Emergency Contraception
Care Process Model Synopsis

Emergency Contraception Algorithm

Inclusion Criteria:
- Adolescents at risk for unintended pregnancy

Exclusion Criteria:
- If > 120 hours (5 days) since unprotected sex, inadequately protected sex, or sexual assault

General Considerations
- The intent of EC is to prevent an unintended pregnancy and must be administered within the specified time frame
- For questions or uncertainty regarding consent, please contact Social Work
- If concern for sexual assault, contact Social Work to determine need for SANE and/or SCAN
- For risk factors or signs/symptoms of STI, refer to *STI CPG*

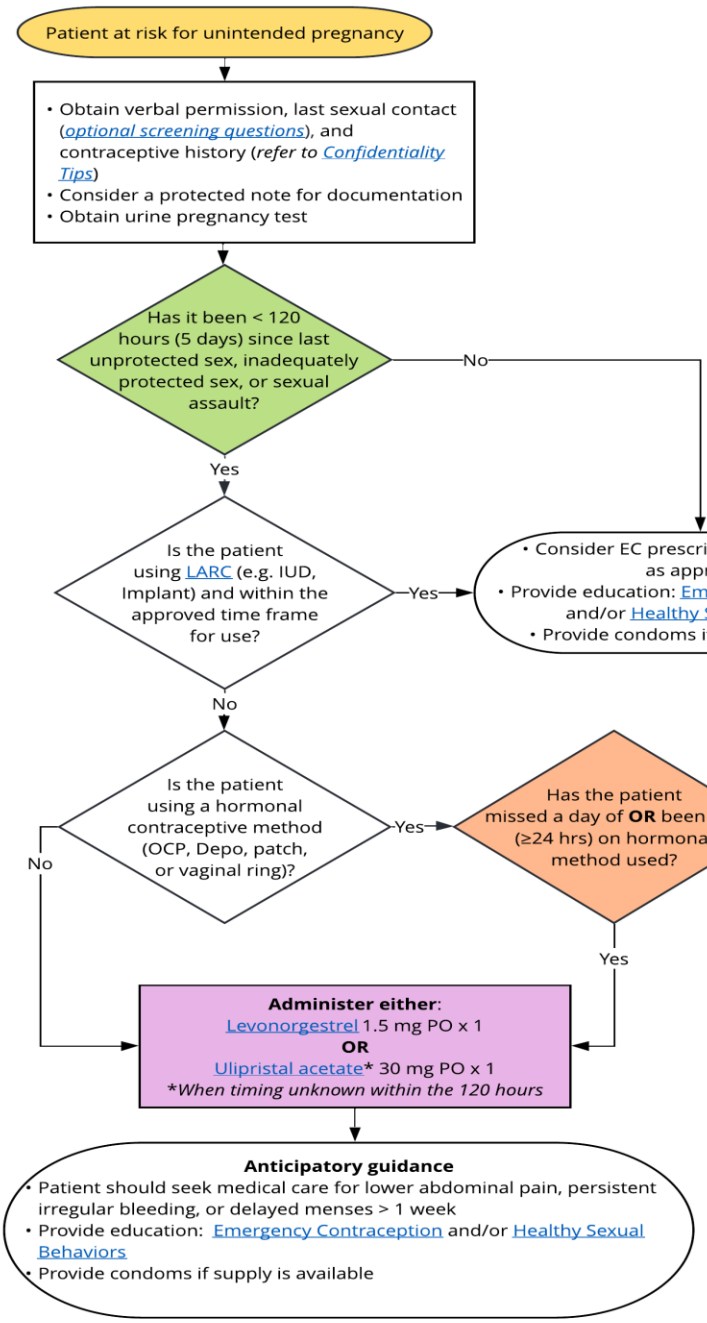
EC Options

Levonorgestrel
- Most effective within first 3 days
- Less effective in patients with BMI > 25
- Allows for immediate initiation of hormonal contraception

Ulipristal Acetate
- Remains effective throughout the 5 post coital days
- Preferred for patient with BMI > 25, but effectiveness may be limited in patients with BMI ≥ 30
- Effectiveness may be decreased if taking while using hormonal contraception
- Patient will need to wait 5 days prior to beginning hormonal contraception

***Copper IUD (Paragard® IUD) is an option, though availability may be limited in some settings. While it is the most effective EC option, patients who do not want to use or do not have access to this method should be offered EC pills even if BMI > 30.*

QR Code for mobile view



Indications for EC
- Unprotected or inadequately protected sex
- Inconsistent or questionable contraceptive use
- Sexual assault

Unprotected or Inadequately Protected Sex
- Lack of any contraception (condom or hormonal method)
- Missed or late hormonal contraception
- Condom broke or slippage during withdrawal

Missed or Late Contraception
- OCP - missed more than one day
- Patch - patch not replaced within one day of scheduled date
- Depo - more than 15 weeks since last injection
- Vaginal ring - late on replacing by >1 day

Abbreviations (laboratory & radiology excluded):
EC = Emergency Contraception
LARC = Long-acting reversible contraception
IUD = Intrauterine device
Depo = Depo-Provera contraceptive injection
OCP = Oral contraceptive pills
STI = Sexually transmitted infection
CPG = Clinical practice guideline
PO = By mouth
BMI = Body mass index
SANE = Sexual Assault Nurse Examiner
SCAN = Safety Care and Nurturing Clinic

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Objective of Care Process Model

The objective of the Emergency Contraception Care Process Model (CPM) is to provide care standards for the patient who presents to the hospital or clinic at risk for unintended pregnancy for which emergency contraception is indicated. The Emergency Contraception CPM provides guidance regarding efficacy, access, and factors to consider for future prevention.

Background

Emergency contraception are methods of prevention used following unprotected sexual intercourse, inadequately protected sexual intercourse, or sexual assault to reduce the risk of pregnancy, particularly unintended pregnancy (Upadhya & American Academy of Pediatrics [AAP] Committee on Adolescence, 2019). Emergency contraception differs from routine hormonal contraceptive methods as it is intended for use only when a method of contraception has not been used, when the method of contraception has been inconsistent (missed or late), or when it is believed a method of contraception has failed (Haeger et al., 2018). Emergency contraception can be an effective intervention to address unintended pregnancies, particularly among adolescents, while simultaneously addressing the Healthy People 2030 objective of reducing pregnancies in adolescents (Office of Disease Prevention and Health Promotion [ODPHP], n.d.).

Emergency contraception options available at Children's Mercy Kansas City include levonorgestrel (Plan B One Step®), ulipristal acetate (ella®), or the copper intrauterine device (IUD; Paragard® IUD). Careful consideration must be made when selecting an appropriate emergency contraception method based on efficacy and access while also recognizing the need for future preventative methods designed for purposes other than emergency use (see *Appendix A*).

Efficacy

When considering emergency contraception, time is a critical factor. For emergency contraception to be effective, administration must occur within 120 hours of unprotected sexual intercourse, inadequately protected sexual intercourse, or following a sexual assault (Upadhya & AAP Committee on Adolescence, 2019). Time also impacts the effectiveness of emergency contraception, as efficacy varies among emergency contraception options based on time since inadequately protected sex occurrence. When considering either levonorgestrel or ulipristal acetate, levonorgestrel is most effective if taken within the first three days (72 hours) following inadequately protected sexual intercourse, whereas the effectiveness of ulipristal acetate stays consistent over the initial five days or 120 hours (Upadhya & AAP Committee on Adolescence, 2019). The copper intrauterine device (IUD) is also effective when inserted within the first 5 days of inadequately protected sexual intercourse (Upadhya & AAP Committee on Adolescence, 2019).

Body mass index (BMI) and concurrent use of hormonal contraception (see *Future Prevention*) are additional factors to consider regarding the efficacy of emergency contraception options. Levonorgestrel has been found to be less effective for an individual whose BMI is greater than 25, whereas ulipristal acetate is effective for individuals with a BMI that does not exceed 35 (Upadhya & AAP Committee on Adolescence, 2019). Effectiveness is not impacted by body weight when considering the copper IUD (Upadhya & AAP Committee on Adolescence, 2019).

Access

While levonorgestrel, ulipristal acetate, and the copper IUD are recognized options for emergency contraception, availability may be limited for each of the options in some settings and geographical areas. Presently, levonorgestrel is the only form of emergency contraception that is available over the counter and does not have an age restriction to obtain (American College of Obstetricians and Gynecologists [ACOG], 2017). Ulipristal acetate does require a prescription to obtain, whereas the copper IUD requires insertion or placement by the healthcare provider (ACOG, 2017). Financial resources and insurance coverage are also factors to consider regarding access to emergency contraception methods (ACOG, 2017).

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Future Prevention

The intent for emergency contraception is to prevent an unintended pregnancy, not long-term routine use (ACOG, 2017; Upadhya & AAP Committee on Adolescence, 2019). While emergency contraception can be prescribed for future use based on presented circumstances, consideration should be made regarding a more effective regular contraceptive method not included in this guideline (Upadhya & AAP Committee on Adolescence, 2019).

Safeguards should be taken when initiating or resuming hormonal contraception following emergency contraception use (Upadhya & AAP Committee on Adolescence, 2019). With use of levonorgestrel, hormonal contraception can be initiated immediately, whereas an individual is advised to wait 5 days prior to beginning hormonal contraception following administration of ulipristal acetate (Upadhya & AAP Committee on Adolescence, 2019). Regardless of whether levonorgestrel or ulipristal acetate is the emergency contraception option provided, abstinence or use of a condom barrier is recommended for 7 days following initiation of a hormonal contraception method (Upadhya & AAP Committee on Adolescence, 2019). The condom barrier is advised as a backup method for pregnancy prevention and ongoing as a method to protect against sexually transmitted infections (Upadhya & AAP Committee on Adolescence, 2019). When using a copper IUD, an additional hormonal contraception method is not necessary for pregnancy prevention. However, use of a condom barrier is recommended to protect against sexually transmitted infection (Upadhya & AAP Committee on Adolescence, 2019).

Target Users

- Physicians (Ambulatory, Urgent Care, Emergency Department, Hospital Medicine, Fellows, Resident Physicians)
- Advanced Practice Providers
- Nurses
- Pharmacists

Target Population

CPM Inclusion Criteria

- Adolescents at risk for unintended pregnancy

CPM Exclusion Criteria

- Adolescents where the period of time following unprotected sexual intercourse, inadequately protected sexual intercourse, or sexual assault exceeds 120 hours

AGREE II

The American Academy of Pediatrics (AAP) policy statement provided guidance to the Emergency Contraception committee (Upadhya & AAP Committee on Adolescence). See Table 1 for AGREE II.

Table 1

AGREE II[a] Summary for the AAP Emergency Contraception Policy Statement (Upadhya & AAP Committee on Adolescence, 2019)

Domain	Percent Agreement	Percent Justification^
Scope and purpose	93%	The aim of the policy statement, the clinical questions posed and target populations **were partially** identified.
Stakeholder involvement	75%	The policy statement **was developed** by the appropriate stakeholders and represents the views of its intended users. The policy statement **did not** directly include the viewpoints of the target population.
Rigor of development	60%	The policy statement developers **did not** provide how the evidence was gathered and synthesized. The policy statement **did** provide how the

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		recommendations were formulated and how the guidelines will be updated.
Clarity and presentation	100%	The policy statement recommendations **are** clear, unambiguous, and easily identified; in addition, different management options are presented.
Applicability	77%	Barriers and facilitators to implementation **were not fully addressed.** The policy statement **did** describe strategies to improve utilization and resource implications in the guideline.
Editorial independence	100%	The recommendations **were not** biased with competing interests.

Note: Four EBP Scholars completed the AGREE II on this guideline.
^Percentage justification is an interpretation based on the Children's Mercy EBP Department standards.

Care Management Recommendations Based on Standards of Care and Expert Opinions

Emergency Contraception Considerations

- The intent of emergency contraception is to prevent an unintended pregnancy and must be administered within 120 hours (five days) of last unprotected sexual intercourse, inadequately protected sexual intercourse, or sexual assault.
- Efficacy, access and future prevention are factors to aid in decision making.
- While the copper IUD is the most effective emergency contraception method, patients who do not want to use or do not have access to this method should be offered emergency contraception pills despite the impact of body mass index on efficacy (Upadhya & AAP Committee on Adolescence, 2019).

Copper Intrauterine Device

- Most effective (99%) emergency contraceptive method
- Effectiveness is not impacted by body weight
- Healthcare provider inserts during a routine visit of which availability may be limited in some settings and geographical areas
- When maintained in place, prevents pregnancy for up to 10 years requiring no additional hormonal contraception
- Use of a condom barrier is recommended to prevent sexually transmitted infection

Levonorgestrel

- Most effective (89%) oral method when used within 72 hours following unprotected sexual intercourse; however, it is less effective for patients with a body mass index greater than 25
- Available at most pharmacies and does not require a prescription
- The patient may resume or initiate hormonal contraception method immediately after use of levonorgestrel
- Use of condom barrier for pregnancy prevention is recommended for a minimum of 7 days following the initiation or resumption of hormonal contraception or recommended indefinitely if not initiating or resuming hormonal contraception
- Use of a condom barrier is recommended to prevent sexually transmitted infection

Ulipristal Acetate

- Most effective (85%) oral method when used 72 to 120 hours following unprotected sexual intercourse – or – when timing within the 120 hours is unknown.
- Most effective oral method for those patients with a body mass index greater than 25. However, ulipristal acetate becomes less effective for patients with a body mass index greater than 30, particularly when exceeding 35.
- Requires a prescription to obtain
- The patient will need to wait for 5 days between ulipristal acetate administration and initiating or resuming hormonal contraception; however, nonhormonal contraceptive methods can be initiated immediately following use

- Use of a condom barrier for pregnancy prevention is recommended for a minimum of 7 days following the initiation or resumption of hormonal contraception or recommended indefinitely if not initiating or resuming hormonal contraception
- Use of a condom barrier is recommended to prevent sexually transmitted infection

Patient at Risk for Unintended Pregnancy

- Obtain verbal permission, the last sexual contact, and contraceptive history
  - Consider a protected note for documentation
  - Obtain a urine pregnancy test
  - If concern regarding sexual assault, contact Social Work to determine need to involve Sexual Assault Nurse Examiner (SANE) and/or Safety Care and Nurturing Clinic (SCAN) consultation
- Consider time period since last unprotected sexual intercourse, inadequately protected sexual intercourse, or sexual assault
  - If time period is greater than 120 hours (five days), consider providing an emergency contraception prescription for future use
  - If time period is less than 120 hours (five days), utilize contraceptive history information obtained to further proceed
- Consider if long-acting reversible contraception (LARC; intrauterine device or implant) has been used and within the approved time frame for use – **or** – if the patient is using a hormonal contraceptive method (oral contraceptive pills, Depo-Provera contraceptive injection, a hormonal patch, or vaginal ring) and has been consistent with use (not missed or been late on a dose, an injection, a hormonal patch replacement, or a vaginal ring replacement)
  - If LARC method is within the approved time frame (see *Appendix B*), Consider prescribing emergency contraception for future use as appropriate, providing education such as Emergency Contraception (Gordon, 2022) and/or the Healthy Sexual Behaviors handout (see *Appendix C),* and supplying condoms if available
  - If hormonal contraceptive methods such as oral contraceptive pills, Depo-Provera contraceptive injection, a hormonal patch, or vaginal ring are being used without missed or late dosing, consider providing an emergency contraception prescription for future use in the event that a dose is missed or late and provide education such as Emergency Contraception (Gordon, 2022) and/or the Healthy Sexual Behaviors handout (see *Appendix C*), and supply condoms if available
- Administer emergency contraception using efficacy, access, and future prevention information to aid in decision making
  - If the patient is not using a contraception method
  - If the LARC method used is outside the approved time frame (Averbach & Hofler, 2022; Committee on Practice Bulletins-Gynecology, Long-Acting Reversible Contraception Work Group, 2017)
    - Intrauterine devices have been approved by the United States Food and Drug Administration (FDA) for a time period between 3 to 10 years dependent upon the device used
    - Contraceptive implants are FDA approved for three years of use
  - If hormonal contraceptive methods are being used and the patient has missed more than 1 day of oral contraception, it has been 15 weeks or more since last Depo-Provera injection, has not replaced the hormonal patch within 1 day of the scheduled date, or has been late by greater than 1 day of replacing the vaginal ring (Curtis et al., 2016)
- Encourage the patient to notify or follow-up with their primary physician if experiencing lower abdominal pain, persistent irregular bleeding, or menses delay greater than 1 week (ACOG, 2015)
- Provide education such as Emergency Contraception (Gordon, 2022) and/or the Healthy Sexual Behaviors handout (see *Appendix C*), and supply condoms if available regardless of whether emergency contraception is indicated or considered for future use

Additional Questions Posed by the CPM Committee

No additional clinical questions were posed for this review.

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Children's Mercy Practice Recommendations and Reasoning

Children's Mercy adopted the majority of the practice recommendations made by the American Academy of Pediatrics Emergency Contraception Policy Statement (Upadhya & AAP Committee on Adolescence, 2019). Variations/Additions include:

- Upadhya and the AAP Committee on Adolescence (2019) recommend that emergency contraception be prescribed over the phone without requiring a pregnancy test when a visit is not possible; whereas provision of emergency contraception when a visit is not possible has not been formally addressed in the care process.
- Upadhya and the AAP Committee on Adolescence (2019) recommends all adolescents and their parents, particularly when the adolescent has varying physical and cognitive abilities, receive emergency contraceptive counseling. The counseling can be completed during routine visits when discussing sexual health and family planning as well as counseling on sexually transmitted infections.
- Upadhya and the AAP Committee on Adolescence (2019) state that pregnancy testing is not required before use of emergency contraception. However, Children's Mercy's policy requires a pregnancy test prior to emergency contraception provision.

Measures

- Utilization of the Emergency Contraception CPM

Potential Value Implications

- Decreased risk of unintended pregnancy in adolescents
- Decreased unwarranted variation in care
- Improved delivery of evidence-based care to adolescents
- Decreased inequities of care related to socioeconomic characteristics of patients

Potential Organizational Barriers and Facilitators

Potential Barriers

- Variability of acceptable level of risk among providers
- Variability of awareness and knowledge of emergency contraception options among providers
- Inconsistent history-taking regarding risk factors for unintended pregnancy
- Hesitancy of patients to seek care and to disclose risks of unintended pregnancy

Potential Facilitators

- Collaborative engagement across care continuum settings during CPM development
- Association of this decision support tool with Children's Mercy STI Clinical Practice Guideline

Power Plans

- While emergency contraception options are available as part of the EDP STI Female Power Plan, the emergency contraception options can be accessed as individual orders

Associated Policies

- Emergency Contraception (2020)
- Pregnancy Screening (2020)
- Pregnancy Screening of Adolescent Patients (2020)

Care Process Preparation

This care process was prepared by the Evidence Based Practice Department (EBP) in collaboration with content experts at Children's Mercy Kansas City. Development of this care process supports the Division of Quality Excellence and Safety's initiative to promote care standardization that is evidenced by measured outcomes. If a conflict of interest is identified the conflict will be disclosed next to the committee member's name.

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Implementation & Follow-Up

Once approved, the CPM was presented to appropriate care teams and implemented. Care measurements will be assessed and shared with appropriate care teams to determine if changes need to occur. This CPM is scheduled for revision in January 2025.

Emergency Contraception CPM Committee Members and Representation

- Abbey Masonbrink, MD, MPH | Hospital Medicine | Committee Chair
- Lisa Post-Jones, MSN, RN, CPN, SANE-P | SANE Program | Reviewer
- Jeanette Higgins, RN, MSN, CPNP | Gynecology | Reviewer
- Diane Petrie, FNP-BC, AAHIVS, CPN | Infectious Diseases | Reviewer
- Amanda Nedved, MD | Urgent Care | Reviewer
- Gladesia Tolbert, DNP, CPNP, PMHS | General Academic Pediatrics/Primary Care Clinic | Reviewer
- Alaina Burns, Pharm.D., BCPPS | Pharmacy | Reviewer
- Melissa Smith, APRN | Emergency Department | Reviewer
- Katie Stangler, RN, MSN, APRN, CPNP, CCRN | Emergency Department | Reviewer
- Andrea Nos, MD | Adolescent Medicine| Reviewer
- Jennifer Hansen, MD | SANE Program| Reviewer
- Rachel Neihart, LCSW, LSCSW | Inpatient Care Management| Reviewer

EBP Committee Members

- Kathleen Berg, MD, FAAP | Hospitalist, Evidence Based Practice
- Andrea Melanson, OTD, OTR/L | Evidence Based Practice
- Kelli Ott, OTD, OTR/L | Evidence Based Practice

Additional Review & Feedback

The CPM was presented to each division or department represented on the CPM committee and other appropriate stakeholders. Feedback was incorporated into the final product.

Care Process Model Development Funding

The development of this guideline was underwritten by the EBP and Hospital Medicine Departments.

Conflict of Interest

The contributors to the Emergency Contraception Care Process Model have no conflicts of interest to disclose related to the subject matter or materials discussed in this care process.

Review Requested

Department/Unit	Date Obtained
Hospital Medicine	December 2022
Emergency Department	November/December 2022
Urgent Care	November 2022
SANE Program	December 2022
Gynecology	December 2022
Primary Care	December 2022
Adolescent Medicine	January 2023
Inpatient Care Management	December 2022
Pharmacy	December 2022
Infectious Diseases	December 2022
Evidence Based Practice	December 2022

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Version History

Date	Comments
September 2018	Version one (algorithm developed)
January 2023	Version two (algorithm revised, synopsis developed)
October 2024	Version three (algorithm revised to include the link to the *Confidentiality Tips* supporting page)

Disclaimer

When evidence is lacking or inconclusive, options in care are provided in the guideline and the power plans that accompany the guideline.

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Appendix
Supporting Tools

Appendix A – Emergency Contraception Options Table

Emergency Contraception Options

	Copper Intrauterine Device (Paragard ® IUD)	**Ulipristal acetate** (ella®)	**Levonorgestrel** (Plan B, Plan B One-Step®and others)
Mechanism of Action	Copper ions create a hostile environment impacting sperm motility	Delays or interferes with ovulation	Suppression of luteinizing hormone, prevents ovaries from releasing eggs while preventing sperm motility
Ease of Access	Healthcare provider inserts during routine visit	Prescription required	Available at most pharmacies without a prescription
Efficacy	99% if inserted within 5 days (120 hours) after unprotected sexual intercourse	85% if taken within 5 days (120 hours) after unprotected sexual intercourse	89% if used within 3 days (72 hours) after unprotected sexual intercourse
Effectiveness Time Frame	May be inserted up to 5 days following intercourse, effectiveness does not decrease over time	May be used up to 5 days following intercourse, effectiveness does not decrease over the 120-hour treatment window	Most effective in the first 3 days, may be used up to 5 days following intercourse
Body Weight Considerations	Effectiveness not impacted by body weight	May be less effective with BMI ≥ 30, especially if BMI > 35[a]	May be less effective in patient with BMI ≥ 25[a]
Resuming or Starting Hormonal Contraception	Maintain in place for continued use up to 10 years; additional hormonal contraception not necessary	Wait at least **5 days** between administration and resuming or starting hormonal contraception *Effectiveness may be decreased if taken while using hormonal contraception	May resume hormonal contraception methods immediately
Pregnancy Prevention Considerations	Protects against pregnancy upon insertion for that episode of unprotected intercourse and subsequent episodes for at least 10 years as long as IUD remains in place	Use of a condom is required for all intercourse prior to resuming or initiating hormonal contraception ***Once hormonal contraception resumed or initiated*:** Use of condom for all intercourse is required for the initial 7 days ***If not resuming or initiating hormonal***	***Once hormonal contraception resumed or initiated:*** Use of condom required for next 7 days ***If not resuming or initiating hormonal contraception***: Use of condom is required for all future intercourse

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		***contraception*:** Use of condom is required for all future intercourse	
Contraindication(s)	Pregnancy, anatomical features which prevent IUD insertion, and copper allergy	Known or suspected pregnancy	Pregnancy
Adverse Effects	May cause menstrual cramping, heavier periods, irregular menses, anemia, back pain, and fainting immediately following insertion	May cause headache, nausea, and abdominal pain	May cause nausea, vomiting, heavier menstrual bleeding, spotting

Note. Adapted from Upadhya, K.K., & American Academy of Pediatrics Committee on Adolescence [AAP]. (2019). Emergency Contraception. *Pediatrics, 144*(6), Article e20193149. https://doi.org/10.1542/peds.2019-3149

[a]Despite the impact on body mass index on efficacy, patients who do not want to use or do not have access to a copper IUD should be offered emergency contraception pills (Upadhya & AAP Committee on Adolescence, 2019)

Appendix B – Approved Years of Use for Long-Acting Reversible Contraception Table

FDA Approved Long-Acting Reversible Contraception

Type	FDA Approved Years of Use
Intrauterine Devices/Systems	
Copper IUD (Paragard®)	10 years of use
Levonorgestrel-Releasing IUDs	
• LNG-52 IUD (Mirena)	8 years of use[a]
• LNG-52 IUD (Liletta)	6 years of use[b]
• LNG-19.5 IUD (Kyleena)	5 years of use
• LNG-13.5 IUD (Skyla)	3 years of use
Contraceptive Implant	3 years of use

Note. Adapted from Committee on Practice Bulletins-Gynecology, Long-Acting Reversible Contraception Work Group (2017). Practice Bulletin No. 186: Long-acting reversible contraception: Implants and intrauterine devices. Obstetrics *and Gynecology, 130*(5), e251-e269. https://doi.org/10.1097/AOG.0000000000002400

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[b]Averbach, S., & Hofler, L. (2022). Long-acting reversible contraception with contraceptive implants and intrauterine devices. *Journal of the American Medical Association, 327*(20), 2013-2015. https://doi:10.1001/jama.2022.5448

Appendix C – Healthy Sexual Behaviors Handout

Children's Mercy KANSAS CITY

Healthy Sexual Behaviors

People between the age of 14 and 24 are at the highest risk of getting an STI (sexually transmitted infection). Some STIs have no cure and can cause long lasting health problems.

Examples of STIs

- HIV (human immunodeficiency virus)
- Chlamydia
- Herpes
- Trichomoniasis
- Gonorrhea
- Syphilis
- HPV (human papilloma virus)

Some sex behaviors can increase your risk of getting a STI or unplanned pregnancy.

These behaviors include

- Vaginal, oral, or anal sex without a condom
- Having more than one sex partner
- Using drugs or alcohol before or during sex
- Using drugs through a needle
- Having sex for money, food, or something else

The only sure way to prevent pregnancy and STIs is to NOT have sex. If you chose to have sex here are some safe sex behaviors to help prevent STIs and unplanned pregnancy:

Condoms

- Can lower the risk of pregnancy and STIs
- Must be used correctly **every time** you have sex
- Condoms can break, slip, or leak. Make sure to learn how to use them correctly

Birth Control

- Can lower the risk of pregnancy but does not prevent STIs
- There are many kinds of birth control. These include:
  - Pills
  - Shots
  - Implants
  - Intra-uterine devices (IUD)
  - Patches, and rings
- Call your primary care provider (PCP) to talk about your choices or request a referral to Children's Mercy Adolescent Speciality Clinic. If you don't have a PCP, you can call the Children's Mercy Adolescent Specialty Clinic at (816) 960 - 4152 schedule a sexual health visit.

PrEP to prevent HIV

- PrEP (pre-exposure prophylaxis) is medicine (daily pill or shot every 2 months) that helps stop HIV from spreading from person to person
- This can be prescribed by your health care provider or by a provider at the Children's Mercy Adolescent Clinic
- We talk to teens about this everyday so please call if you have any questions. (816) 960-4152

Sexual Health Resources

- Center for Disease Control and Prevention (CDC)
  - https://www.cdc.gov/healthyyouth/sexualbehaviors/
  - https://www.cdc.gov/teenpregnancy/pdf/Teen-Condom-Fact_Sheet-English-March-2016.pdf)
- Children's Mercy Hospital Adolescent Clinic (816) 960 - 4152
  - Offers sexual health visits
  - Call for any questions or to set up an appointment

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