

Providing Quality Family Planning Services in the United States: Recommendations of the U.S. Office of Population Affairs (Revised 2024)



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This update, titled Providing Quality Family Planning Services^a in the United States: Recommendations of the U.S. Office of Population Affairs (Revised 2024), provides recommendations developed by the Office of Population Affairs (OPA) within the Office of the Assistant Secretary for Health at the U.S. Department of Health and Human Services (HHS). These recommendations represent an update to Providing Quality Family Planning (QFP) Services: Recommendations of the Centers for Disease Control and Prevention (CDC) and the U.S. Office of Population Affairs (OPA), originally published in 2014. The updated recommendations outline how to provide quality sexual and reproductive health (SRH) services for people of reproductive age but can also be used to guide the care of people of any age when the content is relevant to their needs, including family-building services, contraception, pregnancy testing and counseling, early pregnancy management, sexually transmitted infections (STIs) and human immunodeficiency virus (HIV) prevention and testing services, and other preventive health services. The recommendations aim to enable health care providers with the knowledge, skills, and attitudes to ensure that all people, regardless of individual characteristics such as sex, sexual orientation and gender identity, age, disability, or race, can have their SRH needs met. The primary audience for these recommendations is providers and potential providers of SRH services to people of reproductive age, such as providers working in clinical settings dedicated to SRH service delivery, including those funded by the Title X family planning program^b as well as primary care providers and other subspecialty providers who may identify SRH needs and make referrals.

During the past decade, several changes have taken place in the United States that have affected SRH care delivery, including technological advances, recognition of long-standing inequities, and other legal and regulatory changes. This broader context has been considered in designing the updated recommendations.

This update of the QFP aims to provide guidance on the provision of person-centered SRH care focused on individuals' needs, values, and preferences. The update offers specific recommendations for how to provide high-quality SRH care and connects users to relevant guidelines, primary research, and other resources to inform best practices. In addition to incorporating new evidence,

^aThe title of this document is Providing Quality Family Planning Services, to retain consistency with the title of the initial 2014 publication. However, the recommendations included in this document are broader than the provision of family planning services, and include recommendations for providing quality sexual and reproductive health services. For purposes of this document, "family planning services" are defined as a broad range of medically approved services, which include Food and Drug Administration (FDA)-approved or FDA-cleared contraceptive products and natural family planning methods for patients who want to prevent pregnancy and space births; pregnancy testing and counseling; assistance to achieve pregnancy; basic infertility services; sexually transmitted infection (STI) services; and other pre-pregnancy health services. Family planning services do not include abortion.

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this update incorporates newer approaches to care, including adopting a health equity lens that recognizes the impact of structural and interpersonal racism, classism, ableism, and bias based on sexual orientation and/or gender identity on health and the provision of quality SRH care. OPA will update these QFP recommendations periodically to reflect new findings in the scientific literature and revisions to the clinical guidelines referenced in this update.

Am J Prev Med 2024;67(6S):S41–S86. © 2024 The Authors. Published by Elsevier Inc. All rights are reserved, including those for text and data mining, AI training, and similar technologies.

SECTION 1: INTRODUCTION

Sexual and reproductive health (SRH) is a key aspect of people's overall health and quality of life that is defined as a state of physical, emotional, mental, and social well-being in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity.^{1,2} Quality SRH care supports United States public health objectives, including improving birth outcomes, reducing the rate of sexually transmitted infections (STI), and preventing pregnancy-related mortality and morbidity.³ These recommendations outline how to provide people of reproductive age with high-quality SRH services, including family-building services, contraceptive services, pregnancy testing and counseling, early pregnancy management, STI and human immunodeficiency virus (HIV) prevention and testing services, and other screening and preventive health services. These recommendations aim to enable health care providers to help ensure that all people, regardless of individual characteristics such as sex, gender identity, sexual orientation, age, ability, race, or ethnicity, can meet their SRH goals and needs.

These recommendations were developed by the Office of Population Affairs (OPA) within the Office of the Assistant Secretary for Health at the U.S. Department of Health and Human Services (HHS). OPA promotes health across the reproductive lifespan through innovative, evidence-based adolescent health and family

planning programs, services, strategic partnerships, evaluation, and research. OPA's Title X family planning program has served as the national leader in direct family planning service delivery since the Title X program was established in 1970.⁴

These recommendations represent an update to Providing Quality Family Planning Services: Recommendations of the CDC and the U.S. Office of Population Affairs, originally published in 2014.⁴ OPA followed a rigorous process in consultation with a wide array of experts in the fields of family planning (FP), SRH, and health equity (see [Appendix 4](#)). These recommendations intend to set the standard of SRH care and can be used by all current and potential providers of SRH services.

These recommendations can be implemented in varied settings, including primary care, specialty care (for example, obstetrics/gynecology, neurology, rheumatology), and community settings (for example, mobile clinics, schools, pharmacies). These recommendations are specifically intended for all current and potential providers of SRH services, including, but not limited to, those funded by the Title X family planning program. These recommendations apply to care delivered both in person and by telehealth. This update offers specific recommendations for how to provide high-quality SRH care and connects users to guidelines, primary research, and other resources to inform practice.

In addition to incorporating new evidence, this update includes newer approaches to care by adopting a health equity lens and recognizing the impact of structural and interpersonal racism, classism, ableism, and bias based on sexual orientation and/or gender identity on health and SRH care. The main revisions since the 2014 report are summarized in [Exhibit 1](#).

Inclusion and Equity

Improving the quality of SRH services can lead to improved health outcomes, both directly and through improved patient experiences of care.¹ However, many people have long faced barriers to high-quality SRH care, including inequitable access to information; cost and insurance gaps; unnecessary, inadequate, or biased medical practices; and institutional barriers, such as lack

^bTitle X projects must comply with statutory and regulatory requirements set out in the Title X statute (42 U.S.C. §300 et seq.), any legislative mandates included in annual HHS appropriations, Title X implementing regulations at 42 CFR Part 59, Subpart A (86 Fed. Reg. 56144), and any applicable court orders. As these requirements include restrictions related to abortion and certain related activities, Title X providers are prohibited from using Title X funds for some of the recommendations set out in this document. A separate guidance has been issued to current Title X recipients, which clearly specifies which services in this QFP document are outside the scope of Title X and may not be paid for with Title X funding. This guidance can be found at <https://opa.hhs.gov/grant-programs/title-x-service-grants/about-title-x-service-grants/program-policy-notice>.

Additionally, in places where recommendations in this QFP document may conflict with the Title X statute, legislative mandates, regulations, or court orders, the Title X federal requirements control.

Exhibit 1. Main Differences Between 2014 Report and 2024 QFP Update

2014 QFP Report	2024 QFP Update
Defined quality of care according to National Academies of Sciences, Engineering and Medicine (NASEM) (formerly IOM) six dimensions of quality (safe, effective, timely, patient-centered, efficient, and equitable) ⁵	Maintains multidimensional definition of quality, with expanded emphasis on person centeredness and equity by using a sexual and reproductive health equity framework
Focused on women as recipients of care, with some specific content for male clients	Takes a gender-inclusive approach and uses language throughout to recognize that people of all genders may need and access SRH care
Described how to consider the needs of and provide care to special populations , including adolescents, people with disabilities, and others with reduced access to quality care	Integrates and prioritizes the needs of groups and individuals who experience SRH inequities in shaping the recommendations, rather than considering “special populations” separately; when relevant, highlights evidence or recommendations that may be specific to or more relevant for some groups or individuals
Focused on care provided within the formal health care system , particularly specialized family planning service sites	Includes care from a broad range of provider specialties in varied settings, both within and beyond the formal health care system , including patient-led and self-care options
Drew from existing guidelines and published evidence in establishing recommendations; when evidence was inconclusive or incomplete, recommendations were made on the basis of expert opinion	In addition to incorporating published scientific evidence and existing guidelines, includes more expansive types of evidence, including qualitative evidence and direct input from users and people with lived experience, as well as expert opinion
Offered recommendations on how to provide quality family planning services , including contraceptive services, pregnancy testing and counseling, helping clients achieve pregnancy, basic infertility services, “preconception health services,” and STI services	Adds technical content and expands the scope of services to encompass more elements of SRH care , including the following: <ul style="list-style-type: none"> • Guiding principles: (1) person centeredness, (2) evidence informed, (3) inclusive, (4) accessible, (5) sex and body positive, and (6) trauma informed • Details on approaches to care to help providers carry out these guiding principles: (1) quality counseling, including shared decision making; (2) informed consent; and (3) privacy and confidentiality • New care delivery strategies, such as telehealth and over-the-counter (OTC) oral contraception • Broader content on early pregnancy management and resources • Expanded approach to family building • New or expanded preventive health care services related to mental health, healthy weight, perimenopausal care, gender-affirming care, and human trafficking • New STI and HIV prevention strategies, including self-care approaches and post- and pre-exposure prophylaxis (PEP and PrEP)
Recommended that all persons capable of having a child should have a reproductive life plan (RLP) and that providers should discuss the RLP with clients receiving contraceptive, pregnancy testing and counseling, basic infertility, sexually transmitted disease, and preconception health services	Advises discussing reproductive desires with a person-centered approach that focuses on open-ended communication and nonjudgmental counseling and support; does not endorse a single framework

of trained staff.⁶ Black, indigenous, people of color; lesbian, gay, bisexual, transgender, queer or questioning, and intersex (LGBTQI+) people; people living in poverty; people with disabilities; people with larger bodies; immigrants; and others with (often intersecting) marginalized identities are more likely to face the barriers described above and experience unique systemic barriers

to SRH care and discrimination within and beyond the health care system.^{7–10} These groups also have a history and continued experiences of reproductive injustices, including forced sterilizations and coercive use of contraception.^{11,12}

Delivery of high-quality, unbiased SRH care is one critical step in achieving sexual and reproductive health

Exhibit 2. Overarching Equity Principles Guiding Development of QFP

1. Ground QFP in a holistic vision of SRH that centers justice, equity, and autonomy.
2. Integrate rigorous scientific evidence to benefit the health of individuals and communities while recognizing the limitations of the current evidence base and applying an equity lens in its interpretation.
3. Use inclusive, person-centered definitions and language, driven by diverse partner input.
4. Prioritize inclusion throughout the development and implementation processes so QFP meets the needs of individuals and communities and does not cause unintentional harm.
5. Understand and reflect on the impact of the historical, sociocultural, political, geographical, and economic contexts that influence the lived experiences of communities and the delivery of care.
6. Design QFP so it will expand access to quality care for all, with a particular emphasis on those most impacted by SRH inequities and injustices.
7. Design QFP so the information is easily accessible, user-friendly, and facilitates dissemination and implementation.

*Note: Developed for QFP update and approved by OPA and Expert Workgroup.

equity (SRHE).⁸ SRHE is defined as a state in which all people across the range of age, gender, disability, race, and other intersectional identities have what they need to attain their highest level of SRH, including the ability to self-determine and achieve their reproductive goals.¹ SRHE draws from human rights, health equity, and reproductive justice¹³ frameworks and requires policies, healthcare systems, and other structures to ensure its advancement.¹⁴

The SRHE framework shaped the development of these recommendations, including through the incorporation of the overarching equity principles that were developed to guide this QFP update (Exhibit 2).¹ These principles, detailed further in the methods section, have included the engagement of users of the QFP recommendations and users of SRH services through listening sessions, visioning sessions, and lived experience panels; the use of equity review guides and checklists; and the incorporation of various forms of evidence. The recommendations aim to support the delivery of inclusive, person-centered care. With this goal in mind, this QFP update uses gender-inclusive language throughout and includes a wider range of methods of family building.¹⁵ The term “assigned female at birth” (AFAB) is used to describe particular considerations for people who were born with and may or may not currently have a uterus, ovaries, fallopian tubes, vagina, and vulva without connecting this anatomy to the experience of gender identity.¹⁶ Similarly, the term

“assigned male at birth” (AMAB) is used for people who were born with and may or may not currently have a penis and testes without connecting this anatomy to the experience of gender identity. Because these recommendations apply beyond the formal health care system, the terms “person,” “individual,” “client,” “user,” and “patient” are all used to refer to people who may seek or desire SRH care. Additionally, the term “clinic” is used to define broadly the various types of service sites, health centers, and clinical settings where SRH care is provided.

Historical Context

Past and ongoing reproductive mistreatment of people belonging to communities that have been marginalized is of clinical relevance because it has shaped many present-day health inequities and contributes to ongoing mistrust of the health care system.

Twentieth-century violations of reproductive autonomy include the testing of the oral contraceptive pill on women in Puerto Rico without appropriate informed consent; coercive sterilization of people with physical and intellectual disabilities, those living in poverty, and from marginalized racial and ethnic groups; and the Tuskegee experiment, in which hundreds of Black men were deprived of treatment for syphilis.^{11,17–21} Coercive sterilization practices continue into the 21st century, including among women in carceral settings.

Public health prerogatives to advance science and improve the gene pool were used to justify many of the actions now recognized as unjust.²² These past actions serve as a reminder to providers to interrogate programs and practices, and to engage patients and communities in program development and system redesign to avoid neglecting or misunderstanding community needs and to reduce the risk of additional harm.

Current Context

During the past decade, several changes have taken place in the United States that have affected the delivery of SRH care and understandings of what constitutes quality. This broader context shaped these recommendations. Important considerations include the following:

- *Technological advances* include new contraceptive methods (for example, vaginal pH modulator gel), modifications to existing contraceptive methods (for example, new doses and formulations of hormonal contraceptives and intrauterine devices), new ways of preventing STIs (for example, pre-exposure prophylaxis for HIV), and more widely adopted service delivery options (for example, online platforms, self-care, and over-the-counter access to oral contraceptives).

Existing technologies such as telehealth have also expanded and become more user-friendly.

- *Enhanced recognition of long-standing inequities* within and beyond the health care realm have influenced what is considered high-quality SRH care. Systemic inequalities have long impeded people's ability to receive high-quality SRH care, including, but not limited to, contraceptive care. To advance SRHE, entities delivering SRH care are expected to actively attend to and work to redress inequities and to reform systems. These efforts include offering supportive resources such as transportation assistance to increase access to care, addressing provider bias through ongoing and effective anti-bias training and community engagement, and adopting quality measures that reflect the broad range of experiences and needs of diverse people. SRHE also includes acknowledging and accepting that many people prefer to seek care outside of the formal health care system; therefore, it is crucial to empower them with the resources they may need to do this, including accurate information.
- *Legal and regulatory changes at the federal, state, and local levels* have affected access to SRH care through various mechanisms, including funding, insurance coverage, legal restrictions, public programs, and provider availability. Some of these changes have had the effect of limiting access, whereas others have enhanced access.

Providers should be attentive to and remain aware of new developments that influence the delivery of high-quality SRH care. The Reproductive Health National Training Center (RHNTC) at www.RHNTC.org and the Clinical Training Center for Sexual and Reproductive Health (CTC-SRH) at www.CTCSRH.org offer training on these topics. Other organizations specializing in training on specific health topics covered in this update are listed in the relevant sections. Please refer to [Appendix 3](#) for a glossary of terms used throughout this update and in the broader SRH field.

SECTION 2: METHODS

Recommendations Development Process

OPA developed these recommendations in consultation with a wide array of experts and partners. OPA hired a contractor to convene an Expert Workgroup (EWG) comprising experts in the fields of SRH and health equity who had relevant professional and lived experience representing a broad range of sectors and communities. The EWG and OPA identified research gaps in a series of systematic literature reviews and environmental scans. The contractor then assembled technical expert

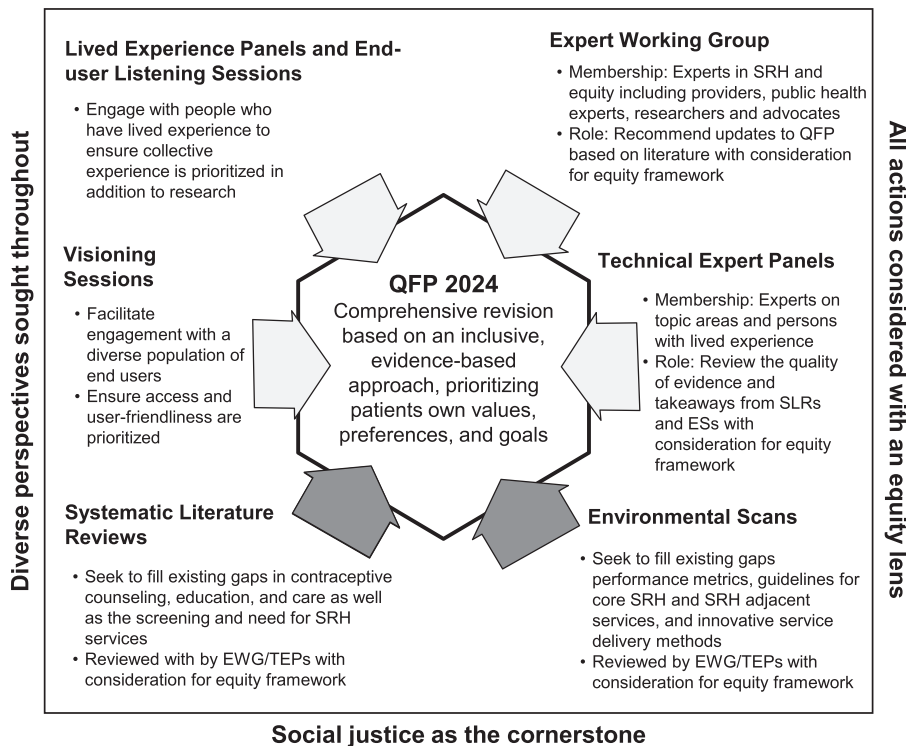
panels (TEPs) of subject matter experts for each of the topics. The TEPs reviewed the results of the literature reviews and the quality of the evidence and provided feedback on recommendations supported by a rigorous review of the evidence and the use of established equity principles (see [Exhibit 2](#)).

Drawing from established procedures for developing clinical guidelines and recommendations, including the National Academies of Sciences, Engineering and Medicine (NASEM) (formerly IOM) standards,⁵ OPA adapted a multistage process in crafting this QFP update. The recommendations were drawn from an extensive literature review; individual feedback from subject matter experts, including persons with lived experience and members of the EWG and the TEPs; and a group of external reviewers ([Appendix 4](#)). Federal agencies and relevant professional organizations were consulted for updated clinical practice guidelines and recommendations. Guidelines, recommendations, statements, and committee opinions from the following organizations are included in this QFP update: Centers for Disease Control and Prevention (CDC), United States Preventive Services Task Force (USPSTF), the Health Resource and Services Administration (HRSA), Women's Preventive Services Initiative (WSPI), American Academy of Pediatrics (AAP), American Society for Colposcopy and Cervical Pathology (ASCCP), American College of Obstetrics and Gynecology (ACOG), American Society of Reproductive Medicine (ASRM), American Urological Association (AUA), Society of Family Planning (SFP), American Cancer Society (ACS), National Comprehensive Cancer Network, World Sexual Health Association, Center for Excellence for Transgender Health, and World Professional Association for Transgender Health (WPATH). In instances where the guidance or related materials of other organizations are described, specific organizational affiliations are included. The systematic literature reviews and other evidence used to prepare these recommendations are published in the *American Journal of Preventive Medicine*.^{23–26} OPA funded all work contributing to this update.

Audience

The primary audience for this update is clinical providers and potential providers of SRH services to people of reproductive age. They include clinicians, educators, community health workers, and other licensed and non-licensed health care providers. These recommendations are addressed to providers working in service sites dedicated to SRH service delivery, including Title X-funded clinics and federally qualified health clinics (FQHCs), as well as primary care

Guided by Equity Principles



providers, specialists, and other providers who may identify SRH needs and make referrals. Medical directors and others responsible for developing clinical protocols may also use the QFP recommendations to support policy and protocol development.

Equity Approach

Acknowledging the importance of incorporating equity throughout SRH services, OPA engaged with the HHS Equity Technical Assistance Center (ETAC) in 2022 to conduct an equity-focused review of the QFP update and recommendations.

The approach sought to reflect QFP's role in supporting SRH care provision that is person-centered, inclusive, equitable, and accessible to ensure high-quality care for all and facilitate dissemination and implementation. A set of equity tools was developed and used throughout the process to ensure a commitment to the stated goal of advancing SRHE.²⁶ These tools were integrated into the review process to ensure all updates and changes were considered through an equity lens and served the larger mission of integrating equity in SRH services. The overarching equity principles were developed to guide all activities involved in the QFP update process and serve as a foundation for QFP recommendations' equity focus.

Specific to the systematic literature reviews, the review team drew from an adapted version of the PRISMA Extension for Equity Review Checklist, as opposed to the standard PRISMA checklist, to confirm equity was appropriately considered throughout the evidence.²⁷ Together, these tools were used to ensure that equity remained the focus of all recommendations at each step in the process.

Incorporating Lived Experience

OPA engaged with people with diverse lived experiences to ensure that recommendations were informed by various perspectives in addition to the published evidence. The following approaches were used:

- Formation of EWG and TEPs to ensure inclusion of persons representative of the diversity of racial, ethnic, disability, sex, sexual orientation and gender identities across the United States, as well as multidisciplinary academic and professional experience, including researchers, clinical providers, and patient advocates (see roster in [Appendix 4](#)).
- Listening sessions with FP clinical providers and administrators: Advised OPA on an individual basis on the content and usability of the original QFP report, discussed proposed updates to the QFP

recommendations and opportunities to improve the QFP update's inclusivity and functionality.

- Visioning sessions with Title X providers: Discussed strategies for making the QFP recommendations user-friendly and adaptable.
- Lived experience panels (LEPs) with users of SRH services: Provided individual feedback on proposed changes to QFP and related research, potential impact of those changes, and the extent to which the evidence reflected their preferences and lived experiences.

Literature Reviews

OPA commissioned a set of systematic literature reviews on the following topics: Contraceptive Counseling, Education, and Care and Screening for the Need and Desire for SRH Care.^{23–26} OPA also commissioned two environmental scans on Performance Measures to Improve the Quality of SRH Services and Guidelines for Core SRH and Adjacent Services (unpublished). Given existing clinical guidelines and recommendations, OPA determined that the largest gaps were related to contraceptive counseling and provision. This determination corresponded well with OPA's core mandate to provide guidance to FP providers. A more detailed description of the methods used to conduct the literature reviews is provided in the accompanying journal supplement.^{23–25} In addition, OPA commissioned a rapid systematic review of SRH Services Delivered via Telehealth.²⁸

Orientation and Organization of the Recommendations

The QFP update is divided into 11 sections. The initial sections describe the context for this update and the methods used to develop the QFP recommendations. Subsequent sections describe the fundamentals of SRH care and how to assess an individual's need and desire for SRH services, the provision of person-centered contraceptive care, STI and HIV screening and treatment, family building, pregnancy testing and counseling, early pregnancy management, screening and other preventive health care services, and how to use performance measures to track and improve the quality of SRH care.

To accompany this update, technical assistance (TA) resources will be available from OPA, the RHNTC, and the CTC-SRH to facilitate adoption of the QFP recommendations. These resources will include a separate supporting website, managed by the RHTNC—www.QFPguide.org—that will provide a searchable format and links to available TA resources to support implementation of QFP recommendations, including tools, job aids, and interactive training sessions.

Exhibit 3. What Services Are Considered Part of SRH Care?

- Services intended to help people achieve their reproductive desires, such as contraception, pregnancy testing and counseling, achieving healthy pregnancy, and family building and adoption
- Prevention and detection of disease, including screening, testing, treatment, vaccination and prophylaxis for STI
- Provision of or referral to pregnancy-related care, including abortion, prenatal care, and treatment of pregnancy loss
- Gender-affirming care
- Screening for health issues that can affect SRH, such as hypertension, mental health conditions, and substance abuse, and either treatment or referral, when indicated

SECTION 3: FUNDAMENTALS OF SEXUAL AND REPRODUCTIVE HEALTH CARE DELIVERY

SRH care encompasses a broad range of services aimed at helping people define and achieve their highest level of health ([Exhibit 3](#)). The QFP update offers recommendations on how to deliver high-quality SRH services commonly provided in primary care, women's health, and other outpatient settings. The specific services offered in any given setting depend on community needs, provider scope, facility capacity, and the legal and regulatory environment. Providers who do not offer full-scope SRH care should screen for the need and desire for SRH services, share the limits of their practice, and refer or connect patients to other settings where they can obtain quality services, as indicated. Given the definition of SRH and the range of services it encompasses, it is important to note that SRH care is not just for people who can or want to become pregnant; rather, it should be accessible and welcoming for all people, regardless of gender, sexuality, disability, or age.

This section explains how the equity principles, described in [Exhibit 2](#), can be integrated into program design and clinical care. It offers guidance about overarching approaches to care and discusses processes for screening individuals for various aspects of SRH care.

Guiding Principles for SRH Care

High-quality SRH care should be free from all forms of bias, including racism, classism, and bias based on disability status, weight, age, sexual orientation, and/or gender identity. Six principles guide the delivery of quality SRH care: (1) person-centered, (2) evidence based, (3) inclusive, (4) accessible, (5) sex and body positive, and (6) trauma-informed. These principles were designed for the QFP update based on a review of relevant literature and input from the EWG and the LEP. Descriptions of each are included below.

Person-centered. Person-centeredness, defined as a focus on an individual person's needs, values, and preferences, is among the essential domains of health care quality.²⁹ Advancing equity and minimizing harm necessitate providing SRH care in a person-centered framework by orienting the clinical team to everyone's unique life context, preferences, and social and structural realities. Respect for individual autonomy is critical, including the right to use or not use contraception, select or decline recommended screening tests, or pursue any preferred pregnancy option.³⁰

Evidence based. Evidence based means the use of evidence to inform clinical care, develop programs, and conduct quality improvement.^{5,31} Providers can consult evidence-based guidelines, such as those referenced throughout this update of the QFP, as part of providing quality care. Primary research and clinical resources such as UpToDate are also useful sources of information. Health systems and other employers can provide access to timely evidence-based resources to support staff in providing evidence-based care.

Inclusive. Inclusivity enables all people to participate in and benefit from services; the goal is for all services to reflect a patient's circumstances appropriately without bias. Efforts to create inclusion should specifically consider the needs of LGBTQI+ people, who often experience discrimination and mistreatment in the health care setting, contributing to disparities in SRH outcomes.³² Inclusiveness involves standardizing and normalizing sexual orientation and gender identity (SOGI) conversations.^{33–35} To establish an inclusive clinical environment, it is essential to address both administrative processes, such as registration and documentation, as well as patient care practices. This includes ensuring that patient information in medical records and portals accurately reflects their identity. Rather than making assumptions, healthcare providers should ask patients about their sex assigned at birth, current anatomy, preferred name, gender identity, and pronouns. These details should be carefully documented in the medical record to ensure respectful and personalized care throughout the patient's journey, including follow-up. The CDC offers suggested language for these questions, and for electronic health record (EHR) documentation.³⁶ These questions should be asked routinely of all patients to normalize and standardize interactions and enable people to describe themselves accurately without being targeted.^{37,38}

Inclusive care is also culturally and linguistically affirming, meaning that services respond to diverse cultural health beliefs and practices, preferred language,

Exhibit 4. Providing Care Inclusive of Adolescents

Confidential SRH services should be made available to adolescents while observing state laws and any legal obligations for reporting.

1. Ensure adolescents know their rights. Adolescents feel safer accessing care and more comfortable sharing personal information during appointments when they know their rights related to confidentiality, including how billing and insurance notifications are handled.
2. Know your state laws and clinic policies. Statutes on rights of minors to consent to health care vary by state. Be familiar with clinic policies around billing for minors and possible limitations of confidentiality related to insurance.
3. Address young people's needs, desires, and concerns. Routinely address needs and preferences for SRH care and individual goals, including those related to pregnancy prevention, enabling healthy pregnancy, and disease prevention, regardless of a person's age or sexual activity. Address relationships, sexual behaviors, and needs for the full range of SRH services.
4. Provide youth-friendly services. Peer educators and support groups can improve clinical outcomes and patient satisfaction with care. The involvement of a trusted adult, with permission, can also improve similar outcomes.
5. Integrate SRH care into other settings, including schools, to increase access and improve educational opportunities for adolescents.
6. Access specialized training. Trainings specific to adolescent care may include adolescent brain development, contraceptive provision, including IUD placement, appropriate referrals, and familiarity with confidentiality laws and policies.

Source: These key steps were adapted from ACOG's Committee Opinion Number 710, Counseling Adolescents About Contraception,⁴¹ and the American Academy of Pediatrics Policy Statement, April 2024.⁴²

health literacy, and other communication needs of patients. The National Culturally and Linguistically Appropriate Services (CLAS) standards should be applied. The National Coalition for Sexual Health offers resources on how to create a more inclusive clinic environment, including self-assessment tools.³⁹

Workforce composition is an essential element of inclusion. Patients benefit when providers and staff in clinical settings are representative of communities being served and made up of individuals of diverse background and identities in terms of age, race, ethnicity, gender identity, disability status, sexual orientation, and other characteristics. The CLAS standards mentioned above include recommendations for recruiting a diverse clinical workforce.⁴⁰ People seeking SRH care value providers' clinical expertise, skill sets, and characteristics—such as empathy and nonjudgmental attitudes—regardless of health professional type, and collaborative interdisciplinary care teams can best deliver quality care.⁴⁰

Specific considerations for providing care inclusive of adolescents are described in [Exhibit 4](#).

Accessible. Care should be logistically, financially, and physically accessible to patients. All clinic settings should be aware of barriers to care and implement policies and procedures to help patients overcome barriers. For example, offering expanded hours, telehealth options, and walk-in appointments assists patients in obtaining timely care. Adopt flexible approaches to late-arrival policies, particularly for adolescents and individuals facing transportation challenges. Aim to reduce the number of visits required, recognizing the burden of multiple visits. Additionally, offering childcare services during appointments can increase accessibility for patients who are parents or caregivers.

Clinics should be familiar with out-of-pocket costs for services, medications, and supplies, whether provided on-site or through referrals. They should also be knowledgeable about coverage options available through commonly used public and private insurance programs. Offering guidance and resources to patients in need of financial assistance can help ensure access to care and reduce financial barriers.

Provider training on how to adapt clinical care to meet the needs of people of all abilities and sizes can improve quality of care. People with disabilities experience disparities in access to quality SRH services. Federal civil rights statutes, such as Section 504 of the Rehabilitation Act, Section 1557 of the Affordable Care Act, and the Americans with Disabilities Act (ADA), require providers to accommodate the needs of people with disabilities. The implementing regulations for Section 504 and Section 1557 further detail the obligations to individuals with disabilities under the statutes for health care programs and activities that receive federal financial assistance.⁴³ Important considerations include examination tables that are easy for individuals to transfer on and off, availability of interpreters for deaf and hard-of-hearing people, and provider training.⁴⁴ The Northwest ADA Center has developed a toolkit that providers can consult

to provide accessible care.⁴⁵ Educational resources explain various approaches to improving SRH care for people with disabilities.⁴⁶

Sex- and body-positive. Care should be affirming and supportive of all bodies and sexual activity that is safe and consensual. Wanted, noncoercive, pleasurable sexual activity has many physical, emotional, and social benefits.⁴⁷ Providing sex-positive SRH care is important to helping people achieve their highest level of sexual health.⁴⁸ Providers should promote open dialogue about sexual functioning and pleasure by using nonjudgmental, open-ended language.³⁹

Trauma-informed. Providers should recognize the high prevalence of trauma, including sexual violence, and its many documented effects on SRH and health in general.⁴⁹ As service sites work toward becoming trauma-informed, there are many resources available, including universal trauma precautions or trauma-informed screening protocols. Trauma screening is an approach that refers to a brief, focused tool used to determine whether an individual has experienced or had reactions to traumatic events. Patients should be reassured that they are in control of any details they share.⁸

Providers should practice universal trauma precautions and trauma-informed care with all patients (Exhibit 5).^{50,51} This kind of care involves a strengths-based approach emphasizing autonomy, safety, trust, and empowerment. The goal of universal trauma precautions is not disclosure but rather to acknowledge the presence and impact of trauma. It assumes that all patients have been exposed to negative conditions or traumatic events.

The Substance Abuse and Mental Health Services Administration (SAMHSA) established a framework to support implementation of trauma-informed approaches grounded in a set of four assumptions:⁵²

Exhibit 5. Key Considerations and Actions to Implement Trauma-Informed Care

Before Exam	During Exam	After Exam
<ul style="list-style-type: none"> • Consider the physical environment • Offer a support person • Establish rapport • Discuss goals and involve patients in the treatment process • Ask how you can support the patient throughout visit • Discuss the exam process • Repeatedly assure patients that they are in control • Observe for signs of distress 	<ul style="list-style-type: none"> • Explain the steps of the exam • Describe what you are going to do, and why • Ask questions to gain permission at every step of the examination or procedure • Allow the patient to be in control • Practice preventive strategies to avoid retraumatization • Watch for discomfort or distress • Stop exam immediately if the patient is distressed 	<ul style="list-style-type: none"> • Allow the patient to get dressed prior to finishing the visit • Discuss and summarize the visit • Make an action plan with the patient for follow-up • Share the timeline for any follow-up needs • Share contact information for further discussion • Provide referrals and resources • Confirm documentation preferences

Source: Clinical Training Center for Sexual and Reproductive Health (CTC-SRH).

(1) realize the widespread effects of trauma; (2) recognize the signs of trauma in patients, families, staff, and others involved with the system; (3) respond by fully integrating knowledge about trauma into policies, procedures, and practices; and (4) resist retraumatization of patients and staff. SAHMSA also recommends adherence to six principles of a trauma-informed approach:⁵³ (1) safety; (2) trustworthiness and transparency; (3) peer support; (4) collaboration and mutuality; (5) empowerment, voice, and choice; and (6) cultural, historical, and gender issues. To support full implementation of trauma-informed approaches to care, changes should involve both organizational and clinical practices.

The following resources offer further guidance:

- The [CTC-SRH clinician guide for trauma-informed care and accompanying video](#).
- The [Trauma-Informed Care Implementation Resource Center](#) resources to guide diverse health care organizations in adopting best practices.
- The [National Center for PTSD](#), U.S. Department of Veterans Affairs provider screening questionnaire and patient tools for post-traumatic stress disorder (PTSD) self-screening.

Approaches to Care

Three approaches to care help providers carry out the principles described above: (1) quality counseling, (2) informed consent, and (3) privacy and confidentiality. Descriptions of each are included below.

Quality counseling. Quality counseling is fundamental to the delivery of person-centered care. Five key principles guide quality counseling:

1. *Establish and maintain rapport with the person.* Rapport is fundamental for establishing trust and open communication and has been shown to affect outcomes, including patient satisfaction.

Several elements build rapport:

- Simple acts such as a warm welcome, a handshake, and “taking the time to connect as human beings”⁵⁴
 - Ensuring privacy and confidentiality
 - Asking permission to discuss SRH topics as well as inquiring, acknowledging, and centering the person’s goals and desires for the visit
 - Matching the patient’s tone, paraphrasing what the patient has said, and asking if you got it right
 - Focus more attention on respectful listening versus talking “at the patient”
2. *Assess the person’s preferences, values, and goals; personalize discussions accordingly.* Both open-ended discussion and structured questionnaires can

contribute to understanding patient preferences, values, and goals. Assessment should encompass not only the type of care but also the type of information a person might want or need as well as how the person prefers to receive information and make decisions. Meet people where they are. Avoid attempts to redirect their goals. Set aside personal biases that may conflict with patient preferences and work to support the patient’s desired outcomes.

3. *Work with the person to interactively establish a plan.* Establishing a plan includes setting goals, using a strengths-based approach in discussing possible difficulties, and developing action plans to deal with these difficulties. Ground all plans in the individual’s own goals, interests, and readiness for change.
4. *Provide accurate and understandable information that supports the person’s desires.* Provide information that is balanced, nonjudgmental, and supported by scientific research. Educational materials and decision aids should be offered in a variety of formats (written, audio/visual, video, interactive) to enable patients to select the format(s) that work best for them. Visual and tactile aids can help patients integrate new information that is relevant to their decision making.^{55–57} Many people have basic or below-basic health literacy; understanding health information improves short- and long-term health outcomes and is essential for shared decision making.⁵⁸ The Agency for Healthcare Research and Quality (AHRQ) offers resources for evaluating educational materials to ensure that they are easy to read and understand.⁵⁹ Test all educational materials with the intended audiences for clarity and comprehension before wide-scale use, specifically involving individuals who are representative of the populations served.
5. *Confirm understanding.* Most people do not understand or recall all the information they are offered in a clinical encounter.⁶⁰ Asking people to repeat back what they heard (“teach-back”) can be a helpful way of confirming their understanding and determining what additional information sharing may be needed.⁵⁹ For example, “*I’ve shared a lot of information and I want to be sure I was clear, can you tell me what you understood about [topic]?*”

Shared Decision Making (SDM), which is one approach to quality counseling, is a joint process in which the health care provider and patient work jointly to help the patient make decisions about their care. For all of the components described above, a shared decision-making approach is recommended. In an SDM model, the patient shares their values and preferences, and the provider shares relevant information with the

patient. The provider and patient then work together to determine what clinically appropriate course of action suits the patient's preferences, clinical needs, and goals. Not all patients wish to engage in SDM, and the patient's decision-making preferences should be respected. In the SRH context, SDM has been shown to improve the quality of contraceptive counseling and contraceptive method satisfaction and is recommended in the delivery of a wide range of SRH services, including pelvic examinations and HIV pre-exposure prophylaxis (PrEP).^{61–63}

Informed consent. As defined by The Joint Commission, informed consent is “a *process of communication* between a clinician and a patient that results in the patient's authorization or agreement to undergo a specific medical intervention.”⁶⁴ Informed consent enables individuals to make decisions about their own care and is necessary for their safety. The process of informed consent involves disclosing relevant information, such as the rationale for a recommendation, anticipated benefits, possible risks and complications, and alternatives, including no intervention. This information can be offered both verbally and in writing, using language that the person can understand. Written consent is one way of documenting that the informed consent process has taken place. Institutions may require written consent in some circumstances (for example, initial consent to care and procedures, such as contraceptive device placement), whereas other circumstances only require a verbal agreement. Each facility should develop a policy and procedure for informed consent processes.

To apply a trauma-informed approach to informed consent in SRH care, providers should have an ongoing and transparent dialogue with patients during the clinical visit that honors patient autonomy and decision making. In this approach, providers should ask for permission to discuss sensitive topics (for example, sexual history, substance use) and to provide the recommended physical exam.

There is long-standing legal support for young people to independently consent to SRH care. At the time of publication, no state requires parental consent for STI services, and most states explicitly allow minors to consent to contraceptive services.^{65,66} Consult official state resources and databases to better understand specific laws and regulations.

Privacy and confidentiality^d. Privacy and confidentiality should be guaranteed for all people seeking SRH care to ensure safety and trust. Confidentiality is especially important in the SRH context due to the personal nature of this care and the potential familial, legal, relational, and professional ramifications of

breaches of confidentiality. Limitations of confidentiality, including mandated disclosure and reporting requirements, should be discussed with all patients. It is expected that all providers should educate themselves on all relevant federal, state, and local laws and any legal obligations.

Confidentiality matters for all individuals, and special consideration should be given to the needs of adolescents, given that confidentiality can greatly influence their willingness to access and use services.⁶⁷ The American Academy of Pediatrics (AAP) offers recommendations on education, office policies and procedures, and communications for upholding adolescent confidentiality as well as resources like those giving suggested language.⁶⁸ Recommendations include talking directly with adolescent patients and their families about the protections and limitations of confidentiality, and reserving time for one-on-one conversation between the provider and the adolescent at each visit, beginning as early as age 11. Telehealth appointments may be a strategy to increase access for adolescents. During telehealth visits, providers can take additional steps to enhance safety and confidentiality by, for example, recommending the use of headphones, using online chat functions, and having a plan in place in case safety concerns arise.

Importantly, maintaining privacy and confidentiality does *not* mean that family members and other trusted parties cannot be engaged in SRH care. When possible, patients can request that a person of their choosing be present when they are receiving care, particularly education, informed consent, or invasive exams. This practice can enhance patient comfort, empowerment, and shared decision making. Providers can encourage adolescents to discuss their SRH with trusted adults in their life, including but not limited to their parent(s) or legal guardian(s).

^dIn April 2024, the HHS Office for Civil Rights (OCR) issued a Final Rule, entitled HIPAA Privacy Rule to Support Reproductive Health Care Privacy (89 Fed. Reg. 32976), which strengthens the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule by prohibiting the disclosure of protected health information related to lawful reproductive health care in certain circumstances. The Final Rule will bolster patient-provider confidentiality and help promote trust and open communication between individuals and their health care providers or health plans, which is essential for high-quality health care. For more information about this Final Rule and other OCR guidance documents related to privacy and reproductive health care, see <https://www.hhs.gov/hipaa/for-professionals/special-topics/reproductive-health/index.html>.

SECTION 4: DETERMINING AN INDIVIDUAL'S NEED AND DESIRE FOR SERVICES

To determine what services may be appropriate for a patient, a provider can begin by asking about the person's needs and expectations. Additionally, taking an initial open-ended sexual history and screening for specific services can help providers with the following:

- Ensure people get services, including counseling and education, which are clinically appropriate and in line with their personal needs and preferences.
- Inform people about available services (both on-site and by referral) and what might be recommended for them.
- Educate people about how they can care for themselves, including health-promoting behaviors, where and how to seek additional information, and over-the-counter tests and treatments.⁶⁹

Essentials of Screening

Providers should be aware of the risks of screening. When undertaken without a person-centered approach, screening can mistakenly communicate implicit expectations or assumptions about people's reproductive needs or desires. People may feel that they are being "targeted"

for STI screening or contraception if the screening process is not explained or normalized. To minimize these risks, the following principles can guide screening:

- Explain why screening is being conducted. It is important to explain that screening is conducted routinely, that it is part of determining what services a person might benefit from, and that the answers to the screening questions are private and will not affect a person's eligibility for care.
- Use a standardized, evidence-based, person-centered tool when possible. Specific tools for screening for reproductive desires and related services are described below and samples are listed in [Exhibit 7](#). Tools can be brief and user-friendly.^{70,71} Although screening is most frequently conducted verbally, written or online questionnaires can also be used for screening, either in person or remotely.
- Recognize that disclosure is not always the goal and that patients may choose to omit aspects of their history for a variety of reasons.

Taking a Sexual History

An open-ended sexual history can help a provider assess what resources and services can be offered to the patient

Exhibit 6. 6 Ps of Sexual History

Topic	Sample question(s)
Partners	<ul style="list-style-type: none"> • Are you currently having sex of any kind—oral, vaginal, or anal—with anyone? (Are you having sex?) • If no, have you ever had sex of any kind with another person? • In recent months, how many sex partners have you had? • Do you or your partner(s) have other sex partners? • Could you tell me about your current sexual partners? OR Tell me about your sex partners—genders, how many partners in the past three months, whatever you think is relevant for me to know.
Practices	<ul style="list-style-type: none"> • I need to ask some more specific questions about the kinds of sex you have had over the last 12 months to better understand if you have risk factors for STIs. Would that be OK? • We have different tests that are used for the different body parts people use to have sex. What parts of your body are involved when you have sex? <ul style="list-style-type: none"> - Do you have penis-in-vagina sex? - Anal sex (penis in the anus)? - Oral sex (mouth on penis, vagina, or anus)?
Protection from STIs	<ul style="list-style-type: none"> • Do you and your partner(s) talk about STI protection? • If you use prevention tools, what methods do you use (for example, condoms or PrEP)? • Have you received vaccines for HPV, hepatitis A, and/or hepatitis B?
Past History of STIs	<ul style="list-style-type: none"> • Have you ever been tested for STIs? • Have you ever been diagnosed with an STI in the past? When? Did you get treatment? • Have you had any symptoms that keep coming back? • Has your partner or any former partners ever been diagnosed or treated for an STI?
Plus*	<ul style="list-style-type: none"> • Pleasure: Is the sex you're having pleasurable for you? • Problems: Are you having any difficulties when you have sex?
Pregnancy Preferences	See Exhibit 7 on screening for reproductive desires and related care

Source: The 5 Ps were developed by the CDC. (<https://www.cdc.gov/hiv/clinicians/screening/sexual-health.html#5ps-approach>; the National Coalition for Sexual Health (NCSH) expands the "6th P" further to include "pleasure, problems, and pride."³⁹

and guide appropriate counseling and information. Even if a person does not currently consider themselves sexually active, it is still important to take a sexual history. Approach and questions can be tailored to each person's identity and understanding.^{4,72} Providers can take a few steps to reduce stigma and build rapport at the outset of taking a sexual history:

- Ensure that the patient understands that they can decline answering questions or sharing information; respect their right to decline.
- Avoid any judgment of the patient's behavior or preferences.
- Avoid using terms that make assumptions about sexual behavior or orientation.
- Ensure shared understanding around terminology and pronunciation to avoid confusion.
- Use a sensitive tone that normalizes the topics being discussed.

The 6 Ps, described in [Exhibit 6](#), can be a useful way to remember the main elements of the sexual history. To complete a full sexual history, providers may consider adding questions about sexual satisfaction and sexual (dys)function. Open-ended questions can introduce each of these topics, with more specific questions being used to obtain more information when and if needed. NCSH resources offer examples to guide providers in asking about—and responding to—patients' sexual health needs and desires.³⁹ Providers should be prepared to answer patients' questions and concerns about sex and make referrals to appropriate care. Patients experiencing sexual concerns or dysfunction can be referred to a qualified sex therapist or a physical therapist. Online resources such as [Bedsider.org](#) offer sources of additional information and sex-positive perspectives on sexuality and sexual health for both patients and providers.⁴¹

Screening for Reproductive Desires and Related Care

A variety of approaches have been tested for screening patients for those SRH services that relate to preventing or preparing for pregnancy—that is, contraceptive care, family building, and preventive health services. There is not sufficient evidence to recommend a particular tool or approach. Given the centrality of these topics in quality SRH care, this section describes a range of evidence- or theory-based and person-centered approaches and how to integrate them into care. In addition to pregnancy-related services, there are a variety of other

preventive health services that may be relevant for people, depending on their health needs and goals (for example, STI screening/testing, tobacco cessation, treatment for substance use disorder). Screening tools for other health care services are described more in depth in pertinent sections. People should be made aware of services available on-site and by referral.

There are two main frameworks for approaching screening for reproductive desires and related care: (1) reproductive desires and (2) service based. [Exhibit 7](#) offers sample tools for conducting each screening approach, though more are available.⁷⁰ Providers and health care settings may select a tool or suite of tools to use based on where these tools have been tested, the population(s) being served, and health records considerations. It is generally recommended to screen patients at first encounter and then on a regular basis as determined by a schedule that providers or their organizations create based on patient needs, performance indicators, and other factors. It is not recommended to screen at every clinical encounter.

Screening for Reproductive Desires. Multiple studies show that screening for reproductive desires can increase counseling rates and patient satisfaction.⁷⁰ Using these screening tools enables providers to offer appropriate services for those patients who are seeking to avoid pregnancy as well as for those who are open to or seeking pregnancy and those interested in other mechanisms to build their families. These tools can be broadly used. In particular, they can open the door for discussing reproductive desires in non-SRH-related encounters or in settings for all people—particularly among those for whom such discussions may be medically relevant (for example, people with chronic medical conditions or those considering a therapeutic treatment that may affect current or future fertility or pregnancy health). They can also be helpful to initiate discussion of family-building interest among LGBTQI+ people and others who may need or desire medical assistance to build their family. Additionally, many people build their families outside of a pregnancy (adoption, fostering, surrogacy).

Screening for reproductive desires is not synonymous with reproductive life planning (RLP), the approach endorsed in the previous QFP recommendations.⁷³ The RLP framework encourages providers to work with all patients to identify their reproductive goals and construct a life plan based on these goals, including shaping their clinical care. This approach is no longer endorsed, given the body of literature suggesting that many people do not relate to the idea of RLP and that a strict pregnancy planning framework may be discordant with

Exhibit 7. Approaches and Sample Tools for Screening for Reproductive Desires and Related Care

Sample Tools	Tool Content	Considerations
Reproductive desires		
Parenthood/Pregnancy Attitude, Timing, and How important is pregnancy prevention (PATH) ⁷³	Three questions: 1. Do you think you might like to have (more) children at some point? 2. When do you think that might be? 3. How important is it to you to prevent pregnancy (until then)?	<ul style="list-style-type: none"> • Can be used for people of any gender • Job aids and other resources available through Envision SRH and RHNTC
One Key Question© (OKQ) ⁷⁸	Single question/prompt: Would you like to become pregnant in the next year? You can answer yes, no, unsure, or okay either way	<ul style="list-style-type: none"> • Copyright and fee based • Not applicable for people who cannot become pregnant and may lead to bias in screening • Most studied of these tools and approaches • Can be programmed into EHR and used in conjunction with electronic clinical quality measures (eCQMs) • Training and resources, including follow-up prompts, available through Power to Decide
Service-based		
Self-Identified Need for Contraception (SINC) ⁷⁹	Single question/prompt: We ask everyone about their reproductive health needs. Do you want to talk about contraception or pregnancy prevention during your visit today?	<ul style="list-style-type: none"> • Should be asked at least once per calendar year • Can be programmed into EHR and used in conjunction with eCQMs • Implementation resources, including follow-up prompts, available through University of California San Francisco Person-Centered Reproductive Health Program
Reproductive Health Services Screening Question ⁸⁰	Single question: Can I help you with any reproductive health services today, such as preventing pregnancy or planning a healthy pregnancy?	<ul style="list-style-type: none"> • Can be used for people of any gender

Source: Tools suggested identified by an environmental scan commissioned by OPA.

many people's lived realities.^{74,75} Reproductive desires can be discussed with a person-centered approach that focuses on open-ended communication and nonjudgmental counseling and support.⁷³

Service-Based Screening. Concepts such as “pregnancy intention” or “planning pregnancy” do not always resonate with people because they do not accommodate nuanced, fluctuating, and sometimes contradictory thoughts and feelings that people can hold regarding future pregnancy. Sometimes pregnancy ambivalence stems from unstable social and structural circumstances, such as housing, relationship, and employment or income insecurity^{74,76,77} that can influence reproductive decision making. Service-based approaches have emerged that involve simply offering a health service such as contraception or the provision of health information about ways to prepare for a potential future

pregnancy. Another advantage of service-based screening approaches is that they are more applicable for people who are interested in contraception for reasons other than pregnancy prevention (for example, menstrual regulation).

SECTION 5: PERSON-CENTERED CONTRACEPTIVE CARE DELIVERY

Person-centered contraceptive services are an essential component of SRH care that can increase patients' satisfaction with and participation in that care.^{4,55,81,82} Person-centered contraceptive care focuses on providing contraception services in alignment with each individual's values, preferences, needs, and desires. This approach presents a shift from previous models that prioritized efficacy and the use of the most effective methods of contraception among patients.^{83,84} Instead,

providers should offer information about and access to a full range of hormonal and nonhormonal contraceptive options, including permanent and reversible methods, either on-site or by referral, but not prioritize one method over the other. This section outlines key steps for offering person-centered contraceptive care regardless of professional role or service delivery setting.

Person-centered care requires providers to put aside their assumptions and opinions about what they believe is best for the patient to identify and center their patients' preferences for contraceptives based on their own goals and values. There is no "best" method of contraception for everyone, nor is the success of care defined by contraceptive uptake and use. People may choose not to use contraceptive methods or opt for less effective pregnancy prevention strategies for various reasons, including concerns about side effects, influences from social media or friends' experiences, shifting or complex needs, religious or personal beliefs, and/or difficulty finding a method that works well for them.⁸⁵ Providers should also support people interested in using birth control methods for reasons other than contraception. Noncontraceptive indications for some methods include STI prevention; gender-affirming care; menstrual management or suppression; and treatment of acne, premenstrual dysphoric disorder (PMDD), heavy or painful periods, polycystic ovary syndrome (PCOS), and endometriosis.

Steps for Contraceptive Care Delivery

Key steps in providing contraceptive services are outlined in [Exhibit 8](#).

Step 1: Establish and maintain rapport with the patient. Establishing rapport with patients is a cornerstone of patient-centered care.^{86,87} Opportunities for rapport begin with the first point of contact and continue through every interaction with the health care

system. In addition to the rapport-building steps described in Section 3, these steps can be taken specifically in contraceptive counseling:

- Respectfully elicit and respond to patients' concerns about contraceptive methods. Demonstrate empathy when a patient appears distressed and validate concerns, especially about risks and side effects.
- Cultivate an awareness of the ways personal biases may influence information shared, language used, counseling practices, and recommendations.^{88–90}
- Focus on patient preferences to guide counseling, with the recognition that contraceptive use is not compulsory and highly preference sensitive. Therefore, providers should not form opinions about people's contraceptive use and related reproductive behaviors or engage in directive counseling.
- Assure patients that you are there to help them achieve whatever the patient determines is best for them. Proactively communicate that they are not required to choose a method or methods for pregnancy prevention. Remind people that their needs may change, and every person's body is different, so stopping or switching methods is common and can be done any time.

Step 2: Personalize contraceptive discussions by asking about individuals' contraceptive preferences, based on their needs, desires, and prior experiences.

Patients are more satisfied with visits where providers ask about and personalize contraceptive discussions to meet their individual needs.^{55,61,86} Ask open-ended questions to elicit people's preferences; for instance: "*Can you tell me something (or some things) that are important to you in your contraception?*" and "*What else are you looking for?*" or "*Is there anything else you're hoping to get out of your contraception?*" or "*Is there anything you don't want (or want to avoid) in a method?*" Open-ended questions enable the patient to explore and express what matters to them and enable the provider to tailor relevant information. For patients who may benefit from follow-up prompts, consider questions that help patients think about method characteristics that are important to them. For example, providers can ask patients about previous side effects that were undesired and what side effects a patient wishes to avoid in the future. Providers can also probe about preferences, such as about menstrual changes. After visits in which this type of counseling is practiced, patients report feeling that they received information in alignment with their needs^{56,81} and they made an informed decision.⁹¹ This type of communication can also reduce bias and

Exhibit 8. Key Steps in Providing Contraceptive Services

- | |
|--|
| <p>Step 1. Establish and maintain rapport with the patient.</p> <p>Step 2. Personalize contraceptive discussions by asking about individuals' contraceptive preferences, based on their desires, needs, and prior experiences.</p> <p>Step 3. Collaboratively determine which contraception (if any) aligns with the patient's preferences.</p> <p>Step 4. Conduct a physical assessment related to contraceptive use, when indicated.</p> <p>Step 5. Provide or refer for the contraceptive method, along with instructions about correct and consistent use; help the patient develop a plan for using the selected method and for follow-up; and confirm understanding.</p> |
|--|

Source: These key steps were adapted from steps outlined in *Providing Quality Family Planning: Recommendations of CDC and the U.S. Office of Population Affairs (2014)*. Updates were made based on recommendations from experts and then approved by the EWG.

Exhibit 9. Illustrative Framework: PHI CARE

Topic	Sample Approach(es)
P—Past Experience	<ul style="list-style-type: none"> It is common to switch methods along your “contraceptive journey”; tell me what methods you have used—what have you liked and disliked?
H—Health History	<ul style="list-style-type: none"> I’d like to review your medical history together to understand which options you could use safely.
I—Important	<ul style="list-style-type: none"> What is important to you about your contraceptive method?
C—Counsel	<ul style="list-style-type: none"> [When using a decision aid] I’d like to share this decision aid with you to discuss your contraceptive options and tell you how the preferences you shared with me apply to the different methods. [For patients who know what they want] Do you want to hear about other potential options, or should we go ahead with the choice you’ve shared with me?
A—Autonomy	<ul style="list-style-type: none"> What do you think of the contraceptive options we discussed? Is there anything else you would like to talk about? While you can start a method, you also do not need to choose a method today.
R—Review	<ul style="list-style-type: none"> In order to access and use [method(s)], this is what you need to know. . .
E—Experience	<ul style="list-style-type: none"> Remember you can always stop or switch methods at any time. Whatever you experience when using the method, I’ll respect it. Everybody is different. I am also here to help you manage side effects. Contraception is a journey, and as your life changes, your needs around contraception may change as well. Come back to see me if you would like to adjust your plan. [When no method is chosen] I am here to support you, and you can always come back to see me.

Source: PHI CARE, a provider tool for operationalizing patient-centered contraceptive counseling.⁹²

mistreatment.^{88–90} The PHI CARE counseling framework described in [Exhibit 9](#) is an illustrative model providers can use to remember the main elements of person-centered contraceptive conversations.

People also have specific preferences for when and how conversations about contraception should occur. For example, patients who seek specialty care for health conditions may prefer to consult with their specialist before

selecting contraceptives. For patients with serious medical conditions for whom pregnancy may confer significantly increased risk, for instance, a provider might say, “*This medical condition*” or “*This medication carries a risk to a developing pregnancy*” or “*I don’t want to make any assumptions, but given this, would you like to talk about ways to safely prevent pregnancy or plan for a pregnancy?*” Providers should be mindful of the timing and approach when offering contraceptive counseling to patients who are peri- and postpartum, and those who have just had an abortion or miscarriage, as well as patients seeking care for issues unrelated to pregnancy prevention, as patients can perceive mistimed contraceptive counseling as coercive. During non-contraceptive visits, if a provider determines that a conversation about reproductive desires or pregnancy prevention may be useful, it is appropriate to offer care while honoring autonomy.

Step 3: Collaboratively determine which contraceptive method (if any) aligns with the patients’ values and preferences. Once a patient has identified what matters to them, providers can discuss the methods that align with those preferences and that are medically safe. It is important to recognize that there are diverse preferences and priorities that can guide a patient’s method selection. In some cases, the counseling in Step 2 may reveal that patients’ preferences for methods conflict. For instance, patients might want to use a method that will ensure regular monthly bleeding (that is, pill, patch, or ring) but also want a method that they do not need to think about often (that is, shot, implant, or IUD). When this situation occurs, providers can help patients prioritize preferences relative to each other. [Exhibit 10](#) provides some sample language that can be used to describe various features of contraceptive methods with patients. Additionally, providers should consider using visual tools to help map preferences onto available contraceptive methods, available at QFPguide.org.

As part of this discussion, providers should assess for and integrate information about potential contraindications to certain methods, as required. Providers should refer to the U.S. Medical Eligibility Criteria for Contraceptive Use 2024 (U.S. MEC) in [Appendix 2](#) for recommendations on safe use of contraception among patients who have certain medical conditions or who are taking certain medications that may interact with contraception.⁹³ If a patient has a medical condition for which certain methods might be unsafe for use, offer to discuss the risks and alternative methods that might be safer, based on the [U.S. MEC](#).

Shared decision making, as described in Section 3, can improve patient satisfaction and helps people make

Exhibit 10. Sample Contraceptive Counseling Language

Proactive and candid description of possible side effects	“Some people who use this IUD have heavier or crampier or longer periods than they did before they got the IUD. What would that be like for you?”
Non-contraceptive health benefits	“I can see why you would want to find a method that also can help with your painful periods. These methods here (show on visual decision aid) can all do that.”
Discreetness of a method/ privacy	“Since you’ve said privacy is important to you, and you can’t use anything that changes your period, would you like to talk about the IUD (hand them a sample IUD)? This needs no supplies, and you will still get your period.”
Effect on future fertility	“Your ability to get pregnant goes back to whatever is normal for you once you stop using the patch.”
Control over discontinuation	“You mentioned that you want to use something you can stop any time. Barrier methods like condoms and some of the hormonal methods like the pill, patch, and ring can be stopped any time, and the hormones in those methods leave your body quickly.”

Source: Adapted from PHI CARE,⁹² a provider tool for operationalizing patient-centered contraceptive counseling: <https://picck.org/wp-content/uploads/2022/09/PICCK-PHI-CARE-Infographic.pdf> and Contraceptive Technology.

contraceptive decisions consistent with their preferences and medical context.⁶¹ Although the process of soliciting preferences and mapping them to the available methods is collaborative, the decision about which method to use should be made by the patient. When patients indicate they are ready to initiate a method or methods, providers can ask open-ended summary questions such as “Given what we talked about and what is important to you about your method, what do you think would be the best choice for you at this time?”⁴ Some patients may explicitly ask for guidance from the provider; in that case, providers can rely on their knowledge of the patient’s preferences and medical history to suggest a method that is likely to be a good fit.

Providers should explore resources helpful to engaging in person-centered contraceptive counseling and using decision aids or tools in the digital version of the QFP at www.QFPguide.org.

Step 4: Conduct a physical assessment related to contraceptive use, if indicated. Physical assessments are rarely needed for contraceptive use and can pose unnecessary barriers for patients. Patients initiating a combined hormonal contraceptive (pill, patch, ring) should have a blood pressure check. Patient self-report of blood pressure (that is, normal versus elevated) is acceptable, especially to facilitate telehealth provision of birth control.⁹⁴ A cervical inspection and bimanual examination are needed for IUD placement. However, no examinations or tests are needed before initiating any other nonhormonal or progestin-only methods.⁹⁴

Step 5: Provide or refer for the contraceptive method, along with instructions about correct and consistent use; help the patient develop a plan or supports for

using the selected method; and confirm patient understanding. Once a patient has selected a method, it should be provided without delay. Providers can refer to the U.S. Selected Practice Recommendations (**U.S. SPR**) to guide method initiation and management. A broad range of Food and Drug Administration (FDA)-approved or FDA-cleared contraceptive products should be available on-site, with strong referral networks for contraceptive methods or products not available on-site. Patients selecting natural family planning methods should be offered counseling and education on the different natural family planning methods (FDA-cleared app, calendar calculation, basal body temperature charting, cervical mucus monitoring, lactational amenorrhea). If STI screening or other preventive services are indicated, these should be offered that day if feasible. Requiring that the patient accept the offer of screening before prescribing contraception, however, has no medical justification and is coercive.⁹⁴

Providers should offer same-day initiation (or “quick start”) of all methods, including implants and IUDs, whenever possible as a patient-centered best practice to increase timeliness of contraceptive care. Prior to placement, providers can be reasonably certain that a person is not pregnant if they have no signs or symptoms of pregnancy, and they meet any one of the following criteria:⁹⁴

- Is ≤7 days after the start of normal menses
- Has not had penis-in-vagina sex since the start of last normal menses
- Has been correctly and consistently using a reliable method of contraception
- Is ≤7 days after spontaneous or induced abortion
- Is within four weeks postpartum
- Is fully or nearly fully breast(chest)feeding (≥85 percent of feeds), amenorrheic, and <6months postpartum

The following tools and algorithms can help providers determine whether there is reasonable certainty that a patient is not pregnant, the appropriateness of quick starting a particular method, and the need for back-up contraception:

- [How to Be Reasonably Certain That a Woman is Not Pregnant](#)
- [Quick Start Algorithm](#)

A urine pregnancy test can be used alongside these criteria. However, a negative urine pregnancy test alone is insufficient to establish reasonable certainty that a person is not pregnant. Early in pregnancy, a person may have a low level of bHCG present in their urine, and this may result in a false-negative result on a standard urine pregnancy test. High-sensitivity pregnancy tests should be recommended for better accuracy early in pregnancy. Routine urine pregnancy testing is not always required and is often unnecessary.⁹⁴

In situations in which a provider cannot be reasonably certain that a person is not pregnant, the benefits of starting most methods likely exceed risks.⁹⁴ Providers can advise patients that, if they desire, they can start the implant, pill, patch, ring, or shot at any time, with follow-up pregnancy testing in two to four weeks. If the patient's preferred method is an IUD, they should be offered a contraceptive method other than an IUD to use until the provider can be reasonably certain that they are not pregnant and can place the Cu-IUD or LNG-IUD. Although the Cu-IUD is not FDA-approved as emergency contraception, it may be considered for such use by a provider based on a determination that it is appropriate for a particular patient.⁹⁴

Emergency contraception (EC) should be offered to all patients as appropriate. For more information on EC, please refer to the section on strategies to increase access to care, where there are detailed instructions about provision of EC pills (ECP).

Working with a patient interactively to establish a plan helps ensure people access and use their preferred method and switch or discontinue their method when desired. This includes discussing issues surrounding access (for example, getting to a pharmacy for refills), use (for example, having condoms and ECPs available when needed), and discontinuation (for example, getting an IUD or implant removed without delay) as well as what to expect and how to manage side effects. Providers should also recognize preferences can change over time and that discontinuation or switching of a method is normal and expected. Providers should also

counsel around and ensure same-day removal of contraceptive implants and IUDs when patients request it. Side effects are one of the most common reasons for discontinuation, so addressing them in a person-centered and timely way is critical. If a patient is initiating a new method, providers can share information and support to optimize the patient's correct use of the method in the context of their unique life circumstances. For example, providers can work with patients to develop a personal technique to remember to take a pill every day. Making a plan can also involve anticipating problems, like what to do if a dose of the shot is late or missed.

Strategies to Increase Access to Care

Many factors affect individuals' ability to access contraceptive services. This section explores strategies that providers and systems can take to address the multilevel barriers that people encounter.

Extended contraceptive supply. Providers can prescribe a full year's supply of combined hormonal methods at the time of the visit.⁹⁴ This is 13 cycles (for example, pill pack, box of patches, rings) for those using hormone-free intervals, or 16 for those using combined hormonal contraception continuously. Although payers vary in how many cycles they reimburse for at a single fill, prescribing a full-year supply enables the patient to receive the maximum number possible.

Advance provision of emergency contraception pills (ECPs). Providers should offer patients an advance supply of ECPs to ensure that the ECPs will be immediately accessible when needed.^{95,96} A review of the evidence showed that advanced provision increases use of ECPs.⁹⁶ There was no difference in contraceptive use, pregnancy rates, and incidence of STIs in those who received advanced provision and those that did not.⁹⁶ Advance provision of ECPs should be coupled with counseling and education on proper use. Advance provision of ECPs is particularly important for expediting access to ulipristal acetate (UPA), which is more effective than levonorgestrel (LNG) ECP but available by prescription only. Although LNG ECP is available over the counter, some payers will not cover the cost without a prescription, so writing a prescription can reduce cost barriers for patients. When possible, it is preferable to provide pills directly to patients instead of writing a prescription, as patients may experience barriers to ECPs at pharmacies.⁹⁵

When offering advance provision of ECPs, it can be helpful to also offer additional guidance on

contraceptive initiation. People using LNG ECPs can start, continue, or resume any method immediately.⁹⁶ People who receive an advance prescription for UPA should be advised that although it is more effective, it may interact with progestin-containing contraceptives, possibly lowering ECP effectiveness. People using UPA should therefore start or resume hormonal contraception no sooner than five days after using UPA.

If a patient wishes to use UPA and is initiating a progestin-containing method that is initiated in the clinical setting (such as DMPA, implant, or LNG IUD), a shared decision-making approach can be used to weigh the risk of reduced UPA effectiveness against the need to return for method initiation.

As described in the U.S. MEC and U.S. SPR, ECPs might be less effective among persons with BMI ≥ 30 kg/m² than among persons with BMI < 25 kg/m². ECPs are classified as U.S. MEC category 2 for persons with BMI ≥ 30 kg/m², meaning the benefits outweigh the risks. Regardless of a person's weight or BMI, all methods of EC can be offered, with complete counseling and clear information.⁹³

Same-day access to contraception. When patients are asked to return at a later date to receive their selected contraceptive method, this creates a barrier to care and reduces the chance of the patient ultimately accessing their method.^{97–99} Logistic and administrative factors can create challenges to providing same-day contraception even when patients are clinically eligible and desiring to start a method. In particular, same-day provision of implants and IUDs can be difficult for some service sites to accommodate due to factors including provider availability, clinic flow, and insurance verification processes. To reduce this barrier, providers and administrators can work to implement clinical practices to facilitate the ability to offer same-day initiation of all contraceptive methods. Partners in Contraceptive Choice and Knowledge (PICCK) provides clinical and administrative resources for implementing same-day contraception. If, for any reason, a provider is unable to provide a patient's method of choice on the same day that they request it, a bridge method should be offered. As part of standard practice, providers should support patients to access methods unavailable through their clinic by facilitating a warm hand-off or referral and offering information about where and how to access methods affordably. Clinics should keep a current list of local experienced providers that provide any services or methods not offered on-site.

Pharmacist-prescribed contraception. Many states permit pharmacists to directly prescribe hormonal contraceptives.¹⁰⁰ This can enable people to access a range

of contraceptive options without a separate visit to another provider to obtain a prescription. Providers should be aware of the pharmacist prescribing policies in their state, and, where available, inform patients of what may be available by pharmacist prescription.

Alternative locations. Mobile clinics, co-locating services, or offering services in temporary pop-up locations support access by meeting people where they are most comfortable receiving care. For example, research suggests co-locating contraceptive services with mental health or substance use disorder services can improve access to contraceptive care.¹⁰¹

Telehealth. Telehealth encompasses a wide range of services, including videoconferencing, telephone calls, remote patient monitoring, and secure messaging, which can occur in real time or asynchronously.^{102,103} Most commonly, telehealth refers to providers using virtual platforms to communicate with and provide care to patients in lieu of—or in addition to—in-person visits. Research has found that telehealth for contraceptive care is acceptable to patients and providers and effective in delivering services, especially for people who wish to avoid a physical exam, reduce wait times, or have privacy concerns.¹⁰³ A wide range of contraceptive services can be safely and effectively provided via telehealth, and telehealth can also be used for contraceptive counseling and management of side effects and other follow-up.^{104,105} In addition, online platforms offer contraceptives to patients with and without insurance through online consultation, and ship methods directly to patients in unmarked packaging.

Contraceptive services that are *suitable for telehealth* provision include:¹⁰⁶

- Contraceptive counseling
- Prescription (initiation or continuation) of oral contraceptive pills, transdermal patch, or vaginal ring
- Discussion of EC options and provision of oral ECP
- Prescription (initiation or continuation) and instruction on self-administered subcutaneous depot medroxyprogesterone acetate (DMPA-SC)
- Prescription of barrier and other peri-coital methods (including diaphragm, cervical cap, spermicides, external and internal condoms, and vaginal pH modulator gel)
- Counseling prior to IUD and implant placement, removal, or replacement
- Evaluation and potential management of side effects (such as unexpected bleeding)
- Consultation for permanent contraception

Strategies for Informing and Empowering Patients for Self-Care

Expanding the range of contraceptive services that people can access and use on their own or with reduced reliance on a clinic or provider can help people overcome barriers to accessing contraceptive care. The World Health Organization (WHO) defines self-care broadly as “the ability of individuals, families, and communities to promote health, prevent disease, maintain health and cope with illness and disability with or without the support of a health worker” and includes “drugs, devices, diagnostics and/or digital interventions that can be provided fully or partially outside formal health services and be used with or without a health worker.”¹⁰⁷ Self-care interventions include provision of user-administered methods, including contraceptive pills, rings, patch, injection, and barrier methods, as well as strategies to enable patients to access methods without a provider. Options for self-care shift frequently due to innovation, new technologies, and evidence as well as changes in clinical guidance and federal and state policy. Providers should be aware of what is permissible in their state and stay abreast of changes that allow or constrain self-managed care to enable patients to access care in alignment with their personal preferences.

Self-administered subcutaneous depot medroxyprogesterone acetate (DMPA-SC). DMPA-SC self-administration is safe and effective and should be offered when possible along with a full range of contraceptive methods, including provider-administered DMPA.^{108,109} Providers can share information—with patients who are interested—about how to administer DMPA-SC, including how to safely dispose of sharps and that administration could be done by the patient or the patient’s partner, friends, and family.¹⁰⁵

Over-the-counter progestin-only pills (OTC POPs). A progestin-only daily oral contraceptive pill is FDA approved and available OTC, online, and in stores. Providers should be prepared to support users of OTC oral contraceptive pills in the successful use and management of this method. Consult ACOG guidance for further information about supporting patients in using OTC oral contraceptives.¹¹⁰

Fertility awareness apps. Fertility awareness–based methods (FABM) are among the oldest methods of self-managed contraception. Many mobile applications exist to track people’s fertility and help them either achieve or avoid pregnancy as well as gain more familiarity with their own cycle. The FABM app that is FDA cleared and

CE marked has an algorithm that uses each person’s body temperature to predict their fertile window.

Providers can include a discussion of these tools as part of person-centered contraceptive care. Relevant information about apps includes whether they are effective and evidence based, whether they are intended for pregnancy prevention or pregnancy planning or both, and the value of additional items for purchase advertised on the sites. Patients interested in fertility awareness apps can be encouraged to explore data privacy, sharing, and security standards related to mHealth apps broadly and fertility apps in particular.¹⁰⁹ Evidence suggests that the accuracy of these apps to predict fertile windows and ovulation can vary because of multiple factors, including variation in individual cycles, which fertility indicators the apps track, and completeness of information entered into the apps by the users. Apps use proprietary algorithms, and those that collect a combination of indicators such as basal body temperature and characteristics of cervical mucus in addition to calendar dates of menses may be more accurate.¹¹¹

SECTION 6: STI AND HIV SERVICES

Person-centered prevention, screening, treatment and education about STIs and HIV is an essential part of SRH care. It is important to meet patients “where they are,” using the principles outlined in Section 3. This means using non-stigmatizing approaches, engaging patients in decision making, and providing patients with the services that meet their needs and goals.

This section covers STI and HIV behavioral risk assessment; prevention strategies, including prevention counseling, pre-exposure vaccination, and prophylactic measures; and screening for STI and HIV. It briefly discusses strategies for delivering STI and HIV screening/testing results and providing treatment for individuals and their partners but does not include detailed STI diagnostic management and treatment regimens. Providers can find comprehensive information—including guidance on providing treatment for individuals with STI symptoms, exposure, or a positive test—in the CDC’s STI Treatment Guidelines.¹¹² Providers can also download the CDC STI Treatment Guide app for mobile devices. In addition to streamlined STI prevention diagnosis and treatment recommendations, the app provides clinical care guidance, sexual history resources, patient materials, and other features to assist with patient management.

Risk Assessment

Understanding a person’s risk for acquiring STIs or HIV can help guide appropriate counseling, testing, and

treatment. A risk assessment should be conducted for each individual person, and providers should not make assumptions about an individual's risk based on demographic factors alone. Risk assessment involves taking a comprehensive medical history, including a sexual history that covers the six Ps (partners, practices, protection, past history of STIs, pregnancy preferences and pleasure). (See guidance on taking a sexual history in Section 3, “Fundamentals of Sexual and Reproductive Health Care Delivery.”)

Remaining aware of STI prevalence and trends in the populations and geographic areas they serve can help providers deliver appropriate care. This information can help a provider assess an individual's risk of HIV and STI acquisition when combined with demographic information and behavioral factors. The reported incidence of STIs in each state is available in the CDC's STI Surveillance Report, produced annually.¹¹³ Providers can use the NCHHSTP AtlasPlus tool on the CDC website to search for state- and county-level STI data and generate tables, maps, and charts showing local STI prevalence.¹¹⁴

Prevention

Prevention counseling. Providers can engage patients in person-centered counseling to help them identify personal risk factors and strategies they can use to reduce their risk. Providers should tailor their counseling approach to each patient's individual risk factors while also aligning it with their specific needs and desires. Prevention counseling can include information about common STIs and their transmission and training in skills to reduce risk—including training in condom use and communication about safer sex. Providers should offer information about the risk of STI transmission associated with different sexual activities so the individual has the information they need to reduce their individual risk and communicate about safer sex with their partner(s).

Providers should strive to use patient-centered language that is specific and accessible rather than vague or jargon. For example:

Instead of . . .

- “Always use condoms”
- “Have fewer, safer partners”
- “Have safer sex”

Use . . .

- “What could you do that would make condoms more accessible to you (for example, putting condoms on the nightstand beside the bed)?”
- “Tell me about the last time you used a condom. What has worked for you in the past?”

- “What have you been doing to protect yourself?”
- “What conversations have you had with your partner (s) about protecting yourselves from STIs?”
- “What questions might come up for you when considering whether to have sex with someone who is also having sex with other people?”⁴⁷

Wherever possible, condoms (external and internal) should be provided to all patients free of charge at clinical sites to increase access to condoms in the community.

Pre-exposure vaccination. Pre-exposure vaccination is the most effective method of preventing certain diseases caused by viruses that can be transmitted sexually—including hepatitis A virus (HAV), hepatitis B virus (HBV), human papillomavirus (HPV), and Mpox. Providers can discuss vaccination with all patients, give clear recommendations, and either provide vaccination or referral for vaccination in accordance with recommendations from the CDC¹¹⁸ and medical professional organizations. Section 10, “Screening and Other Preventive Health Care Services,” provides an overview of vaccination recommendations based on age and risk factors.

Pre-exposure prophylaxis for HIV. Pre-exposure prophylaxis (PrEP) is recommended for HIV prevention in adults who have had anal or vaginal sex in the last six months and have any of the following risk factors: an HIV-positive sexual partner; a bacterial STI in the past six months; history of inconsistent or no condom use with sexual partner(s); and (for persons who inject drugs) an HIV-positive injecting partner or sharing injection equipment. However, providers should not limit discussion of PrEP to only those deemed at risk of acquiring HIV; rather, information about PrEP can be provided to all sexually active individuals, including those without known risk factors.^{115,116} When discussing STIs and strategies to prevent STIs, providers can ask, “Are you aware of PrEP, there are medications that can prevent HIV? Have you ever used it or considered using it?” Providers should attempt to assess each patient's risk of acquiring HIV before initiating PrEP. However, because people may not feel comfortable reporting sexual or injection behaviors that put them at risk for HIV, PrEP should be offered to any person who requests it. Providers can refer to the CDC Clinical Practice Guideline on Preexposure Prophylaxis for the Prevention of HIV Infection in the United States for detailed guidance on providing PrEP services.¹¹⁷

Post-exposure prophylaxis for HIV and STIs. Non-occupational post-exposure prophylaxis (nPEP) consists

of a combination of antiretroviral medications administered after a potential exposure to HIV. CDC provides detailed guidance for offering nPEP, including timing, recommended testing, and medication regimens.¹¹⁹ When considering nPEP, providers and patients can discuss whether the reported exposure presents a substantial risk of transmission (for example, having unprotected sex with, being sexually assaulted by, or sharing needles with someone who is known to be HIV-positive) or if the exposure was to someone with unknown HIV status. Sexually active patients who receive nPEP should be evaluated for PrEP after completing nPEP and testing negative for HIV.

Because of high rates of bacterial STI (syphilis, chlamydia, and gonorrhea) among cisgender men who have sex with men (MSM) and transgender women (TGW), CDC recommends all MSM and TGW who have been diagnosed in the past 12 months with a bacterial STI receive counseling about doxycycline postexposure prophylaxis (doxy PEP).¹²⁰ Doxy PEP involves taking doxycycline within 72 hours after having oral, vaginal, or anal sex. CDC recommendations offer detailed information about research, prescribing, and shared decision-making considerations. Although the pharmacokinetics of doxycycline and experience in treating bacterial STIs suggest that doxy PEP should be effective in other populations, clinical data to support doxy PEP in other populations (for example, cisgender women, cisgender heterosexual men, transgender men, and other queer and nonbinary persons assigned female at birth) are limited. As a result, providers can use clinical judgment and shared decision making to inform use of doxy PEP among those not currently included in CDC recommendations.^{120–122}

Screening

Providers should offer screening for STIs in accordance with CDC treatment guidelines and USPSTF recommendations for STI and HIV screening that are summarized in [Exhibit 11](#), which is not intended to be comprehensive.¹²³ Individuals should be engaged in decision making about STI testing and allowed access to the testing they want and the ability to opt out of testing they do not want to receive. Testing for specific STIs should be provided to all individuals upon request, regardless of risk factors. It is important to note, however, that the risk-benefit ratio of some types of screening requires careful consideration (for example, asymptomatic herpes screening).

Providers should clearly communicate all screening recommendations with patients, including the rationale for any recommended tests and the reasons why testing

for some STIs may not be indicated. Opt-out screening can be implemented as a strategy to normalize testing, decrease stigma, and increase screening rates. When employing opt-out screening, the provider informs the patient that a test will be performed as routine unless the patient declines. Opt-out strategies are frequently used to support screening in adolescent populations or in geographic locations with a high prevalence of STIs.

Treatment

[CDC STI Treatment Guidelines](#) should guide treatment of all STIs.¹²⁶ In settings where same-day treatment is available, treatment for persons with STI symptoms and their partners can be offered while awaiting the results of diagnostic tests.¹²⁷ When possible, STI treatment should be provided on-site rather than called into a pharmacy to reduce barriers and ensure access to medication. To limit possible complications, pregnant people diagnosed with an STI should be treated immediately in accordance with CDC STI Treatment Guidelines; treatment does not need to be initiated by an obstetrician/gynecologist or other specialist.¹²⁷ The presence of an STI is a biological marker of risk for acquiring other STIs.¹²⁸ Therefore, people diagnosed with an STI should be offered testing for gonorrhea, chlamydia, HIV, and syphilis unless these tests were already done at the time of initial screening. Individuals with HIV infection should be linked to ongoing HIV care and treatment.^{128,129}

Strategies to Increase Access to Care

A major barrier to STI and HIV testing and treatment services is stigma. Individuals may experience fear, shame, and discomfort that prevent them from seeking out STI and HIV services or from disclosing risk factors to providers. Strategies to increase access to STI and HIV care therefore include those that support confidentiality and enable people to exercise more autonomy in the care they receive and how they receive it. Modalities that emphasize and enable self-care are increasingly commonplace in the care of STIs and HIV. Some of these include self-swabbing for specimen collection, at-home testing, and telehealth. Providers may offer these strategies to patients when possible.

Express visits. STI express visits increase access to care by allowing people to receive walk-in STI testing and treatment without a full clinical exam. Research has found that express visits increase clinic capacity, reduce time to treatment, reduce visit time, decrease visit cost, and are associated with high patient satisfaction.^{130,131} Express visits rely on a system of triage to quickly assess

Exhibit 11. STI Screening Recommendations for Asymptomatic Individuals

Type of STI	Age	Screening recommendations
Chlamydia and gonorrhea	<25 years	<ul style="list-style-type: none"> At least annually for sexually active persons assigned female at birth (AFAB). Extragenital (pharyngeal and rectal) screening can be considered based on reported sexual behaviors and exposure. All pregnant people. Routine screening is not recommended for asymptomatic persons assigned male at birth (AMAB) who have sex with persons assigned female at birth (AFAB). However, screening for persons assigned male at birth (AMAB) and younger than age 25 should be offered in high-prevalence clinical settings (such as adolescent clinics, correctional facilities, and STI and sexual health clinics).
	≥25 years*	<ul style="list-style-type: none"> At least annually for sexually active persons assigned female at birth (AFAB) who are at increased risk.* Extragenital (pharyngeal and rectal) screening can be considered based on reported symptoms, sexual behaviors, and exposure. All pregnant people.
	All ages	<ul style="list-style-type: none"> At least annually for sexually active persons assigned male at birth (AMAB) who have sex with persons assigned male at birth (AMAB); every 3 to 6 months if at increased risk.** At least annually for persons with HIV.
Syphilis	All ages	<ul style="list-style-type: none"> All pregnant individuals serologically for syphilis at the first prenatal care visit, followed by universal rescreening during the third trimester and again at birth.¹²⁴ Asymptomatic persons assigned female at birth (AFAB) and at increased risk (geography, history of incarceration, and transactional sex work). Asymptomatic persons assigned male at birth (AMAB) and at increased risk (history of incarceration, transactional sex work, geography, and younger than age 29). At least annually for sexually active persons assigned male at birth (AMAB) who have sex with persons assigned male at birth (AMAB). At least annually for sexually active individuals with HIV.
Herpes	All ages	<ul style="list-style-type: none"> Evidence does not support routine serologic screening for adolescents and adults.^ Type-specific HSV serologic testing can be offered for individuals presenting for an STI evaluation based on individual risk. Type-specific HSV serologic testing can be offered for people with HIV presenting for an STI evaluation.
Trichomonas	All ages	<ul style="list-style-type: none"> Screening should be offered for persons assigned female at birth (AFAB) receiving care in high-prevalence settings (for example, STI clinics and correctional facilities). Screening should be offered for persons assigned female at birth (AFAB) at high risk for infection.****
HIV/AIDS	13–64 years	<ul style="list-style-type: none"> At least once for all individuals.
	All ages	<ul style="list-style-type: none"> At least annually for persons assigned male at birth (AMAB) who have sex with persons assigned male at birth (AMAB) if the patient and their sex partner(s) have had more than one partner since most recent HIV test. All individuals who seek evaluation and treatment for STIs. All pregnant people.
Hepatitis B	All ages	<ul style="list-style-type: none"> All individuals at increased risk.***** All persons assigned male at birth (AMAB) who have sex with persons assigned male at birth (AMAB) should be tested for HBsAg, anti-HBc, and anti-HBs. Individuals with HIV should be tested for HBsAg, anti-HBc, and anti-HBs.

(continued on next page)

Exhibit 11. STI Screening Recommendations for Asymptomatic Individuals (continued)

Type of STI	Age	Screening recommendations
Hepatitis C	18–79 years	<ul style="list-style-type: none"> All individuals except in areas where the hepatitis C infection (HCV) positivity is <0.1%.
	All ages	<ul style="list-style-type: none"> Pregnant people except in settings where the hepatitis C infection (HCV) positivity is <0.1%. Serologic testing at initial evaluation for persons with HIV. Annual testing for persons assigned male at birth (AMAB) who have sex with persons assigned male at birth (AMAB) with HIV infection.
Mpox ¹²⁵		<p>Recommended for all persons who had known or suspected exposure to someone with Mpox. Recommended for all persons who had a sex partner in the past two weeks who was diagnosed with Mpox. Recommended for gay, bisexual, or other MSM, and transgender and gender-diverse people (including adolescents) who had in the past six months, or anticipate having:</p> <ul style="list-style-type: none"> A new diagnosis of one or more STI More than one sex partner <p>People who had in the past six months, or anticipate having:</p> <ul style="list-style-type: none"> Sex at a commercial sex venue Sex in association with a large public event in an area where Mpox transmission is occurring Sex in exchange for money or other items <p>People who are sexual partners of people with the above risks, People with HIV infection or other cause of immunosuppression who have recent or who anticipate potential Mpox exposure.</p> <ul style="list-style-type: none"> People who work in settings where they may be exposed to Mpox.

¹²⁵ <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/genital-herpes-serologic-screening>.

*Per USPSTF, women age 25 years or older are at increased risk for chlamydial and gonococcal infections if they have a new partner, more than one sex partner, a sex partner with concurrent partners, or a sex partner who has an STI; practice inconsistent condom use when not in a mutually monogamous relationship; have a previous or coexisting STI; have a history of exchanging sex for money or drugs; or have a history of incarceration.

**Adapted from CDC Guidelines. Per the CDC, men who have sex with men are at increased risk for chlamydial and gonococcal infections if they are on PrEP, with HIV infection, or if they or their sex partners have multiple partners.

***Per USPSTF, risk of syphilis infection is increased among men who have sex with men; persons with HIV infection or other sexually transmitted infections; persons who use drugs; and persons with a history of incarceration, sex work, or military service. Clinicians should be aware of the prevalence of syphilis infections in their community and assess each person's individual risk.

****Per the CDC, individuals at risk for trichomonas include women with multiple sex partners and those with a history of transactional sex, drug misuse, STI, or incarceration.

*****Per USPSTF, individuals at increased risk for hepatitis B include individuals born in countries or regions with an HBsAg prevalence of 2 percent or greater (regardless of vaccination history in their country of origin) and adolescents and adults born in the United States who did not receive the HBV vaccine as infants and whose parents were born in regions with an HBsAg prevalence of 8 percent or greater (regardless of their biological mother's HBsAg status); persons who have injected drugs in the past or are injecting drugs currently; men who have sex with men; persons with HIV; and sex partners, needle-sharing contacts, and household contacts of persons known to be HBsAg positive.

Sources: <https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm>

<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/chlamydia-and-gonorrhea-screening>

<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/syphilis-infection-nonpregnant-adults-adolescents-screening>

<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-b-virus-infection-screening>.

which patients are eligible for express services; they can be implemented alongside comprehensive services. Clinical settings interested in starting or scaling up STI express visits can find adaptable resources in a toolkit developed by the National Association of County and City Health Officials in collaboration with the CDC.¹³¹

Self-testing. Self-testing is another option that can benefit individuals who do not want to or are not able to come into a facility for testing and may help reach people who would not otherwise get tested. An FDA-approved home tests for HIV and syphilis allow people to test and find out their result in a location of their

choosing. Other STI test kits produced by various private and public entities enable people to collect their own specimens, which they then mail in for testing. Providers should support all people who want to access testing through self-tests. Clinic protocols and workflows should be adapted to facilitate timely access to follow-up care and treatment for persons selecting self-testing.

Performing self-swab for specimen. Many people who receive in-clinic testing prefer to collect their own specimens for STI testing. Specimens obtained through self-swabbing have the same sensitivity as clinician-obtained samples. Providers can offer people the option to

perform their own swabs with FDA-authorized self-collection kits during in-clinic testing as part of a trauma-informed and person-centered approach. Visual aids—which can be posted in restrooms or other areas where self-swabbing occurs—can help explain how to effectively collect a specimen. Diagrams in English and Spanish show how to self-collect vaginal, anal, and oral swabs.¹³²

Partner services, including expedited partner therapy.

Patients should also be counseled about the need to communicate with, evaluate, and treat partner(s) to avoid reinfection. Clinical staff can offer to assist those notifying partners of STI exposure through coaching on partner notification, providing written information to share with partners, or reaching out to partners directly with the person's consent and authorization. In some cases, state health departments may provide partner notification for some STIs as part of a broader range of public health services; if this is the case, patients can be informed of these services and that their partners may be notified of their exposure. People may also use online anonymous partner notification services, though the effectiveness of these services is unknown.

It is important to encourage all partners to seek timely evaluation and treatment. If a person did not receive same-day testing and treatment, providers can encourage them to bring their partner(s) with them when returning for treatment and treat everyone concurrently. Expedited partner therapy (EPT)—which involves treating the sex partners of persons diagnosed with chlamydia or gonorrhea by providing prescriptions or medications to the person to give to their partner(s) without the health care provider first examining the partner(s)—is a strategy to increase access to treatment for individuals who might not otherwise receive timely treatment.¹³³ EPT is legal in most states.¹³⁴ Providers should routinely offer EPT to people with chlamydia as a way to support patients to ensure all their partners will be able to receive timely treatment regardless of the partner's ability to seek and obtain treatment on their own. For partners exposed to gonorrhea, every effort should be made to provide treatment using the recommended intramuscular treatment regimen; however, if an exposed partner is unable or unlikely to access intramuscular treatment, EPT can be provided using the oral treatment regimen recommended by the CDC.¹³⁵

SECTION 7: FAMILY BUILDING

People build their families in various ways, including through pregnancy, adoption, fostering, and surrogacy.

The provider's role is to offer personalized, non-biased, nonjudgmental, medically appropriate care to meet the needs and desires of individual patients. For persons who wish to carry a pregnancy and give birth, providers can help enable healthy pregnancy by providing pre-pregnancy care and offering basic fertility services as needed. For persons in need of infertility services and for people with sperm, providers can help safeguard their health and optimize fertility. Depending on the scope of practice and clinical setting, providers may offer or refer patients to medically assisted reproduction services—including comprehensive infertility evaluations, medications to increase fertility, therapeutic donor insemination (TDI), and intrauterine insemination (IUI). Providers should understand the importance of timely referrals for patients requiring more specialized care, such as donor gametes or embryos, in vitro fertilization (IVF), or gestational surrogacy. Providers should also offer resources for adoption services for patients who want to explore building their family through adoption.

It is important to recognize that family building can present social, economic, and systems-level challenges. The services that enable many LGBTQI+ people, unpartnered people, and people experiencing infertility to achieve their reproductive goals and build families are often expensive, not covered by insurance, and inaccessible, especially to people from groups that are marginalized and in many geographic regions of the country. In addition, people from these groups may face stigma or discrimination in the process of family building. Some people also may wish to focus on building families at an early stage in their life, including but not limited to people with progressively debilitating disorders or heritable conditions that may result in early cessation of fertility. Providers can affirm an individual's family-building plans or goals, including whether, how, or with whom a person desires to build their family.

Enabling Healthy Pregnancy

Pregnancy is one way that people build families. Enabling healthy pregnancy by providing pre-pregnancy care is an essential component of quality SRH services. Providers should collect a thorough history and offer basic services and education about how to achieve a healthy pregnancy for all people who wish to become pregnant and those who would find pregnancy acceptable, including people who may become pregnant through penis-in-vagina sex and people who may use medically assisted reproduction. Information about healthy pregnancy can also be offered to those who are not immediately interested in pregnancy or would find pregnancy unacceptable at the present time. For those

with partners, evaluation of all partners occurs concurrently, if appropriate.

The history collected should focus on the patient's expressed reproductive goals and include only what is relevant to their circumstances. Elements of a comprehensive sexual and reproductive history in support of achieving pregnancy include:

- Medical history, including current health issues; review of systems, past illnesses, and surgeries, with special attention to endocrine (thyroid, hirsutism) and autoimmune disorders; and any illness, injuries, or medical conditions that may affect reproductive function.
- Fertility history as appropriate, including length of time patient has engaged in unprotected penis-in-vagina sex, level of fertility awareness, and previous infertility evaluation or treatment.
- Genitourinary and reproductive history, including history of STI or exposure, and sexual history. (See guidance on the 6 Ps in Section 3, "Fundamentals of Sexual and Reproductive Health Care Delivery.") For persons assigned female at birth (AFAB): sexual dysfunction, vaginismus, dyspareunia; menstrual history, including oligomenorrhea, dysmenorrhea, amenorrhea, obstetric/pregnancy history; gynecologic history, including endometriosis, fibroids, pelvic inflammatory disease (PID), abnormal cervical cytology, and procedures. For persons assigned male at birth (AMAB): erectile or ejaculatory dysfunction, trauma, infection, varicocele, and procedures.
- Past surgeries or hospitalizations specifically affecting reproductive organs or systems.
- Family history and genetic carrier screening.
- Current medications and ingested substances, including over-the-counter medications, vitamins or herbs, exogenous steroid hormones, and prescription medications, all to assess for compatibility with pregnancy or risk of infertility.
- Social and lifestyle history: relationship status, family structure, sexual partners, employment and recreational activities (with special attention to impact on reproductive function), nutrition, exercise, sleep, stress, and use of substances such as caffeine, alcohol, tobacco, and recreational drugs.
- Immunization status and titers infections associated with pregnancy complications but that are vaccine-preventable (varicella, measles, rubella).
- Mental health history, including current and past depression, anxiety, bipolar disorder, eating disorders, PTSD, substance use disorder, other psychiatric disorders, or physical, sexual or emotional abuse; screening for current domestic abuse and safety in the patient's home.

Professional organizations such as ACOG and the CDC¹³⁶ recommend that counseling to support achieving a healthy pregnancy include:

- Adequate nutritional intake and maintaining regular moderate physical exercise.
- Daily folic acid supplementation to decrease the risk of neural tube defects.
- Persons with chronic medical conditions (such as heart disease or autoimmune disorders) should discuss their desires for pregnancy with their providers to maximize control of the medical condition and avoid potentially teratogenic medications or those associated with pregnancy or fertility complications.
- Persons with diabetes aim for glucose levels as close to normal as is safely possible—ideally A1C <6.5 percent.
- Recommend that any individual contributing to pregnancy through gestation of pregnancy, egg, or sperm provision avoid alcohol, nicotine and other recreational drugs, and high caffeine intake, which may all negatively impact fertility and pregnancy outcomes.
- Recommending limiting exposures to toxins that may be harmful to a developing fetus, including lead, radiation, and chemical solvents.
- Fertility awareness education, including information about the fertile phase and tools such as ovulation predictor kits and cervical mucus monitoring that can be used to help identify ovulation.

Basic Infertility Services and Fertility Support

In alignment with ASRM guidelines, the pace and extent of the infertility evaluation should consider the patient's preferences, age, duration of infertility, relationship circumstances, medical history, and, in some cases, geographic location and access to higher levels of care.¹³⁷ This includes people who experience infertility while attempting to achieve pregnancy through penis-in-vagina sex with sperm involved as well as people who require donor gametes or medical assistance to build their family due to their gender, sexual orientation, and/or partner status. It is important that services are not only inclusive, but specifically oriented toward the needs of LGBTQI+ people when indicated.

Clinics can provide basic evaluation and counseling, share resources, and make referrals for people desiring to build a family through pregnancy—with or without the use of medically assisted reproduction (MAR)—or through foster care or adoption. Sites can also provide education about TDI, IUI, donor ova, donor sperm, donor embryo, and gestational carriers as well as MAR procedures such as IVF.¹³⁷ All MAR technology options available to heterosexual cisgender people are also

available to LGBTQI+ persons. Prompt referrals to specialty care should be made for people who want or would benefit from MAR. For patients pursuing TDI, avoid delays to treatment. TDI recipients using cryopreserved sperm have higher success rates with IUI over intracervical insemination and do not benefit from ovarian reserve testing or ovarian stimulation.¹³⁸ Age is the most predictive factor for IUI success,¹³⁸ although timing of the IUI procedure is also a vital factor.¹³⁹

All persons attempting to achieve pregnancy should be screened for infertility, and sites are encouraged to follow the recommendations outlined in “Enabling Healthy Pregnancy.” Evaluation of infertility should be performed for all persons attempting to conceive through penis-in-vagina sex with sperm after 12 months if younger than age 35 years and at 6 months if age 35 years or older. For people older than age 40 years or those with a medical history associated with infertility, consider immediate evaluation or referral for MAR.

For persons AFAB, a physical examination that includes vital signs; thyroid examination to identify any enlargement, nodule, or tenderness; and integumentary examination for signs of androgen excess should be performed. Genital exams, including pelvic exam, are not required for basic infertility evaluation. Assessment of ovulatory function for people AFAB is often best determined by a thorough menstrual history, and in many cases, this is all that is required. Menstrual cycles should be 21–35 days, regular, predictable, and consistent in terms of symptoms and flow. If a patient has a history of oligomenorrhea or amenorrhea, this is sufficient to establish anovulation and warrants further investigation to identify underlying etiology.¹³⁷

For individuals AMAB, the semen analysis is the first and most simple screen for infertility. Abnormal results should be followed up with a physical exam to assess for infection, varicocele, or other causes of impaired sperm production.

Few laboratory tests are needed in the initial infertility evaluation and should be limited to findings of the history and physical exam. The following tests should not be ordered routinely unless specifically indicated: prolactin (galactorrhea), estradiol, follicle-stimulating hormone (FSH), luteinizing hormone (LH), progesterone, endometrial biopsy, thrombophilia testing, karyotype, immunologic testing, advance sperm function testing, and laparoscopy for unexplained fertility.¹³⁷

SECTION 8: PREGNANCY TESTING AND COUNSELING

This section provides guidance on pregnancy testing and person-centered counseling, including options

counseling, and clinical guidance on individualized care that is responsive to each person’s needs and desires (see Section 3, “Approaches to Care”).

Pregnancy testing relies on measurement of human chorionic gonadotropin (hCG) in serum or urine. Urine testing is available as an over-the-counter or “at-home” test or as a point-of-care test and delivers a qualitative result of “positive” or “negative.” Unless otherwise specified, the following information refers to point-of-care urine testing.

A positive or negative pregnancy test result may have different significance for different people. Some people will be happy with the results; others may express mixed emotions; and some may be surprised, disappointed, or upset. The provider or clinic staff’s role in delivering pregnancy test results is to create an open, inclusive and non-judgemental environment; validate and normalize multiple, complex and varied feelings around pregnancy; actively listen and clarify facts; reassure the patient of their support. It is important that staff who are giving the results of positive pregnancy tests are prepared to discuss all pregnancy options with the patient. Confidentiality must be ensured, but if a patient asks to include a partner or other support person in the discussion, this should be honored.

Pregnancy Testing and Results

Individuals present to a health care facility for urine pregnancy testing for many reasons, some of which are listed below:

- Some will have already taken home tests and are seeking confirmation of negative or positive results.
- For others, it may be the first evaluation for pregnancy after a missed menstrual period or with symptoms of early pregnancy, such as breast tenderness or nausea.
- Pre-procedural pregnancy tests may be done before procedures such as IUD placement or uterine or endometrial biopsies to prevent the pregnancy from inadvertent impacts caused by cervical or uterine manipulation.

In general, a history and physical exam are not required for patients who present for pregnancy testing. However, collecting a brief, focused history, including the first day of the last menstrual period (LMP), use of a contraceptive method, date(s) of unprotected penis-in-vagina sex or family-building attempts via MAR, and a brief review of systems, can be useful in the diagnosis and in assessing gestational duration, patient decision making, and clinical management, including the need for further care.

Pregnancy test results should be presented in a neutral tone that is simple and straightforward, for example:

“Your pregnancy test today is negative. This means that you are not pregnant.” When conveying the test result, allow time for the person to reflect on the result and to ask any questions they may have. Exhibit 12 outlines detailed steps to provide person-centered delivery of pregnancy test results.

All patients should be provided or referred for any additional health care needs, including STI screening; fertility/infertility assessment; prenatal, abortion, or adoption care; and related social services, such as housing or nutritional support. Many of these additional services can be offered to the patient at the facility where the pregnancy test was performed to facilitate continuity of care.

Negative Pregnancy Test

Persons with a negative pregnancy test who do not want to become pregnant can be offered contraceptive services. Person-centered contraceptive counseling should only be provided as desired by the patient. If desired, contraceptive services should be offered at the same visit. Persons with a negative pregnancy test who indicate that they have had penis-in-vagina sex within the last five days should be counseled about and offered EC, if desired. A urine pregnancy test result may be negative in the setting of recent intercourse (for example, pregnancy not yet established) and early pregnancy (for example, hCG levels in urine are not yet detectable). For additional details about contraception and EC, see Section 5, “Person-Centered Contraceptive Care Delivery and Strategies to Increase Access to Care.”

Persons with a negative pregnancy test who wish to become pregnant should be offered services to help achieve pregnancy and engaged in a conversation about being prepared for a healthy pregnancy. For details, refer to Section 7, “Enabling a Healthy Pregnancy and Basic Infertility Services and Fertility Support.”

Positive Pregnancy Test

If the pregnancy test is positive, the provider should assist the patient in estimating gestational duration (age) so that appropriate care and counseling can be provided. Pregnancy dating can be more difficult if the patient does not know their LMP or if they have irregular cycles. Any hormonal contraceptive use or gender-affirming hormones in the last cycle, including emergency contraception, make the LMP unreliable. If the person is unsure of the timing of their last normal menstrual period, a pelvic examination or pelvic ultrasound (more accurate) can help assess gestational age.

Pregnancy Options Counseling and Referral

Patients should be fully informed about all pregnancy options: parenting, adoption, and abortion.^e An All

Options Model is defined as “creating space and using active listening to explore someone’s pregnancy decisions, feelings, and experiences, with curiosity and empathy, and without an agenda.”^{140,141} The goal of pregnancy options counseling is to equip people with information and resources.

Providers must offer nondirective counseling and be equipped to offer factual, neutral, nonjudgmental information about each option. Providers working in communities that are in states with restrictive abortion laws may consider using third-person language to share information. Options counseling should be provided in accordance with recommendations from professional medical associations, such as AAP.¹⁴²

- For persons desiring to continue the pregnancy, affirm their decision and offer prenatal care and/or referrals. Talk with the person to learn of any other referrals or resources that may be helpful to them.
- For persons interested in pursuing adoption, affirm and offer resources to support this decision, including prenatal care and/or referrals. Providers may share appropriate community and/or national resources and referrals.
- For persons desiring to end the pregnancy, affirm this decision, and offer resource information. Based on gestational age and setting, explain to the patient what options may be available (such as medication abortion or uterine aspiration). When considering providing abortion care on-site or referring for abortion care, providers should be aware of factors affecting abortion access—including proximity of abortion care facilities—and legal restrictions on abortion care, including state-based legal restrictions impacting individuals seeking abortion services.

A person receiving options counseling does not need to declare or come to a decision by the end of the counseling session. It is important to remember that

^eFederal conscience laws protect health care providers that refuse to participate in certain health care services on religious or moral grounds. These laws include the Church Amendments, codified at 42 U.S.C. § 300a-7; the Coats-Snowe Amendment, contained in 42 U.S.C. § 238n, et seq.; the Weldon Amendment, contained in Consolidated Appropriations Act, 2024, Public Law 118–47, div. H, tit. V, sec. 507(d)(1), 138 Stat. 460, 703 (Mar. 23, 2024); and others. The Department complies with all applicable federal conscience laws. More information about conscience laws is available here: [Conscience Protections | HHS.gov](https://www.hhs.gov/opa/conscience-protections). As noted in footnote b, the Title X statute (42 U.S.C. §300 et seq.), legislative mandates included in annual HHS appropriations, and the Title X implementing regulations at 42 CFR Part 59, Subpart A (86 Fed. Reg. 56144) prohibit providers from using Title X funds for abortion and certain related activities. For additional information about Title X restrictions, see OPA guidance at <https://opa.hhs.gov/grant-programs/title-x-service-grants/about-title-x-service-grants/program-policy-notice>.

patients have the right to receive, request, and refuse referrals and resources or information about all pregnancy options. They also have the right to defer making any decisions about their pregnancy during the visit. If a patient chooses to defer making a decision, discuss a timetable with the patient to help them understand their options at different gestational ages.

SECTION 9: EARLY PREGNANCY MANAGEMENT

This section offers guidance on early pregnancy management, including initial prenatal counseling and care as well as management of miscarriage and abortion. Even providers who do not offer full-scope prenatal care can and should offer basic early pregnancy care, encompassing management of urgent complications (such as early pregnancy loss), screening for medication use and other relevant conditions, and education on folic acid use and other time-sensitive topics. Providers should initiate referrals, ideally with a warm handoff, for any needed services not provided on-site, including prenatal care and planning for birth. High-quality, person-centered care in the earliest phases of pregnancy is crucial for improving maternal and infant health outcomes, and significant disparities in access to this care currently exist.¹⁴¹

Prenatal Counseling and Care

For persons considering or planning to continue a pregnancy, provide initial counseling (including offering education on healthy prenatal practices, prescribing folic acid and reviewing urgent warning signs and symptoms). It is expected that all pregnant people should be offered screening for STIs (including gonorrhea, chlamydia, syphilis, and HIV) and counseled about risk reduction strategies and potential risks to newborns. If needed, treatment should be provided in accordance with the most current CDC STI Treatment Guidelines.¹²⁸

Early Pregnancy Loss

Early pregnancy loss during the first trimester is commonly known as miscarriage or spontaneous abortion.¹⁴³ Given how common early pregnancy loss is and that many people are unable to establish prenatal care until after the first trimester, providers of SRH care should be able to identify signs and symptoms of early pregnancy loss and be equipped to provide appropriate treatment or referrals. All pregnant persons should receive information about the signs and symptoms of early pregnancy loss and given instructions to report any concerns to a provider for further evaluation.

Providers can confirm early pregnancy loss by reviewing a patient's medical history; identifying the signs and symptoms, including vaginal spotting or bleeding with or without pain, and bleeding and/or passage of tissue from the vagina; and/or by conducting a physical exam that may include a pelvic ultrasound and quantitative β -hCG testing, depending on the resources available on-site.

Pregnancy loss can be managed in several ways: (1) expectantly, (2) with medications, and (3) uterine aspiration. Patient preference is paramount in determining the course of action. Expectant management is essentially “wait and watch” to assess whether the pregnancy resolves itself with no medical interventions. Decision aid tools have been shown to improve knowledge of treatment options and can be helpful to both providers and patients.¹⁴⁴

Providers should also be prepared to identify and provide treatment or referral in the event of a suspected ectopic pregnancy. An ectopic pregnancy, or pregnancy occurring outside of the uterus, requires immediate medical care. Ectopic pregnancy occurs in about two out of every 100 pregnancies.¹⁴⁵ Providers should be aware of the signs of ectopic pregnancy: (1) abnormal vaginal bleeding, (2) low back pain, (3) mild pain in the abdomen or pelvis, and (4) mild cramping on one side of the pelvis.¹⁴⁶ Ectopic pregnancy can be dangerous if not treated and can cause internal bleeding, infection—and, in some cases, death—to the pregnant person.

Persons experiencing pregnancy loss may benefit from additional social support. The provider can assess the patient's need and desire for social support and refer them to appropriate counseling or supportive services. For additional information about management of early pregnancy loss, please refer to ACOG.¹⁴³

Abortion^f

Medical termination of intrauterine pregnancy can be managed with medication or through a procedure

^fAs noted in footnote e, federal conscience laws protect health care providers that refuse to participate in certain health care services on religious or moral grounds. These laws include the Church Amendments, codified at 42 U.S.C. § 300a-7; the Coats-Snowe Amendment, contained in 42 U.S.C. § 238n, et seq.; the Weldon Amendment, contained in Consolidated Appropriations Act, 2024, Public Law 118–47, div. H, tit. V, sec. 507(d) (1), 138 Stat. 460, 703 (Mar. 23, 2024); and others. The Department complies with all applicable federal conscience laws. More information about conscience laws is available here: [Conscience Protections | HHS.gov](https://www.hhs.gov/conscience-protections). As noted in footnote b, the Title X statute (42 U.S.C. §300 et seq.), legislative mandates included in annual HHS appropriations, and the Title X implementing regulations at 42 CFR Part 59, Subpart A (86 Fed. Reg. 56144) prohibit providers from using Title X funds for abortion and certain related activities. For additional information about Title X restrictions, see OPA guidance at <https://opa.hhs.gov/grant-programs/title-x-service-grants/about-title-x-service-grants/program-policy-notice>.

Exhibit 12. Practical Tips for Discussing a Pregnancy Test Result**Before delivering the result**

Understand that some people may not wish to process or even talk with health care providers about their pregnancy test result, and this is completely acceptable.

Although people will often want partners, loved ones, family members, or others to be part of the subsequent discussion, it is good practice to relay this information to the person alone first, giving them an opportunity to share any sensitive information and inform the clinician about preferences regarding sharing.

Be clear and use a neutral tone.

“Your urine pregnancy test today is positive. That means you are pregnant.”

Pause for patient response

“Would you like a few minutes alone, or would you like me to stay here with you?”

Seek understanding, and pay attention to verbal and nonverbal responses.

Ask open-ended questions: “What thoughts or feelings are coming up for you right now?”

Validate and normalize

“It’s normal to experience and go through several emotions as you are processing this information.”

For positive pregnancy tests, offer to share pregnancy options

“Let me know how I can be most helpful to you. We can discuss any options you are interested in hearing about, including options for continuing or ending your pregnancy, or you can take time to think things over on your own.”

Source: Adapted from Reproductive Health Access Project at <https://www.reproductiveaccess.org/resource/pregnancy-options-counseling-model/> and Provide at <https://providecare.org/practice-guide-all-options-pregnancy-counseling/#1664484177056-1f1809fd-ac61>.

involving uterine aspiration.² Management with medication typically involves a combination of mifepristone and misoprostol. Mifepristone 200 mg is approved by FDA, in a regimen with misoprostol, for the medical termination of pregnancy through 70 days of gestation. The Mifepristone Risk Evaluation and Mitigation Strategy (REMS) Program sets out requirements that must be followed for the use of mifepristone for medical termination of early intrauterine pregnancy.¹⁴⁷ In some circumstances, uterine aspiration may be appropriate for termination of an intrauterine pregnancy, including for reasons of patient preference or when medically indicated (such as for those patients with contraindications to mifepristone or misoprostol). Persons desiring medication or procedural services for termination of pregnancy should receive referrals to timely care. The provider should assess each person’s need and desire for social support and refer them to appropriate counseling or supportive services upon request (Exhibit 12).

Some patients may utilize telehealth services for medical abortion, using FDA-approved mifepristone, dispensed consistent with the Mifepristone REMS Program,

which includes dispensing through a certified pharmacy either in person or via mail order. Providers should be prepared to provide post-abortion care, including management of side effects or complications.¹⁴⁸ Post-abortion care includes an assessment of signs and symptoms of ongoing pregnancy and/or incomplete abortion; the need for contraceptive, fertility, or STI services; and, if needed, a focused physical examination to assess any complaints.¹⁴⁸ Providers can refer to WHO guidelines for comprehensive recommendations.

SECTION 10: SCREENING AND OTHER PREVENTIVE HEALTH CARE SERVICES

For many people of reproductive age, a clinic or health center offering SRH services may be their only source of health care; therefore, visits can include provision of or referral to other preventive health services to improve the overall health of individuals and communities. This section provides guidance on the following preventive health services related to SRH: screening for chronic medical conditions (for example, diabetes and hypertension) that can impact fertility and family building; providing immunizations; cancer screening; providing gender-affirming care; and discussing topics such as perimenopause, mental health, use of alcohol and other substances, sexual assault, intimate partner violence, and human trafficking. The Women’s Preventive Services Initiative (WPSI) also provides detailed guidance on these topics.¹⁴⁹

SRH clinics that do not have the capacity to offer primary care services should have strong linkages to community providers to facilitate referrals for needs identified during SRH visits. In addition to the specific recommendations regarding the preventive health services below, it is useful if providers and clinic staff understand how social determinants of health influence health outcomes and how to provide support. At the patient level, providers can look for clinical flags, ask patients about social needs in a compassionate way, and help them access support services.¹⁵⁰ Clinics can use tools to help identify social needs, including:

- The Accountable Health Communities Health-Related Social Needs Screening Tool¹⁵¹
- HealthBegins Upstream Risks Screening Tool¹⁵²
- WellRx¹⁵³
- Your Current Life Situation Survey¹⁵⁴
- Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences (PRAPARE)¹⁵⁵

Clinics should provide culturally sensitive services by using interpreters and patient navigators where possible and ensuring care is accessible to those most in need (for

example, by offering bus fare and child care, extending clinic hours, etc.).¹⁵⁰ When patients do not have access to a primary care provider, SRH providers should aim to offer the following suite of services: counseling about healthy weight, screening for chronic medical conditions, screening for and administration of immunizations, screening for cancer, gender-affirming care, perimenopausal care, screening for mental health, alcohol and other substance abuse, sexual violence and intimate partner violence, and human trafficking. These services should be provided in accordance with federal and professional medical recommendations that recognize the essential role of primary care services for all people and the impact that social factors, including economic stability, social and community context, and health care access, have on health and well-being.

Moving Beyond “Preconception Health”

The 2014 edition of the QFP recommended a suite of primary care services to promote the health of individuals before conception. This document aims to move beyond the notion of primary care solely for the promotion of healthy pregnancy and birth by recommending all individuals, regardless of pregnancy intention, be offered primary care services in accordance with the SRHE framework.

Source: Dehlendorf C, Akers AY, Borrero S, Callegari LS, Cadena D, Gomez AM, Hart J, Jimenez L, Kuppermann M, Levy B, Lu MC, Malin K, Simpson M, Verbiest S, Yeung M, Crear-Perry J. Evolving the Preconception Health Framework: A Call for Reproductive and Sexual Health Equity. *Obstet Gynecol.* 2021 Feb 1;137(2):234–239. 10.1097/AOG.0000000000004255. PMID: 33416289; PMCID: PMC7813442.

Healthy Weight

Preventive health services include patient-centered conversations about healthy behaviors with people (at any weight) and may include discussions about the relationship of weight to one’s overall reproductive health and fertility. People with a higher body weight or those in larger bodies may encounter weight stigma and discrimination in health care settings, which can negatively affect health outcomes. Providers can reduce this stigma and improve outcomes by moving away from a focus on weighing patients and counseling about weight loss and toward healthy behaviors for people at any weight. If obtaining an individual’s weight is required for continuity of care, ask for the patient’s permission to discuss the topic before addressing weight-related issues, and become aware of strategies to guard against weight-related stress some might have in health care settings.

When applicable, patients should be provided the information that body size (both high and low weight) can affect their fertility.

Screening for Chronic Medical Conditions

Hypertension. Providers should screen for hypertension with office blood pressure measurement in accordance with USPSTF recommendations.¹⁵⁶ Ambulatory blood pressure monitoring and home blood pressure monitoring with validated and accurate devices can be used outside of a clinical setting to confirm a diagnosis of hypertension before starting treatment. Annual screening for hypertension in adults at increased risk for hypertension is recommended. Less frequent screening, every three to five years, is appropriate for adults ages 18 to 39 who are not at increased risk for hypertension and with a prior normal blood pressure reading. Providers should inform patients that hypertension in pregnancy can impact pregnancy outcomes, and close monitoring is critical.

Diabetes. Providers should screen adults ages 35 years and older with BMI ≥ 25 kg/m² for prediabetes and Type 2 diabetes in accordance with USPSTF recommendations.¹⁵⁷ Providers should offer or refer individuals with prediabetes and diabetes to effective prevention and treatment interventions. People with Type 1 or Type 2 diabetes should be encouraged to see a provider before trying to get pregnant, because diabetes increases risk of cesarean birth, large-for-gestational age babies, and children developing obesity or Type 2 diabetes in the future. Importantly, blood sugar goals are lower in pregnancy, so education and adjustments to medical management may be required. People with a history of gestational diabetes should be screened for Type 2 diabetes ideally within the first year postpartum, and every three years afterwards, for a minimum of 10 years after pregnancy.¹⁵⁸

Immunizations

Providers should screen for immunization status and provide vaccinations as indicated in the CDC’s immunization schedules.¹⁵⁹ Vaccines related to SRH care include HPV, Mpox, Hepatitis A and Hepatitis B. A full list of immunizations and schedules can be viewed on the CDC website or through the CDC’s Vaccine Schedules App for Providers. Additional information and recommendations related to specific vaccines are published and regularly updated by the Advisory Committee on Immunization Practices.¹⁶⁰ Clinics that are unable to offer vaccines should make appropriate referrals to community providers for immunization.

Providers should be aware of state laws that regulate the ability of adolescent patients to consent to

Exhibit 13. Cancer Screening Recommendations by Type of Cancer, for People of Reproductive Age

Type of cancer	Age, years	Screening recommendations	Source
Breast ¹⁶³	<40	No screening	USPSTF
	40–74	Mammography biennially	USPSTF
Persons with BRCA mutations or increased risk of breast cancer ¹⁶⁴	25	Persons with BRCA1 or BRCA2 mutations should receive a clinical breast exam every six to 12 months and annual breast imaging starting at age 25.	ACOG
Cervix ¹⁶⁵	<21	No screening	USPSTF
	21–29	Screen every three years with cytology alone.	USPSTF
	>30	Screen with a co-test (cytology and hrHPV testing) every five years, hrHPV testing alone every five years, or cytology every three years.	USPSTF
Anus ¹⁶⁶	>35	Screen adults at higher risk who are age 35 and older, with screening initiated no later than age 45, with digital anal rectal examination (DARE) or anal cytology and/or hrHPV testing with DARE: <ul style="list-style-type: none"> • People living with HIV • Non-HIV immunosuppressed • Men who have sex with men • Transgender women • History of vulvar high-grade squamous intraepithelial lesion (HSIL) or cancer • Other groups with high incidence 	Evidence Review
Oropharynx ¹⁶⁷		Screen annually with dental examination.	USPSTF
Penis and scrotum ¹⁶⁶		Screen individuals with a history of anogenital HSIL or cancer by visually inspecting the penis and scrotum.	Evidence Review
Testicular ^{168,169}	15–55	Testicular self-exam is not currently recommended by USPSTF. Testicular exam at routine physicals can be a decision between patient and provider. Providers can encourage patients to be familiar with their testicles.	USPSTF

vaccines. Organizations such as Teens for Vaccines¹⁶¹ and VaxTeen¹⁶² track consent laws for minors by state and offer resources for providers and patients to help adolescents access vaccines. Providers can also refer to state immunization registries/Immunization Information Systems to determine which vaccines patients have received.

Screening for Cancer

Providers should screen individuals for cancer in body parts that are part of sexual and reproductive anatomy. Screening recommendations by type of cancer can be found in [Exhibit 13](#).

Gender-Affirming Care

Providers should support the sexual and reproductive health care needs of all people regardless of their gender identity by providing gender-inclusive and affirming care as well as information on gender-affirming hormone therapy and preventive care. ACOG, SFP, and WPATH make the following recommendations regarding health care for transgender and gender-diverse (TGD) individuals:¹⁷⁰

- Create inclusive and inviting clinical environments. Providers should take steps to educate themselves and their medical teams about appropriate language and the health care needs of transgender patients.
- Clinics should ensure that gender identity and sex assigned at birth are clearly documented in the medical record as well as the patient's legal name, their chosen name(s), and pronouns.
- Fertility and parenting desires should be discussed early in the process of transition before the initiation of hormone therapy or gender affirmation surgery.
- Gender-affirming hormone therapy has not been studied as contraception. Individuals who do not wish to become pregnant or cause pregnancy in others should be counseled about the possibility of pregnancy if they are having penis-in-vagina sex. All currently available contraceptive methods can be offered for use in TGD patients, including those currently or previously on gender-affirming testosterone therapy, with consideration for commonly accepted medical contraindications in cisgender women.
- Hysterectomy with or without bilateral salpingo-oophorectomy is medically necessary for patients with gender dysphoria who desire this procedure.

- To guide preventive medical care, screening should be based on the organs that a person currently has, regardless of the person's gender identity, sexual orientation, or sexual activity.

In addition, providers can ask TGD patients about perceived levels of social support and social connectedness and refer them to available community support systems. Clinics should have a list of LGBTQI+ groups in the community available to share with patients; a list of national resources is available below:

- Lesbian, Gay, Bisexual, and Transgender (LGBT) National Help Center provides multiple hotlines for peer counseling; online peer chat options; and local resource searches for gay, lesbian, bisexual, transgender, and questioning people.
- PFLAG (Formerly Known as Parents, Families, and Friends of Lesbians and Gays) provides peer-to-peer support through in-person and virtual meetings, online outreach, and a variety of additional resources and programs. Hundreds of local PFLAG chapters are in operation across the country.
- Trans Lifeline provides a hotline—staffed by transgender people, for transgender people—to provide individual support for the needs of members of the community.
- The Trevor Project provides phone, instant messaging, and text services for LGBTQ individuals to communicate with a trained specialist; an online social networking space for youth and their friends and allies in the LGBTQ community; and an online resource center.

Finally, providers should be aware of policies and laws that protect youth and adults who identify as transgender and gender diverse from discrimination and violence.¹⁷¹

For sample language providers can use to deliver gender-affirming care, see a job aid created by the Reproductive Health National Training Center.¹⁷²

Perimenopausal Care

Providers should be able to offer basic guidance about what to expect during perimenopause, counsel on lifestyle changes to help mitigate symptoms, and therapeutic options, either directly or by referral. Providers should also advise patients that pregnancy can still occur during perimenopause; patients wishing to avoid pregnancy should be offered contraceptive counseling.^{94,173} Laboratory testing, including testing for follicle-stimulating hormone (FSH) levels, is not helpful in diagnosing

menopause or determining fertility and should be avoided. The North American Menopause Society (NAMS) offers position statements, questionnaires, and clinical guidance on this topic.¹⁷⁴

Perimenopause lasts four years on average and is often associated with irregular menses, vaginal dryness, vasomotor instability, sleep disturbances, mood changes, and other symptoms.¹⁷⁵ Symptom management includes lifestyle changes, hormone therapy, and other nontraditional treatment options.¹⁷⁶ A shared decision-making approach to menopause therapy includes discussion of symptoms and a review of treatment options including the risks and benefits, and a discussion of the patient's beliefs, preferences, and goals.

Providers should be able to offer basic guidance about what to expect during perimenopause, counsel on lifestyle changes to help mitigate symptoms, and therapeutic options, either directly or by referral.

- Lifestyle changes include smoking cessation, sleep hygiene, maintaining a lower ambient temperature, and using non-estrogen water- or silicone-based vaginal lubricants.¹⁷⁷
- Systemic hormone therapy with estrogen, with or without progestin, has been shown to be the most effective treatment for hot flashes and night sweats, as well as protecting against bone loss.^{178,179}
- Local estrogen is the most effective treatment for genitourinary symptoms of menopause, including vaginal dryness, pain with sex, and dysuria.^{177,179}
- Any patient with a uterus who uses systemic estrogen therapy should also use progestin to reduce the risk of endometrial hyperplasia and cancer.^{177,180} Progestin can be administered continuously or intermittently through a variety of delivery systems, including orally or via intrauterine device.¹⁸⁰
- Consider non-hormonal medical management of vasomotor symptoms with medications like paroxetine and fezolinetant for patients who prefer non-hormonal management or those ineligible for hormone therapy.¹⁷⁸

Both NAMS and ACOG also offer fact sheets and other information for patients.^{166,181}

Mental Health

USPSTF recommends screening for depression and anxiety in all adults from ages 18 to 64 years, including people who are pregnant and postpartum.^{182,183} Pregnant persons should be screened for perinatal depression.¹⁸⁴ USPSTF and AAP recommend screening adolescents annually for major depressive disorder and anxiety.^{185–189} Though the optimal screening

interval is unknown, repeated screening may be most productive in adolescents with risk factors for anxiety, and opportunistic screening may be appropriate for adolescents with infrequent health care visits. Pregnant persons should be screened for perinatal depression.¹⁸⁴

Providers should discuss the limits of their confidentiality and be aware of the age of consent for mental health services in their states and reporting requirements for adolescents.

Commonly used screening tools can be found in Exhibit 14.

Alcohol and Other Substance Use

Providers should routinely discuss use of alcohol, tobacco, and other substances with patients and provide brief behavioral counseling interventions and referrals to appropriate care.^{190,191} The CDC and USPSTF recommend regular screening of adults, including pregnant people, and adolescents for use of tobacco, alcohol, and other substances.^{93,191–195}

Exhibit 15 lists commonly used tools to screen for unhealthy use of alcohol and other substances. In addition to selecting an appropriate screening tool, providers should be prepared to support patients with a substance use disorder in a person-centered way, regardless of their desire to seek treatment. A person’s alcohol or substance use is not a barrier to receiving the SRH services, including pre-pregnancy care, they desire.

For discussions on the use of other substances, providers should be aware of the shifting nature of the opioid epidemic and the emergence of polysubstance use.²⁰¹ Providers can review data published online by the National Survey on Drug Use and Health to understand the extent of substance use in a particular area.²⁰² Clinical service sites should be aware of community resources for patients who express a desire to connect with substance use treatment programs.

Sexual Violence and Intimate Partner Violence

Providers should be prepared to use a trauma-informed approach to discuss sexual violence and intimate partner violence (IPV) during routine clinical visits.^{203,204} ACOG and AAP recommend that universal education about IPV be offered to all patients at least annually.

Universal education is the clinical strategy used to educate all patients on healthy and unhealthy relationships and the health consequences of IPV. This approach differs from screening in that it advocates for all patients to be given information on the health impact of IPV regardless of whether or not they disclose current or past experiences of violence, thus reaching more

Exhibit 14. Commonly Used Screening Tools for Mental Health Conditions

Screening Tool Name	Mental Health Condition	Patient Age	
		Adults	Adolescents
Generalized Anxiety Disorder scale-7 (GAD-7)	Anxiety	X	X
Screen for Child Anxiety Related Disorders (SCARED) Center for Epidemiologic Studies Depression Scale (CES-D)	Anxiety		X
Patient Health Questionnaire-2 (PHQ2)	Depression	X	
Patient Health Questionnaire-9 (PHQ9)	Depression	X	
Patient Health Questionnaire-9 Modified for Adolescents (PHQ9M)	Depression		X

Sources: https://adaa.org/sites/default/files/GAD-7_Anxiety-updated_0.pdf, https://www.aacap.org/App_Themes/AACAP/docs/member_resources/toolbox_for_clinical_practice_and_outcomes/symptoms/Scared-Child.pdf, <https://www.apa.org/depression-guideline/epidemiologic-studies-scale.pdf>, https://cde.nida.nih.gov/sites/nida_cde/files/PatientHealthQuestionnaire-2_v1.0_2014Jul2.pdf, <https://www.apa.org/depression-guideline/patient-health-questionnaire.pdf>, https://www.aacap.org/App_Themes/AACAP/docs/member_resources/toolbox_for_clinical_practice_and_outcomes/symptoms/GLAD-PC_PHQ-9.pdf

people who may choose not to disclose. Universal education can be coupled with direct inquiry and an offer for a warm referral and available resources for IPV—as needed and when a patient discloses violence in response to use of CUES (description below) or other screening. Before discussing sexual violence and IPV, providers should understand their state reporting requirements, make a plan to see the patient alone, and disclose the limits of their confidentiality.²⁰⁵ When a person discloses sexual violence or IPV, the provider should convey empathy, validation, and nonjudgmental care. It is important to connect patients to additional services they may need, including forensic nursing care, housing, legal advocacy, and support groups.

Exhibit 15. Commonly Used Screening Tools for Alcohol and Other Substance Use

Screening tool name	Substance Type		Age		How Tool Is Administered	
	Alcohol	Drugs	Adults	Adole-scents	Self-Led	Clinician-Led
Screening to Brief Intervention (S2BI)	X	X		X	X	X
Brief Screener for Alcohol, Tobacco, and Other Drugs (BSTAD)	X	X		X	X	X
Tobacco, Alcohol, Prescription Medication, and Other Substance Use (TAPS)	X	X	X		X	X
Alcohol Screening and Brief Intervention for Youth: A Practitioner’s Guide (NIAAA)	X			X		X
Opioid Risk Tool – OUD (ORT-OUD) Chart		X	X		X	

Sources: <https://nida.nih.gov/s2bi/>,¹⁹⁶ <https://nida.nih.gov/bstad/>,¹⁹⁷ <https://nida.nih.gov/taps2/>,¹⁹⁸ <https://www.niaaa.nih.gov/alcohol-effects-health/professional-education-materials/alcohol-screening-and-brief-intervention-youth-practitioners-guide>,¹⁹⁹ <https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/opioid-risk-tool-oud-ort-oud>.²⁰⁰

Futures Without Violence developed the CUES intervention to improve care for persons experiencing intimate partner violence.²⁰⁶ This intervention focuses on a team-based approach to addressing IPV, with the following key elements:

- **C: Confidentiality.** Always see the patient alone for at least part of the visit, and disclose your limits of confidentiality before discussing IPV.
- **UE: Universal Education + Empowerment.** Use safety cards to talk with all patients about healthy and unhealthy relationships and the health effects of violence. Always give at least two cards to each patient so they can share with caregivers, loved ones, friends, and family.
- **S: Support.** Disclosure is not the goal, but it will happen. Discuss a person-centered care plan to encourage harm reduction. Make a warm referral to a domestic or sexual violence advocacy organization, and document the disclosure in order to follow up at the next visit.

RHNTC, in partnership with Futures Without Violence, developed a health-care-staff-facing video series illustrating how to apply different components of the CUES intervention in response to IPV.

Human Trafficking

Providers and other clinical staff should be trained to recognize the indicators of human trafficking, often called “red flags;” be prepared to complete an evidence-based human trafficking screening tool; and be equipped to assist victims of trafficking in receiving additional information, support, and referral to care. Signs of human tracking include:

- Scripted or inconsistent history
- Signs of physical or sexual abuse, medical neglect, or torture

- Unwilling or hesitant to answer questions about an injury or illness
- Accompanied by an individual who does not let the patient speak for themselves, refuses to allow for privacy, or insists on interpreting for them
- Evidence of controlling or dominating relationships (excessive concerns about pleasing a family member, romantic partner, or employer)
- Fearful or nervous behavior or avoiding eye contact
- Resistance to assistance
- Hostile behavior
- Unable to provide an address
- Unaware of the location, the current date, or the time
- Person is not being paid or wages are withheld
- Does not have identification or other documents
- Is not in control of own money

The National Human Trafficking Prevention Framework, developed by the HHS Office on Trafficking in Persons, hosts SOAR to Health and Wellness, an online training for health care and social service providers. The SOAR training equips professionals with skills to identify, treat, and respond appropriately to human trafficking.

Assisting victims of human trafficking or someone at risk of trafficking requires thoughtful planning using a trauma-informed approach. This may include working with the patient to complete a safety plan or referring them via a warm handoff to an organization that provides safety planning services.²⁰⁷ Service sites should ensure they have a comprehensive human trafficking referral directory that includes anti-trafficking organizations and programs that offer emergency, transitional, and long-term services to victims and survivors.

Service sites should post the Federal Human Trafficking Hotline number in visible locations (Exhibit 16).

Exhibit 16. Commonly Used Screening Tools for Human Trafficking

Tool	Demographic	Environment
Commercial Sexual Exploitation-Identification Tool (CSE-IT)	Ages 10+; sex trafficking only	Multiple settings, including child welfare and juvenile justice systems, schools, homeless youth shelters, health care, and mental health settings
Human Trafficking Interview and Assessment Measure (HTIAM-14)	Homeless youth; sex and labor trafficking	Service provider setting
Human Trafficking Screening Tool (HTST/HTST-SF)	Ages 18–24; sex trafficking only	Runaway and homeless youth system settings
Quick Youth Indicators for Trafficking (QYIT)	Homeless youth; sex and labor trafficking	Service provider setting
Short Screen for Child Sex Trafficking	Ages 12–18; sex trafficking only	Health care setting
Vera Institute’s Trafficking Victim Identification Tool (TVIT)	Ages 13+; sex and labor trafficking	Not specified

Source: Tools listed from the National Human Trafficking Prevention Framework, developed by the HHS Office on Trafficking in Persons, and endorsed by the EWG.

SECTION 11: USING PERFORMANCE MEASURES TO TRACK AND IMPROVE QUALITY OF CARE

Standardized performance measures within health care settings help to identify opportunities to improve patient care, reduce costs, and increase efficiency of care delivery while also allowing for monitoring of success in satisfying regulatory requirements and supporting public accountability.^{208,209} These measures are increasingly emphasized as a means of promoting and ensuring quality in health systems.

This section describes the use of these measures to help identify weaknesses, prioritize opportunities, and identify what works and doesn’t work to drive quality improvement (QI) efforts in the context of SRH. Quality improvement draws on a wide range of approaches and methods, most of which share underlying principles and steps to identify the quality issue(s), understand the problem from a range of perspectives, design and plan delivery of an improvement intervention, identify and test solutions, and implement the solution and ensure the intervention becomes standard practice.

Within the context of SRH, performance measures can be embedded in a health care system’s QI process to help assess its capacity and effectiveness at meeting an individual’s SRH needs and preferences—and to identify, track, and address inequities. Such QI processes should be based on the underlying principles shared above and focus on efforts to improve access and patient-centeredness.²¹⁰

The following terminology is used to define performance measures for SRH services. A performance measure is a valid and reliable measure of a health care structure, process, or outcome that captures a component of quality SRH services consistent with the

definition of quality family planning and SRH and aggregated at a provider, facility, plan, state, or regional level.²¹¹

- *Structure* refers to the context in which care is delivered, including the physical environment, staff, financing, and equipment.
- *Process* refers to the transactions between patients and providers throughout the delivery of health care.
- *Outcomes* refer to the effects of the structure and process of health care on the health status of patients and populations and on the patient experience of care.
- *Validity and Reliability*: Validity of a performance measure refers to whether it measures what it was intended to measure. Reliability refers to whether the same results can be produced consistently under the same conditions.

Importantly, performance measures can, in some cases, adversely impact outcomes and patient experience by incentivizing specific behaviors or processes inconsistent with quality care. For example, metrics for frequency of testing for sexually transmitted infections can contribute to patients being tested without their knowledge or consent.^{212,213} To protect against these effects, measures that reflect experience of care and people’s lived experience are critical. This is particularly important in SRH due to the personal nature of decisions related to reproduction, the historical and contemporary reproductive oppression and coercion in the United States, and the well-documented inequities in care by race and ethnicity.^{214,215} To ensure appropriate use, performance measurement and QI processes should emphasize people’s experiences and preferences, avoid creating harm by monitoring and protecting against

adverse impacts of performance measures, allow for evaluation of inequities through appropriate data stratification, and disseminate results intentionally to promote implementation of evidence-based practices and help ensure measures are being interpreted and applied in a meaningful way.²¹⁵

Determining Which Performance Measures Are Needed

Sites that offer SRH services should select, measure, and assess at least one intermediate- or outcome-based performance measure on an ongoing basis. Structure- and process-based performance measures can also be used to better determine how to improve quality. For core components of SRH care for which there are no validated performance measures, teams may use quality measures (for example, unvalidated indicators) to support local QI activities, but not public reporting. When evaluating the need, quality, acceptability, and priority of a specific performance measure, clinical service sites can consider three key factors:²¹⁶

- **Importance.** Is the focus of the measure supported by evidence that it is an important component of quality? Is the topic important to measure and report—for example, does it address a priority aspect of health care? Is there an opportunity for improvement?
- **Scientific Acceptability.** What is the level of evidence for the measure (for example, that a change in the measure is likely to represent a true change in health outcomes)? Does the measure produce consistent (reliable) and credible (valid) results about the quality of care?
- **Feasibility.** Are the results meaningful, understandable, and useful information for QI? Can the measure be implemented without undue burden (for example, captured with electronic data or electronic health records)?

Using the list in [Exhibit 17](#), service delivery sites can select at least one intermediate- or outcome-based performance measure. This non-exhaustive list of measures aligns with the QFP recommendations, the Centers for Medicare and Medicaid Services (CMS) core set of Adult and Child Health Care Quality Measures,* and the approved and HRSA-supported WPSI recommendations.⁺ The measures on the list have been developed by a variety of entities such as the National Committee for Quality Assurance (NCQA), Partnership for Quality Measurement (PQM), Quality Payment Program, and HRSA’s National Performance Measures. These measures are used to assess quality in

many federal and nonfederal programs. The exhibit highlights measures that are ready to implement and actionable, such as the Person-Centered Contraceptive Counseling (PCCC) measure, and other valid and reliable measures, such as those for STI screening rates and access to appointments. It also includes a range of structure-, process-, and outcome-based measures.

Additional resources for selecting and understanding the best ways to use reporting measures include the following:

- [Medicaid Adult Core Set Reporting Resources](#)
- [Medicaid Child Core Set Reporting Resources](#)
- [PQM Submission Tool and Repository Measure Database](#)
- [WPSI aligned performance measures](#)

Implementing Measures and Interpreting the Data

Although the measures each service site uses may vary, all sites should address the following cross-cutting considerations when implementing the measures and interpreting the data.²¹⁷

- *Understand that performance measures cannot address or solve every problem.* They can signal that there is an issue, but teams should be prepared to dedicate additional effort to dig deeper and understand what really needs to be fixed.
- *Be aware of the ways that “improving” performance may inadvertently lead to coercive practices.* In one example, a service site identified measures for increasing sexual risk assessment and chlamydia screening for tracking improvement during a QI project. The team also developed balancing measures to provide a marker of potential unintended consequences of improvement activities or gaps in improvement. These measures included unnecessary screening of patients who were not documented as sexually active, and no screening for sexually active patients. Another possibility is for service sites to use the PCCC measure and contraceptive provision measure in tandem to ensure contraceptive provision is not accompanied by bias, reproductive coercion, and/or an otherwise negative patient experience ([Exhibit 18](#)).
- *Whenever possible, stratify by demographics* (for example, race, ethnicity, preferred language, age, sex, sexual orientation and gender identity, disability status, payment used for visit, federal poverty level, and/or other socioeconomic indicators) and *visit characteristics* (for example, visit type, provider). Service sites can monitor differences to determine what service delivery processes, systems, and policies may be

Exhibit 17. Examples of Performance Measures for SRH and Related Services

Sample Measures	Type of Measure	Steward and/or Endorsing Entity
Access measures not specific to SRH care		
Getting timely appointments, care, and information	PRO-PM	Consumer Assessment of Healthcare Providers and Systems (CAHPS); PQM 0005
How well providers communicate with patients	PRO-PM	CAHPS; PQM 0005
Helpful, courteous, and respectful office staff	PRO-PM	CAHPS; PQM 0005
Contraception		
Contraceptive Care – Most & Moderately Effective Methods* [±]	Intermediate outcome	OPA MME; PQM 2903
Contraceptive Care – Access to LARC* [±]	Structure	OPA LARC; PQM 2904
Contraceptive Care – Postpartum Access to LARC* [±]	Structure	OPA Postpartum LARC; PQM 2902
SINC-Based Contraceptive Care – Non-Postpartum	Intermediate Outcome	University of California – San Francisco (UCSF) eCQM; PQM 3699e
SINC-Based Contraceptive Care – Postpartum	Intermediate Outcome	UCSF eCQM; PQM 3699e
Person-Centered Contraceptive Counseling (PCCC) Measure	PRO-PM	UCSF PCCC; PQM 3543
Sexually Transmitted Infections and HIV		
Chlamydia screening and follow up*	Process	NCQA
Chlamydia screening in women* [±]	Process	NCQA; PCQM 0033
Human Papillomavirus Vaccine for Female Adolescents (HPV)	Process	NCQA
HIV/AIDS: Sexually Transmitted Diseases-Screening for Chlamydia, Gonorrhea, and Syphilis*	Process	HRSA
HIV linkage to care	Process	HRSA
Language		
L1A: Screening for preferred spoken language for health care	Process	George Washington University
L2: Patients receiving language services supported by qualified language services providers	Process	George Washington University
Other Preventive Health Services		
Breast Cancer Screening for average risk women* [±]	Process	NCQA; PQM 2372
Cervical Cancer Screening*	Process	NCQA; PCQM 0032
Screening for Depression and Follow-Up Plan [±]	Process	CMS
Wellness Preventive Visit		
Well-Woman Visit* [±]	Process	HRSA
Adolescent Well-Visit* [±]	Process	HRSA

* Denotes inclusion in CMS Adult and Child Health Care Quality Measures.

[±] Denotes measure is in the approved and HRSA-supported WPSI recommendations.

LARC = long-acting reversible contraceptive.

driving suboptimal performance and inequities, and where opportunities for improvement exist to advance SRHE. In one example, 75 percent of respondents to a service site's PCCC survey selected "excellent" in response to questions that addressed the domains of patient experience of counseling: interpersonal connection, adequate information, and decision support. After disaggregating scores by preferred language, data showed that respondents to surveys in Spanish were less likely to report a top score than respondents who completed surveys in English (60 percent vs. 78 percent).

- *If measurable differences are observed between different groups, service sites should engage with patients, community members, and community advisory*

boards. Actionable feedback can be provided on experiences of care, perceived barriers, and interventions and supports that might help alleviate these barriers. In response to the disparate PCCC scores referenced above, the service site shadowed several Spanish-speaking patients throughout their visit to gain insight into how this group experienced care; and, at the end of the visit, they asked each patient what went well and what did not go well. The service site also sought feedback on potential barriers to an optimal patient experience from its community advisory board, which included patients, frontline community health and social service providers, and representatives from community-based organizations.

Exhibit 18. Spotlight on Contraceptive Performance Measures

Before 2016, there were no validated, standardized clinical performance measures for assessing the quality of contraceptive care. Stakeholders developed measures to address this gap, which were endorsed by the National Quality Forum.

- *Contraceptive provision and use measures* help ensure providers meet patients' contraceptive needs by providing them with access to methods to control their fertility as desired, including those, like long-acting reversible contraceptive methods, that have the most barriers to provision.
- *The Person-Centered Contraceptive Counseling (PCCC) measure* helps ensure that people receive contraceptive care focused on their preferences and desires, including being treated respectfully during contraceptive counseling, having the support to make informed choices concerning their contraceptive options, and not experiencing coercive or directive counseling toward choosing a particular method.
- *Use of the two types of measures in combination* is recommended to ensure patient preferences are respected in the context of efforts to increase access to contraception given fears that the provision measures may incentivize providers to inappropriately promote the more effective methods of contraception.

Sources: <https://opa.hhs.gov/research-evaluation/title-x-services-research/contraceptive-care-measures>; <https://pcccmeasure.ucsf.edu>.

- *Consider implementation-related and external factors.* Service sites can develop approaches that consider a range of factors, which are impacted by capacity (linked to setting type and funding source), community context, state and local requirements, and political climate. For example, some Title X multidisciplinary teams have come together with the shared goal of increasing chlamydia screening rates. Through learning sessions and action periods over six to 15 months, they learn from subject matter experts, engage with other teams to learn from each other, and apply and test improvements in their own clinical settings.²¹⁸ The evidence-based interventions they choose to implement (for example, integrating screening into routine care, adopting opt-out language in scripts and education materials, and utilizing diverse payment options to address cost barriers) will vary based on baseline performance, capacity, patient population, and community needs, but all focus on achieving the same overall goal.²¹⁹

Using Data to Improve Quality

Performance data should be shared widely with clinic staff at all levels and across all disciplines. Dissemination strategies include adding data to existing quality reports

or dashboards, reporting out during staff meetings or team huddles, sharing dashboards and tables via email, and posting dashboards and charts in staff areas. Staff at all levels can be offered opportunities to provide feedback about potential drivers of current performance and potential strategies for improvement.²²⁰ Broad dissemination provides an opportunity for service sites to communicate with a larger audience about their vision for high-quality SRH care and foster buy-in for QI efforts.

Service sites can begin to identify opportunities for improving care quality once they have successfully incorporated the performance measures into their data review process. Similarly, as to the process of selecting measures, effective QI strategies are equity focused and person-centered, integrate consideration of historical and ongoing harms, and meaningfully address inequities. When selecting which intervention(s) to prioritize, service sites should solicit meaningful participation from internal partners about feasibility and potential impact. The broader the group of partners, the greater the likelihood of uncovering experiential knowledge that can complement or inform QI activities. Examples of steps that may improve quality of SRH care include developing job aids, providing equity-focused and task-specific training for providers, streamlining health center workflow, conducting more patient and community education, and strengthening relationships with referral sites through formal memoranda of understanding.²²¹

Additional SRH-focused quality improvement resources are listed below:

- The New York Department of Health's guide for Engaging Primary Care Providers in Chlamydia Screening Quality Improvement, details the approach and highlights key successes of a quality improvement framework for the delivery of sexual health services by pediatric primary care providers.²²²
- The Texas Department of State Health Services website highlights a range of Ryan White Program clinical quality management resources, including tools and a leadership training toolkit.²²³
- The RHNTC has several resources available to support performance improvement on the contraceptive care measures, including a change package outlining the rationale, improvement strategies, and Title X success stories and a toolkit to support health care organizations in ensuring access to the full range of contraceptive methods for patients.

Moving Forward

Existing performance measures do not allow for assessment of all aspects of quality in comprehensive SRH

services. Additional work is underway to develop new measures at both the population and individual levels, with the overarching goal being to support programs and policies that advance person-centeredness and reproductive autonomy and ensure that SRH services align with the broad experiences, desires, and needs of diverse people. A future, full “suite” of SRH measures could potentially assess (1) a person’s desire for services, determining whether they access the care they wanted to receive; (2) service provision and patient satisfaction with services; and (3) patient SRH outcomes, such as pregnancy, fertility, and sexual and reproductive well-being.²¹⁶ Many new measure development efforts are focused on cultivating equitable collaborations and engaging communities throughout the measurement and QI processes, which has long been called for by reproductive justice advocates.²²⁴ Looking forward, there will be an ongoing need to continuously assess the degree to which measurement and associated QI efforts are aligned with best practices for equity-focused, patient-centered sexual and reproductive health care.

CONCLUSION

During the past decade, several changes have taken place in the United States that have affected the delivery of SRH care, including family planning services, and the understanding of what constitutes quality. This broader context has been accounted for in designing these recommendations. This update of the QFP expands on previous recommendations on providing person-centered SRH care and expands the definition of quality to include individuals’ needs, values, and preferences.

In addition to incorporating new evidence, this update incorporates newer approaches to care, including adopting a health equity lens and recognizing the impact of structural and interpersonal racism, classism, ableism, and bias based on sexual orientation and/or gender identity on health and SRH care. The aim is to enable a broad range of health care providers to help ensure that all people, regardless of individual characteristics can have their SRH needs met. Specific updates include an expanded emphasis on person-centeredness and equity, an explicit gender-inclusive approach, and use of language throughout to recognize that people of all genders may need and access SRH care and center the needs of groups and individuals who experience SRH inequities in shaping the recommendations, rather than considering “special populations” separately. Additionally, the evidence supports a recommendation to discuss reproductive desires with a person-centered approach that focuses on open-ended communication and nonjudgmental counseling and does not endorse a single

framework to achieve these discussions. Additional technical content includes (1) guiding principles and details on approaches to care to help providers carry out these guiding principles, (2) new care delivery strategies, like telehealth and over-the-counter (OTC) oral contraception, (3) a broader content on early pregnancy management and resources, (4) and expanded approach to family building, (5) new or expanded preventive health care services related to mental health, healthy weight, perimenopausal care, gender-affirming care, and human trafficking, (6) new STI and HIV prevention strategies, including self-care approaches and post- and pre-exposure prophylaxis (PEP and PrEP).

The new recommendations also include care for a broad range of provider specialties in varied settings both within and beyond the formal health care system, including patient-led and self-care options and intentionally incorporate published scientific evidence and existing guidelines, and include more expansive types of evidence. In sum, these recommendations intend to set the standard of SRH care and can be used by all current and future providers of SRH services in varied settings, including primary care, specialty care (for example, obstetrics/gynecology, neurology, and rheumatology), and community settings (for example, mobile clinics, schools, and pharmacies). These recommendations are specifically intended for all current or potential providers of SRH services, including those funded by the Title X program.

OPA will update the QFP recommendations periodically to reflect new findings in the scientific literature and revisions to the clinical guidelines referenced in this update of the QFP.

DECLARATION OF INTEREST STATEMENT

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