

NASPAG Clinical Consensus on Adolescent Pregnancy Testing: Balancing Confidentiality, Consent, and Disclosure



Kimberly Hoover, MD^{1,*}, Amanda V. French, MD², Lauren A. Kanner, MD³, Katherine Debiec, MD⁴, Sloane Berger-Chen, MD⁵

¹ Department of Obstetrics and Gynecology, University of Alabama Birmingham, Birmingham, Alabama

² Department of Obstetrics and Gynecology and Reproductive Biology, Massachusetts General Hospital, Harvard Medical School, Boston, Massachusetts

³ Department of Pediatrics, University of Iowa Carver College of Medicine, Iowa City, Iowa

⁴ Department of Obstetrics and Gynecology, University of Washington and Seattle Children's, Seattle, Washington

⁵ Department of Obstetrics, Gynecology and Reproductive Sciences, University of California, San Francisco, California

ABSTRACT

Objective: Members of NASPAG provide reproductive health care to adolescent patients. This document aims to provide a comprehensive overview of the recommended counseling for any clinician caring for an adolescent patient with a positive pregnancy test, while addressing legal, ethical, and clinical considerations. The document will discuss strategies for guiding patients through the pregnancy testing process, as well as various issues to consider when ordering tests, disclosing results, and managing the situation if the test is positive. Due to variability between institutions and clinical scenarios, this review will not explicitly advise for or against universal pregnancy testing in medical settings.

Key Words: Pregnancy testing, Adolescent, Unplanned pregnancy, Unintended pregnancy, Human chorionic gonadotropin, Preoperative testing, Confidentiality, Reproductive autonomy, Adolescent health

Methods

Evidence

A search of PubMed, Cochrane Wiley, and the Cochrane systematic reviews (plus any other database per discretion of authors) was conducted in October 2024 for English language materials involving human subjects published since 1999 using the following terms: adolescent confidentiality, unplanned pregnancy, unintended pregnancy, adolescent pregnancy, adoption, pregnancy testing, adolescent abortion, social determinants of adolescent pregnancy, adolescent pregnancy outcomes.

The recommendations in this clinical consensus were drafted by a designated working group of the 2024-2025 NASPAG Education Committee using a structured, evidence-informed methodology. Systematic methods were used to identify and appraise relevant evidence, with explicit criteria for evidence selection and critical evaluation of the quality and applicability of the literature. Consensus was achieved through iterative discussion and collaborative analysis until collective agreement was reached. The draft was reviewed and revised by the full NASPAG Education Committee before undergoing external review by the NASPAG Board of Directors to ensure validity, clarity, and applicability. Patient and public perspectives were not incorporated into the development process. A procedure for future

updating has been established to incorporate new evidence and evolving clinical practice.

Recommendations: Due to the quality of data on this topic, all recommendations are level IIIC: opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees with recommendations based primarily on consensus and expert opinion.

Recommendations Definitions

Studies were reviewed and evaluated for quality according to the method outlined by the US Preventive Services Task Force:

- I. Evidence obtained from at least one properly designed randomized controlled trial.
- II-1. Evidence obtained from well-designed controlled trials without randomization.
- II-2. Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group.
- II-3. Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments also could be regarded as this type of evidence.
- III. Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

Based on the highest level of evidence found in the data, recommendations are provided and graded according to the following categories:

* Address correspondence to: Kimberly Hoover, MD, Department of Obstetrics and Gynecology, University of Alabama Birmingham, 1700 6th Ave South, Birmingham, 35249, AL.

E-mail address: khoover@uabmc.edu (Kimberly Hoover).

Level A—Recommendations are based on good and consistent scientific evidence.

Level B—Recommendations are based on limited or inconsistent scientific evidence.

Level C—Recommendations are based primarily on consensus and expert opinion.

Recommendation

Adolescents should be offered confidential pregnancy testing. Pregnancy test disclosure should be discussed and planned before testing is performed. Best practice includes direct knowledge of your organization's resources for supporting a pregnant adolescent; an ideal team includes providers with expertise in adolescent or adolescent gynecology care, social services, and risk management. Laws and guidelines regarding reproductive rights for teens vary by country, state, institution, and practice setting. Teams should be aware of their local regulations. The open adoption process is associated with an improved sense of self and opportunities later in life for the adolescent birth parent. Pregnant adolescents face higher health and social risks and legal or other access barriers to abortion, but exploring all options helps teens make informed, value-based decisions that support their well-being and future.

Background

Adolescence is widely considered to be the age range from 10 to 19 years, though pregnancy can occur in any postmenarchal individual. Adolescent pregnancy, birth, and abortion rates¹ in the United States (US) have been declining over several decades, reaching the lowest recorded levels in 2020. In 2020, for women aged 15–17, there were 11 pregnancies per 1000, down from a peak in 1989 of 75 pregnancies per 1000. Similarly, for women aged 18–19, there were 50 pregnancies per 1000 women compared to a peak of 175 in 1991.² Although these rates have declined, adolescent pregnancy does still occur; timely diagnosis, disclosure, and early management are essential to comprehensive care. Regardless of whether an adolescent has sought care for the express purpose of pregnancy detection or a pregnancy test has been performed as routine testing during a medical encounter, the disclosure of the results has deep ramifications. Adolescents who test positive for pregnancy are at increased risk for depression and self-harm. The American Academy of Pediatrics recommends routine, careful psychological evaluation and support. Pregnant adolescents with a history of mental health issues or trauma, or who have poor social support, are at higher risk. The younger the pregnant individual, the more likely that local age-of-consent and mandatory child abuse reporting laws will establish reasonable suspicion of abuse and trigger a report to child protective services. Similar consideration applies to patients of any age who are unable to give consent due to intellectual or physical limitations.

Adolescent patients are often routinely tested in medical settings such as the emergency department, during preoperative testing, or before performing a radiologic procedure. Testing is often done without the patients' express knowledge or consent. Ensuring that disclosure optimizes patient confidentiality is imperative to respect the adolescent's autonomy. How and with whom the adolescent then decides to share the information may also be daunting.³ Adolescents may be afraid of rejection or crisis with an intimate

partner or their family. Clinicians must screen for the potential for this type of violence. If there is an imminent risk, involvement from social services, law enforcement, or child protective services should be sought.^{4–6} There is no universally accepted intervention to prevent self-harm or family violence; confidential, culturally sensitive multidisciplinary care must be individualized. Importantly, however, for some patients and families, a pregnancy might be welcome news, and positive support from the family can be anticipated. Clinicians must be aware of the potential range of responses and risks that patients and families may experience upon receiving this news.^{7–9}

Maintaining the confidentiality of minors' medical information can be complex due to legal, ethical, and practical considerations. Exploring all options after a positive pregnancy test—parenting, adoption, or abortion—empowers teens to make informed decisions that align with their values and circumstances, each offering unique benefits like personal growth, future opportunities, or emotional well-being, depending on their individual chosen path.

In most regions, legal medical decision-making is granted at the age of majority (when an individual is considered an adult). Adolescents under the age of majority are minors, generally under the care of an adult parent or guardian, and are treated differently in legal and medical contexts. However, this definition may be modified in some aspects of reproductive care and varies by location. Although there are exceptions, 18 is the most common age of majority in the US. In some regions and contexts, adolescents are considered minors until age 19 or even 21. In contrast, there is no age of consent for treatment or counselling in Canada. Capacity to consent in Canada is determined by the ability to understand the information relevant to the proposed treatment and appreciate the consequences of either consenting or refusing consent.^{10,11}

Clinical Consensus

Preoperative Testing

Before procedures, therapies, or specific radiologic studies, pregnancy testing may be considered routine or required, but there are ethical and logistical considerations for adolescents. Consideration of confidentiality is key when a provider is planning to perform a pregnancy test. Simply asking the question of whether an adolescent patient needs a pregnancy test can present a confidentiality concern. The need for the test to be performed, how it is initiated, and how and where the result is communicated can all have a profound impact on patient care.

Please see [Table 1](#) for examples of the advantages and disadvantages of routine pregnancy testing.^{12–14}

The American Academy of Pediatrics recommends involving pediatric patients in their own healthcare decision-making. Shared decision-making leads to better healthcare outcomes.¹⁵ Privacy may not be offered to adolescents. Clinicians are encouraged to create a framework in advance to perform confidential testing and result disclosure.

Communicating this routine workflow with adolescents and parents or guardians can minimize confidentiality

Table 1
Universal Point-of-Care Pregnancy Testing in Adolescents.

Advantages	Disadvantages
Initiates timely care and allows exploration of all options Potentially limits fetal harm Potentially limits maternal harm Potentially mitigates liability Parent/guardian or patient may not provide an accurate sexual history Adolescents may have an incomplete understanding of anatomy, sexual behaviors, and the inherent risk of pregnancy Adolescents may be reticent to reveal the possibility of pregnancy if the option for confidential disclosure is not available	Potential false negative result (user error, test taken too early) Not cost-effective Low probability of a positive pregnancy test Uncertain relationship between anesthetic, radiologic, chemotherapeutic, or surgical exposure in early undiagnosed pregnancy Potential data breach in the electronic medical record Potential harm to the pregnant minor related to the test result disclosure Privacy concerns about pregnancy test documentation

Table 2
Sample Workflow for Pretreatment Adolescent Pregnancy Testing.

1. Inform patients and families at the beginning of all encounters that private conversations with adolescents are the standard of care. 2. Inform patients at pretreatment visits that they will confidentially be asked to provide a pregnancy test at check-in, and explain the rationale for testing. 3. Inform patients that if a pregnancy test is positive or if the patient declines testing required for a certain treatment, the treatment may be canceled or rescheduled. 4. Provide the patient with a urine specimen cup. 5. Escort the patient to the treatment space without parents or guardians. Explain that a urine pregnancy test will be performed, and ask if there are any concerns about testing or results. 6. Involve other members of the medical team if the patient has concerns about pregnancy testing or requests that testing not be done. 7. If testing is done, deliver results to the patient alone, before any parent, guardian, or other accompanying person enters the room.

Table 3
Tips for Optimizing Adolescent Confidentiality During Disclosure of Positive Pregnancy Test.

1. Consider forming a support team that can be present if an unexpected positive result is found. Members can include the preoperative nursing staff, the team providing gynecology or adolescent medicine care, child life services, social work, and risk management. 2. When speaking privately with a teen, ensure families or caregivers are not within earshot. Families can be asked to remain in the waiting room throughout the check-in process. 3. Disclose the positive pregnancy test with age-appropriate language. a. Example: "I want to take a moment to talk with you about your test results. The pregnancy test is positive, which means that you are pregnant. This news might bring a lot of emotions—maybe surprise, worry, or even confusion—and that's completely okay. This is serious information, but you don't have to manage this situation alone. Right now, the most important thing is making sure you have the support and information you need to make the best decisions for yourself. There are options available to you, and I'm here to help and answer any questions you have—whether about your health, your safety, what happens next, or who you might want to talk to. You don't have to figure everything out today. Would you like to talk about what you're feeling right now, or do you have any thoughts or questions? Would you like me to bring your parent into the room?" 4. If an adolescent does not want family to know about a positive pregnancy test, the provider MUST BE AWARE of hospital policies, state guidelines, and any legal responsibilities for disclosing this information. 5. Knowledge of your electronic medical record (EMR) system's ability to maintain confidentiality is critical. Parents and other medical providers may have access to the EMR.

breaches that may put a teen at risk. It is important to support the recommendations of the American Academy of Pediatrics (AAP), the Society of Adolescent Health and Medicine,¹⁶ and the American College of Obstetricians and Gynecologists (ACOG). In the US, considering the requirements of both the Health Insurance Portability and Accountability Act (HIPAA)¹⁷ and the 21st Century Cures Act is also necessary. The Office of the National Coordinator for Health Information Technology Rule (Cures Act),¹⁸ was enacted to maintain confidentiality for adolescent patients in all health care settings (Tables 2 and 3).^{19,20}

Disclosing Results

Those providing healthcare to minors in the US must be cognizant of complex and evolving state privacy laws regarding the disclosure of healthcare information of minors. Federal laws, including the HIPAA Privacy Rule, the Title X Family Planning Program, the 21st Century Cures Act, and

confidentiality regulations for substance use disorder programs (42 CFR Part 2), all provide some safeguards for confidentiality in the case of minors. The HIPAA Privacy Rule permits (but does not require) disclosure of health information to the legal guardian when the minor is in physical or mental harm or is a physical threat to others.²¹

State laws, however, often determine or affect how these federal laws apply, especially for minors. Many states have more detailed laws regarding situations where confidentiality may be at risk.^{17,19} Although HIPAA sets a federal baseline for privacy, HIPAA defers to state laws in specific areas regarding the disclosure of healthcare information.²² Many states do not allow disclosure without the minor patient's consent when medical information is obtained from services that are legally obtained without parental consent. Most states explicitly allow patients under the age of 18 to seek sexual health care and reproductive services without parental consent. Examples of reproductive services include contraception, prenatal care, and sexually transmit-

ted infection (STI) counseling, testing, and treatment.²² It is vitally important that healthcare providers know their current state laws and the age of consent allowed for such services. Resources for further consultation include state/provincial government websites, the interactive state map produced by the Center for Reproductive Rights,²³ and the Guttmacher Institute.²⁴

Laws regarding disclosure may be different for ambulatory vs inpatient care, even within the same state, as inpatient settings may not follow the same ambulatory protections concerning the confidentiality of a minor's medical information. State and provincial government websites can provide guidance. Providers may consult risk management at their institution for specific advice if clinical practice, institutional policy, and legal statutes appear to conflict.

Although there are protections for adolescents to access medical services for contraception and STI testing without parental consent, the healthcare provider must be aware of areas where confidential documentation may appear. The electronic medical record (EMR), patient and/or parent communication “portal,” after-visit summary, insurance carrier explanation of benefits statement, and student health centers are all locations where private information may be inadvertently disclosed to others.^{17,19} Minors should also be educated about all circumstances and locations where their healthcare information must be disclosed without their consent.²⁵ Conversations about areas of potential disclosure should be done before any testing is performed to ensure that adolescents do not lose trust in their medical providers.²⁰

Emancipation

Emancipation describes when an adolescent who has not reached the legal age of majority is free of parental/legal guardian control. The emancipation process varies by state in the US, but in most cases, a minor is considered emancipated when married, on active-duty military status, or living separately from the parent or legal guardian and managing their financial affairs. Once emancipated, a minor does not require parental/guardian consent for medical care.²⁶

Pregnancy does not automatically result in the emancipation of a minor. Thirty states explicitly allow minors to legally consent to medical care for their child; approximately 20 states do not have specific laws regarding minor parent consent for medical care for their child. Approximately 40 states allow minors to place their child for adoption, although roughly 10 states require the pregnant minor's parental involvement in the adoption process.²⁷

Mature Minor

The mature minor doctrine is a legal principle in which a person who has not reached the age of legal majority (as defined by state law) is mature enough to consent for certain types of medical care. A judge or doctor may determine if the minor is capable of making informed decisions. The mature minor doctrine is not a law; it is a legal guideline, and it varies considerably by state in the US and

by province and territory in Canada. In the majority of US states where a mature minor doctrine is recognized, some level of parental/guardian involvement in medical decision making is still required.²⁸

Reproductive Autonomy

After accounting for spontaneous abortions, which are often underestimated, the majority of adolescents will face choices of abortion, parenting or adoption.²⁹ An informed, nonjudgmental approach centered on the adolescent's preferences is recommended.¹⁵ A 2025 qualitative study suggests one model of appropriate, intentional support to boost adolescent and young adult agency in making decisions related to pregnancy.³⁰ Coercive counseling, making assumptions about the social acceptability of early childbearing, and casting adolescent pregnancy as a negative “problem” should be avoided.³¹ Placing unnecessary value burdens on an adolescent assumes a shared value system and will distance them from the care they need. Pregnancies in this age group are disproportionately unplanned, and nearly half of those in those aged 15 and younger end in abortion.³²

Abortion

Abortions can be performed medically or surgically. Medical abortions are conducted by taking a combination of oral medications (mifepristone and misoprostol) obtained in a clinic, online, or prescribed via telehealth. The process of medical abortion is generally completed at home within a few days of taking the medications and does not require anesthesia. Medication abortion is FDA-approved for pregnancies up to 10 weeks of gestation, but may be an option up to 11 weeks of gestation. Surgical abortion is the only option after 11 weeks of gestation. A surgical abortion is typically completed via a suction device to remove uterine contents in a clinic or hospital, with an anxiolytic and local or systemic anesthesia.

In the US, the Supreme Court's ruling in June of 2022 in *Dobbs v. Jackson Women's Health Organization*, 142 S. Ct. 2228 (2022) overturned *Roe v. Wade*, 410 US 113 (1973), and eliminated the federal constitutional right to abortion. After this ruling, 42 states passed laws limiting or banning abortion access. Healthcare providers must be knowledgeable of state laws to counsel within legal guidelines,⁹ while being conscious of the vulnerability of their pregnant patients.

Multiple studies show that limited access to abortion largely affects marginalized populations, particularly adolescents.^{33–35} Of the nine states where legal abortion is available, one requires parental involvement for an adolescent to obtain abortion services. Judicial bypass is a legal process wherein the adolescent files a petition to the court, then goes before a judge in a hearing to prove health maturity. If approved, the adolescent can proceed with the abortion and avoid the barrier of parental involvement.³⁴ This court process can take several days, which is time-consuming and prolongs the gestation, which may place the pregnancy past the legal time frame in which an abortion can be safely performed. The judicial bypass process

involves a power dynamic shift, which can be intimidating to adolescents, violates their confidentiality in a public forum, and may raise concerns about citizenship status for immigrants seeking health care. Since the overturn of *Roe v. Wade*, the cost of abortion and travel to obtain services, and the fear of legal prosecution have expeditiously risen in the US.^{36–38}

Continuing a Pregnancy and Parenting

Eliner et al.³⁹ reviewed the US Centers for Disease Control and Prevention's live births database from 2016 to 2019, which included 661,062 adolescent (<20 years old) pregnancies, and found a significant increase in risk, compared to adult pregnancies, of hypertensive disorders (including eclampsia), preterm birth, blood transfusions, and sexually transmitted disease. Postpartum and neonatal complications, including congenital birth defects, low 5-minute APGAR scores, neonatal sepsis, and assisted ventilation, were also significantly increased. These adverse outcomes have been consistent across multiple studies.^{40–42} Other studies have shown fewer cesarean and operative deliveries and a lower incidence of gestational diabetes amongst teens.^{43–45} Pregnancy outcomes are intimately associated with sociodemographic and environmental factors, such as unstable housing, limited education, few job opportunities, increased risk of substance use, food insecurity, and increased exposure to violence, which in turn lead to limited access to care and compound the socioemotional stressors of adolescent pregnancy. Ageism and racism also contribute to health care disparities. Amjad et al.'s⁴⁶ systematic review and meta-analysis of 31 studies evaluating social determinants of health showed that race and low socioeconomic status were significant markers for poor pregnancy outcomes. Many of these adverse pregnancy outcomes are modifiable; interventions on social determinants of health, coupled with quality maternal care, could potentially improve both the rates and outcomes of unintended teen pregnancy.^{44,47,48}

Continuing a Pregnancy and Choosing Adoption

Choosing adoption as a parenting plan is another option; however, there are currently no national statistics available on how many adolescents follow this path in the US.¹⁵ Most adoption agencies and attorneys will not have an expectant mother match with a prospective adoptive family until the third trimester, to allow expectant parents ample time to consider the choice. The process for making a parenting plan for adoption is similar regardless of the age of the expectant mother, including the right to legally sign for parental rights termination. Current research has changed the historical rhetoric around adoption to recognize the importance of openness for the adoption triad of birth parents, adoptee, and adoptive parents. The triadic relationship strategy is best for the adoptee's formation of a sense of self and helps to ease the trauma associated with adoption for both birth parents and adoptees. This approach has been especially beneficial to pregnant adolescents; they express greater ease with making the decision for adop-

tion. An open adoption process allows adolescents to see the child grow, while simultaneously continuing to mature themselves and maintaining various lifetime opportunities that may still be open to them.⁴⁹

The adoption process can be facilitated via private services, attorneys, or adoption agencies. For information on adoption resources, see Table 4. Private domestic adoptions usually involve counseling for birth parents. State laws vary regarding when a birth parent can terminate parental rights to place the child for adoption, but physical custody can be granted to the preadoptive parents before the legal termination of rights, if desired by the expectant parent. The laws for maternal termination of parental rights range from before delivery to 30 days postdelivery. Each state also defines when adoptive families can finalize the adoption, which generally occurs between 7 days and 6 months after birth or placement with adoptive parents. State laws about terminating a father's parental rights vary in terms of how and when a birth father will be notified about a pregnancy and/or birth, what the parenting plan is, and the timeline of when his parental rights are permanently terminated if he does not actively sign away these rights. Discussion with the adoption attorney and/or agency can clarify local laws for both adoptive and expectant parents.

Conclusion/Summary

Regardless of how an adolescent learns of their pregnancy, ensuring confidential disclosure optimizes patient confidentiality and is imperative to respecting the adolescent's autonomy. Securing resources in advance to support both the patient and family in situations when a positive pregnancy test result is possible should be considered. Maintaining the confidentiality of medical information for minors can be complex due to legal, ethical, and practical considerations. Knowledge of your region's laws regarding reproductive rights is paramount before disclosing pregnancy testing results. An informed, nonjudgmental approach centered on the adolescent's preferences is recommended when discussing pregnancy options.

Recommendations Definitions

Studies were reviewed and evaluated for quality according to the method outlined by the US Preventive Services Task Force:

- I. Evidence obtained from at least one properly designed randomized controlled trial.
- II-1. Evidence obtained from well-designed controlled trials without randomization.
- II-2. Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group.
- II-3. Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments could also be regarded as this type of evidence.
- III. Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

Table 4
Resources for Information in the United States.

Resource	Description	Website	Contact
Adoption.com	Guidance on pregnancy and adoption options, referrals to adoption professional.	www.adoption.com	General information, adoptive parent profiles
Adoption Network Law Center	A for-profit company that facilitates private domestic adoptions. Offers a downloadable “Pregnancy & Adoption Planning Guide.”	www.adoptionnetwork.com	24/7 support via phone or online form
Adoption Support Alliance	Lists of resources, including therapists, online resources, and books specific for different types of adoptions, including domestic infant, transracial, international, and foster-adopt. Curriculum on foundations in adoption.	www.adoptionsupportalliance.org/resources	General information, not a direct service
All-Options Pregnancy Resource Center	Support for pregnancy, parenting, abortion, and adoption. Toolkit for counseling available.	www.all-options.org	1-888-493-0092
HealthyChildren.org (AAP)	Guidance on adolescent pregnancy options, with a focus on nonjudgmental support. Targeted for both patients and physicians.	www.healthychildren.org Comprehensive overview of options: www.healthychildren.org/English/ages-stages/teen/dating-sex/Pages/Teenage-Pregnancy.aspx	General information, not a direct service
Juvenile Law Center	A nonprofit law firm and advocacy organization. Provides information and resources for pregnant and parenting teens.	https://jlc.org/sites/default/files/attachments/2018-02/resources_for_pregnant_and_parenting_teens_fact_sheet.pdf	Online form: jlc.org/contact Phone: 215-625-0551
National Abortion Federation	Confidential consultation, options counseling, referrals to abortion providers, and limited financial assistance.	www.prochoice.org/patients/naf-hotline	Hotline: 800-772-9100 Referral line: 877-257-0012
National Council for Adoption	Support and education for birth parents, adoptive families, adoption professionals, help finding attorneys and agents. Adoption advocacy.	www.adoptioncouncil.org	General information, as well as local attorney and agency finder
National Safe Haven Alliance	Information on Safe Haven laws for safely and anonymously relinquishing newborns, relevant for delayed decisions.	www.nationalsafehavenalliance.org	1-866-99BABY1 (National Safe Haven Crisis Line)
Planned Parenthood	Pregnancy options counseling, including adoption, abortion, and parenting, and referrals to adoption agencies. Offers expert, nonjudgmental care.	www.plannedparenthood.org	1-800-230-PLAN or book online
Pregnancy Resource Center	Free, confidential support for unplanned pregnancies, including adoption info and community referrals. Offers pregnancy quiz and ultrasound referrals.	www.pregnancyresource.net	Online or local center connections

Based on the highest level of evidence found in the data, recommendations are provided and graded according to the following categories:

- Level A—Recommendations are based on good and consistent scientific evidence.
- Level B—Recommendations are based on limited or inconsistent scientific evidence.
- Level C—Recommendations are based primarily on consensus and expert opinion.

Summary of Recommendations

Due to the quality of data on this topic, all recommendations are level IIC: opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees with recommendations based primarily on consensus and expert opinion. The recommendations in this clinical consensus were drafted by a designated working group of the 2024–2025 NASPAG Education Committee using a structured, evidence-informed methodology. Systematic methods were used to identify and appraise relevant evidence, with explicit criteria for evidence selection

and critical evaluation of the quality and applicability of the literature. Consensus was achieved through iterative discussion and collaborative analysis until collective agreement was reached. The draft was reviewed and revised by the full NASPAG Education Committee before undergoing external review by the NASPAG Board of Directors to ensure validity, clarity, and applicability. Patient and public perspectives were not incorporated into the development process. A procedure for future updating has been established to incorporate new evidence and evolving clinical practice.

Recommendations

1. Adolescents should be offered confidential pregnancy testing.
2. Pregnancy test disclosure should be discussed and planned before testing is performed.
3. Best practice includes direct knowledge of your organization's resources for supporting a pregnant adolescent; an ideal team includes providers with expertise in adolescent or adolescent gynecology care, social services, and risk management.

4. Laws and guidelines regarding reproductive rights for teens vary by country, state, institution, and practice setting. Teams should be aware of their local regulations.
5. The open adoption process is associated with an improved sense of self and opportunities later in life for the adolescent birth parent.
6. Pregnant adolescents face higher health and social risks and legal or other access barriers to abortion, but exploring all options helps teens make informed, value-based decisions that support their well-being and future.

2024 NASPAG Education Committee

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Sloane Berger-Chen

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Summary: Counseling Teens with a Positive Pregnancy Test

- **Offer confidential testing:** Ensure teens can access pregnancy tests privately, while following local laws.
- **Plan the disclosure:** Discuss how results will be shared before testing. Use age-appropriate language.
- **Know local laws:** Check state or regional guidelines on teen reproductive rights and confidentiality.
- **Build a support team:** Include social workers, adolescent medicine specialists, or counselors to assist teens.
- **Discuss all options:** Support teens in exploring parenting, adoption, or abortion without judgment.
- **Resources:** Connect teens to trusted organizations.

Authors/Disclaimer

This Clinical Consensus has been prepared by Kimberly Hoover, M.D., Amanda V. French, M.D., Lauren Kan-

ner, M.D., Katherine Debiec, M.D., and Sloane Berger-Chen, M.D., and reviewed by the North American Society of Pediatric and Adolescent Gynecology (NASPAG) Education Committee (year 2024-2025) members and approved by the JPAG Editor-in-Chief and by the NASPAG Board of Directors. The information contained in this Clinical Consensus reflects the currently available best evidence for practice at the time of publication. The information is designed to aid practitioners in making decisions about appropriate patient care, but should not be construed as dictating an exclusive course of treatment or procedure. Variations in practice may be warranted based on the needs of the individual patient, resources, and limitations unique to the institution or type of practice. The development of this clinical consensus statement was guided by the AGREE II instrument, which provided a framework for ensuring a rigorous and transparent methodology.¹

Conflicts of Interest

Dr Hoover has no relevant disclosures. Dr Kanner is on the editorial board of the Journal of Pediatric and Adolescent Gynecology. Dr French is on the editorial board of the Journal of Pediatric and Adolescent Gynecology. Dr Berger-Chen has no relevant disclosures. Dr Debiec is a Nexplanon (etonorgestrel implant) trainer for Organon.

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