Contraception updates for adolescents

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Purpose of review
To discuss updated guidelines for the provision of contraception to adolescents, review several contraceptive methods that have entered the market in recent years, and summarize insights from the literature that can assist clinicians in providing accurate, destigmatized contraceptive counseling to patients of all sizes.

Recent findings
The 2024 United States Selected Practice Recommendations (US SPR) and United States Medical Eligibility for Contraceptive Use (US MEC) guidelines include changes to recommendations for contraception use in persons with various health conditions, and new advice for management of implant-associated breakthrough bleeding, pain control for intrauterine device (IUD) insertions, and counseling for patients who take testosterone. Subcutaneous Depo-Provera usage increased during the COVID-19 pandemic, and multiple studies demonstrate favorable patient experiences with it. Annovera, Miudella, Opill, Phexxi, Slynd, and Twirla are newer contraceptives which have distinct features that may make them attractive options for some patients. Contraception-related weight changes continue to be an active area of research. With the Food and Drug Administration (FDA) recommending broader BMI inclusion criteria, providers can expect more information about safety and efficacy of new contraceptives in individuals across the weight spectrum.

Summary
Updated evidence-based guidelines and several new contraceptive options should empower providers to provide patient-centered contraception counseling to patients with a variety of health conditions and contraceptive preferences.

Keywords
adolescents, contraception, reproductive health, weight

INTRODUCTION

The contraceptive landscape is evolving rapidly, affecting pregnancy-capable people worldwide. Adolescents' access to contraception is crucially important; in the United States (US), increasing contraceptive use has led to decreasing rates of adolescent pregnancy in recent years [1]. Adolescents today have access to an expanding array of contraceptive options, updated guidelines around safety and efficacy, and a shift toward person-centered contraception counseling. A person-centered discussion of pregnancy prevention requires the clinician to prioritize the patient's values and preferences, versus the previously taught efficacy-based counseling method [2]. Several new contraceptives have been approved recently, alongside a global pandemic which challenged providers to maintain reproductive healthcare access to patients of all ages. A nationally representative survey in the US during the first two years of the COVID-19 pandemic found there was no significant change in rates of starting or stopping contraception in young adults [3▪]. In 2024, the US joined the global majority in offering over-the-counter (OTC) hormonal contraception, and postmarket data are emerging. Finally, in light of growing knowledge of the complex relationship between health and weight, and evidence that individuals with a higher BMI may have unmet contraceptive needs [4], an overview of recent literature on weight-related contraceptive challenges is provided.

SUMMARY OF 2024 MEC AND SPR CHANGES

The US Medical Eligibility for Contraceptive Use (US MEC) [5▪▪] and the US Selected Practice Recommendations for Contraceptive Use (US SPR) [6▪▪] are companion documents originally adapted from

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KEY POINTS

- Healthcare providers who engage in contraceptive counseling and management for adolescents should be aware of key changes made to the US MEC and US SPR in the 2024 update.
- Subcutaneous Depo-Provera usage increased during the COVID-19 pandemic with favorable patient response and should be included in routine contraception counseling options.
- Patients with BMI in the overweight or obese category do not have absolute contraindications to any method of contraception, but should be counseled about the possibility of decreased efficacy and increased risk of venous thromboembolism with certain methods.
- Annovera, Miudella, Phexxi, Slynd, and Twirla are new prescription contraceptives, which together with over-the-counter Opill offer a significant expansion of options to patients with a variety of contraceptive needs and preferences.
- Forthcoming innovations include a medication abortion regimen that utilizes ulipristal acetate, which providers should be prepared to explain is distinct from ulipristal acetate use as emergency contraception.

WHO guidelines, and are revised regularly to reflect the most current evidence. All healthcare providers have access to the US MEC and SPR either on the web or through an interactive app. Those who routinely participate in contraception counseling and management are advised to download these documents directly from the CDC website or via access provided by professional societies [7]. Several updates which are relevant to adolescents are reviewed here.

Key 2024 US MEC updates

The US MEC document comprises recommendations for different contraceptive methods based on various health conditions [5▪▪]. For each health condition, contraceptive methods are assigned a risk category ranging from 1 (no risk) to 4 (unacceptable health risk). Risk categories are described further in Table 1: US Medical Eligibility Criteria categories for contraceptive use. Regarding obesity, while combined hormonal contraceptive (CHC) use is still considered a category 2, a substantive clarification has been added to note that obesity is just one of several risk factors which independently increase risk for venous thromboembolism (VTE). Such factors include smoking, diabetes, hypertension, and dyslipidemia. If an individual has obesity and other VTE risk factors, CHC use might increase thrombosis risk to an unacceptable level. Recommendations for patients with history of or current thrombosis have been clarified, with the major change being that CHCs are no longer absolutely contraindicated in patients with an active deep vein thrombosis (DVT) or pulmonary embolism who are therapeutically anticoagulated. For providers who care for solid organ transplant recipients, presence or absence of graft failure determines recommendation for CHCs; communication with the patient's transplant team to review their posttransplant course may be needed. Most contraceptive methods are considered safe for solid organ transplant recipients. Finally, guidelines are for patients with sickle cell disease have become more stringent, considering their already increased risk for stroke and VTE compared to the general population. CHC use is now considered contraindicated in this population, and depot medroxyprogesterone acetate (DMPA) risk category has increased due to concern that these methods may further elevate VTE risk.

Key 2024 US SPR updates

The US SPR document provides recommendations for managing common contraception-related challenges [6▪▪]. The 2024 SPR recommends that subcutaneous DMPA (DMPA-SC) be offered alongside intramuscular Depo-Provera (DMPA-IM) as part of routine contraceptive counseling. See the DMPA-SC section in this manuscript for more information. The updates discuss intrauterine device (IUD) placement and pain control at length, and this is an active area of study which may yield additional future updates. At this time, misoprostol is not recommended for routine use in IUD insertions but may be used after a failed attempt. There is evidence

Table 1. US Medical Eligibility Criteria categories for contraceptive use [5▪▪]

Category	Recommendation
1	A condition for which there is no restriction for the use of the contraceptive method
2	A condition where the advantages of using the method generally outweigh the theoretical or proven risks
3	A condition where the theoretical or proven risks usually outweigh the advantages of using the method
4	A condition that represents an unacceptable health risk if the contraceptive method is used

recommending paracervical lidocaine injections and topical lidocaine on the cervical os for pain control. Management of bleeding irregularities during contraceptive implant use is also covered in detail. Some patients will experience spotting or light bleeding during implant use, and while generally not harmful, unscheduled bleeding may be bothersome, and the patient may be interested in intervention other than implant removal. For patients who desire treatment for unscheduled bleeding, have been evaluated for underlying health conditions, and do not desire implant removal, there are several pharmacologic treatment options. These include combined oral contraceptive pills or oral estrogen, tranexamic acid, NSAIDs, and selective estrogen receptor modulators. The final major update is regarding patients who use exogenous testosterone; while testosterone usage may suppress menses in some, it is not a contraceptive method and testosterone users may still become pregnant. Testosterone therapy is not a contraindication to any contraceptive method; providers should be prepared to provide contraception counseling to patients on testosterone who are engaging in sexual activity which could result in unintended pregnancy.

WEIGHT AND CONTRACEPTION

There are multiple factors to consider when discussing weight and contraception. Women with obesity experience unplanned pregnancy at a higher rate than woman without obesity, which has been attributed in part to lower contraception use and greater contraceptive failure in the former group [8]. While the relationship between obesity and infertility is well established [9], adolescents in larger bodies are still at risk for unplanned pregnancy and providers should recommend contraception when indicated in patients of all sizes. Inclusivity of patients across the BMI spectrum has historically been limited in contraceptive studies, therefore in 2007 the Food and Drug Administration (FDA) recommended that enrollment criteria be more reflective of real-world prescribing with regard to BMI [10,11]. When discussing weight, the clinician is responsible for providing accurate information in a nonstigmatizing way, while centering the patient's goals [12▪]. Examples of language that may be used in this context are provided in Table 2: How to discuss contraception with individuals in larger bodies.

Weight and effectiveness

Effectiveness of progestin-only pills and the hormonal IUD does not vary based on BMI, though rates of levonorgestrel IUD expulsion increase with higher BMI [12▪,13]. One secondary analysis of the norelgestromin/ethinyl estradiol patch suggests higher rates of failure above 90 kg, and another in BMI at least 30 kg/m^2 [14]. The etonogestrel/ethinyl estradiol vaginal ring is likely still effective in people with obesity [15], whereas the newer segesterone acetate/ethinyl estradiol ring has not been adequately studied in people with BMI at least 30 kg/m^2 [16]. Combined oral contraceptive pills may have minimally decreased effectiveness with BMI more than 30 kg/m^2, though there is conflicting evidence [5▪▪,14]. Contraceptive implant effectiveness does not vary based on BMI [17], however, there are limited efficacy data in people with BMI at least 40 kg/m^2 [12▪]. DMPA does not appear to be less effective in adult women with BMI more than 30 kg/m^2 [18]. In regard to emergency contraception, while the overall pregnancy rate in all emergency contraception users is low, effectiveness decreases with increasing weight, especially with levonorgestrel; individuals who are at least 70 kg or have a BMI at least 30 kg/m^2 should be counselled that ulipristal acetate (UPA) is more effective [19▪]. Doubling the dose of emergency contraception pills for use in patients with larger BMIs has not been shown to increase efficacy [19▪,20▪].

Table 2. How to discuss contraception with individuals in larger bodies (original)

Language to avoid	Alternative
This contraceptive method is not available to you because you are obese. If you lost weight, you would have more options.	Being a certain size or weight does not rule out any contraceptive method. Some of the studies looking at safety and effectiveness of different birth controls were not weight inclusive. This means we have less information about how some medicines act in bodies of different sizes.
Being fat makes it more likely your birth control will fail.	Some forms of birth control are less effective in people of higher weight. Let's talk about your goals for contraception and work together to find a method that is effective and meets your other needs.
At your weight, the risk of developing a blood clot makes it too dangerous to use birth control.	There are risks with every contraceptive method regardless of someone's size. Having a higher weight is one of several things that can make someone more likely to develop a blood clot.

Weight gain associated with contraception

Weight gain is a normal and healthy part of adolescence. If significant weight gain has occurred during contraceptive use, it is worth exploring the youth's feelings around the change and presence of other contributing factors. The adolescent should be advised that if they choose to stop their contraception or switch methods, this may not result in reversal of the weight gain. DMPA is the only method with significant evidence showing that a minority of patients will gain weight during use, though some studies do not demonstrate this association [12▪]. For those who do gain weight, it starts early in DMPA use and may be associated with higher pretreatment weight [21]. There is a growing body of research assessing weight changes in adolescents using the etonogestrel implant. One recent study found a mean BMI change of approximately one BMI unit over three years of etonogestrel implant use, similar to BMI changes in the study group receiving DMPA [22▪▪]. However, more research is needed to identify patient-specific characteristics that increase likelihood of implant-associated weight gain [22▪▪].

SUBCUTANEOUS DEPO-PROVERA (DMPA-SC)

The CDC and WHO recommend DMPA-SC be included in contraception counseling [6▪▪,23]. DMPA-SC is self-administered, eliminating the need for in-person appointments multiple times per year. Several organizations have developed DMPA-SC implementation resources that outline options for patient education on self-injection and sharps disposal, workflow for follow-up needs, and administrative logistics [24,25]. The COVID-19 pandemic was an opportunity for providers to expand access to DMPA-SC to maintain social distancing guidelines. Both adults and adolescents who transitioned from DMPA-IM to DMPA-SC advocate for DMPA-SC being a routine part of contraceptive counseling [26▪▪,27]. Patients speak highly of the autonomy they feel, the convenience of not needing to go the provider's office as frequently, and decreased injection pain compared to DMPA-IM [26▪▪,27]. Most patients chose to continue using DMPA-SC after social distancing guidelines relaxed [26▪▪,27].

NEWER CONTRACEPTIVES

Several contraceptive options have entered the US market in recent years, and others are in clinical trials. Six of the more recently introduced methods are included below.

Annovera (segesterone acetate/ethinyl estradiol)

Annovera (Organon & Co, Jersey City, New Jersey, USA) is an intra-vaginal system that received FDA approval in 2018. As with the etonogestrel/ethinyl estradiol contraceptive, it is a flexible, pliable ring-shaped device, which is placed by the user into the vagina, where it stays for 21 continuous days then is removed for 7 days. The ring is reusable for thirteen 28-day cycles. The product labeling indicates that it should be used in people with BMI less than 29 kg/m^2; this is due to two episodes of VTE that occurred in individuals with BMI more than 29 kg/m^2 during clinical trials [16]. Users note a highly favorable bleeding pattern and low discontinuation rates; about one in eight will discontinue use in the first year which is comparable with discontinuation rates of other CHCs [28]. Expulsions occur more frequently in users of Annovera than in users of the etonogestrel/ethinyl estradiol ring, however this was not shown to result in higher rates of discontinuation [28,29]. While continuous use (no monthly seven-day removal period) of Annovera has not been studied, research looking at a segesterone acetate/ethinyl estradiol vaginal ring designed to be used continuously is ongoing [30]. Annovera may be an attractive choice for users who have barriers to retrieving prescriptions multiple times per year.

Miudella (copper)

Miudella (Sebela Pharmaceuticals, Roswell, Georgia, USA) is an intrauterine device which received FDA approval in 2025. It is approved for pregnancy prevention for three years, though this may be extended as clinical trials continue. In addition to containing less copper than the Paragard IUD (CooperSurgical, Inc, Stafford, Texas, USA), Miudella offers several other design differences including smaller size, a tapered and rounded inserter tip intended to ease passage through the cervix, precut strings, and a preloaded inserter [31▪]. A Phase III clinical trial demonstrated lower discontinuation rates secondary to bleeding or pain at one year and three years compared to Paragard [31▪,32]. This trial is ongoing and plans to follow enrollees for eight years post Miudella insertion [31▪]. This is the first nonhormonal IUD to enter the US market since the 1980s, making it a meaningful advancement in the provision of hormone-free contraceptive options [32].

Slynd (drospirenone)

Slynd (Exeltis USA, Inc, Florham Park, New Jersey, USA) is a contraceptive pill that received FDA

approval in 2019. It comes in a 28-day pack containing 24 hormonal pills and four inert pills. Drospirenone has a half-life of 25–30 h, significantly longer than that of other progestins. Advantages of this include improved irregular bleeding and more flexible effective dosing windows; whereas the norethindrone progestin-only pill has a 3-h missed pill window, Slynd offers a 24-h missed pill window [33]. Noncontraceptive actions of drospirenone such as improvement in acne and premenstrual symptoms may also make it an attractive option for some patients [34]. Drospirenone has antimineralocorticoid properties and may cause hyperkalemia in a small number of users; risks of use may outweigh benefits in patients with renal disease [34]. One study looking at continuous Slynd use in adolescents found it to be a well tolerated, viable method of menstrual suppression, and while breakthrough bleeding was the most common side effect, most of those who experienced it did not discontinue use [35▪▪]. Slynd is a significant advancement in contraceptive options for individuals with estrogen contraindications who want to maintain cyclical bleeding.

Twirla (levonorgestrel/ethinyl estradiol)

Twirla (Agile Therapeutics, Inc, Princeton, New Jersey, USA) is a transdermal patch that received FDA approval in 2020. It was developed with the intention of creating a transdermal product with less estrogen than the norelgestromin/ethinyl estradiol patch, and thus, a lower VTE risk [36]. Users are directed to use the patch in 28-day cycles: three consecutive administrations of 7-day patches followed by seven patch-free days [36]. The manufacturer advises use in individuals with BMI less than 30 kg/m^2, as effectiveness was shown to be lower in women with higher BMIs [36,37]. Risk of VTE in Twirla users is also higher in people with BMI at least 30 kg/m^2 [36,37]. Discontinuation rates of Twirla are similar to those of other CHCs; 11% of adult women followed for 1 year of use discontinued Twirla due to adverse effects, which were most commonly nausea and application site irritation [37]. While direct safety comparisons have not been made, the lower estrogen exposure in Twirla compared to the norelgestromin/ethinyl estradiol patch may make it an attractive option for patients interested in a transdermal method who want to minimize VTE risk.

Phexxi (lactic acid/citric acid/potassium bitartrate)

Phexxi (Evofem Bio-sciences, Inc, San Diego, California, USA) is a prescription vaginal gel that received FDA approval in 2020. It works as a chemical barrier by maintaining a vaginal acidity level which impedes sperm motility [38]. One box of Phexxi contains 12 prefilled, single dose applicators [38]. Phexxi should be administered intravaginally up to 1 h before each episode of vaginal intercourse [38]. Systemic exposure is minimal and likely clinically insignificant [39]. It does not interact with other intravaginal products such as yeast or bacterial vaginosis treatment, and can be used in conjunction with other contraceptives, except for an intravaginal ring [38,39]. The most common adverse effects include vaginal burning sensation (18%), itching (14.5%), yeast infection (9.1%), and urinary tract infection (9%). The manufacturer recommends Phexxi be avoided in patients with recurrent urinary tract infections or urinary tract abnormalities [38]. About 10% of assigned male at birth sexual partners of Phexxi users may experience mild reactions such as itching and burning [38]. The effectiveness of Phexxi is comparable to other on-demand methods such condoms and spermicides [39]. There is some indication that Phexxi may also prevent urogenital chlamydia and gonorrhea infections [39].

Opill (norgestrel)

Opill (Perrigo, Inc, Grand Rapids, Michigan, USA) is an OTC progestin-only oral contraceptive which received FDA approval in 2023. There is evidence that Opill became widely available within one to two months after it was released in March 2024, though independent pharmacies were less likely to stock it than chain pharmacies [40▪]. While the near-immediate availability is promising, there may be significant barriers to access especially in an adolescent population, including insurance coverage. Some adolescents may prefer the discrete nature of a contraceptive that does not appear on an insurance explanation of benefits, however for those who want to apply their insurance, OTC medications may not be covered by their plan. One survey about OTC contraception reported that teenagers were willing to pay a median of $10 per month [41], significantly lower than the suggested retail price for Opill of $19.99 per month [42]. Additional research is needed to evaluate adolescents' usage of Opill and any challenges they experience procuring it.

Other innovations

A comprehensive discussion of forthcoming contraception advances is beyond the scope of this review, but one which the general pediatrician may be asked about will be mentioned here. While currently only

approved for use as emergency contraception in the US, UPA is being studied in combination with misoprostol as an alternative regimen for medication abortion [43▪▪]. Providers should be prepared to answer questions from patients about UPA. It is important to recognize that this was a small proof-of-concept study, that the study dose of UPA was double the dose of UPA used for emergency contraception and that the study did not assess UPA alone nor did they compare their regimen with an existing medication abortion regimen.

CONCLUSION

Adolescents and their healthcare providers have access to more contraceptive options and knowledge than ever before. Many of the newer contraceptives were designed to improve upon existing methods, or to expand contraceptive access to individuals with high-risk medical conditions. The US MEC and SPR are valuable tools for providers to engage in patient-centered counseling that is specific to each unique adolescent who seeks their guidance. Weight should always be discussed with patient-first language, and the provider should be cognizant of the reproductive challenges their patients with higher BMIs might have, and mindful in how they discuss weight to not cause harm.

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Conflicts of interest

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This study provides proof-of-concept evidence for the use of ulipristal acetate in an alternative medication abortion regimen. Providers should be prepared to answer questions from patients that distinguish ulipristal acetate's use as a highly effective, nonabortive emergency contraception from its potential role in an abortion regimen.