients with HIV) aged 22 to 26 who haven't previously been vaccinated
- ii. For more information, consult **City of New York** and **CDC** resources.

## 5 Remove **barriers to care**.

- A. Stock contraception and other sexual health emergency medications (like **PEP**) on site in clinical areas or pharmacies for immediate provision.
- B. Use appointment systems and patient flow procedures to accommodate patients (e.g., offer care during non-school hours for adolescents, offer walk-in services, etc.).
- C. Use communication technologies consistent with patients' preferred modes of communication and regulations of health care facilities (e.g., text message appointment reminders).
- D. Know where to refer the patient for free or low-cost sexual and reproductive health care services (e.g., Title X service sites) if there are services you do not provide.<sup>39</sup>
  - i. Title X service sites can be identified through the Office of Population Affairs **Title X Family Planning Database**.
- E. Facilitate uninsured patients' enrollment in available insurance options, including presumptive eligibility for the New York State Family Planning Benefit Program (**FPBP**), Family Planning Extension Program (**FPEP**) and Medicaid (for pregnant patients).
  - i. Uninsured patients may qualify for health insurance options through the **NY State of Health insurance plan marketplace**.
- F. Actively manage payment and billing to cover costs of services provided:
  - i. Utilize government insurance resources; for current guidelines on health insurance policies and programs, consult the **Centers for Medicare and Medicaid Standards** and/or **NY State Department of Health** information on patient eligibility and enrollment.

<sup>d</sup> Amendments were proposed in the November 25, 2015 New York State Register, proposing to amend Part 23 of the State Sanitary Code regarding sexually transmitted diseases, authorizing health care practitioners to administer HPV vaccine to minors without the consent or knowledge of the minor's parent or guardian. [10 NYCRR §23.4]. The regulations have been filed with the Secretary of State, and they became effective upon publication of the Notice of Adoption in the State Register on May 18, 2016. The Regulatory Impact Statement that is being published with the Part 23 regulation amendments states: "Section 23.4 permits health care providers to prescribe and administer HPV vaccine to sexually active minors during confidential sexual and reproductive health care visits without consent or knowledge of the parent or guardian."





- ii. Utilize commercial insurance.
- iii. Participate in the **340B drug pricing program** to obtain contraceptive devices at discounted prices, if your organization is eligible.
- iv. Utilize self-pay options and inform patients about device manufacturer payment plans or **patient assistance programs**.

## 6 Build **staff capacity** to serve patients of different ages, cultural backgrounds, sexual orientations and gender identities.

- A. When hiring, include interview questions to assess candidates' comfort with and enthusiasm for providing sexual and reproductive health services, including to teens, and regardless of sexual orientation and gender identity.
- B. Prepare all staff to meet patients' special needs via annual training in:
  - i. Adolescents' rights regarding sexual and reproductive health and behavioral and mental health, including confidentiality
  - ii. Customer service training for front-line staff that addresses minors' rights to sexual health care, confidentiality, friendliness toward teens and comprehensive, medically accurate information about sexual and reproductive health services
  - iii. Cultural competence, with emphasis on the institutional and structural causes of health disparities
  - iv. **Language access services** and care considerations for patients with limited English proficiency
  - v. Special considerations for LGBTQ patients, including youth





## 7 Be welcoming and attentive to the health needs of LGBTQ patients.

- A. Be responsive to the health needs of patients who are LGBTQ, including men who have sex with men, women who have sex with women, same-gender-loving, transgender, genderqueer, gender fluid, intersex, asexual and/or any sexual or gender minority.<sup>40, 41</sup>
- B. Create a welcoming and inclusive environment. This includes:
  - i. Requiring ongoing training for front-line, security and clinical staff and volunteers on LGBTQ cultural responsiveness
  - ii. Prominently displaying nondiscrimination policies and patient bill of rights documents in waiting rooms and examination rooms
  - iii. Ensuring that medical records and forms are inclusive of LGBTQ patients' sexual orientation and gender identities
- C. Be familiar with relevant terminology, such as sex, gender identity, gender-affirming care, gender expression, transgender, transman/transwoman, genderqueer and gender nonconforming. For additional terms and definitions see Box 3 in the City Health Information document *Providing Primary Care to Transgender Adults*, available on the New York City Health Department website.



- D. Discuss contraception and fertility goals with all patients, regardless of sexual orientation and gender identity and expression, while being mindful of patients' identities and lived experiences. Conversations regarding contraception should ideally serve as an opportunity for further discussions regarding condoms and PrEP as tools to prevent STIs and HIV.
- E. For transgender patients, be familiar with clinical standards of a third-party payer coverage for gender-affirming care, including nonmedical changes in gender expression, hormone therapy and surgical treatment.<sup>4, 42, 43</sup>
  - i. Offer gender-affirming services on site or provide referrals to health care settings better equipped to provide these services. When referring patients to another provider, follow up to ensure timely provision of services.
- F. LGBTQ people, especially youth and those with unstable housing, experience disproportionately high rates of sexual coercion compared to the general population.<sup>17</sup> Ensure that **information on LGBTQ-specific resources** for victims of interpersonal and/or relationship violence are made available to patients immediately (e.g., by displaying posters and brochures in waiting areas and patient visit rooms) and by referral.



## 8 Adopt and implement **policies** that support patient-centered sexual and reproductive health care.

- A. Hold staff and providers accountable for providing high-quality care that includes same-day initiation of contraception services.<sup>7,8</sup>
  - i. Model these policies, including confidentiality and patient care policies, on evidence-based sexual and reproductive health care guidelines endorsed by professional organizations and public health entities.
  - ii. Set and adhere to a schedule for reviewing, updating and disseminating policies (e.g., annually).
- B. Conduct ongoing training in
  - i. **Sexual and Reproductive Justice framework**
  - ii. **Trauma-informed care**
  - iii. **Patient-centered** education and counseling methods
  - iv. Values clarification, with emphasis on **identifying and overcoming biases**

- v. Updated clinical guidelines to support evidence-based sexual and reproductive health practices
- vi. **LGBTQ cultural competency**, including important health concerns for gender and sexual minorities
- vii. Provision of **language access services**

- C. Hold training sessions to reinforce these policies
  - i. Ensure descriptions of current policies are available in writing (e.g., via employee handbook) and are accessible to all staff.

## 9 Use data to monitor and improve the quality of patient care.

- A. Build prompting systems (e.g., in electronic health records) to encourage providers to offer sexual and reproductive health screening and service provision.<sup>44</sup>
- B. Routinely monitor data to ensure patients' needs are assessed and met (e.g., percentage of patients whose sexual history is taken at least annually, percentage of those screened for STI and HIV, percentage of those offered contraception counseling).



# Setting-Specific Contraception and STI/HIV Prevention Care Best Practices

The preceding content should serve as foundational recommendations for any provider, while the additional best practices below are specific to the abortion, pre/postpartum and primary care settings.

- By age 45, three out of 10 women will have had an abortion.<sup>45</sup> The abortion care visit presents a timely opportunity to offer interested patients contraception education, counseling and provision.
- Offering contraception care in abortion, primary care and postpartum settings can help reduce unintended pregnancies and help patients space the birth of subsequent children, which affects both maternal and child health.<sup>46, 47</sup>

## Post-Abortion Care

### 1 Integrate **contraceptive counseling** into the abortion process.

- A. Provide contraception information as part of the registration and/or intake process. Inform patients of the range of contraceptive methods that will be available to them immediately after the abortion and the opportunity to obtain more information at the appointment.
- B. At the appointment but prior to the abortion procedure, provide counseling and patient education materials about the full range of FDA-approved contraceptive methods to help patients choose which, if any, is best for them.<sup>48, 49</sup>







## 2 Use every opportunity to **assess and meet** the sexual and reproductive health needs of patients accessing abortion services.

- A. Address identified sexual and reproductive health needs at the same visit as the abortion, without delaying until a follow-up visit.
- B. Develop protocols for integrating post-abortion contraception care into the visit(s) to standardize care and support clear patient flow.

## 3 Apply up-to-date **clinical guidelines** for post-abortion contraception care.

- A. Offer the full range of FDA-approved contraceptive methods at the abortion visit via on-site dispensing, insertion or prescription.<sup>25</sup>
- B. If the patient requests methods not available on-site, provide referrals on the same day as the abortion to sites that offer said methods. Develop policies to ensure follow-up on referrals.
- C. STI screening is generally not required for a patient initiating contraception, including IUDs and implants. If it is clinically indicated, the provider may conduct STI testing at the abortion visit. However, do not delay the IUD or implant insertion while awaiting the results of STI testing.
- D. If the patient desires, offer implant insertion at the abortion visit, immediately after the procedure.<sup>25</sup>
- E. If the patient desires, offer IUD insertion at the abortion visit, immediately after the procedure.<sup>25</sup>
  - i. No additional prophylactic antibiotics are needed with post-abortion IUD insertion.<sup>25</sup>
  - ii. If you conduct STI testing, you may insert the IUD at the same visit as the abortion and should follow up with the patient as indicated by the STI test results.





## Prenatal, Labor and Delivery, and Postpartum Care

### 1 Integrate **contraception, birth spacing and breastfeeding counseling** into all pregnancy-related visits.

- A. Provide contraception counseling and patient education materials for the full range of FDA-approved contraceptive methods at
  - i. Prenatal visits
  - ii. Admission for delivery
  - iii. Prior to discharge
  - iv. Follow-up/postpartum visits<sup>50-52</sup>
- B. As long as patients have no pre-existing conditions that would preclude breastfeeding an infant (e.g., HIV infection, untreated tuberculosis, use of certain medications or illicit drugs),<sup>53, 54</sup> recommend that the infant be fed only breast milk for the first six months of life. Recommend the patient continue breast milk feeding as complementary foods are introduced for an additional six months or longer.<sup>53, 55</sup>
- C. Choosing whether or not to breastfeed may influence patients' decisions to use certain types of contraception; tailor recommendations accordingly and refer to evidence-based guidelines.
  - i. For a visual representation of contraceptive contraindications by health condition (including pregnancy and breastfeeding status) see the [CDC MEC charts](#).<sup>50</sup>
- D. For patients who are breastfeeding, Lactational Amenorrhea Method (LAM) may be an effective form of contraception for up to six months postpartum.<sup>56, 57</sup> Patients should only rely on LAM for contraceptive purposes if they are exclusively (100% of feeding episodes) or nearly exclusively (85-90% of feeding episodes) breastfeeding and have not yet resumed menstruating.<sup>56</sup>
- E. Counsel patients at prenatal, labor and delivery, and follow-up/postpartum visits about optimal interpregnancy intervals (i.e., birth spacing) to reduce the risk of negative maternal-child health outcomes.

- i. Evidence suggests that patients who become pregnant *less* than 18-24 months after delivering a child are at greater risk of maternal-child health concerns, including pre-term birth, infant low birth weight and small infant size for gestational age. Patients who become pregnant five years or *more* after their last delivery are at increased risk of pre-eclampsia.<sup>58-60</sup>

## 2 Ensure the **confidentiality** of postpartum contraception care.

- A. Ensure that patients and providers have time alone to speak.
- B. Give patients the opportunity to have their chosen contraceptive method provided/inserted privately without others present.

## 3 Use every opportunity to **assess and meet** contraception needs of patients who are pregnant or recently gave birth.

- A. Take a brief sexual history at the prenatal and postpartum visits to identify needs for education, contraception, STI and HIV screening/testing or other services.
- B. Educate pregnant patients on the need for continued use of condoms to prevent transmission of HIV and other STIs, particularly if the patient is at elevated risk of exposure (e.g., has an HIV-positive partner, uses intravenous drugs).<sup>61</sup>
  - i. Offer routine HIV testing to all prenatal care patients; re-screen for HIV during the third trimester of pregnancy if the patient is determined to be at ongoing risk of infection.<sup>7,8,29</sup>
- C. Routinely assess patients for **reproductive coercion** and **intimate partner violence** at prenatal, labor and delivery, and postpartum visits, and provide prompt treatment and referrals.<sup>62</sup>
- D. Address identified sexual and reproductive health needs at the prenatal, labor and delivery, and postpartum visits, without delaying until a follow-up visit.

- E. Develop protocols for integrating contraception provision into labor and delivery and postpartum visits to standardize care and support effective patient flow.

## 4 Apply up-to-date **clinical guidelines** for labor and delivery and postpartum contraception services.

- A. Offer contraception options to all peripartum patients in accordance with their personal preferences, breastfeeding intentions, medical history and risk factors, and in alignment with contraceptive initiation criteria.<sup>25, 50</sup>
  - i. Additional pelvic exams and Pap smears should not be required for STI and HIV testing or contraception provision.
  - ii. If a patient requests methods not available during hospitalization, assist the patient in making an appointment prior to discharge with another clinician who can provide the requested method. The patient should be provided with contact information and the date and time of the appointment.
- B. Offer contraceptive methods during the maternity stay via on-site dispensing or prescription. Assess appropriateness of postpartum initiation based on patients' breastfeeding intentions, medical history and risk factors, and other criteria.<sup>50</sup>







- i. IUDs and implants may be inserted immediately after vaginal or Cesarean delivery if the patient has been screened for contraindications during the prenatal period and has no additional risk factors.<sup>50</sup>
  - Insertion of an IUD is safe within 10 minutes after delivery of the placenta. Waiting longer than 10 minutes is associated with a higher expulsion rate.<sup>50,63</sup> There is also a higher risk of IUD expulsion among patients who have an IUD inserted within 28 days postpartum compared to those who opt for delayed insertion.<sup>50</sup>
  - Patients who experience peripartum infection should wait at least three months postpartum before having an IUD placed.<sup>23,64</sup>
- C. Use of combined hormonal contraceptives (CHCs), such as pills, the patch and the ring, sooner than 21 days postpartum is considered an unacceptable health risk due to the elevated risk of venous thromboembolism (VTE).
  - i. This recommendation is made for all patients, regardless of breastfeeding intentions and/or presence of additional risk factors for VTE.<sup>50</sup>
- D. For non-breastfeeding patients, the following CDC MEC guidelines on CHC use apply:<sup>50</sup>
  - i. Patients who are 21 to 42 days postpartum and have additional risk factors for VTE should generally not use CHCs, as the risks outweigh possible benefits.
  - ii. For patients who are 21 to 42 days postpartum and do not have additional risk factors for VTE, the benefits of CHC use generally outweigh the risks.
  - iii. No restriction on postpartum CHC applies to patients more than 42 days after delivery; however, other risk factors or contraindications for CHCs must still be considered.
- E. For breastfeeding patients, the following CDC MEC guidelines on CHC use apply:<sup>50</sup>
  - i. Patients who are 21 to 29 days postpartum should generally not use CHCs, whether or not they have additional risk factors for VTE.
  - ii. Patients who are 30 to 42 days postpartum and have additional risk factors for VTE should generally not use CHCs.
  - iii. For patients who are 30 to 42 days postpartum and do not have additional risk factors for VTE, the benefits of CHC use generally outweigh the risks.
  - iv. For patients who are more than 42 days postpartum, the benefits of CHC use generally outweigh the risks; however, other risk factors or contraindications for CHCs must still be considered.
- F. According to the CDC MEC guidelines for the post-partum period, the benefits of progestin-only contraceptive methods (e.g. progestin-only pills, the shot, the implant and the hormonal IUD) as well as the non-hormonal IUD, generally outweigh the risks.<sup>50</sup>
  - i. These methods are usually safe to use for patients who are breastfeeding, and may be offered before discharge from delivery care, provided other patient risk factors or contraindications are considered.
- G. Encourage postpartum patients to use condoms to reduce the risk of unintended pregnancy and STIs, including HIV. Condoms may be initiated any time postpartum.
- H. Use of the cervical cap or diaphragm should be delayed until six weeks postpartum.
- I. Use the postpartum visit to reevaluate patients' satisfaction and consistency of use of the chosen method. If they are not satisfied, offer another contraceptive method.

# Primary Care

## 1 Integrate preconception care, pregnancy intention and contraceptive counseling into primary care visits.

A. At a minimum, initiate conversation about pregnancy intention, preconception care and contraception at the annual visit and whenever new diagnoses or medications may be relevant to pregnancy risks or contraceptive method contraindications.<sup>7, 8, 65, 66</sup>

- i. Consider using the “One Key Question®” approach:
  - Pose the question: *“Would you like to become pregnant in the next year?”*
    - For patients who answer “yes,” offer preconception counseling and screenings to ensure that they are in optimal health for a pregnancy.
    - For patients who answer “no,” counsel on the full range of contraception options to ensure that the method they use is optimal for their circumstances.
    - Patients who are ambivalent or unsure of their pregnancy intentions comprise a substantial portion of the population; offer these patients a combination of both services.

B. Discuss the relationship between patients’ sexual and reproductive health goals, overall health and well-being and contraception choices (e.g., medical conditions that affect pregnancy risk, potential drug interactions, contraceptive contraindications, side effects, etc.).

C. During primary care visits, when taking a medication history, include an inquiry about contraception and whether the patient is satisfied with their current contraceptive method.

- i. If the patient is unhappy with their current contraceptive method, assess method concerns and recommend alternatives.

D. For adolescents, primary care visits should (at a minimum) include:<sup>5, 66, 67</sup>

- i. Time alone with the provider
- ii. Discussion about sexual activity, including STI and HIV prevention counseling as appropriate
- iii. Contraception and pregnancy intention counseling and services



# Tools and Resources

## CONTRACEPTION CARE AND PROVISION

| Resource Type                    | Title   | Reference   |
|----------------------------------|---|---|
| General Resource                 | Sexual and Reproductive Health: Information for Providers   | New York City Health Department   |
| General Resource                 | One Key Question®: Preventive Reproductive Health is Part of High Quality Primary Care.   | Bellanca, H.K., Hunter, M.S. <i>Contraception</i> 2013;88:3-6.  |
| Best Practices, General Resource | A Guide to Taking a Sexual History  | New York City Health Department   |
| Best Practices                   | U. S. Medical Eligibility Criteria for Contraceptive Use, 2010  | CDC   |
| Best Practices                   | U.S. Selected Practice Recommendations for Contraceptive Use, 2013: Adapted from the World Health Organization selected practice recommendations for contraceptive use, 2 <sup>nd</sup> ed. | CDC MMWR Recomm Rep 2013; w62:1-60  |
| Best Practices                   | Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs  | Gavin, L., Moskosky, S., Carter, M., et al. <i>Centers for Disease Control and Prevention</i> . MMWR Recomm Rep 2014;63:1-54. |
| Best Practices                   | Update: Providing Quality Family Planning Services: Recommendations from CDC and the U.S. Office of Population Affairs, 2015  | Gavin, L., Pazol, K. <i>Centers for Disease Control and Prevention</i> . MMWR Morb Mortal Wkly Rep 2016;65:231-4.             |

## STI AND HIV PREVENTION AND TREATMENT

| Resource Type  | Title   | Reference  |
|----------------|---|--|
| Training       | HIV, HCV and STD Clinical Education Initiative  | The New York State Department of Health AIDS Clinical Education Initiative (CEI)                                     |
| Best Practices | Sexually Transmitted Diseases Treatment Guidelines, 2015  | Workowski, K.A., Bolan, G.A. MMWR Recomm Rep 2015;64:1-137. Errata: Vol. 64, No. RR-3; August 28, 2015 / 64(33);924. |
| Best Practices | Pre-exposure Prophylaxis for the Prevention of HIV Infection in the United States—2014: A Clinical Practice Guideline | CDC  |



## ADOLESCENT HEALTH CARE

| Resource Type                    | Title  | Reference                                  |
|----------------------------------|--|--|
| Workshop Guide                   | Teens In NYC: Getting Sexual Health Services Workshop Facilitation Guide | New York City Health Department            |
| Toolkit                          | AHWG's Provider Toolkit Series   | Adolescent Health Working Group (AHWG)     |
| Best Practices, General Resource | Clinical Care Guidelines and Resources                                   | Society for Adolescent Health and Medicine |
| Best Practices, General Resource | GAPS-The Guidelines for Adolescent Preventive Services                   | American Academy of Family Physicians      |

## PATIENT-CENTERED CARE AND THE SEXUAL AND REPRODUCTIVE JUSTICE FRAMEWORK

| Resource Type    | Title  | Reference  |
|------------------|--|--|
| General Resource | What is Reproductive Justice?                              | Asian Communities for Reproductive Justice                               |
| General Resource | Forward Together: Resources                                | Forward Together   |
| General Resource | Trauma-Informed Approach and Trauma-Specific Interventions | Substance Abuse and Mental Health Services Administration                |
| General Resource | A 2020 Vision of Patient-Centered Primary Care             | Davis, K., Schoenbaum, S.C., Audet, A.M. J Gen Intern Med 2005;20:953-7. |
| General Resource | Unconscious Bias   | University of California, San Francisco Office of Diversity and Outreach |
| Training         | Trust Black Women: Training                                | Trust Black Women  |

## LGBTQ HEALTH CARE

| Resource Type                    | Title  | Reference  |
|----------------------------------|--|--|
| General Resource                 | Lesbian, Gay, Bisexual and Transgender Health  | CDC  |
| Best Practices                   | Program Assistance Letter: Approved changes for CY 2016 UDS Reporting. A. Sexual Orientation and Gender Identity – Tables 3A, 3B | Health Resources and Services Administration   |
| Best Practices, General Resource | Taking Routine Histories of Sexual Health: A System-Wide Approach for Health Centers   | National LGBT Health Education Center and the National Association of Community Health Centers. November 2015. |
| Best Practices, General Resource | Lesbian and Bisexual Health Fact Sheet   | Office on Women’s Health   |
| Best Practices, General Resource | Providing Comprehensive Health Care to Men Who Have Sex With Men (MSM)   | New York City Health Department. <a href="#">City Health Information 2014;33</a> .                             |
| Best Practices, General Resource | Center of Excellence for Transgender Health – Learning Center Audience: Health Care Providers                                    | University of California San Francisco   |
| Best Practices, General Resource | Providing Primary Care to Transgender Adults   | New York City Health Department. <a href="#">City Health Information 2014;34</a> .                             |
| Training                         | Webinars Sponsored by the National LGBT Health Education Center  | National LGBT Health Education Center: A Program of The Fenway Institute                                       |

## INTIMATE PARTNER VIOLENCE AND REPRODUCTIVE COERCION

| Resource Type                    | Title  | Reference   |
|----------------------------------|--|---|
| Best Practices, Toolkit          | Addressing Intimate Partner Violence, Reproductive and Sexual Coercion: A Guide for Obstetric, Gynecologic and Reproductive Health Care Settings | Chamberlain, L., Levenson, R. <a href="#">Futures Without Violence</a> , 2012, 2nd ed. San Francisco, CA. |
| Toolkit                          | Exposing Reproductive Coercion: A Toolkit for Awareness Raising, Assessment, and Intervention  | Cappelletti, M., Gatimu, J., Shaw, G. (2014). <a href="#">FWHC, NCADV</a> .                               |
| Webinar Slides, General Resource | Redefining Safety Planning in the Context of Reproductive Coercion   | <a href="#">Futures Without Violence</a>  |
| Journal Article                  | Guarding Against Coercion While Ensuring Access: A Delicate Balance  | Gold, R.B. <a href="#">Guttmacher Policy Review 2014;17</a> .   |
| Journal Article                  | Celebration Meets Caution: LARC’s Boons, Potential Busts, and the Benefits of a Reproductive Justice Approach                                    | Higgins, J.A. <a href="#">Contraception 2014;89:237-41</a> .  |

## HEALTH INSURANCE ACCESS

| Resource Type    | Title   | Reference                           |
|------------------|---|-------------------------------------|
| General Resource | Health Insurance Programs   | New York State Department of Health |
| General Resource | New York State Medicaid Family Planning Services Frequently Asked Questions, May 2015 | New York State Department of Health |
| General Resource | Family Planning Benefit Program (FPBP) Update   | New York State Department of Health |
| General Resource | Family Planning Extension Program   | NYC Health Insurance Link           |

## FINANCIAL ASSISTANCE AND DEVICE REIMBURSEMENT

| Resource Type    | Title   | Reference  |
|------------------|---|--|
| General Resource | 340 B Drug Pricing Program                                  | U.S. Department of Health and Human Services   |
| General Resource | ARCH Patient Assistance Program for Skyla and Mirena        | Bayer Healthcare Pharmaceuticals Inc.  |
| General Resource | Skyla: Specialty Pharmacy Program                           | Bayer Healthcare Pharmaceuticals Inc.  |
| General Resource | Liletta Patient Savings Program                             | Actavis Pharma Inc.  |
| General Resource | Intrauterine Devices and Implants: A Guide to Reimbursement | Armstrong, E., Gandal-Powers, M., Levin, S., Kelinson, A.K., Luchowski, A., Thompson, K. |



# References

1. National LGBT Health Education Center and the National Association of Community Health Centers. Taking Routine Histories of Sexual Health: A System-Wide Approach for Health Centers: Fenway Institute and the National Association of Community Health Centers; November 2015. Available at: [http://www.lgbthealtheducation.org/wp-content/uploads/COM-827-sexual-history\\_toolkit\\_2015.pdf](http://www.lgbthealtheducation.org/wp-content/uploads/COM-827-sexual-history_toolkit_2015.pdf).
2. Centers for Disease Control and Prevention. Lesbian, Gay, Bisexual and Transgender Health; 2014: Available at: <http://www.cdc.gov/lgbthealth/>.
3. New York City Department of Health and Mental Hygiene. Providing Comprehensive Health Care to Men Who Have Sex With Men (MSM). City Health Information 2014;33. Available at: [www.nyc.gov/health](http://www.nyc.gov/health)
4. New York City Department of Health and Mental Hygiene. Providing Primary Care to Transgender Adults. City Health Information 2014;34. Available at: [www.nyc.gov/health](http://www.nyc.gov/health)
5. American Academy of Pediatrics Committee on Adolescence. Contraception for adolescents. Pediatrics 2014;134:e1244-56.
6. Nusbaum MR, Hamilton CD. The proactive sexual health history. Am Fam Physician 2002;66:1705-12.
7. Gavin L, Moskosky S, Carter M, et al. Providing quality family planning services: Recommendations of CDC and the U.S. Office of Population Affairs. MMWR Recomm Rep 2014;63:1-54.
8. Gavin L, Pazol K. Update: Providing Quality Family Planning Services - Recommendations from CDC and the U.S. Office of Population Affairs, 2015. MMWR Morb Mortal Wkly Rep 2016;65:231-4.
9. American Academy of Pediatrics. Bright Futures Tool and Resource Kit. Elk Grove Village, IL: American Academy of Pediatrics; 2010.
10. Bellanca HK, Hunter MS. One Key Question®: Preventive reproductive health is part of high quality primary care. Contraception 2013;88:3-6.
11. Gold RB. Guarding against coercion while ensuring access: A delicate balance. Guttmacher Policy Review 2014;17.
12. Higgins JA. Celebration meets caution: LARC's boons, potential busts, and the benefits of a reproductive justice approach. Contraception 2014;89:237-41.
13. New York City Department of Health and Mental Hygiene. Intimate Partner Violence: Encouraging Disclosure and Referral in the Primary Care Setting. City Health Information 2008;27 (suppl 2). Available at: [www.nyc.gov/health](http://www.nyc.gov/health)
14. American College of Obstetricians and Gynecologists. ACOG Committee Opinion No. 554: Reproductive and sexual coercion. Obstet Gynecol 2013;121:411-5.
15. New York Civil Liberties Union, Feierman J, Lieberman D, et al. Teenagers, Health Care & the Law: A Guide to the Law on Minors' Rights in New York State; 2nd Edition. 2013: Available at <http://www.nyclu.org/files/thl.pdf>
16. Futures Without Violence. Redefining Safety Planning in the Context of Reproductive Coercion; 2013: Available at <http://www.futureswithoutviolence.org/redefining-reproductive-coercion/>.
17. National Sexual Violence Resource Center, Pennsylvania Coalition Against Rape. Sexual Violence & Individuals Who Identify as LGBTQ. Annotated Bibliography, 2012: Available at: [http://www.nsvrc.org/sites/default/files/Publications\\_NSVRC\\_Bibliographies\\_Sexual-Violence-LGBTQ.pdf](http://www.nsvrc.org/sites/default/files/Publications_NSVRC_Bibliographies_Sexual-Violence-LGBTQ.pdf).
18. Ard KL, Makadon HJ. Addressing intimate partner violence in lesbian, gay, bisexual, and transgender patients. J Gen Intern Med 2011;26:930-3.
19. New York City Department of Health and Mental Hygiene Notice of Privacy Practices; 2016: <http://www1.nyc.gov/assets/doh/downloads/pdf/public/hipaa.pdf>.
20. U.S. Department of Health & Human Services. Summary of the HIPAA Privacy Rule; 2013; Available at: <http://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html>.
21. New York State Department of Health. Health Care Professionals & Patient Safety; 2015: Available at <https://www.health.ny.gov/professionals/index.htm#doctors>.
22. American College of Obstetricians and Gynecologists. ACOG Committee Opinion No. 599: Committee on Adolescent Health Care: Adolescent confidentiality and electronic health records. Obstet Gynecol 2014;123:1148-50.

23. American College of Obstetricians and Gynecologists. ACOG Practice Bulletin No. 121: Long-acting reversible contraception: Implants and intrauterine devices. *Obstet Gynecol* 2011;118:184-96.
24. The American College of Obstetricians and Gynecologists. ACOG Committee Opinion No. 392, December 2007. Intrauterine device and adolescents. *Obstet Gynecol* 2007;110:1493-5.
25. Centers for Disease Control and Prevention. U.S. Selected Practice Recommendations for Contraceptive Use, 2013: Adapted from the World Health Organization selected practice recommendations for contraceptive use, 2nd edition. *MMWR Recomm Rep* 2013;62:1-60.
26. Centers for Disease Control and Prevention. U.S. Medical Eligibility Criteria for Contraceptive Use, 2010. *MMWR Recomm Rep* 2010;59:1-86. Update available July 8, 2011 at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6026a3.htm>.
27. Ott MA, Sucato GS. Contraception for adolescents. *Pediatrics* 2014;134:e1257-81.
28. Cleland K, Raymond EG, Westley E, Trussell J. Emergency contraception review: evidence-based recommendations for clinicians. *Clin Obstet Gynecol* 2014;57:741-50.
29. Workowski KA, Bolan GA. Sexually transmitted diseases treatment guidelines, 2015. *MMWR Recomm Rep* 2015;64:1-137. Errata: Vol. 64, No. RR-3; August 28, 2015 / 64(33); pg. 924.
30. LeFevre ML. Screening for Chlamydia and gonorrhea: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med* 2014;161:902-10.
31. Centers for Disease Control and Prevention. Recommendations for partner services programs for HIV infection, syphilis, gonorrhea, and chlamydial infection. *MMWR Recomm Rep* 2008;57:1-83; quiz CE1-4.
32. New York State Department of Health. Information on Partner Services; 2011: Available at [http://www.health.ny.gov/diseases/communicable/std/partner\\_services/index.htm](http://www.health.ny.gov/diseases/communicable/std/partner_services/index.htm).
33. State of New York Department of Health. Expedited Partner Therapy (EPT) guidelines for health care providers in New York State for Chlamydia trachomatis. 2011: Available at [https://www.health.ny.gov/diseases/communicable/std/ept/docs/guidelines\\_for\\_providers.pdf](https://www.health.ny.gov/diseases/communicable/std/ept/docs/guidelines_for_providers.pdf).
34. New York City Department of Health and Mental Hygiene. HIV Testing, Reporting and Partner Notification: A Guide for Providers: New York Knows. Available at: [www.nyc.gov/health](http://www.nyc.gov/health)
35. New York State Department of Health. Frequently Asked Questions regarding the NYS HIV Testing Law; 2015. Available at: <http://www.health.ny.gov/diseases/aids/providers/testing/law/docs/faqs.pdf>.
36. New York State Department of Health. New York State HIV Testing Law update: May, 2014; 2014. Available at: <http://www.health.ny.gov/diseases/aids/providers/testing/law/docs/updates.pdf>.
37. New York City Department of Health and Mental Hygiene. HIV Reporting and Partner Notification Questions and Answers: New York Knows. Available at: [https://www.health.ny.gov/diseases/aids/providers/regulations/reporting\\_and\\_notification/question\\_answer.htm](https://www.health.ny.gov/diseases/aids/providers/regulations/reporting_and_notification/question_answer.htm).
38. Centers for Disease Control and Prevention. Advisory Committee on Immunization Practices (ACIP) recommended immunization schedules for persons aged 0 through 18 years and adults aged 19 years and older—United States, 2013. *MMWR Surveill Summ* 2013;62 Suppl 1. Erratum in *MMWR Surveill Summ*. 2013 Apr 5;62(13): 256:1.
39. American College of Obstetricians and Gynecologists. ACOG Committee Opinion No. 615: Access to contraception. *Obstet Gynecol* 2015;125:250-5.
40. Institute of Medicine (US) Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities. *The health of Lesbian, Gay, Bisexual, and Transgender people: Building a foundation for better understanding*. National Academies Press (US) 2011.
41. The Joint Commission. *Advancing effective communication, cultural competence, and patient- and family-centered care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) community: A field guide*. Oak Brook, IL 2011. Available at <http://www.jointcommission.org/assets/1/18/LGBTFieldGuide.pdf>.
42. University of California San Francisco. Center of Excellence for Transgender Health—Learning Center Audience: Health Care Providers. 2014: Available at <http://transhealth.ucsf.edu/trans?page=lib-providers>.
43. The World Professional Association for Transgender Health. *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People*. 7th Version; 2012. Available at: [http://www.wpath.org/uploaded\\_files/140/files/Standards%20of%20Care,%20V7%20Full%20Book.pdf](http://www.wpath.org/uploaded_files/140/files/Standards%20of%20Care,%20V7%20Full%20Book.pdf).

44. The American Congress of Obstetricians and Gynecologists. ACOG Committee Opinion No. 461: Tracking and reminder systems. *Obstet Gynecol* 2010;116:464-6.
45. Guttmacher Institute. Fact Sheet: Induced abortion in the United States; 2014: Available at [http://www.guttmacher.org/pubs/fb\\_induced\\_abortion.html](http://www.guttmacher.org/pubs/fb_induced_abortion.html).
46. United States Agency for International Development (USAID). Birth spacing. Three to five saves lives. *Popul Rep L* 2002:1-23.
47. World Health Organization. Report of a WHO technical consultation on birth spacing. Geneva, Switzerland; 2005. Available at: [http://www.who.int/maternal\\_child\\_adolescent/documents/birth\\_spacing.pdf](http://www.who.int/maternal_child_adolescent/documents/birth_spacing.pdf).
48. Langston AM, Joslin-Roher SL, Westhoff CL. Immediate postabortion access to IUDs, implants and DMPA reduces repeat pregnancy within 1 year in a New York City practice. *Contraception* 2014;89:103-8.
49. Morse J, Freedman L, Speidel JJ, Thompson KM, Stratton L, Harper CC. Postabortion contraception: qualitative interviews on counseling and provision of long-acting reversible contraceptive methods. *Perspect Sex Reprod Health* 2012;44:100-6.
50. Centers for Disease Control and Prevention. Update to CDC's U.S. Medical Eligibility Criteria for Contraceptive Use, 2010: Revised recommendations for the use of contraceptive methods during the postpartum period. *MMWR Morb Mortal Wkly Rep* 2011;60:878-83.
51. Lopez LM, Hiller JE, Grimes DA. Education for contraceptive use by women after childbirth. *Cochrane Database Syst Rev* 2010:CD001863.
52. Speroff L, Mishell DR, Jr. The postpartum visit: It's time for a change in order to optimally initiate contraception. *Contraception* 2008;78:90-8.
53. American Academy of Pediatrics. Breastfeeding and the use of human milk. *Pediatrics* 2012;129:e827-41.
54. American Academy of Pediatrics. Transfer of drugs and other chemicals into human milk. *Pediatrics* 2001;108:776-89.
55. American College of Obstetricians and Gynecologists. ACOG Committee Opinion No. 361: Breastfeeding: Maternal and infant aspects. *Obstet Gynecol* 2007;109:479-80.
56. Labbok MH, Perez A, Valdes V, et al. The Lactational Amenorrhea Method (LAM): A postpartum introductory family planning method with policy and program implications. *Adv Contracept* 1994;10:93-109.
57. Valdes V, Labbok MH, Pugin E, Perez A. The efficacy of the lactational amenorrhea method (LAM) among working women. *Contraception* 2000;62:217-9.
58. Conde-Agudelo A, Rosas-Bermudez A, Castano F, Norton MH. Effects of birth spacing on maternal, perinatal, infant, and child health: A systematic review of causal mechanisms. *Stud Fam Plann* 2012;43:93-114.
59. Conde-Agudelo A, Rosas-Bermudez A, Kafury-Goeta AC. Effects of birth spacing on maternal health: A systematic review. *Am J Obstet Gynecol* 2007;196:297-308.
60. Conde-Agudelo A, Rosas-Bermudez A, Kafury-Goeta AC. Birth spacing and risk of adverse perinatal outcomes: A meta-analysis. *JAMA* 2006;295:1809-23.
61. Wheeler R, Earnshaw VA, Kershaw T, Ickovics JR. Postpartum sexually transmitted disease: refining our understanding of the population at risk. *Sex Transm Dis* 2012;39:509-13.
62. American College of Obstetricians and Gynecologists. ACOG Committee Opinion No. 518: Intimate partner violence. *Obstet Gynecol* 2012;119:412-7.
63. Grimes DA, Lopez LM, Schulz KF, Van Vliet HA, Stanwood NL. Immediate post-partum insertion of intrauterine devices. *Cochrane Database Syst Rev* 2010:CD003036.
64. Hardeman J, Weiss BD. Intrauterine devices: An update. *Am Fam Physician* 2014;89:445-50.
65. American College of Obstetricians and Gynecologists. ACOG Committee Opinion number 313, September 2005. The importance of preconception care in the continuum of women's health care. *Obstet Gynecol* 2005;106:665-6.
66. American College of Obstetricians and Gynecologists. ACOG Committee Opinion No. 598: Committee on Adolescent Health Care: The initial reproductive health visit. *Obstet Gynecol* 2014;123:1143-7.
67. American Academy of Family Physicians. Adolescent health care, confidentiality; 2015. Available at: <http://www.aafp.org/about/policies/all/adolescent-confidentiality.html>.





