



Trends in Adolescent Contraceptive Use from the Contraceptive CHOICE Project

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Learning Objectives

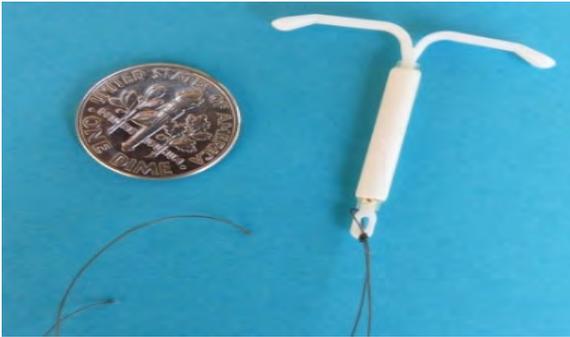
- Describe trends in use, continuation, and satisfaction of long-acting reversible contraception (LARC) among CHOICE adolescent participants
- Compare trends in teen pregnancy between CHOICE and national data
- Identify common barriers to LARC provision for adolescents and brainstorm successful strategies



Unintended Pregnancy in U.S.

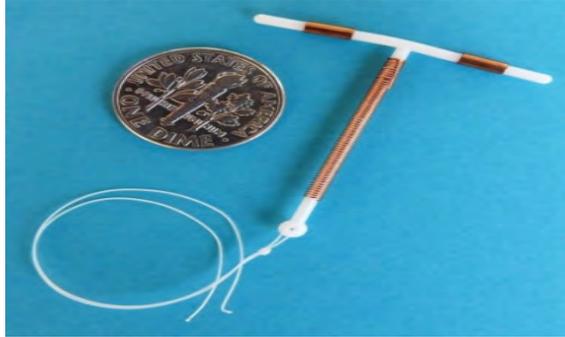
- Over 3 million unintended pregnancies
 - 59% mistimed
 - 39% unwanted
- 1.2 million abortions
- 367,752 births to teens 15-19 years
- Contraception
 - 52% non-use
 - 43% incorrect use

Long-acting Reversible Contraception (LARC)



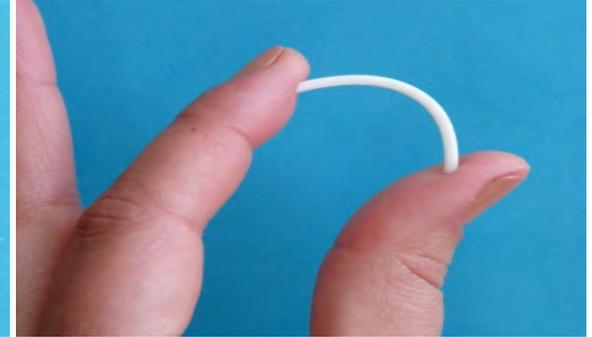
LNG-IUS

- 99% effective
- 20 mcg levonorgestrel/day
- Up to 5 years



Copper T IUD

- 99% effective
- Copper ions
- Up to 10 years



Subdermal Implant

- 99% effective
- 60 mcg etonogestrel/day
- Up to 3 years



LARC Use by Adolescents

- Approximately 4.5% of contracepting adolescents use an intrauterine device (IUD) or Implant
- Recommend as “first-line” by American College of Obstetricians and Gynecologists
- CDC Medical Eligibility criteria
 - Category 2 for IUD
 - Advantages generally outweigh theoretical or proven risks
 - Category 1 for Implant
 - No restriction (method can be used)

Providers Reluctant to Provide IUD to Teens



- Appropriate candidates for IUDs
 - 62% nulliparous
 - 45% STI in past 2 years
 - 37% PID in past 5 years
 - 37% non-monogamous relationship
 - 31% adolescent
- Offer IUD
 - 98% if 35 y.o., married, with 3 children
 - 50% if unmarried 17 y.o., monogamous, and one child
 - 19% if unmarried 17 y.o., never been pregnant

Concerns About Safety

- Survey of 635 office-based physicians & 1,323 Title X providers
 - 30% of respondents said IUDs were very unsafe, unsafe, or were unsure for nulliparous women
- Responses varied by provider type, safety concerns higher among:
 - Office-based family medicine
 - Providers who had not received training
 - Providers who trained more than 25 yrs ago
 - Providers without on-site access to IUDs

The Contraceptive CHOICE Project



The CHOICE Project: Objectives



- To promote LARC (IUDs and implant)
 - Remove financial barriers
 - Increase patient access
- To measure acceptability, satisfaction, side-effects, and rates of continuation across a variety of reversible contraceptive methods, including long-acting reversible methods

The CHOICE Project: Objectives



- To provide enough no-cost contraception to make a population impact on unintended pregnancies:
 - Measures
 - Teen Pregnancy
 - Repeat abortion

The CHOICE Project: Inclusion Criteria



- Study participants 14-45 years
- Residents of Saint Louis City or Country
- Sexually active with male partner or plans to become sexually active
- Does not desire pregnancy during next 12 months
 - Desires reversible contraception
- Willing to start a new contraceptive method

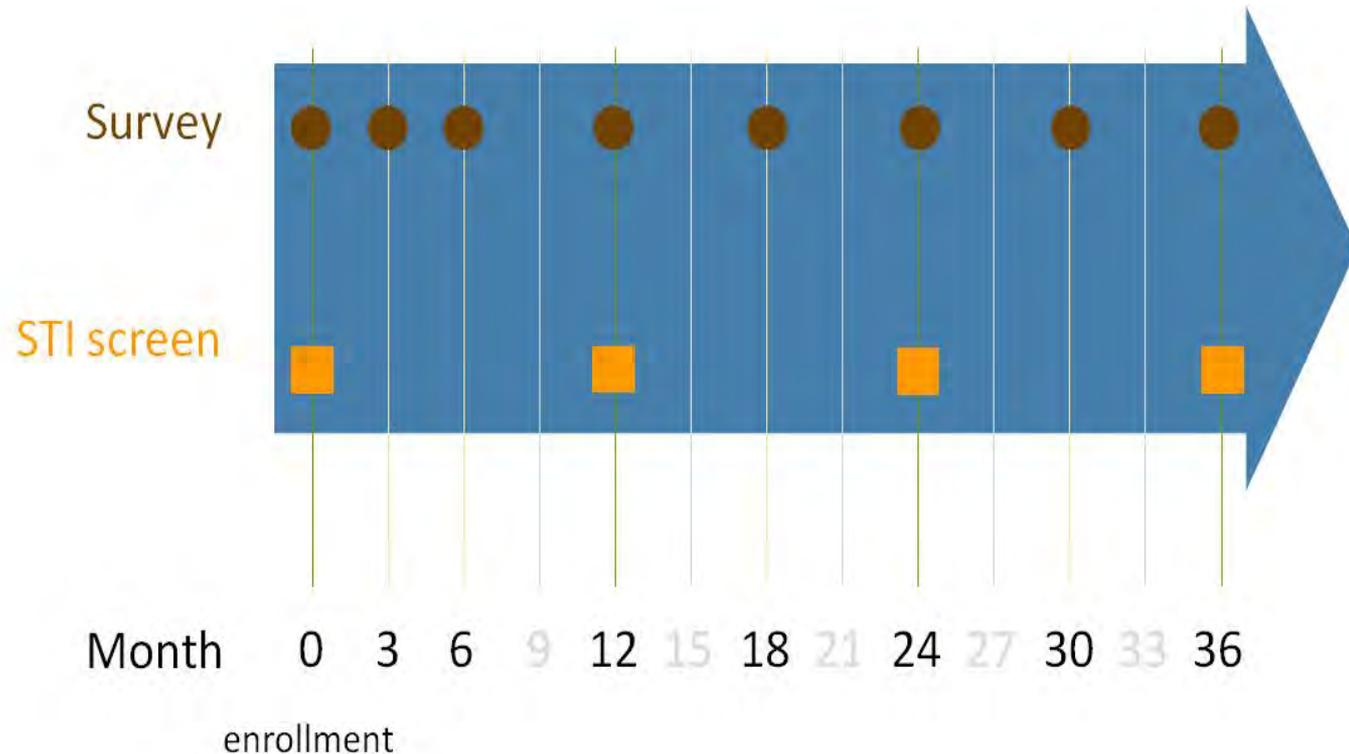
Contraceptive CHOICE Project: Study Details



ELIGIBLE

Tiered
Contraceptive
Counseling

LNG-IUS
Cu-IUD
Implant
DMPA
Pills
Patch
Ring
Other





Contraceptive Counseling

- Standardized script read to all participants that enrolled at university site **regardless of age**
 - Included commonly used reversible methods
 - All women heard about all the methods
 - Tiered counseling = start with **most effective** methods first
 - Evidence-based using CDC medical eligibility criteria
- Provided by trained non-clinicians
- Additional teaching aids used

CHOICE Counseling Room



Contraceptive “Menu of Options”

THE
CONTRACEPTIVE
CHOICE
PROJECT

Which contraceptive method is right for you?

Hormonal IUD

It is inserted into the uterus by a health care provider. It can last up to 5 years. You do not need to use before sex. Periods are generally lighter and less painful. It does not provide protection against STD's.

Copper IUD

It is inserted into the uterus by a health care provider and can last up to 12 years. You do not need to use before sex, it does not provide protection against STD's.

Implant

The implant is inserted into your arm by a health care professional, and lasts up to 3 years. Periods are usually lighter and less painful. You do not need to use before intercourse. The implant does not provide protection against STD's.

Injections

Injections (a shot) are given by a health care professional every 3 months. Periods are generally lighter and less painful. You do not need to use before sex. Injections do not provide protection against STD's.

Pills (Oral Contraceptives)

The pill must be taken at approximately the same time every day. You do not need to use before sex. Periods may become lighter and less painful. Oral Contraceptives do not provide protection against STD's.

Patch

The patch is applied to the skin 1 time per week for 3 weeks, then it is removed for 1 week allowing for a period. Periods are generally lighter and less painful. The patch will not provide protection against STD's.

Vaginal Ring

The vaginal ring is inserted into the vagina and lasts for 3 weeks. After that it is removed for 1 week allowing for a period. Periods are generally lighter and less painful. The vaginal ring does not provide protection against STD's.

Condoms

The male condom is applied onto the penis just before sex. It must be used before every sexual encounter to provide protection against pregnancy and STD's.

Emergency Contraception

Emergency contraception can help prevent pregnancy after unprotected sex or contraceptive failure. It comes in the form of a pill or the copper IUD. The pill can be take up to 5 days after unprotected sex and the copper IUD can be placed up to 5 days after unprotected sex. It does not replace the consistent use of contraception. It does not provide protection against STD's.

Baseline Characteristics: 1,404 Teens



Enrollment Clinic	n	%
University	909	64.7
Community & The SPOT	290	20.6
Abortion	205	14.6
Age		
14 to 17 years	484	34.5
18 to 19 years	920	65.5
Race		
Black	877	62.5
White	416	29.6
Other	111	7.9
Ethnicity		
Hispanic	73	5.2

Baseline Characteristics: 1,404 Teens



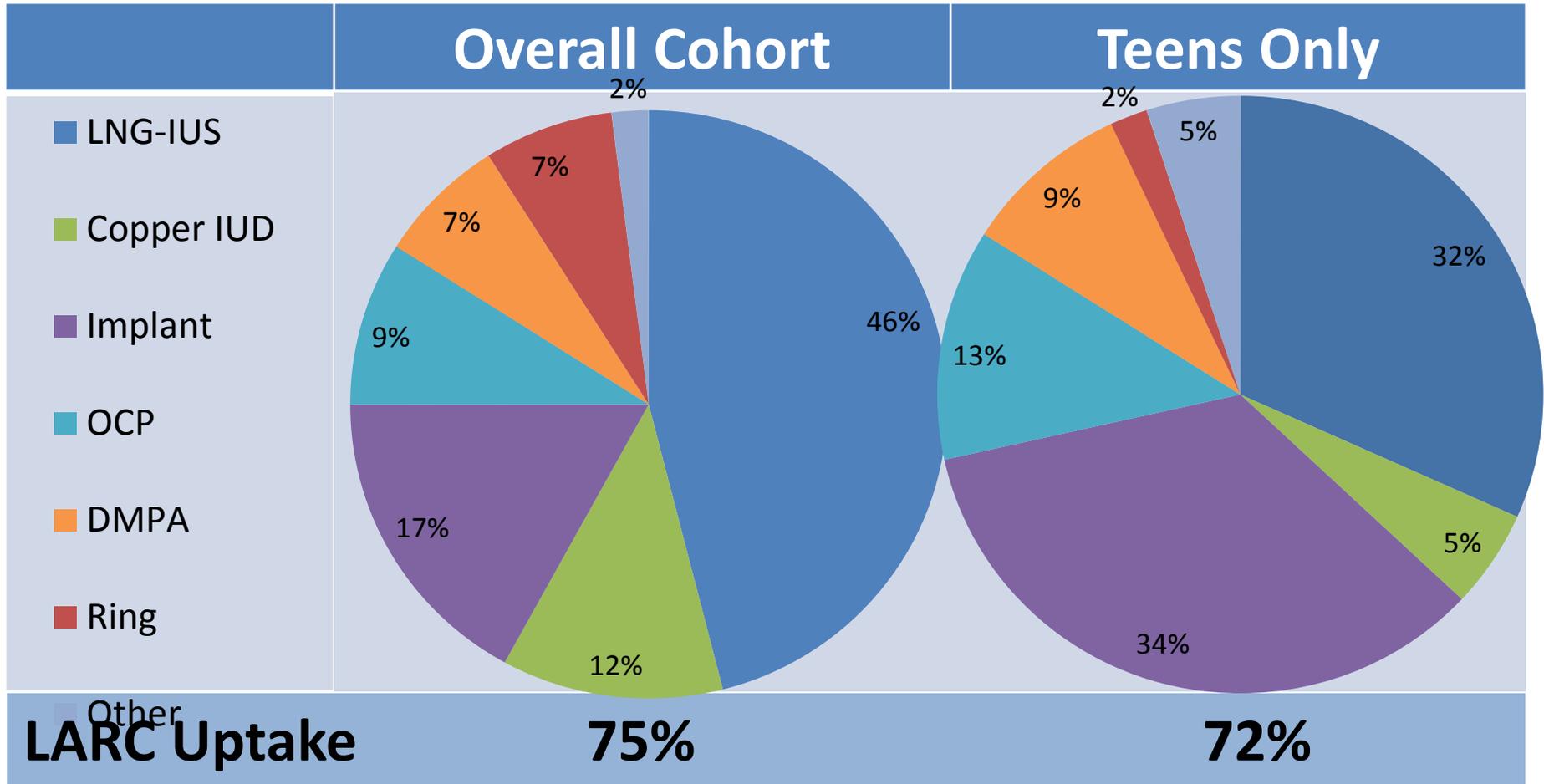
Insurance	n	%
None	392	28.8
Private	583	42.8
Public	386	28.4
Mother's Education		
<= High School	594	42.4
Some college	433	30.9
College+	314	22.4
Sexually Transmitted Infection		
Reported history at enrollment	381	27.1
Tested positive at enrollment*	117	9.1
*positive for CT, GC or TV		

Baseline Characteristics: 1,404 Teens

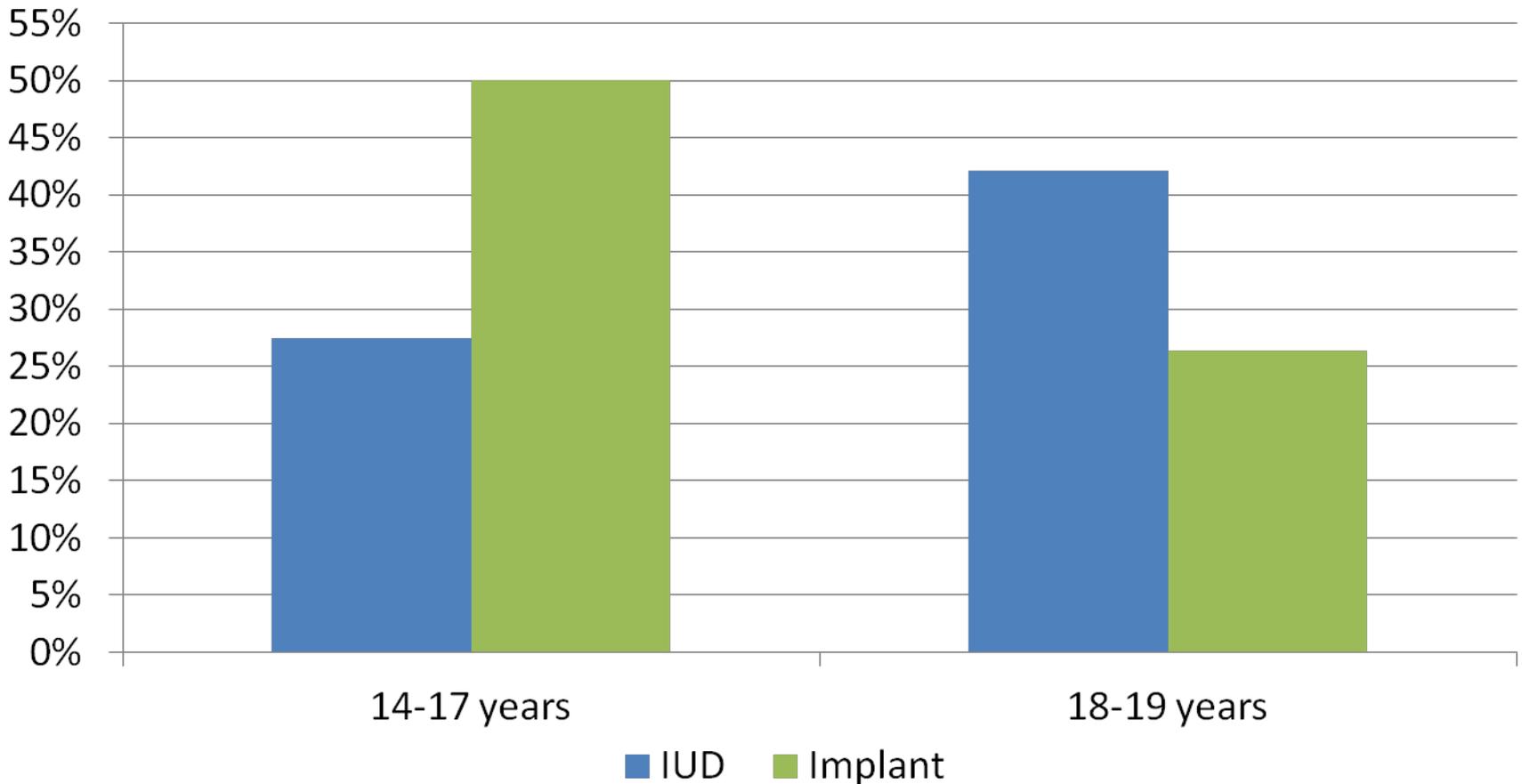


Age at first sexual intercourse	Mean	
	15 years	
Prior pregnancy	n	%
Yes	708	50.4
Parity		
0	1061	75.6
1	290	20.7
2+	53	3.8
Prior unintended pregnancy	n	%
Yes	671	47.8
History of abortion	n	%
Yes	259	18.5

Contraceptive Method Chosen



Choice of LARC Methods by Teens

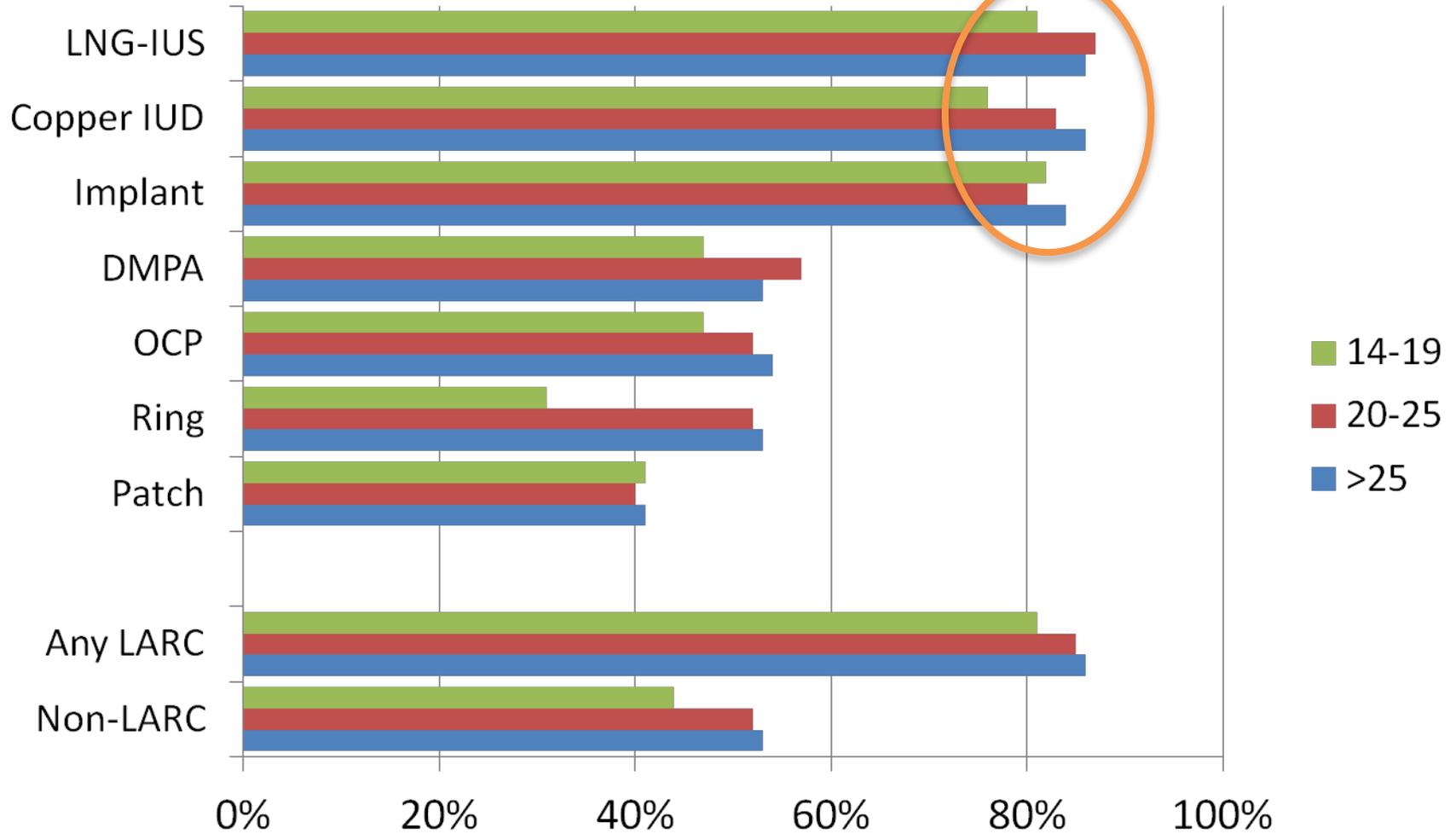


12-Month Continuation: Overall Cohort



Method	Continuation Rate (%)
LNG-IUS	87.5
Copper IUD	84.1
Implant	83.3
Any LARC	86.2
DMPA	56.2
OCPs	55.0
Ring	54.2
Patch	49.5
Non-LARC	54.7

12-month Continuation: By Age



12-Month Satisfaction: Overall Cohort



Method	Satisfied* (%)
LNG- IUS	85.7
Copper IUD	80.1
Implant	78.7
Any LARC	83.7
DMPA	54.0
Pills	53.6
Ring	52.7
Patch	44.4
Non-LARC	52.7

*Very or somewhat satisfied combined

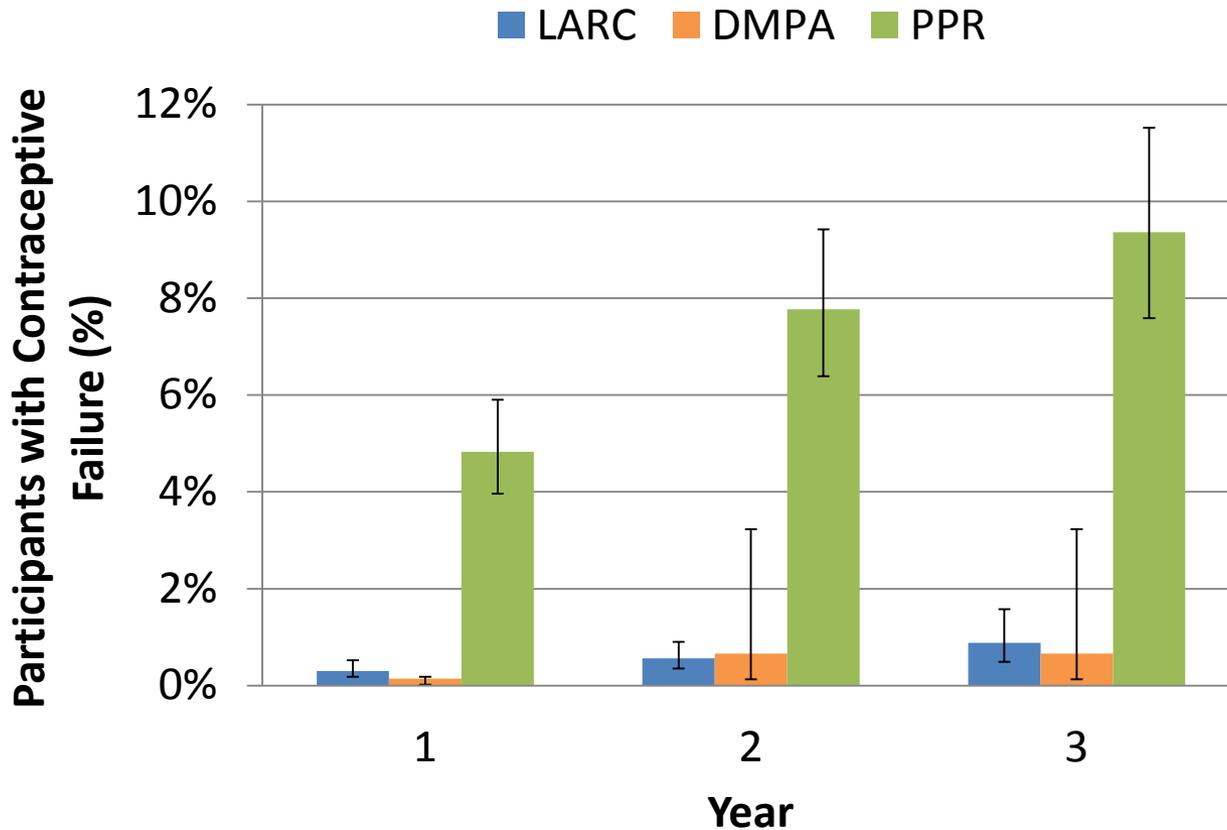
12-Month Satisfaction: By Age



Method	14-19 years	20+ years
LNG-IUS	77%	84%
Copper IUD	72%	81%
Implant	74%	78%
LARC	75%	82%
DMPA	43%	52%
OCP	46%	50%
Ring	31%	52%
Patch	35%	38%
Non-LARC	42%	50%

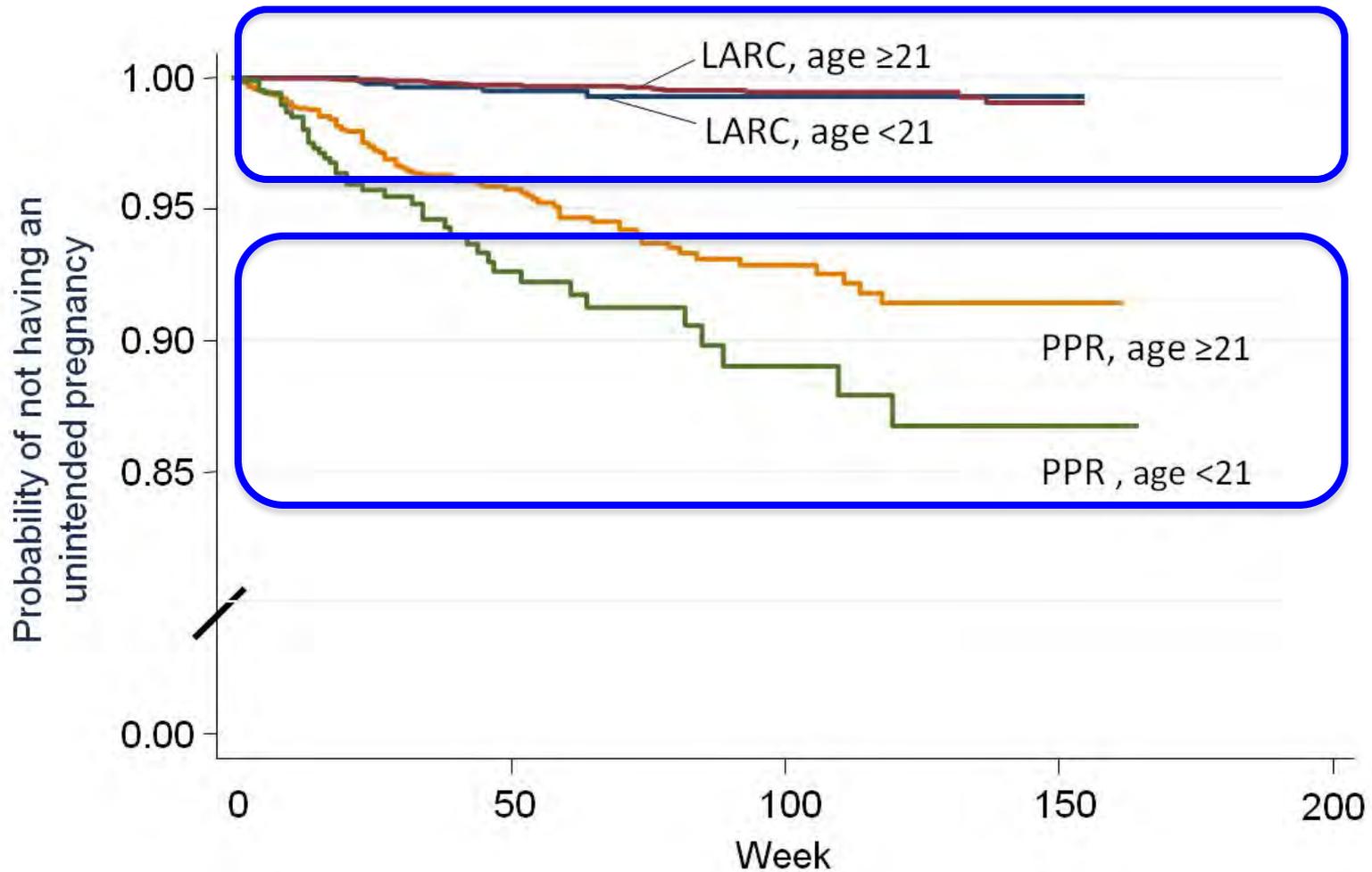
*Very or somewhat satisfied combined

Unintended Pregnancy by Contraceptive Method



$HR_{adj} = 22.3$
95% CI 14.0, 35.4

Method Failure by Age



Teen Outcomes: CHOICE Compared to U.S.



	CHOICE Annual Rate*	2008 U.S. Rate*	Reduction
Pregnancy	29.6	67.8	56%
Pregnancy among sexually active teens	29.6	158.5	81%
Birth	16.3	40.2	59%
Birth (2010)	16.3	34.3	52%
Abortion	9.1	17.8	49%

*All rates per 1,000 teens 15-19 years

What if CHOICE Model Was Adopted Nationally Among All Sexually Active Teens?



Outcome	Number in 2008	National rate per 1,000 sexually experienced teens	CHOICE rate	Percent reduction	Number prevented
Pregnancy	733,010	158.5	29.6	81	593,738
Birth	434,758	94.0	16.3	78	360,849
Abortion	192,090	41.5	9.1	83	149,830



The Secret: 3 Key Ingredients

- Education regarding all methods, especially LARC
 - Reframe the conversation to start with the most effective methods
- Access to providers who will offer & provide LARC
 - Dispel myths and increase the practice of evidence-based medicine
- Affordable contraception
 - Institute of Medicine recommendation, Affordable Care Act, Medicaid Expansion

Successful Implementation of CHOICE Model



Key Element	Barrier	Facilitator
Education	Limited time for contraceptive counseling during appointment	Counseling provided by non-clinician trained in tiered-based counseling
Access	Outdated myths regarding teens as LARC candidates	Identify local “champion clinician” who is LARC proficient, trusted, and can dispel myths
Cost	Lack of reimbursement for contraceptive method, insertion & removal	Network with clinics that have identified how best to manage cost issue through effective billing or payer mix
	Up-front cost of stocking LARC methods for same-day insertions	Investigate ways to purchase a few methods that serve as temporary supply



Dissemination Strategies

- Create online Resource Center to disseminate CHOICE materials
 - Contraceptive counseling script, video, and training protocols
 - Triage system to manage and document calls
 - Practical responses to commonly asked questions
 - Tools to create a LARC-friendly clinic and staff
- Provide technical assistance to end users
- Evaluate how CHOICE materials are adopted and adapted for successful use

Examples of Dissemination

Which family planning method is right for you?

MOST EFFECTIVE	Hormonal IUD It is inserted into the uterus by a health care provider. It can last up to 5 years. You do not need to use before sex. Periods are generally lighter and less painful. It does not provide protection against STD's.
	Copper IUD It is inserted into the uterus by a health care provider and can last up to 12 years. You do not need to use before sex, it does not provide protection against STD's.
	Implant The implant is inserted into your arm by a health care professional, and lasts up to 3 years. Periods are usually lighter and less painful. You do not need to use before intercourse. The implant does not provide protection against STD's.
MODERATELY EFFECTIVE	Injections Injections (a shot) are given by a health care professional every 3 months. Periods are generally lighter and less painful. You do not need to use before sex. Injections do not provide protection against STD's.
	Pills (Oral Contraceptives) The pill must be taken at approximately the same time every day. You do not need to use before sex. Periods may become lighter and less painful. Oral Contraceptives do not provide protection against STD's.
	Patch The patch is applied to the skin 1 time per week for 3 weeks, then it is removed for 1 week allowing for a period. Periods are generally lighter and less painful. The patch will not provide protection against STD's.
	Vaginal Ring The vaginal ring is inserted into the vagina and lasts for 3 weeks. After that it is removed for 1 week allowing for a period. Periods are generally lighter and less painful. The vaginal ring does not provide protection against STD's.
LEAST EFFECTIVE	Condoms The male condom is applied onto the penis just before sex. It must be used before every sexual encounter to provide protection against pregnancy and STD's.
	Emergency Contraception Emergency contraception can help prevent pregnancy after unprotected sex or contraceptive failure. It comes in the form of a pill or the copper IUD. The pill can be taken up to 5 days after unprotected sex and the copper IUD can be placed up to 5 days after unprotected sex. It does not replace the consistent use of contraception. It does not provide protection against STD's.

EMERGENCY ONLY

THE CONTRACEPTIVE CHOICE PROJECT

For more information about family planning methods or a list of our free health education classes, call (317) 221 - 2317.

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HealthyStart
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INDIANAPOLIS, INDIANA

FliP it

Family Planning Options

INDIANAPOLIS
HealthyStart
CONSEJO SALUDABLE
INDIANAPOLIS, INDIANA

Hormonal IUD



The hormonal IUD is a little, T-shaped piece of plastic that is placed in your uterus. It releases a small amount of hormones, called progestin, which keeps sperm from getting through the cervix into the uterus and meeting up with an egg. It's effective up to 5 years and may give you lighter periods.

Advantages	Disadvantages
- Good for 5 years	- Possible irregular periods, which may be greatest at the beginning
- More than 99% effective	- Must be inserted by a clinician
- Quick return to fertility	
- May have lighter periods	
- Forgettable	

LARC FIRST

LONG-ACTING REVERSIBLE CONTRACEPTION

Are you using one of
the most effective
contraceptive
methods?

ASK US FOR MORE INFORMATION

LARC FIRST

**Patient choice is
our priority**

We make sure every woman
and teen is aware of all her
contraceptive options

LARC FIRST

LONG-ACTING REVERSIBLE CONTRACEPTION

Our patients are using
the most effective
contraception!

MONTH

MONTH

MONTH

NON-HORMONAL IUD

NON-HORMONAL IUD

NON-HORMONAL IUD

HORMONAL IUD

HORMONAL IUD

HORMONAL IUD

IMPLANT

IMPLANT

IMPLANT



Lessons Learned

- LARC methods are highly effective at preventing pregnancy **regardless of age**
- Teens overwhelmingly choose LARC
- Teens much more likely to still be using LARC at 1 year compared to more commonly used non-LARC methods
- Successfully promote LARC use among teens
 - Education, access, cost, & LARC-friendly clinic



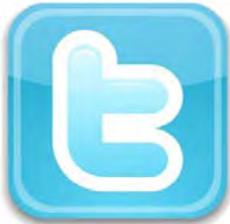
To Learn More Visit



www.choiceproject.wustl.edu



www.facebook.com/choiceproject



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www.youtube.com/user/WUSTLChoiceProject

LARC Services for Teens and Young Adults in Publicly Funded Clinics

Lori Frohwirth, Research Associate



Third Annual Teen Pregnancy Prevention
Grantee Conference: Ready,
Set, Sustain: Continuing Our Success
May 20-22, 2013, National Harbor, MD

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Unintended pregnancy rates have increased overall

	2001	2006
% of pregnancies unintended	48%	49%
15-19	82%	82%
20-24	59%	64%
Unintended pregnancy rate	50	52
15-19	67	60
20-24	101	107

Factors driving (changes in) unintended pregnancy

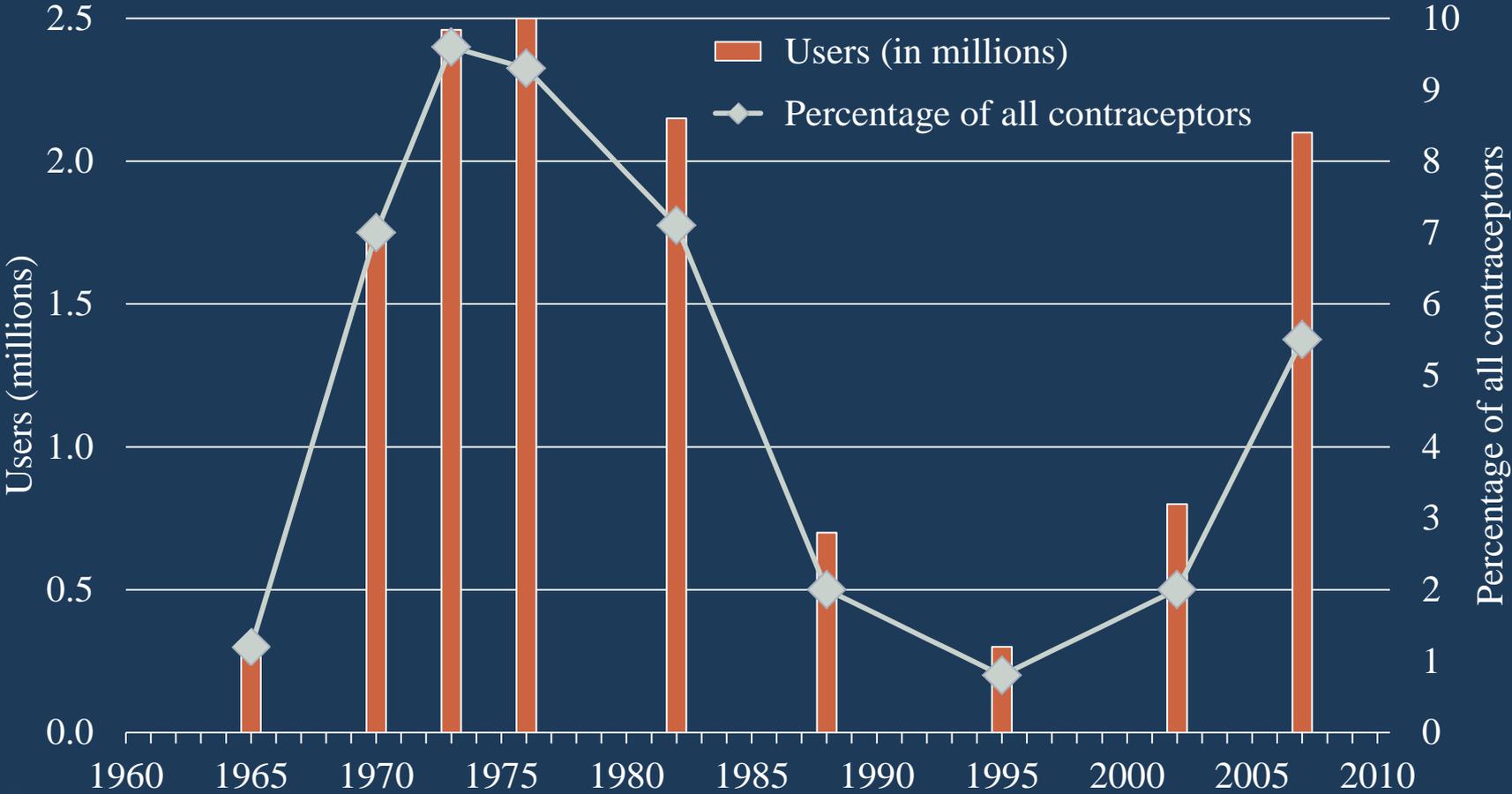
- Sexual activity
- Fecundity
- Contraceptive use
- Desire for pregnancy
- Population composition

Why focus on LARC methods?

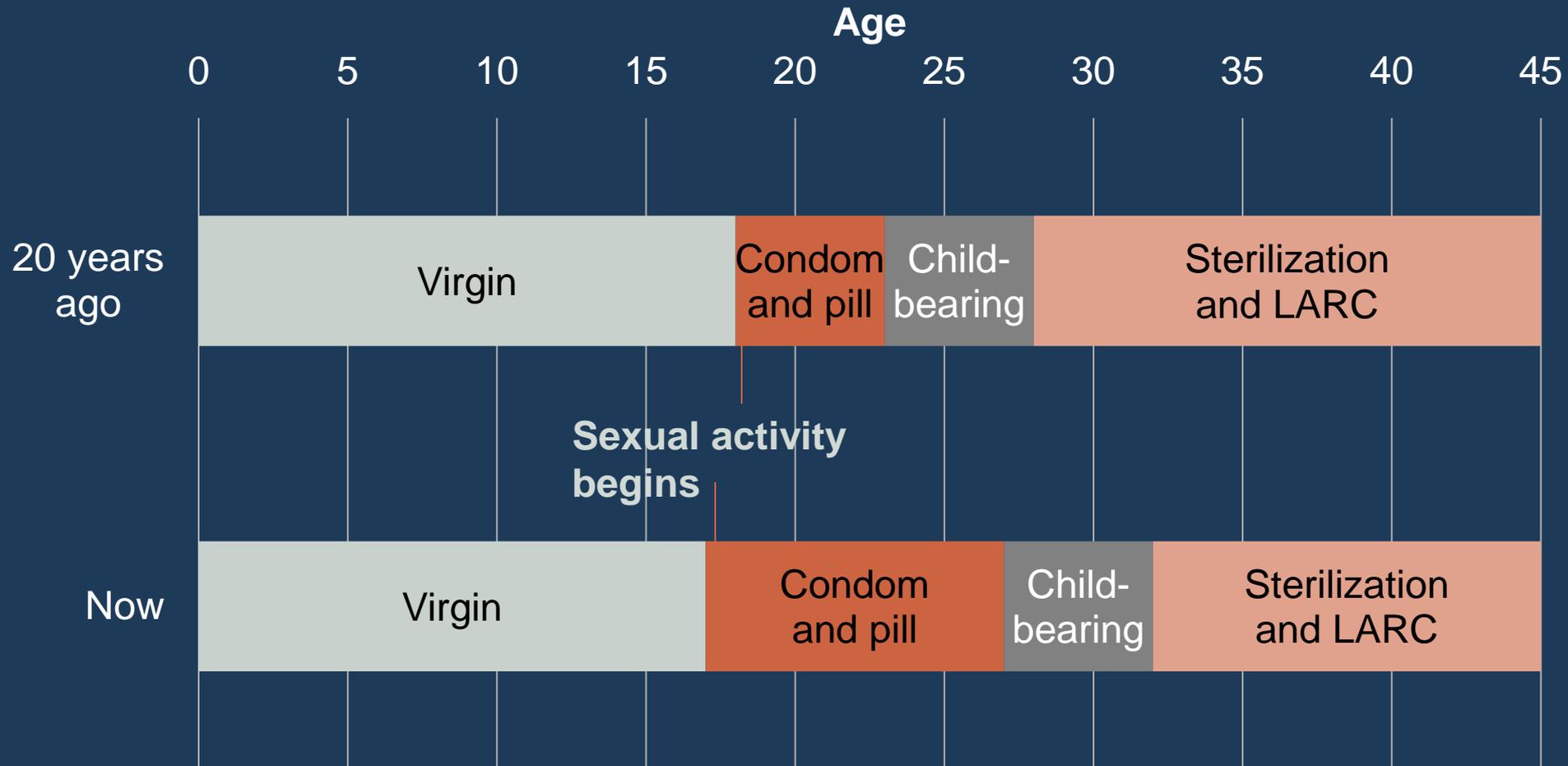
- Persistent high rates of unintended pregnancy
- Evidence that inserting LARC methods post-abortion reduces repeat abortion rates
- Many unintended pregnancies due to user error, not method failure
- Other pros:
 - High efficacy
 - High compliance, continuation rates
 - High satisfaction
 - Few side effects
 - Rapid return to fertility



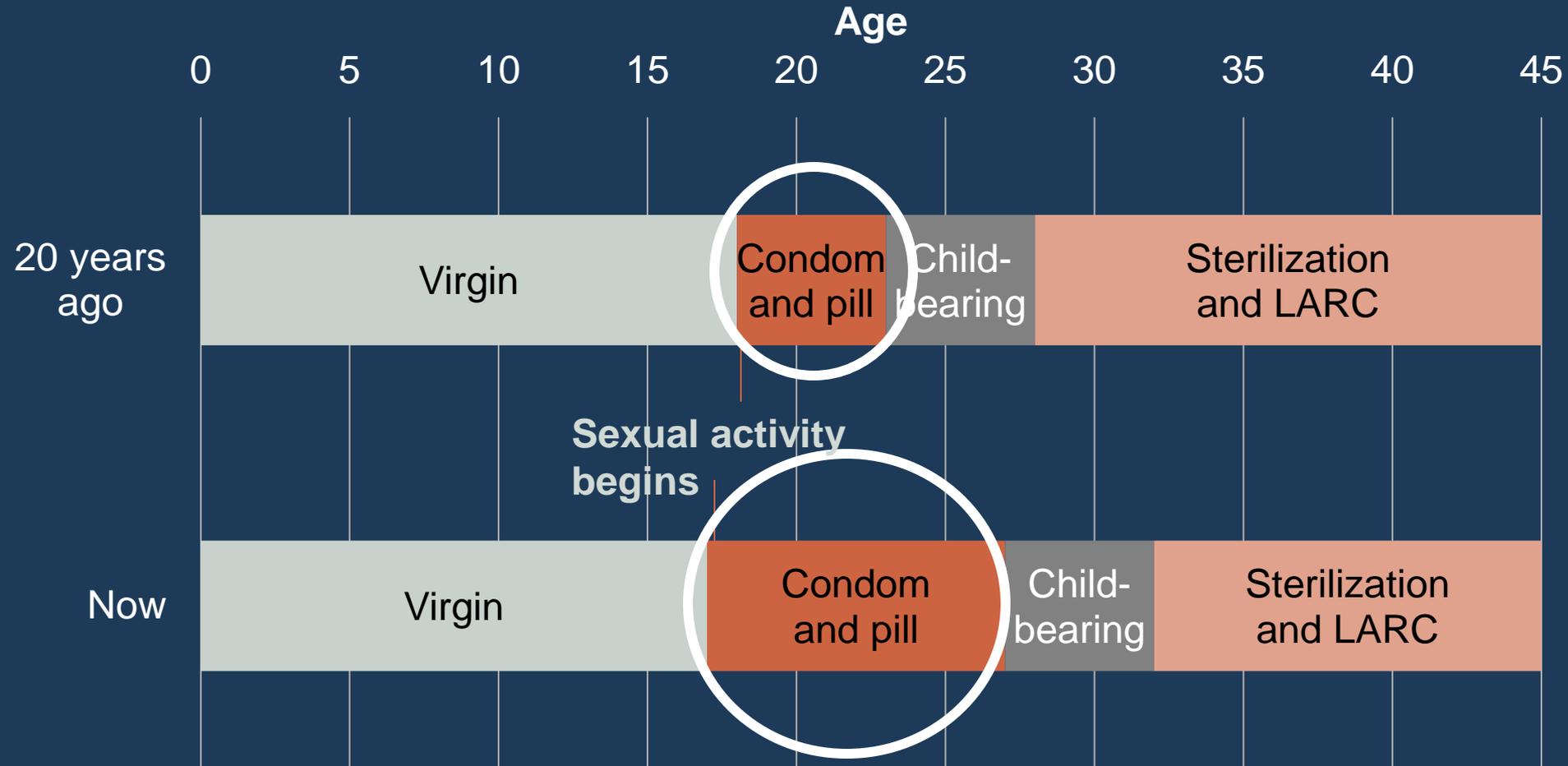
IUD use in the United States, 1965–2008



What *might* be happening as childbearing shifts later?



What *might* be happening as childbearing shifts later?



Evidence on LARC methods and young women

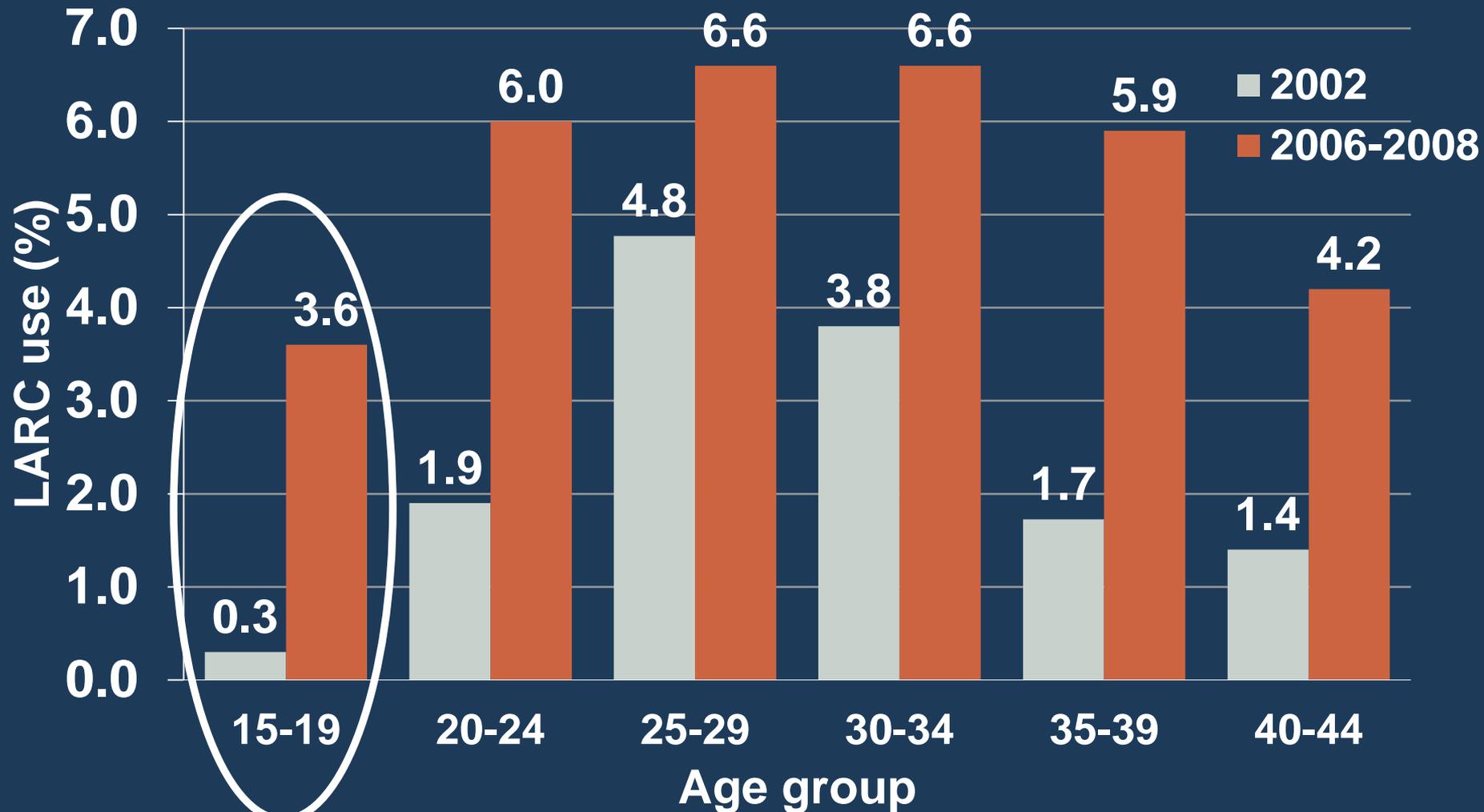
Professional opinion on IUDs has evolved

- ACOG 1992: IUD “especially suited” for older, parous, monogamous women
- ACOG 2005: IUD “should be considered for all women who seek a reliable, reversible contraceptive”
- ACOG 2007: IUDs “should be considered first-line choices for both nulliparous and parous adolescents”

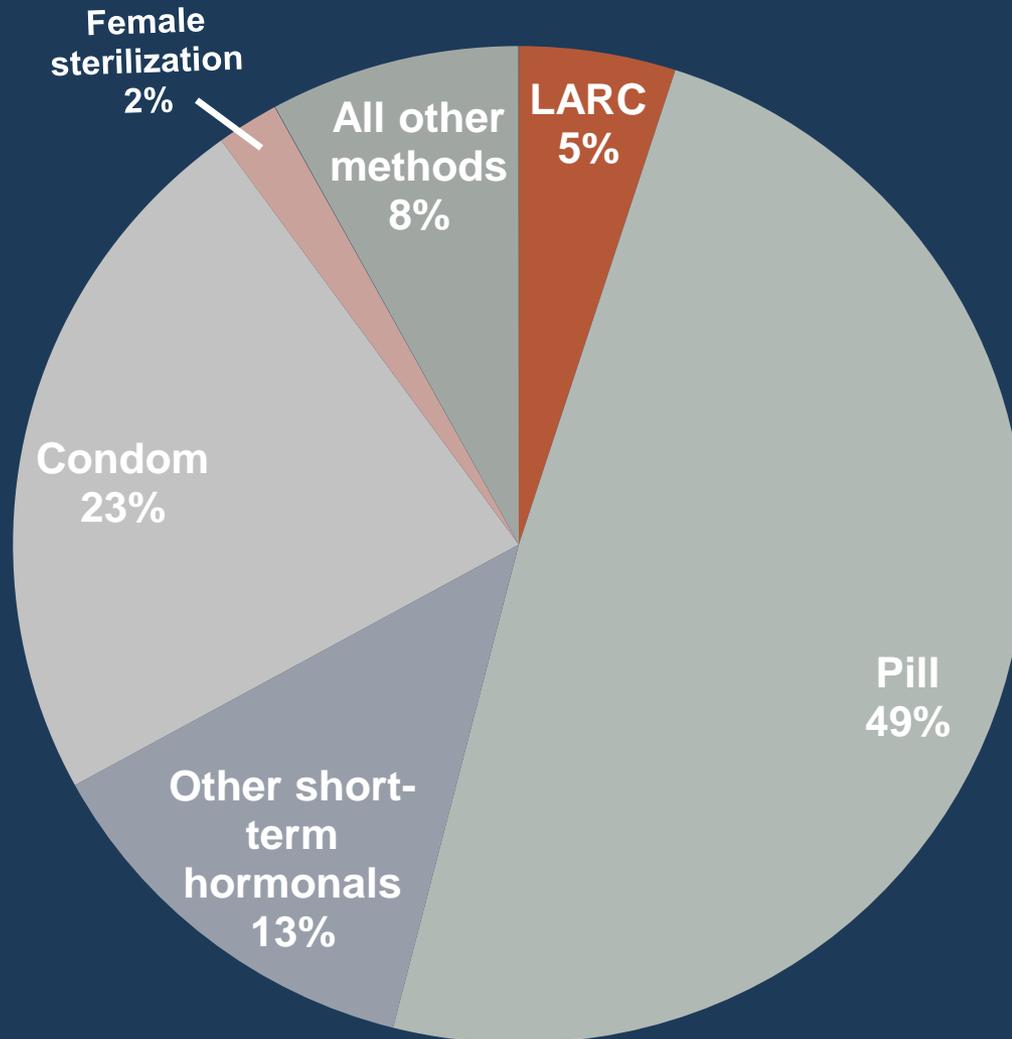
Clinical Guidelines for IUD Use in Nulliparous Women

- Mirena and Paragard are effective and safe
- IUDs have comparable or higher continuation rates compared to other methods
- IUDs do not increase risk of PID or infertility. Mirena may reduce risk
- Due to expulsion rates and bleeding profile, Mirena may be better tolerated than Paragard
- Insertion of an IUD may be more challenging in nulliparous women

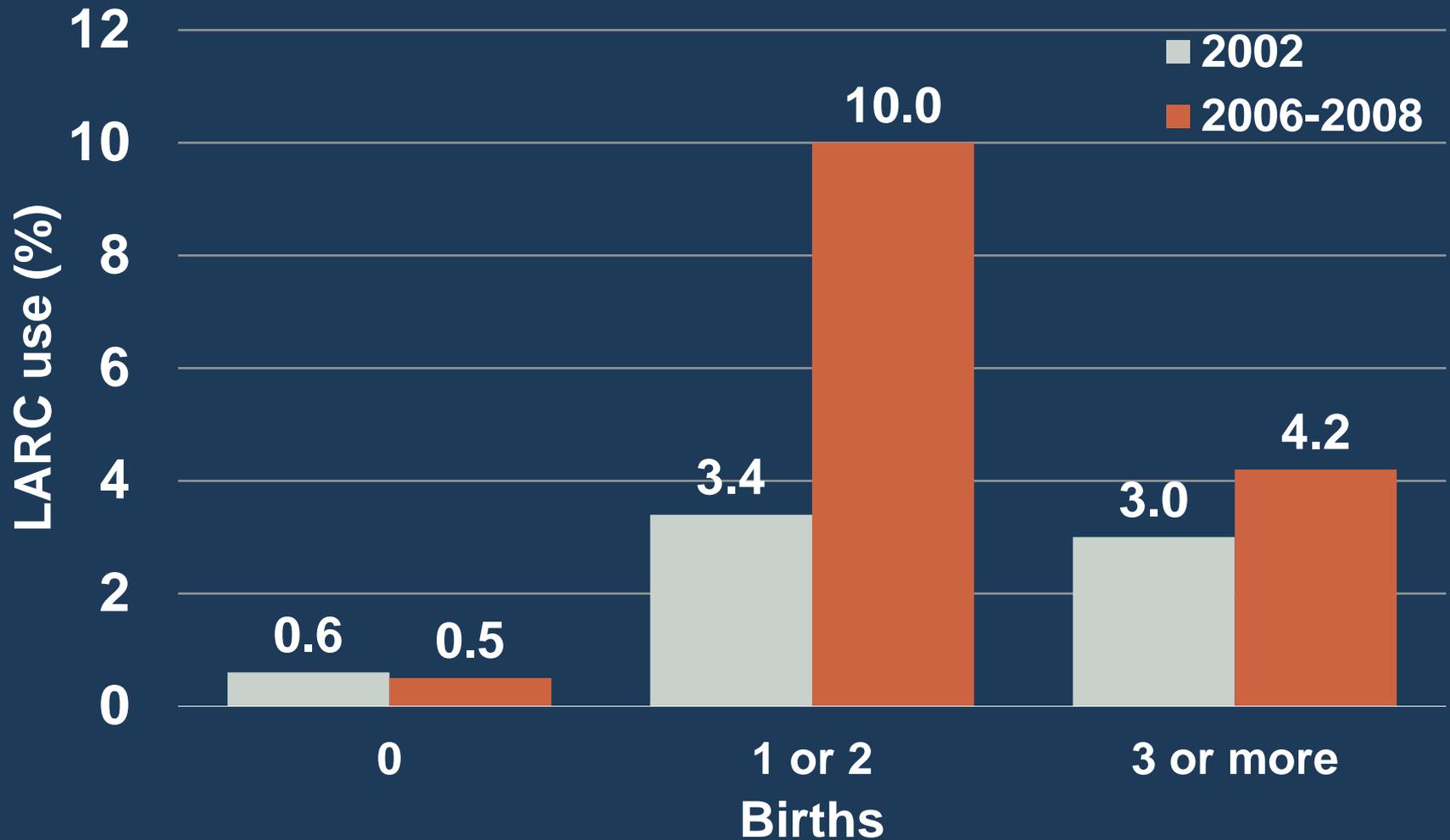
Since 2002, LARC use has increased within all age groups



But LARC methods are still unpopular among adolescent and young adult contraceptors



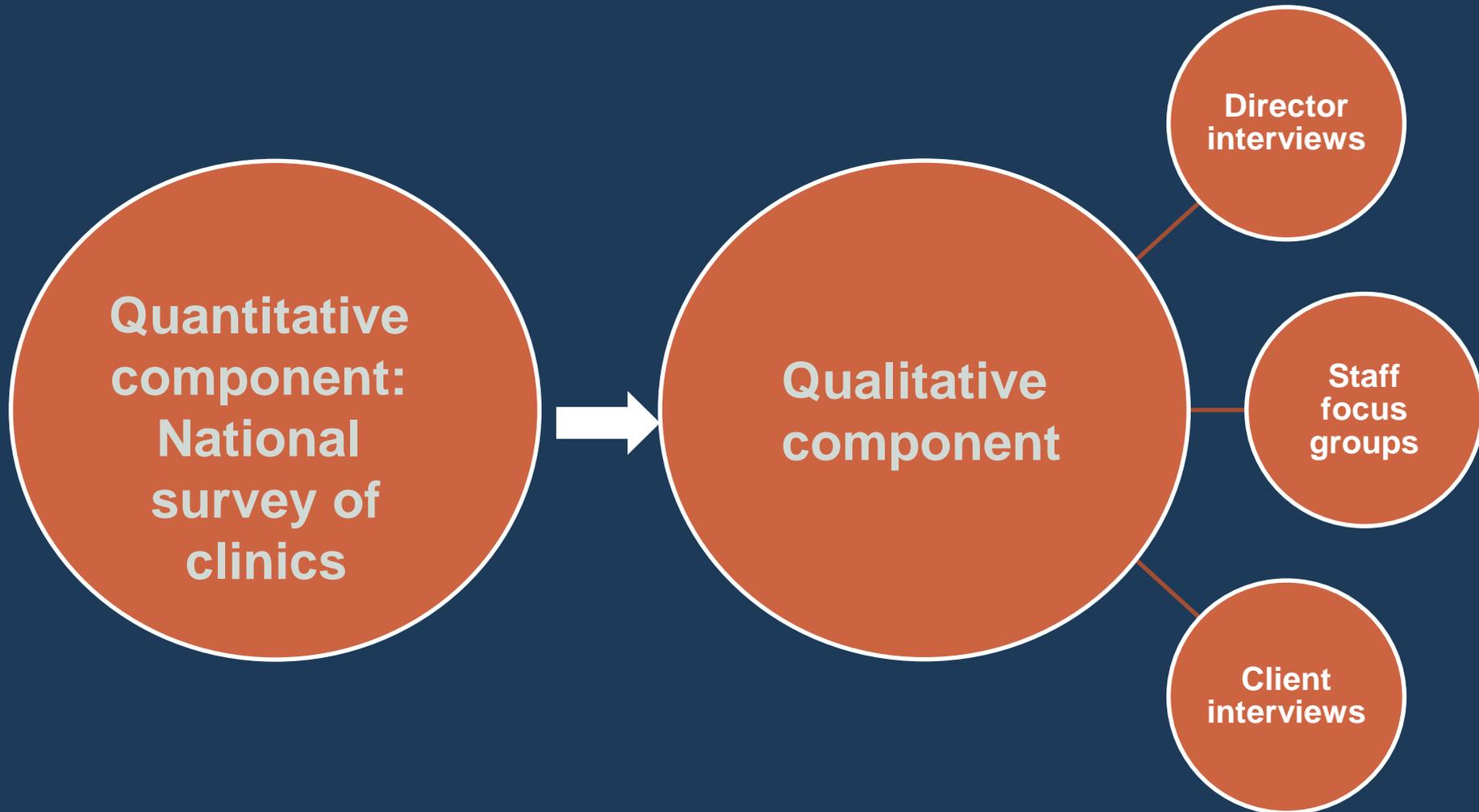
Women who have had 1 or 2 births are most likely group to use LARC



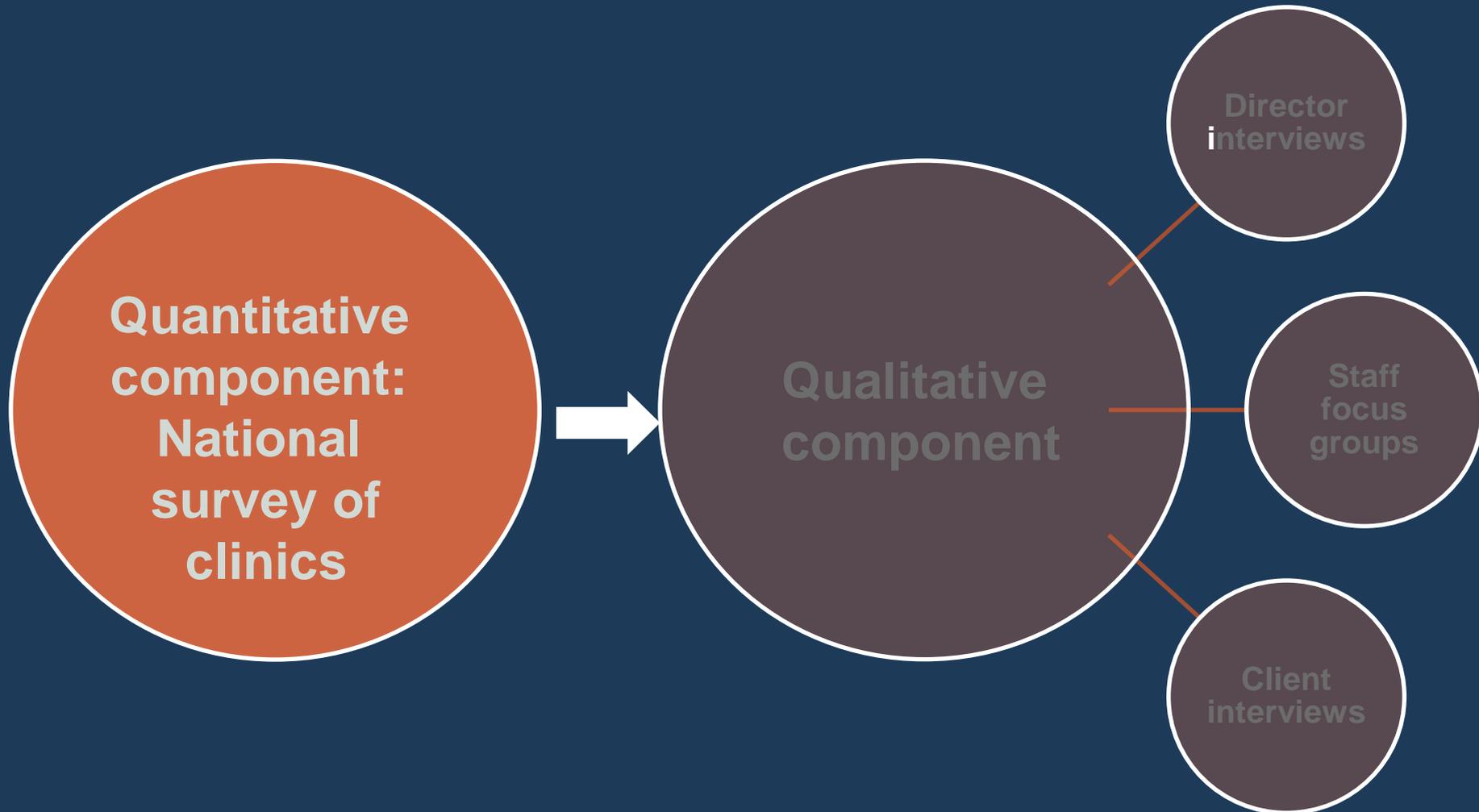
Goal of Guttmacher study

- To what extent is the provision of LARC methods integrated into services for adolescents and young adults?
 - Key barriers
 - Effective strategies

Mixed-method Approach



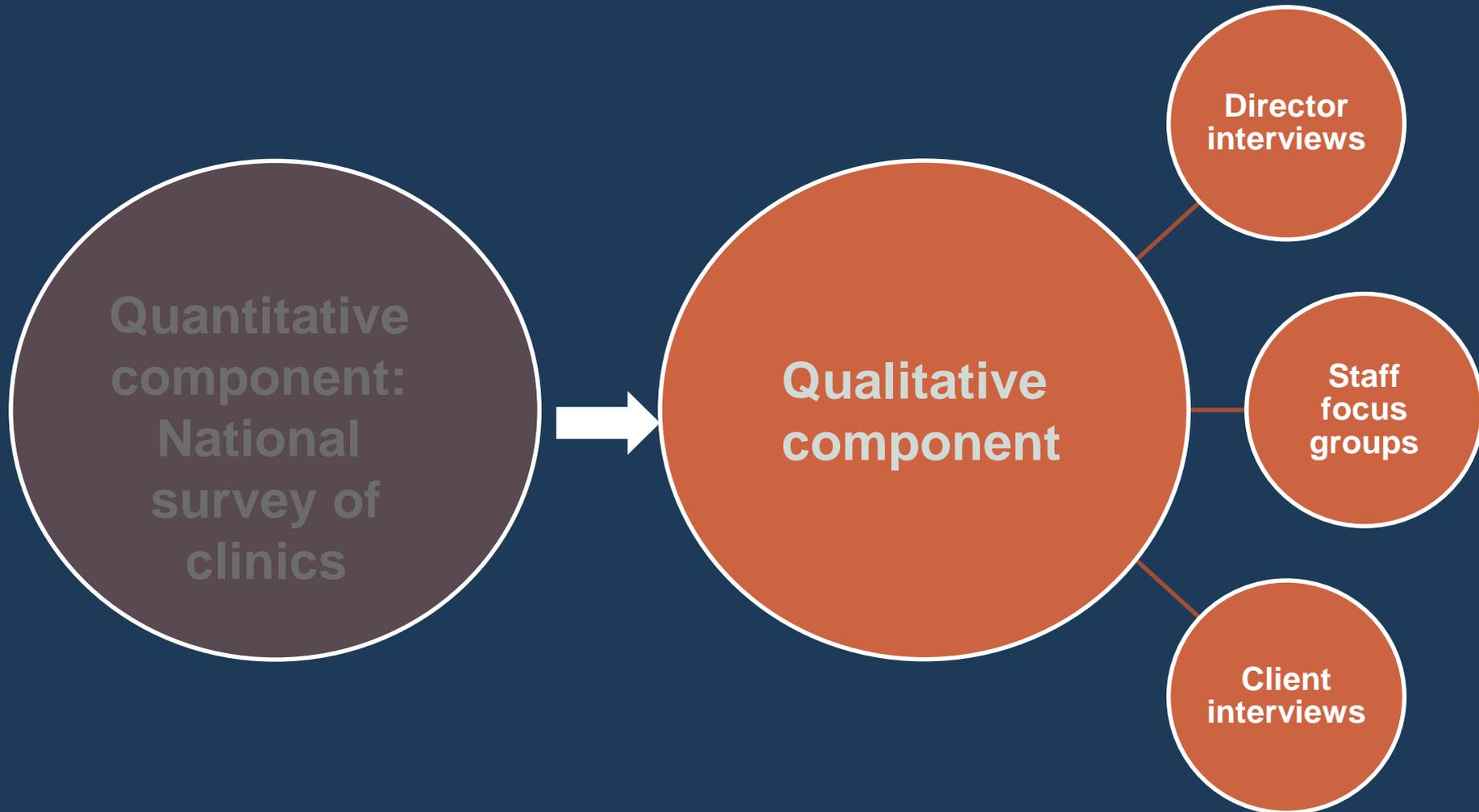
Mixed-method approach



Mixed-method approach: Quantitative survey of clinics

- Look at outreach efforts and services tailored to adolescents and young adults
- Examine provision of LARC methods
 - Staff knowledge and training
 - Practice and protocols
 - Use, availability and costs
 - Interest in increased access
 - Barriers

Mixed-method approach



Mixed-method approach: **Qualitative component**

- Identify Title X grantees with high and low LARC utilization among young women
- Grantees helped to identify clinic sites
- Conducted interviews/focus groups with
 - Clinic directors (N = 20)
 - Clinic staff (6 FGDs)
 - Clients (N = 48)

Key issues for directors and clinic staff

- Clinic approaches to reaching/serving adolescents, young adults generally
- Provision of LARC methods:
 - Attitudes
 - Workforce/training issues and needs
 - Counseling practices
 - Perceptions of patient attitudes and knowledge
 - Barriers and opportunities

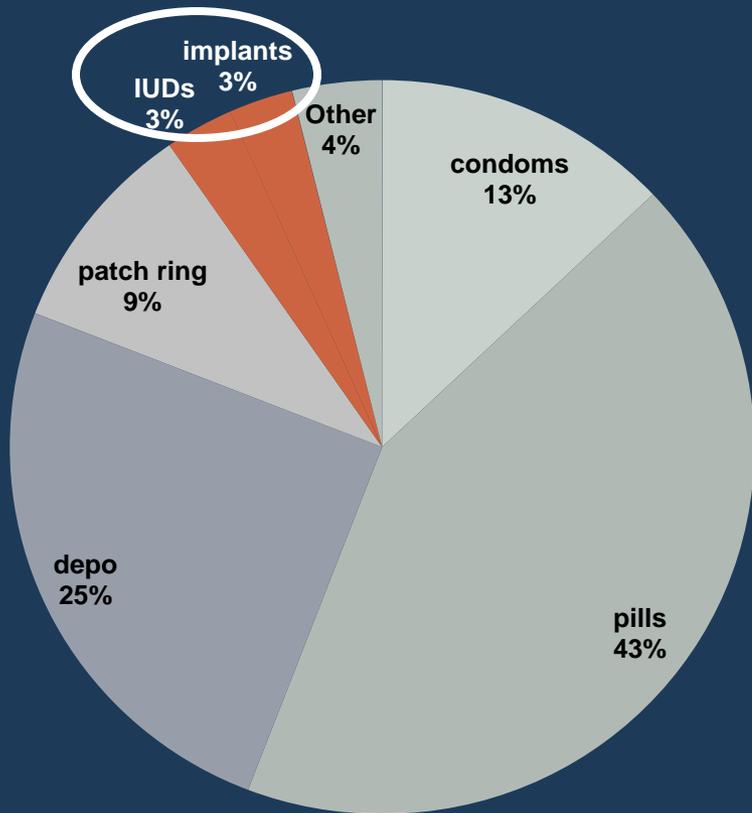
Key issues for clients

- Clients' priorities re locating, choosing, and accessing services
- LARC methods:
 - Attitudes
 - Knowledge
 - Experience
 - Interest
 - Concerns
 - Perceived stigma

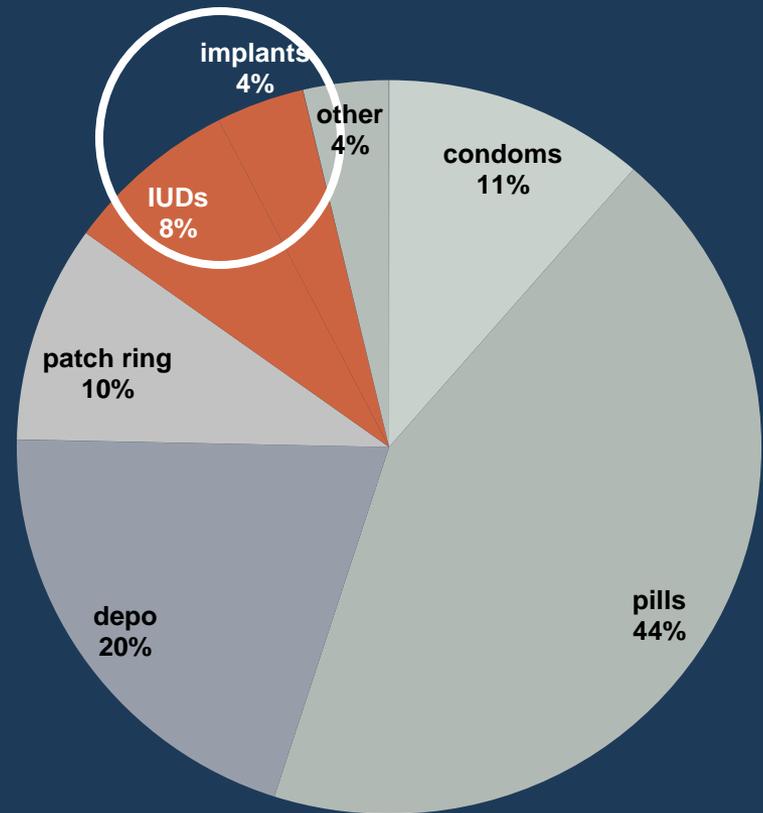
Results

LARC methods are more commonly provided to young adults than to teens

To teens



To young adults



LARC Use among Younger Patients

- Increases in LARC use among 15-24 yrs
 - IUDs: 47% of facilities
 - Implants: 37% of facilities
- Use of hormonal IUD (64%) more common than copper IUD (16%) among younger patients
- Most sites (74%) purchase LARCs and insert them on site
 - More common at PPs and hospitals, less common at HDs and FQHCs
 - More common at Title X-funded facilities

LARC Counseling

- Regular discussion of LARC methods with younger patients
 - IUDs: 43% discuss with teens, 58% with young adults
 - Implants: 41% discuss with teens, 46% with young adults
- Staff indicate that teens need extra time discussing and support around LARC methods
- Staff counsel teens to manage expectations of LARC with goal of preventing early removal

LARC Counseling

"It's the whole thing of knowing what to anticipate... knowing that teenagers have a higher rate of not letting it work and wanting it out... we just want to make sure they're fully educated, fully aware that, you know the side effects and what could happen... It's strictly, you know that, counseling and making sure they are aware, we want it to be successful for them and I think for them, to know what to expect, kind of even though it may be different for them and their body, I think that helps them to be successful if they're ready to anticipate what could happen."

- Director at high LARC utilization site

Staff training on IUDs is low

	Paragard (%)	Mirena (%)	Implant (%)
Staff trained	29	43	73
Staff scheduled for training	26	30	71

- Training at high LARC utilization sites more often included non-clinical staff
- Training on LARC methods came from several sources
 - Directors at low LARC utilization sites more often only described internal sources of training (in-house, shadowing, etc.)

Knowledge of LARC Methods among Younger Women

- Majority of patients knew about IUDs, more so than implants
- More detailed knowledge expressed among patients at high sites
- Young adults had more knowledge about side effects of LARCs
- Misinformation
 - Confusion about differences between IUD, implant, ring
 - Teens more often talked about IUD moving around
 - Young adults more often talked about health risks of IUDs

Knowledge of LARC Methods among Younger Women

“My friend, well a girl I go to school with, was saying that she got [the IUD] and I just, I feel like, I just don’t really like it because anything could go wrong. It might be positioned wrong or during intercourse something could happen and knock it wrong or break it or shove it somewhere it shouldn’t be, so I don’t really like them, I don’t think they’re the safest way to go, it could cause future problems in your uterus and you might not be able to have a proper pregnancy. I just never liked them.”

- Teen patient, high LARC utilization site

Candidacy for LARC Methods: Provider Perspectives

- Most directors and staff identified young women as appropriate candidates for LARCs
- LARCs are particularly useful for certain populations
 - Women who can't use hormones (copper IUD)
 - College women
 - Women in the military
- Some staff concerns about LARCs among non-monogamous or nulliparous women
 - *“And I think [another respondent’s] point is well taken and I will jump out there and say that adolescents have risky behavior and if they are using copper IUDs that don’t thicken the endocervical mucus then maybe there is some worry about upper tract infections and things like that.”*
- FGD participant, low site
 - *“For someone who’s a teen who has never been pregnant, again, I don’t think she would be a good candidate for it.”* - FGD participant, high site

Candidacy for LARC Methods: Patient Perspectives

- LARCs work well for young women's busy lifestyles
- LARCs cover young women through several life milestones (young adults)
- LARCs are ideal because young women forget pills and are irresponsible and lazy

Candidacy for LARC Methods: Patient Perspectives

“I think [IUDs and implants] are good for women my age because I think we all have 5000 things on our plate. Women my age are going to grad school and working full time and thinking about starting commitments like buying cars and stuff like that and they’re thinking about all of these big things that the day to day can slip right by. And so things like pills or...any other form of birth control that requires you to have any sort of planning in advance, that’s always inconvenient, so I think we’re just...young and probably stupid most of the time and making decisions on the fly and something like that, where it’s just done taken care of, check that off the list and move on with life, that’s probably good.”

- Young adult patient at low LARC utilization site

Pros vs. Cons of LARC Methods

Pros

- Discreet
- Effective
- Forgettable
- Reversible
- Beneficial side effects
- Long-lasting
- Limited user control
- Cost effective

Cons

- Location of methods
- Novelty of methods
- Foreign object in body
- Lack of STI protection
- Fear of insertion/removal
- Side effects
- Long-lasting
- Doctor controlled
- Costly

Pros vs. Cons of LARC Methods

Pros

- Discreet
- Effective
- Forgettable
- Reversible
- Beneficial side effects
- Long-lasting
- Limited user control
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Cons

- Location of methods
- Novelty of methods
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Staff Concerns about LARCs

- Anatomy of nulliparous women poses difficulties for IUD insertion
- Changes in guidelines means that IUD insertion may be patient's first gyne experience
- LARC users won't return to clinic
- Teens are impatient with side effects = discontinuation
"I just wish they were a little bit more open minded and a little bit more patient with possible side effects. I mean you have these young women that will go and chop off their hair and if they don't like it they'll think to themselves oh, it will grow back, but with birth control if like two days later they are having bleeding they call right away and they are like I want this taken out right now."

- FGD participant, low site

IUDs vs. Implants - Providers

- Staff leaned towards Implants over IUDs for young women
 - Insertion poses less challenges for providers, better tolerated by clients
- Exceptions to this preference were the side effects of Implants (bleeding) as well as patient perception of insertion

IUDs vs. Implants - Patients

- Length of Action

- *"I mean if you're getting in something inserted the one that lasts longer would be more appealing to me."*

- *Teen, low site*

- *"Three years does not sound as bad as 5, I would probably be willing to try that. [...] Again I don't know why it's so shockingly different when it's essentially the same idea but for whatever reason, 3 more years seems way more reasonable than 5 to me, again because I'm anti committal, shorter time."*

- *Young adult, low site*

IUDs vs. Implants - Patients

- Location

- *"I think I would rather go for the IUD if I had to choose between the two. [...] But it sounds kind of weird being under the skin of your arm [...] Just, you think, your uterus, that's going to prevent pregnancy because it's close to down there. The arm is far away."*

- *Young adult, low site*

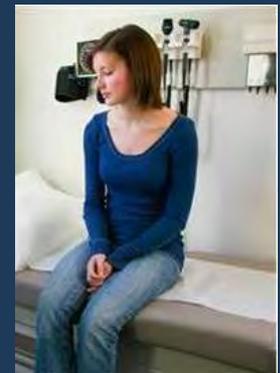
- *"I don't know if it's a biased observation of me because I just feel like putting something in your vagina is just weird. I felt like that would just affect children but then maybe under the skin wouldn't be as damaging maybe."*

- *Teen, low site*

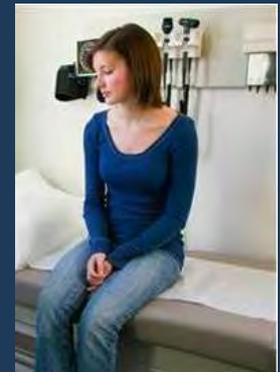
Challenges in LARC provision to adolescents and young adults

	%
Cost and reimbursement	
LARCs are too costly	60
Inadequate LARC reimbursement from private insurance	44
Inadequate LARC reimbursement from Medicaid	40
Staff concerns about IUD use in...	
Adolescents	47
Non-monogamous women	44
Women without children	40
More staff training needed	
Inserting implants	47
Inserting IUDs	38
Inadequate supply of LARCs available	44

Challenges to LARC Provision



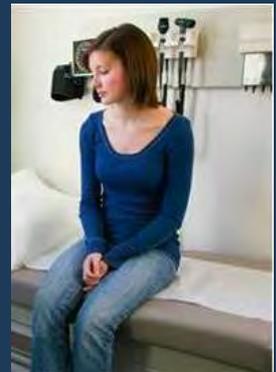
Challenges to LARC Provision



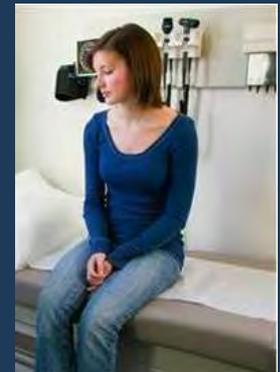
Protocols/policies



Challenges to LARC Provision



Challenges to LARC Provision



Challenges to LARC Provision



Limited time



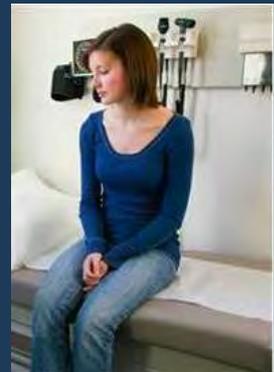
Staff resistance



Protocols/policies



High costs

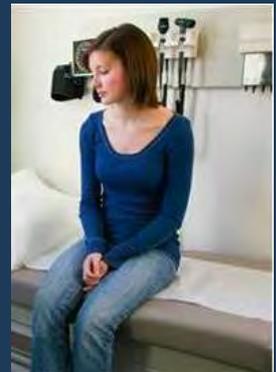


Challenges to LARC Provision

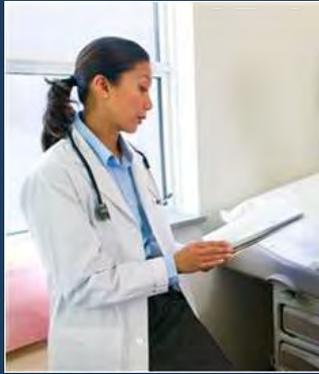
“So, when I, in this critical time of budget slashing and grants not being funded, if you ask me running this program, I love Depo. We were paying a quarter, a quarter, a vial two years ago for Depo. Now it is up to \$2.10. It is still a deal...So that’s my argument on the other side: the IUD costs me a lot more money. If she takes it out in three months, I’m crying. Even if the insurance company is paying for it that is a waste of a lot of money and provider time.”

- Director at high LARC utilization site

Challenges



Successful Strategies



Limited time



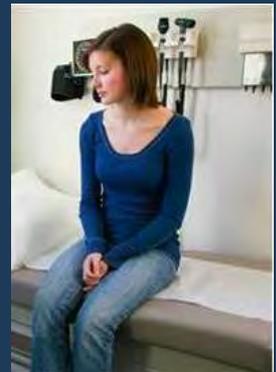
Staff resistance



Protocols/policies



Offer free or discounted LARCs



Successful Strategies



Limited time

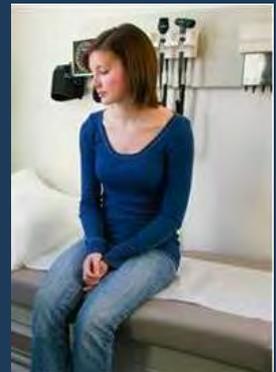


Train ALL staff, not just clinical staff

Protocols/policies



Offer free or discounted LARCs



Successful Strategies



Supplement counseling with other resources for info

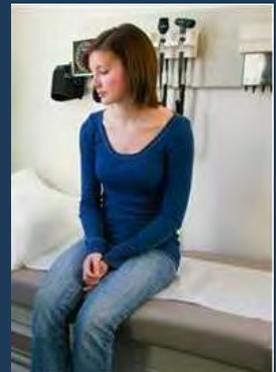


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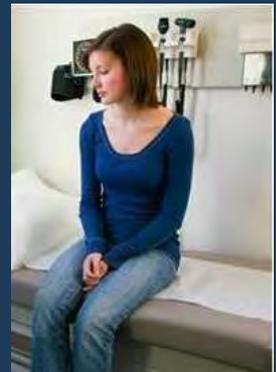


Train ALL staff, not just clinical staff

Increase awareness of guidelines for LARC provision



Offer free or discounted LARCs



Summary

- The majority of providers recognize the potential of LARC methods for young women
- Facility-related barriers around costs and logistics of providing LARCs are most common

**This work is supported by the Office of
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Thank you

www.guttmacher.org

