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**Meeting the Contraceptive Needs of
Teens and Young Adults:
Youth-Friendly and Long-Acting Reversible Contraceptive
Services in U.S. Family Planning Facilities**

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This work is described in part in an abstract that was presented at the Reproductive Health Disparities among Youth: Improving Services and Ensuring Access annual meeting in Chicago, Illinois in May 2012 and has been accepted for a poster presentation at the North American Forum on Family Planning annual meeting in Denver, Colorado in October 2012.

Abbreviations: LARC – long-acting reversible contraception, IUD – intrauterine device, FQHC – federally qualified health center, HD – health department, PP – Planned Parenthood

Abstract

Purpose: Increased use of contraceptive services, including long-acting reversible contraceptives (LARCs), among sexually active teens and young adults could significantly reduce unintended pregnancy. Objectives were to describe youth-friendly contraceptive services (including LARC) available to teens and young adults at U.S. publicly funded family planning facilities.

Methods: Between April and September 2011, center directors at a nationally representative sample of 1,196 U.S. publicly funded family planning facilities were surveyed to assess accessibility and provision of contraceptive services for teens and young adults; 584 (52%) responded.

Results: Facilities were accessible to young clients in several ways, including not requiring scheduled appointments for method refills (67%) and having flexible hours (64%). Most facilities provided outreach and/or education to young people (70%), and 27% used social network media to do this. Most facilities took steps to ensure confidentiality for young clients. These youth-friendly practices were more common at Planned Parenthood, Title X, and reproductive health focused facilities than at other facilities. Long acting reversible contraceptive methods were regularly discussed with younger clients at less than half the facilities. Youth-friendly sites had increased rates of LARC provision among younger clients. The most common challenges to providing contraceptive and LARC services to younger clients were the costs of LARC methods (60%), inconvenient clinic hours (51%), staff concerns about intrauterine device (IUD) use among teens (47%), and limited training on implant insertion (47%).

Conclusions: Improving the ability of family planning facilities to provide youth-friendly contraceptive and LARC-specific methods to younger clients may increase the use of highly effective contraception in this population.

Key words: long-acting reversible contraception (LARC), youth-friendly services, young adults,
Title X, unplanned pregnancy, teen pregnancy, contraception

Implications and contribution

This study indicates that publicly funded family planning facilities across the United States vary in their ability to provide youth-friendly contraceptive services, including LARC, to teens and young adults. Improving these services may facilitate increased use of highly effective contraception and help reduce unintended pregnancy among young women.

Introduction

Unintended pregnancy among teens and young adults in the United States remains a public health concern, with more than 1.7 million unintended pregnancies reported among women aged 15–24 years in 2006 [1]. Although the proportion of unintended pregnancies among teens aged 15–19 years is high at 82%, it has remained stable over time; in contrast, the proportion of unintended pregnancies among young adults aged 20–24 years increased from 59% in 2001 to 64% in 2006 [1]. Compared to older women of reproductive age, teens aged 15-19 and young adults aged 20-24 have the highest proportions of contraceptive nonuse [2]. A significant portion of unintended pregnancies (43%) results from incorrect or inconsistent use of contraception [3,4], which is more likely to occur with user-dependent methods (e.g., oral contraceptive pills, condoms) than with methods that require less user involvement (e.g., intrauterine devices (IUDs), implants). Among U.S. teens and young adults using contraception, pills are the most common primary method, followed by condoms; proportionately, fewer older women rely on these methods [2].

Increased use of reversible, nonuser-dependent methods that are long-acting and highly effective [5] could significantly reduce the rate of unintended pregnancy among young women. These methods, known as long-acting reversible contraceptives or LARCs, include IUDs and

implants. Until recently, LARC methods were viewed as primarily appropriate for women later in their reproductive years. That assumption is now changing, as LARCs have been shown to be safe, effective, and acceptable for teens and young adults, including those with no children [6-8]. Although use has increased substantially since 2002, including among those aged 15–19 and 20–24 years, current use of LARCs remains low among U.S. women overall (6%) [9]. Barriers to LARC use in the United States may include provider attitudes and practices, women’s knowledge and attitudes, cost, and accessibility [10–18]. Long acting reversible contraceptive methods are highly acceptable and desirable among young people when financial barriers are removed [19], and IUDs have similar or better continuation rates than pills among teens [20]. The American College of Obstetricians and Gynecologists recently recommended these methods as first-line choices for adolescents [21].

Publicly funded family planning facilities, which serve a disproportionately high number of young clients in the United States [22], represent an ideal setting to meet the contraceptive needs of many teens and young adults. Teenagers represented 1 of 4 contraceptive clients served by these facilities in 2006, which reached nearly 2 million women aged <20 years [23]. Without these facilities, many of which receive funding through the federal Title X program, the number of unintended pregnancies and abortions in the United States is estimated to be nearly two-thirds higher among teens and among women overall [24].

One strategy to increase the use of contraceptives, including LARCs, among interested adolescents and young adults, is to ensure the availability of youth-friendly services at publicly funded family planning centers. The World Health Organization defines youth-friendly services as services that are equitable, accessible, acceptable, appropriate, and effective for young people [25]. Strategies to make health facilities more youth-friendly include convenient locations, hours,

and wait times; ensuring confidentiality; having separate waiting areas and examination rooms with age-appropriate educational materials; and improving provider knowledge and competencies related to teen development [26,27]. Studies of interventions that incorporate youth-friendly strategies into family planning services have found significant improvements in several behavioral outcomes and satisfaction with services [28–31].

We describe youth-friendly contraceptive services, both general and LARC-specific, available to teens and young adults at publicly funded family planning facilities across the country. We also identify challenges to providing contraceptive services to younger populations. Our findings will help to identify areas in need of improvement to better meet the contraceptive needs of teens and young adults in the United States.

Methods

Sample

Between April and September 2011, we surveyed a nationally representative sample of 1,196 publicly funded facilities that provide family planning services in the United States. The sample was drawn from the Guttmacher Institute's regularly updated national database of publicly funded family planning facilities, numbering 7,895 sites when the sample was drawn. Prior to drawing the sample, sites were removed from the universe if they were school-based health centers (N = 146), functioned as satellite centers (i.e. they were only open for a few hours each week and services were provided by staff from another (main) location, N = 99) or were a combination of these categories (N = 7). Since fielding of this survey coincided with a data collection effort using similar sampling strategies and there were concerns about overburdening facilities with requests, we also excluded facilities sampled for this other effort (N=1247).

Sampled facilities were stratified by type (Federally Qualified Health Centers [FQHCs], Planned Parenthood affiliates, health departments, hospitals, and other agencies) and by whether they received any Title X funding. “Other” agencies included Indian Health Services sites, Federally Qualified Look Alike sites, social service agencies that provide family planning, free clinics, and visiting nurse association sites. Facilities were randomly selected within each stratum. Because there are many more facilities of some types than others (e.g., more health departments than FQHCs), we varied the sampling proportion of each facility type to ensure a sufficient number of cases to make estimates specific to each type.

Survey instrument

Our four-page questionnaire consisted of 23 primarily close-ended questions and asked for basic information about the facility, client caseload, demographics, and contraceptive services available to teens and young adults. We defined teens as persons aged <20 years and young adults as those aged 20–24 years. Questions, many of which were standard items asked in previous Guttmacher surveys of family planning facilities, addressed general and LARC services for teens and young adults, as well as challenges to providing these services. The questionnaire took approximately 15 minutes to complete.

Data collection

Questionnaires were mailed in mid-April 2011 to either the facility director or, in cases where multiple facilities within one agency were being sampled (N=153), to the agency director at the main facility site. The agency director could either complete the questionnaires for each facility or forward them to the appropriate person at each facility. A reminder was sent to agency

directors in May 2011. To improve response, follow-up phone calls were made to non-respondents between May and September 2011. Sites that had not responded by July were offered a \$25 gift card for completed questionnaires.

Data analysis

To account for non-response, responses were weighted to reflect the total universe of family planning facilities at the time the sample was drawn based on the distribution of these facilities by type and Title X funding status. We used chi-square analyses to examine associations between youth-friendly and LARC-specific service practices and the following key facility characteristics: facility type, Title X funding status and whether a facility focused primarily on reproductive health services or had a more general, primary care focus. We also examined the relationship between youth-friendly services and LARC services, using the measure of whether staff had been trained to meet adolescents' contraceptive needs as a proxy of whether or not a facility was youth-friendly, as this factor is a key characteristic of youth-friendly services [26,27]. We used SPSS Statistics Version 18 for our analyses. This study was considered exempt from review by the chairman of the federally registered institutional review board of the Guttmacher Institute.

Results

Response

Administrators at 584 eligible facilities responded to the questionnaire, for an overall response rate of 52%. Planned Parenthood facilities had the highest response rate (80%), followed by health departments (65%) and FQHCs (49%); 36% of other facilities and 30% of

hospitals responded. Compared to non-responders, facilities that responded to the survey were more likely to be Planned Parenthoods and health departments, to have received Title X funding, and to be located in the South and Midwest.

Overview of facilities

Characteristics of the study sample are presented in Table 1. Most health departments (87%) and Planned Parenthoods (67%) received Title X funding and provided services primarily focused on reproductive health (68% and 98%, respectively). The majority of FQHCs did not receive Title X funding (79%) and had a more general, primary care focus (89%). Most facilities that primarily focused on reproductive health indicated that they received Title X funding (68%).

Facility practices related to contraceptive services

Facilities varied in how they provided contraceptive services to younger clients (Table 2). All associations between the three site characteristics examined (facility type, receipt of Title X funding, and service focus) and contraceptive-related practices for teens and young adults were significant at $p \leq 0.01$. Exceptions to this finding were for the associations between (1) receipt of Title X and walk-in appointment availability and (2) service focus and walk-in appointment, extended hour availability, and the use of peer educators, for which there were no significant associations. A facility's service focus was associated with having a designated check-in area for teens ($p=0.034$).

At most facilities (78%) and at all Planned Parenthoods, younger clients were able to access hormonal contraceptive methods (excluding the hormonal IUD) without having a pelvic exam. A higher proportion of health departments, Title X, and reproductive health focused facilities also

incorporated this practice more often than the other types of facilities. About two-thirds of all facilities reported that they were accessible to clients in multiple ways: through public transportation (67%), by not requiring scheduled appointments for contraceptive refills (67%), and by offering walk-in or same-day appointments during flexible hours. Planned Parenthoods more frequently offer these flexible appointments and hours.

Fewer than half of facilities (43%) had teen-friendly décor (as defined by the respondent) in their waiting and examination rooms, but most Planned Parenthoods (70%) did. Although 27% of facilities reported using social networking media to provide education or outreach to potential clients, few offered online appointment scheduling for patients (9%) or sent text messages to patients (8%). The exception was Planned Parenthood affiliates; 63% offered online scheduling and 75% used social media to reach clients or provide education. Facilities that received Title X funding and those that primarily focused on reproductive health also reported using these youth-friendly practices more often.

Most facilities provided outreach and/or education to young people through community organizations, employers, or faith-based groups (70%) or local schools (69%); health departments, Title X-funded, and reproductive health-focused facilities offered these outreach activities more commonly than their counterparts. Additionally, staff members at most facilities had received training to meet teens' special contraceptive needs (78%). Among the types of facilities, FQHCs reported these teen-specific trainings least often (58%).

The majority of facilities took steps to ensure confidentiality for younger clients; most (77%) required consent from a minor in order for parents to access medical records, and 60% had incorporated additional measures to ensure confidentiality when contacting teen clients. Planned

Parenthood, Title X, and reproductive health-focused facilities incorporated these practices to a greater extent than did their counterparts.

For all facilities combined, contraceptive methods were provided to teens and young adults in a similar pattern, with one notable exception (Figure 1). Whereas pills were the most common primary contraceptive method provided to both age groups, followed by Depo-Provera and condoms, LARC methods, in particular the IUD, were more commonly provided to young adults than to teens.

LARC services for teens and young adults

All associations between the three site characteristics examined (facility type, receipt of Title X funding and service focus) and LARC-related services for teens and young adults were significant at $p < 0.01$ (Table 3). The only exceptions to this finding were for the associations between (1) receipt of Title X funds and past IUD trainings and future implant trainings and (2) service focus and future hormonal IUD training, for which there were no significant associations. A facility's receipt of Title X funds was associated with past staff trainings on the implant ($p=0.038$).

With teens, IUDs were discussed “often” or “always” at 43% of facilities, and implants were discussed as frequently at 40% of facilities. With young adults, IUDs were discussed “often” or “always” at 56% of facilities and implants at 44% of facilities. In comparison, other methods including the pill, condom, and other short-term hormonal methods (i.e., shot, patch, or ring) were discussed “often” or “always” with both teens and young adults at 80-100 % of responding facilities, depending on the method (data not shown).

Nearly half (47%) of facilities indicated that IUD use among teen and young adult clients had increased over the past two years, and 37% indicated a rise in implant use among these age groups. Planned Parenthood and reproductive health-focused facilities were most likely to report increases in LARC use among teens and young adults

Fewer than half of the facilities (43%) reported that removals of LARC methods among teen and young adult clients were more common than among older adults. Across all facility types and regardless of receipt of Title X funds or service focus, the hormonal IUD (64%) was more commonly provided to teens and young adults than the copper IUD (16%).

Most facilities provided the IUD (82%) and implant (65%) to patients on-site. On-site insertions were made possible through either direct purchase of the IUD (74%) or implant (59%) from the manufacturers or by having patients bring in the IUD (8%) or implant (6%) after obtaining a prescription. A larger proportion of facilities followed alternative dispensing routes for implants than for IUDs. Planned Parenthoods and “other” types of facilities and hospitals provided IUDs and implants directly to clients more often than health departments and FQHCs; relative to other facility types, hospitals and FQHCs more commonly provided prescriptions for IUDs (and, for FQHCs, implants) that clients had to fill elsewhere before having them inserted at the site. Facilities that receive Title X funding, and those that were reproductive health-focused, more commonly reported direct LARC dispensing.

Staff training on LARC methods was most common for the implant, followed by the hormonal IUD and then the copper IUD. Facilities focused on providing reproductive health services more commonly reported having staff trained on all three LARC methods than did their primary care- focused facility counterparts.

Respondents from facilities that were more youth-friendly were significantly more likely to indicate that both LARC methods are typically discussed during a contraceptive visit with teens and young adults. In addition, IUD and implant provision among teens and young adults was more likely to have increased at youth-friendly facilities than at non-youth-friendly ones. Youth-friendly facilities were more likely to directly dispense the IUD but not the implant to patients, less likely to have staff trained on the implant and more likely to have future staff trainings scheduled on the IUD.

Challenges to providing contraceptive services to younger clients

Respondents rated the degree to which potential challenges limited a facility's ability to provide contraceptive services to teens and young adults (Figure 2). Inconvenient center hours (51%) and too few staff (39%) were cited as the two most common challenges. Costs of LARC methods (60%), staff concerns about IUD use among teens (47%) and the need for more training on implant insertion for staff (47%) were reported to be the most common challenges to providing LARC-specific services to younger clients.

Discussion

Publicly funded family planning facilities across the United States vary in their provision of youth-friendly contraceptive services to teens and young adults. Of the five key characteristics identified by the World Health Organization as constituting youth-friendly services [25], our study focused particularly on assessing facilities' ability to make services accessible, acceptable, and effective. The majority of publicly funded facilities are making their services accessible to younger clients through locations easily accessed via public transportation, flexible hours,

appointment flexibility, and outreach efforts. Planned Parenthood facilities are especially successful in incorporating these aspects of youth-friendly service delivery, while hospitals are almost universally accessible through public transportation, and health departments are very effective at providing outreach in the community and in local schools.

Acceptable practices that consider the culture of younger clients varied to a much greater extent across facilities. Most sites incorporated practices to protect minors' confidentiality; however, fewer facilities have adopted newer technology that helps connect with younger clients or incorporated practices to make teens feel more welcome. Effective health services that incorporate evidence-based practices and emphasize staff training were adopted at the majority of facilities. A high proportion, with Planned Parenthoods and health departments leading the rest, allowed teens and young adults to begin using hormonal contraceptives without requiring a pelvic exam, a safe practice shown to increase the adoption of contraception among young women [32]. A similar pattern also emerged regarding having staff members trained to meet teens' special contraceptive needs.

Despite national trends indicating that use of LARCs is increasing among teens and young adults [9], and evidence indicating that LARC methods are some of the most cost effective methods currently available [33], about half of responding facilities indicated that LARC use among these two age groups had stayed about the same over the preceding two years. However, a greater proportion of Planned Parenthood facilities reported increases in IUD and implant use, likely reflecting that these sites are primarily focused on providing reproductive health services. Similarly, Planned Parenthoods, most of which are Title X-funded and reproductive health-focused, make IUDs and implants more accessible by having them available on-site. Young women seeking these methods at FQHCs and health departments, in contrast, may need to obtain

the method from an outside pharmacy or obtain a referral to another provider. Staff training on the implant was higher across all facilities than for hormonal or copper IUDs, likely because the U.S. manufacturer of the implant requires their own trainings for integration of implants into a center's method mix. Despite this, however, nearly half of facilities indicated that staff members needed more training on this method.

Provision of a broad range of youth-friendly services may reflect a facility's healthcare provision infrastructure and patient population. For example, having a central organization that issues guidelines with regards to evidence-based protocols, training regimens and outreach to young women, as Planned Parenthood facilities have, may make it easier for these facilities to incorporate youth-friendly practices. In addition, these sites almost all focus on providing reproductive health services. Although FQHCs are able to incorporate some youth-friendly practices to a similar degree as other facility types, they fall behind their counterparts in the areas of confidentiality and staff training, perhaps because they serve a broader client population and are less able to stretch their resources to these areas.

The Title X program has a long history of providing a broad range of methods at its network of facilities, with a special focus on providing services to disadvantaged groups, including younger clients. It releases guidelines that outline requirements to protect clients' confidentiality, among other practices [34]. The Title X program's commitment to younger women is clear from the findings of this study, as receiving Title X funds bolsters a facility's provision of youth-friendly services, in particular outreach, staff training, and incorporating confidentiality practices.

Certain challenges to incorporating youth-friendly services, such as inconvenient center hours, too few staff, and costs of LARC methods, represent areas that may be difficult for

facilities to address or improve upon, especially given current funding cuts at federal and state levels. Other challenges with regards to staff training on LARC methods and addressing staff concerns may be somewhat more straightforward to tackle, especially with U.S. guidelines for eligibility criteria for contraceptive use emphasizing the appropriateness of LARCs for teens and nulliparous women [8], and strong endorsement by leading reproductive health organizations [6,7].

Our study has some limitations. Because we rely on clinic directors' self-reports of their contraceptive services and practices, our data may be biased and reflect more socially desirable practices rather than actual clinical practice. As data come from only publicly-funded sites, we cannot generalize our findings to youth-friendly and LARC-specific contraceptive services available at private facilities. Publicly-funded sites also serve a disproportionately high number of women at risk for unintended pregnancy, including young women, minority women and low income women. Staff at these sites may be particularly attuned to how LARC services, in particular, might benefit these women. Finally, although our response rate of 52% is somewhat low, our data were weighted to account for differences between non-responders and responders. This response rate is comparable to response rates achieved in the past five to ten years in national survey efforts conducted by the Guttmacher Institute that targeted a similar population.

The direct impact of youth-friendly services on reducing teen pregnancy is unclear [28,30]. However, broader adoption of youth-friendly services within reproductive health service settings may increase access to and use of contraception among teens and young adults [28,30], ultimately leading to a reduction in unintended pregnancy. Continuing to incorporate LARCs into the method mix at family planning facilities and emphasizing the potential of these methods for younger women would be an especially effective approach to reduce unintended pregnancy.

Supporting efforts to increase family planning facilities' provision of contraceptive services, including LARC, which are appropriate to the needs, goals and life circumstances of young people, may facilitate increased use of highly effective contraception and help reduce unintended pregnancy.

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Table 1. Facility characteristics, 2011 Survey of Contraceptive Service Provision to Teens and Young Adults

	TOTAL
	N=584
	%
Facility Type	
Health Department	33
Hospital	9
Planned Parenthood	10
FQHC	28
Other	20
Title X funding	
Yes	52
No	48
Primary Service Focus	
Reproductive health focus	52
Primary care focus	48
Annual contraceptive client caseload	
< 1000	38
1000-2550	25
2551-5150	21
> 5150	15
Proportion of young clients*	
>50% teens and young adults	77
≤50% teens and young adults	23

Note: Data are weighted to reflect the distribution of facilities by type and Title X funding status in the full universe of publicly funded family planning facilities in the US in 2012. *Not all respondents provided data for the proportion of their clients that fell between ages 15-24 (N = 514)

Table 2. Facility practices related to providing contraceptive services to teens and young adults, by key facility characteristics

	Total N=584	Facility type					p-value	Title X funding status			Service focus		
		Health Dept N = 157	Hospital N = 28	PP N = 147	FQHC N = 159	Other N = 93		Yes N = 397	No N = 187	p-value	Reproductive Health N = 337	Primary care N = 228	p-value
	%	%	%	%	%	%		%	%		%	%	
Accessibility													
Teens and young adults can begin use of hormonal contraceptives without a pelvic exam	78	83	74	100	66	77	<.001	86	69	<.001	88	69	<.001
Facility is easily accessible using public transportation	67	58	95	83	63	67	<.001	66	69	.010	68	65	.004
Clients are not required to schedule an appointment to obtain method refills	67	54	66	96	65	76	<.001	62	72	<.001	74	61	<.001
Walk-in or same day appointments are available during after-school, evening, and/or weekend hours	64	55	51	86	64	72	<.001	65	63	.052	64	64	.403
Facility hours include evening and/or weekend hours	54	34	41	91	65	58	<.001	50	58	<.001	54	54	.596
Dedicated adolescent-only hours and/or days	11	9	16	9	9	15	<.001	14	7	<.001	12	9	<.001
Environmental adaptations													
Waiting and exam rooms are designed/decorated to appeal to adolescents	43	36	35	70	33	57	<.001	45	41	<.001	50	35	<.001
Designated adolescent check-in area available	10	6	16	4	9	20	<.001	9	12	<.001	9	11	.034
Use of technology													
Facility uses social networking media to reach potential clients or to provide education	27	20	12	75	14	41	<.001	32	22	<.001	42	11	<.001
Clients can schedule appointments online	9	3	0	63	2	7	<.001	13	6	<.001	16	2	<.001
Facility uses text messages to reach clients for follow-up or educational purposes	8	11	0	9	4	12	<.001	9	6	<.001	11	4	<.001

Table 2 cont. Facility practices related to providing contraceptive services to teens and young adults, by key facility characteristics

	Total N=584	Facility type						Title X funding status			Service focus		
		Health Dept N = 157	Hospital N = 28	PP N = 147	FQHC N = 159	Other N = 93	p-value	Yes N = 397	No N = 187	p-value	Reproductive Health N = 337	Primary care N = 228	p-value
		%	%	%	%	%		%	%		%	%	
Outreach													
Facility provides outreach and/or education with community organizations, employers, or faith-based groups to reach young people	70	82	39	64	64	76	<.001	82	57	<.001	75	63	<.001
Facility provides outreach and/or education in local schools for young people	69	80	53	66	61	72	<.001	78	60	<.001	74	64	<.001
Facility has programs specifically to reach male adolescents about contraception	26	32	21	27	17	31	<.001	34	17	<.001	31	21	<.001
Facility uses peer educators/counselors	22	10	26	31	23	33	<.001	18	26	<.001	21	22	.241
Staff training and focus													
Staff have received training to meet teens' special contraceptive needs	78	90	74	85	58	86	<.001	91	65	<.001	89	68	<.001
Staff trained on how to communicate with teens over the phone	61	61	60	65	50	72	<.001	67	54	<.001	66	56	<.001
Dedicated staff member to coordinate or oversee contraceptive services for adolescents	28	29	35	17	21	39	<.001	29	26	0.002	30	26	<.001
Confidentiality													
Minor clients must give consent for parents or guardians to access their medical records	77	81	58	92	77	72	<.001	81	73	<.001	82	72	<.001
Staff will use code name or shielded language when calling for appointment reminders or follow-up	60	61	47	87	46	68	<.001	68	51	<.001	68	52	<.001

Note: Data are weighted to reflect the distribution of facilities by type and Title X funding status in the full universe of publicly funded family planning facilities in the US in 2012.

Table 3. LARC-related services for teens and young adult by key facility characteristics

	Total N=584	Facility type						Title X funding status			Service focus			Youth-friendly site		
		Health Dept N = 157	Hospital N = 28	PP N = 147	FQHC N = 159	Other N = 93	p-value	Yes N = 397	No N = 187	p-value	Reproductive Health N = 337	Primary care N = 228	p-value	Yes N = 455	No N = 129	p-value
	%	%	%	%	%	%		%	%		%	%		%	%	
COUNSELING																
IUDs are discussed often or always during a typical initial contraceptive visit with a...																
Teen	43	48	44	46	37	39	<.001	48	37	<.001	49	36	<.001	45	34	<.001
Young adult	56	64	53	54	49	52	<.001	63	48	<.001	62	49	<.001	59	46	<.001
Implants are discussed often or always during a typical initial contraceptive visit with a...																
Teen	40	41	44	48	35	40	<.001	44	36	<.001	47	34	<.001	43	31	<.001
Young adult	44	42	44	48	42	47	<.001	45	43	.004	48	40	<.001	45	39	<.001
TRENDS																
IUD use among adolescent and young adults in past 2 years has...																
Increased	47	45	46	64	47	40	<.001	48	45	<.001	57	35	<.001	49	36	<.001
Stayed about the same	49	50	46	34	49	56		49	49		39	61		47	58	
Decreased	4	4	9	2	4	4		3	6		3	3		4	6	
Implant use among adolescent and young adults in past 2 years has...																
Increased	37	31	45	59	35	36	<.001	36	39	<.001	46	28	<.001	39	29	<.001
Stayed about the same	56	63	48	40	59	55		59	53		49	65		54	65	
Decreased	6	6	7	2	6	9		5	8		5	6		6	6	
IUD and implant rate of removal among adolescents and young adults is...																
Higher than adults 25+	43	44	38	46	34	54	<.001	44	41	<.001	46	39	<.001	45	32	<.001
About the same as adults 25+	48	44	62	47	56	39		46	52		42	55		46	58	
Lower than adults 25+	9	13	0	6	10	7		10	7		12	5		9	9	
Most common type of IUD among adolescent and young adults																
Hormonal IUD	64	64	57	60	61	72	<.001	63	66	<.001	66	62	<.001	64	62	<.001
Equally split between IUD types	20	14	18	27	27	19		18	23		16	25		19	27	
Copper IUD	16	22	24	13	11	9		20	11		18	14		17	11	

Table 3 cont. LARC-related services for teens and young adult by key facility characteristics

	Total N=584	Facility type						Title X funding status			Service focus			Youth-friendly site		
		Health Dept N = 157	Hospital N = 28	PP N = 147	FQHC N = 159	Other N = 93	p-value	Yes N = 397	No N = 187	p-value	Reproductive Health N = 337	Primary care N = 228	p-value	Yes N = 455	No N = 129	p-value
DISPENSING	%	%	%	%	%	%		%	%		%	%				
When providing clients with IUDs...							<.001			<.001			<.001			<.001
Clinic purchases method & inserts on site	74	68	77	95	66	79		78	68		85	58		75	68	
Clinic provides Rx to outside pharmacy, clinic inserts	8	2	23	2	18	2		2	16		3	15		6	20	
Clinic does not provide method or refers out	9	9	0	3	10	14		7	11		4	15		12	8	
Other	7	15	0	0	4	3		10	2		5	10		8	4	
When providing clients with implants...							<.001			<.001			<.001			<.001
Clinic purchases method & inserts on site	59	49	82	87	53	51		62	55		69	46		58	69	
Clinic provides Rx to outside pharmacy, clinic inserts	6	8	0	2	14	1		6	8		4	10		5	13	
Clinic does not provide method or refers out	27	34	0	10	23	43		24	31		17	39		28	16	
Other	8	9	18	1	10	4		9	6		10	5		9	2	
TRAINING																
In the past 2 years, clinic staff have received training for...																
Implant	73	67	80	85	76	69	<.001	72	75	.038	75	68	<.001	71	82	<.001
Hormonal IUD	43	46	40	35	43	46	<.001	42	45	.121	45	39	<.001	43	45	0.198
Copper IUD	29	28	36	29	25	31	<.001	28	29	.491	32	23	<.001	29	27	0.284
In the coming year, clinic staff are scheduled to receive training for:																
Implant	71	67	70	91	70	63	<.001	71	71	.890	74	64	<.001	69	82	<.001
Hormonal IUD	30	47	10	18	34	16	<.001	39	20	<.001	32	29	.076	32	19	<.001
Copper IUD	26	17	20	22	33	31	<.001	20	32	<.001	24	29	.009	28	12	<.001

Note: Data are weighted to reflect the distribution of facilities by type and Title X funding status in the full universe of publicly funded family planning facilities in the US in 2012. Measure of "youth-friendly" site is based on item asking about staff having received training to meet adolescents' special contraceptive needs, as this is identified in literature as a key aspect of youth-friendly services.

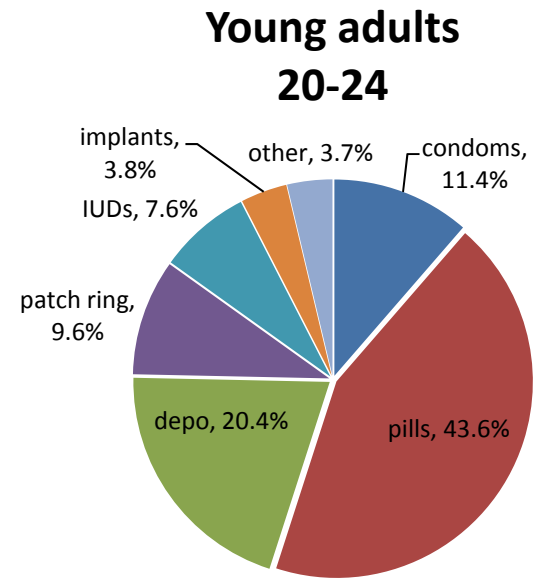
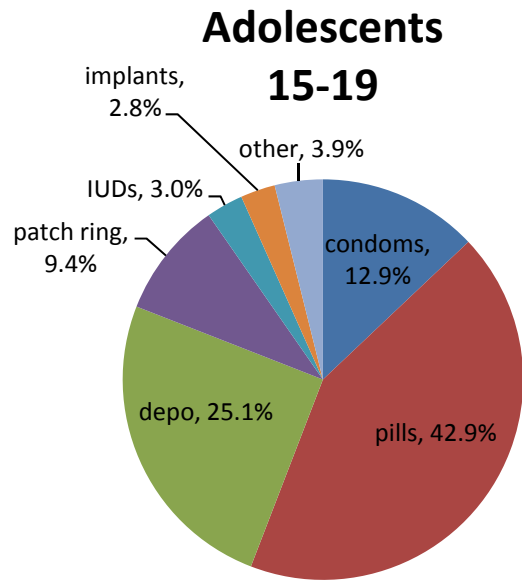
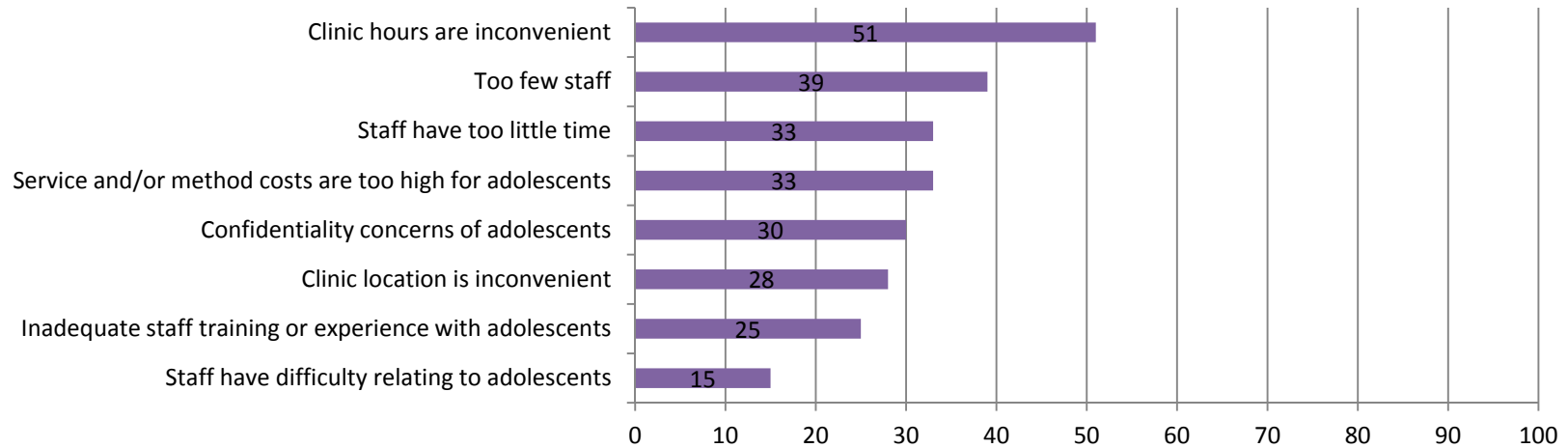


Figure 1: Most common primary contraceptive method provided to young clients at responding facilities, by age group

General Limitations to Providing Youth-Friendly Services



Limitations to Providing LARC-Specific Services to Teens and Young Adults

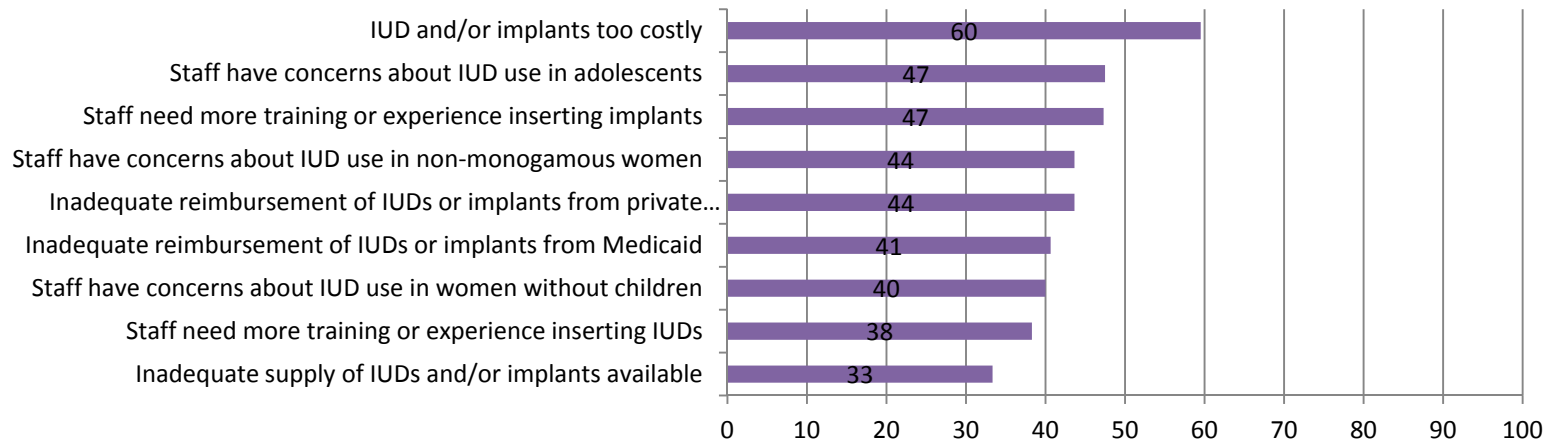


Figure 2: Challenges to providing contraceptive services to teens and young adults, in general (N=571) and in LARC-specific circumstances (N = 551)