



FAMILY PLANNING COMMUNITY NEEDS ASSESSMENT

for the DC Family Planning
Project (DCFPP)



WASHINGTON AREA
WOMEN'S
FOUNDATION

Milken Institute School
of Public Health

THE GEORGE WASHINGTON UNIVERSITY



About Washington Area Women's Foundation

Washington Area Women's Foundation mobilizes our community to ensure that economically vulnerable women and girls in the Washington region have the resources they need to thrive. Since 1998, The Women's Foundation has worked to transform the lives of women and girls in the Washington region through research, grantmaking and advocacy.

As the Washington region's sole public foundation, specifically committed to investing in women and girls, The Women's Foundation works to create economic opportunities that have positive ripple effects across society and open doors to progress. An open door can change a woman's life, and the lives of those around her. But not all doors are open to all women. That's why we won't rest until all women, especially young women and girls of color, have equal access to economic security, safety and opportunity.

About the DC Family Planning Project (DCFPP)

The DCFPP, housed at Washington Area Women's Foundation (WAWF), is a city-wide coalition, comprising community members, advocates, health care providers, foundation leaders, government agency partners, and national experts working together to improve the quality of reproductive health services; increase community-wide awareness and understanding of birth control options; and remove barriers that impede access to and consistent utilization of birth control methods throughout the District of Columbia. WAWF engaged The George Washington University Milken School of Public Health to conduct this Family Planning Community Needs Assessment for the DCFPP.

About Milken Institute School of Public Health at the George Washington University

Established in July 1997 as the School of Public Health and Health Services, Milken Institute School of Public Health is the only school of public health in the nation's capital. Today, more than 1,900 students from 54 U.S. states and territories and more than 50 countries pursue undergraduate, graduate and doctoral-level degrees in public health.

District of Columbia Family Planning Community Needs Assessment

Conducted by
The George Washington University Milken Institute School of Public Health
for Washington Area Women's Foundation, DC Family Planning Project

GW Needs Assessment Research Team

Amita N. Vyas, PhD, MHS
Susan F. Wood, PhD
Megan M. Landry, DrPH
Leah E. Masselink, PhD
Holly K. Mead, PhD
Leighton Ku, PhD

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Executive Summary



Nationwide, the rate of unintended pregnancy, defined as those pregnancies that are mistimed or unwanted, is one of the highest in the developed world. Outcomes of unintended pregnancies can include an increased risk of adverse health outcomes for a woman and her child, as well as short- and long-term educational and economic consequences for the individual and society as a whole. In 2010, 62% of all pregnancies in the District of Columbia (DC) were unintended compared with 45% nationally.¹ In the same year, the federal and DC governments spent \$64.1 million on these unintended pregnancies through payments for prenatal, delivery, postpartum, and infant care for low-income women.² Further, although the unintended pregnancy rate has been declining in recent years in the general population, disparities remain. Poor and low-income women continue to bear the brunt of this disparity.³ Recent trends in DC reveal a decrease in overall pregnancy rates, especially for adolescents and young women, similar to trends occurring nationally. In fact, overall teen births (aged 15–19) dropped significantly from 879 births in 2011 to 501 births to teen mothers in 2015.⁴ Nevertheless, DC still had 25.6 births per 1,000 teens (aged 15–19) in 2015, higher than the national teen birth rate of 22.3 births per 1,000 teens.⁵ Additionally, teen births to mothers living in Wards 4, 5, 7 and 8 remain significantly higher than in other Wards of the city.⁶

Contraception is an essential component of overall health care. A woman's ability to obtain and correctly use contraceptives can positively impact her education and workforce participation, as well as subsequent outcomes related to income, family stability, mental health and happiness, and the well-being of her children.⁷ Studies indicate that teen pregnancy can impact a young woman's ability to graduate from high school and to enroll in and graduate from college.⁸ Access to family planning services, including both privately and publicly funded services is one necessary component to reducing unintended pregnancies, and more importantly, to ensuring women and families in DC have the ability to plan if and when to have a child.

The George Washington University Milken Institute School of Public Health (GW), with support from The Alexander and Margaret Stewart Trust and Washington Area Women's Foundation (WAWF), conducted a community needs assessment aimed at providing an in-depth analysis of the family planning landscape for women aged 15–29 in DC. This comprehensive community assessment, which includes both primary and secondary data, was designed, implemented, and analyzed between July 2017 and May 2018. A mixed-methods (qualitative and quantitative) approach was utilized and included: 1) a quantitative web-based survey of 53 family planning clinic/practice administrators; 2) 23 in-depth interviews with family planning providers; 3) a quantitative community survey with a purposive non-random stratified sample of 1,573 adolescents and women aged 15–29 living in or receiving health care services in DC across all eight Wards; and 4) nine qualitative focus groups with 40 women aged 15–29. Together, the synthesis of data across all components of the needs assessment identified gaps, barriers, and facilitators to family planning services and contraceptive utilization in DC.

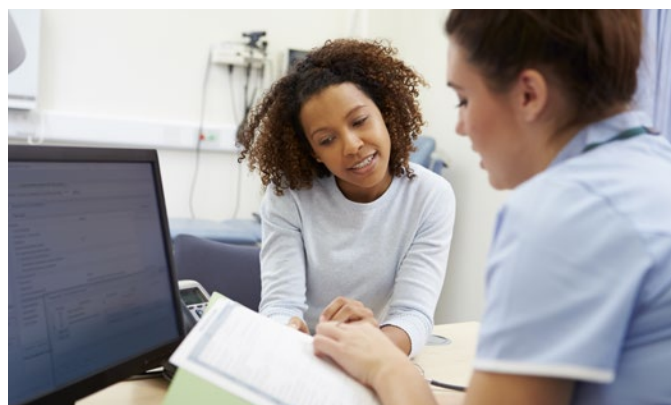
There are several key findings from this study that provide insights for both service delivery sites as well as for direct outreach to the community, including the following:

- a disconnect between availability of contraceptive services and utilization of these services;
- limited availability of adolescent-friendly services;
- widespread confidentiality concerns regarding adolescent reproductive health services;
- a significant number of sexually active adolescents and young women in DC who are not accessing reproductive health care at all;
- low levels of knowledge of Long Acting Reversible Contraceptive (LARC) methods (which include intrauterine devices (IUDs) and implants), particularly amongst 15–19 year-olds, non-Hispanic black adolescents/women and adolescents/women living in Wards 4, 5, 7 and 8; and
- negative perceptions and concerns about the safety, side effects, and comfort of LARC methods, which influence many women’s decisions regarding contraceptive methods.

The following recommendations stem from the key findings, as well as broader discussions with the DCFPP Community Advisory Board to identify potential next steps for improving reproductive health outcomes and reducing unintended pregnancy in DC:

1. Increase proactive clinic/provider outreach to the community in innovative, non-traditional settings to increase awareness of the availability of family planning methods and services.
2. Develop and make available more adolescent friendly and adolescent specific programs.
3. Expand development and implementation of confidentiality best practices and standards for adolescent reproductive health services.
4. Develop and implement new professional provider mentorship programs to increase the number of providers trained to provide comprehensive contraceptive counseling and device insertion.

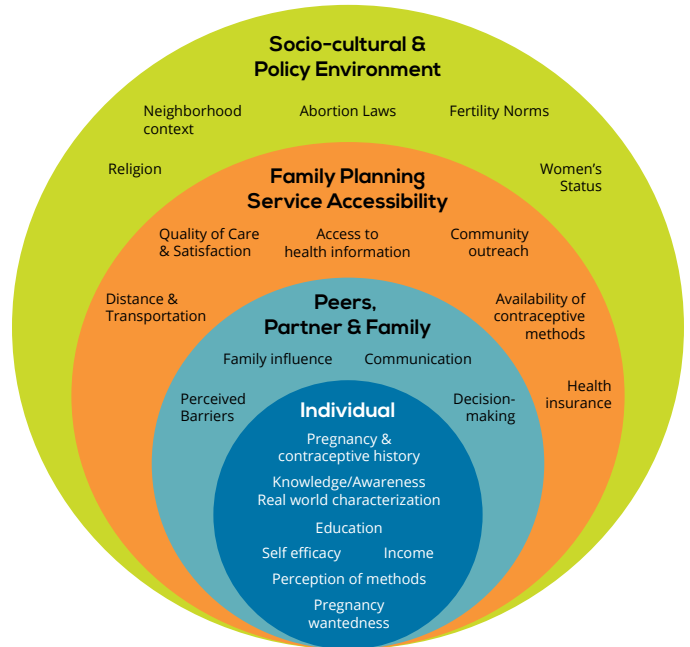
5. Develop, support and evaluate sustainable sexual and reproductive health counseling strategies that can improve understanding and facilitate fully informed decision-making by women seeking contraception.
6. Develop and implement a broad-based education and outreach campaign focused on increasing knowledge about the range of available contraceptive methods.
7. Build a community coalition to explore ways to acknowledge and address the role of race/racism, reproductive rights abuses, implicit bias, myths, misperceptions, and mistrust of the medical community on reproductive health care decision-making and outcomes.
8. Improve and support expanded comprehensive sexual health education in schools.
9. Expand access to and utilization of reproductive health services at school-based health centers (SBHCs).
10. Support expanded Medicaid reimbursement levels for reproductive health services, including non-clinician counseling services.
11. Advocate for and support more in-depth reproductive health training for medical professionals, including counseling approaches.
12. Expand upon and support current research to better understand young women’s reproductive goals and behaviors.
13. Establish a rigorous evaluation program to measure outcomes of interventions and campaigns.



Introduction

The George Washington University Milken Institute School of Public Health (GW), with support from The Alexander and Margaret Stewart Trust and Washington Area Women’s Foundation (WAWF), conducted a community needs assessment aimed at providing an in-depth analysis of the family planning landscape for women aged 15–29 in DC. This needs assessment is the first step towards developing a meaningful, culturally salient, and evidence-based intervention that would address multiple components that influence access to and availability of care, including eliminating structural barriers, training clinicians and staff, and encouraging community outreach/engagement. As such, the needs assessment was grounded in the social-ecological theoretical model (though not all components of the model were examined) (Figure 1.1). The findings from this assessment provide key insights for the DC Family Planning Project (DCFPP) to guide a potential city-wide intervention aimed at ensuring adolescent girls and women can make fully informed contraception decisions; access and consistently use their desired contraceptive method without barriers; and ultimately improve their health, well-being, and future opportunities.

FIGURE 1.1: A SOCIAL-ECOLOGICAL MODEL FOR FAMILY PLANNING



This comprehensive community assessment, which includes both primary and secondary data, was designed, implemented, and analyzed between July 2017 and May 2018. A mixed-methods (qualitative and quantitative) approach was utilized and included: 1) a quantitative web-based survey of 53 family planning clinic/practice administrators; 2) 23 in-depth interviews with family planning providers; 3) a quantitative community survey with a purposive non-random stratified sample of 1,573 adolescents and women aged 15–29 living in or receiving health care services in DC across all eight Wards; and 4) nine qualitative focus groups with 40 women aged 15–29. Together, the synthesis of data across all components of the needs assessment identified gaps, barriers, and facilitators to family planning services and contraceptive utilization in DC.



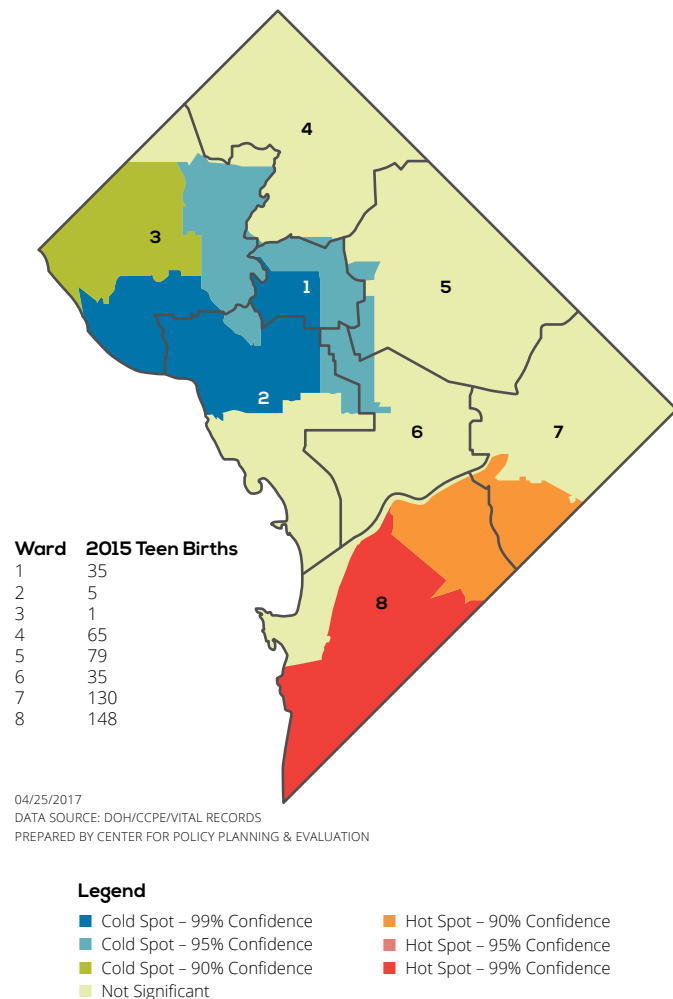
Background

In the United States, the rate of unintended pregnancy, defined as those pregnancies that are mistimed or unwanted, is one of the highest in the developed world. There are 61 million women of childbearing age in the United States and nearly half of the 6.7 million pregnancies each year are unintended.⁹ The unintended pregnancy rate has been declining in recent years, but disparities remain. Poor and low-income women continue to be more likely to experience unintended pregnancy at rates higher than women at higher income levels.¹⁰ Outcomes of unintended pregnancies also vary across subgroups.¹¹ Poor women are nearly seven times more likely to experience unplanned births which can carry an increased risk of adverse health outcomes for a woman and her child, as well as short and long-term educational and economic consequences.¹² These educational and economic consequences can be magnified for young people. Nationally, 75% of all teen pregnancies are unintended and teens account for 15% of all unintended pregnancies annually.¹³ Studies indicate that teen pregnancy interferes with a young woman's ability to graduate from high school and to enroll in and graduate from college.¹⁴ Conversely, planning, delaying, and spacing births can help young women achieve their educational and career goals.¹⁵

It is crucial that policymakers and practitioners understand the trends within state and local communities because national estimates often mask areas of need and existing geographic disparities. In 2010, 62% of all pregnancies in DC were unintended.¹⁶ 85% of the resulting unplanned births were paid for by public funds.¹⁷ The federal and DC governments spent \$64.1 million that year on unintended pregnancies in DC through payments for prenatal, delivery, postpartum, and infant care for low-income women.¹⁸

Recent trends in DC reveal a decrease in overall pregnancy rates, especially for adolescents and young women. The overall pregnancy rate (including both unintended and intended pregnancies) for women aged 15–44 in DC decreased between 2011–2015 by 11.5%, from 68 per 1,000 women to 60.2 per 1,000 women, and adolescents 15–19 had the largest decrease in pregnancy rates (54.5 to 31.7 per 1,000 women).¹⁹ Further, there were fewer pregnancies to girls under 15, down to 8 pregnancies and 5 births in 2015.²⁰ Women aged 20–24 saw the next largest decrease in pregnancy rates from 74.1 to 64.4 per 1,000 women of that age.²¹ Induced abortion rates also have reduced over time, with the overall rate decreasing from 11.7 per 1,000 women in 2011 to 7.0 per 1,000 women in 2015.²² The overall fertility rate in DC has been declining, dropping from 55.9 births per 1,000 women in 2011 to 52.8 births per 1,000 women in 2015.²³ Overall teen births (aged 15–19) also dropped significantly from 879 births in 2011 to 501 births to teen mothers in 2015.²⁴ Nevertheless, DC still had 25.6 births per 1,000 teens (aged 15–19) in 2015, higher than the national teen birth rate of 22.3 births per 1,000 teens.²⁵ Additionally, teen births to mothers living in Wards 4, 5, 7 and 8 remain significantly higher than in other Wards of the city.²⁶ As shown in Figure 2.1, the DC Department of Health has identified Ward 8 and part of Ward 7 as 'Hot Spots' for teen births, while much of Wards 1, 2 and 3 are considered 'Cold Spots' for the incidence of teen births.

FIGURE 2.1: HOT SPOT ANALYSIS OF DISTRICT OF COLUMBIA TEEN BIRTHS, 2015



Women who use contraceptives consistently and correctly throughout the year account for only 5% of all unintended pregnancies each year.²⁷ One reason that women have identified for contraceptive non-use is difficulty accessing the desired method.²⁸ Increasing access to all forms of contraception, including IUDs and implants, has been shown to have a significant impact on unintended pregnancy rates and other social determinants of health. A woman’s ability to obtain and correctly use contraceptives, which helps her to plan and space pregnancies, can positively impact her education and workforce participation, as well as subsequent outcomes related to income, family stability, mental health and happiness, and the well-being of her children.²⁹

Contraception is an essential component of overall health care. Over 99% of U.S. women of reproductive age who have engaged in sexual intercourse have used contraception at some point in their lifetimes, and nearly 90% of women at risk of unintended pregnancy are using a contraceptive method.³⁰ However, nationally 18% of adolescent girls aged 15–19 who are at risk of unintended pregnancy are *not* using a contraceptive method.³¹

Several factors influence contraceptive uptake: low-income women are more likely to be uninsured and experience difficulties accessing the most effective forms of birth control; women with private health insurance may have limited access to contraceptives due to high out-of-pocket costs such as deductibles or co-payments; and lack of knowledge about contraceptives, misconceptions about side-effects, and fear of health risks influence contraceptive decision-making. Further, in DC there is a substantial need for publicly supported family planning services for women with a family income less than 250% of the federal poverty level (approximately 35,000 women), and women younger than 20 years old (approximately 10,000 women).³²

As identified by the 2017 District of Columbia Health Systems Plan, there is also a wide range of social determinants of health and barriers to care facing many residents of DC. The major factors of poverty and race, along with housing insecurity, lower educational levels and health literacy, concerns about safety and violence, limited transportation, and the existence of food deserts all affect the ability to reach one’s full potential. Each of these factors, along with access to a trusted health care provider and supporting health care system, affect access to family planning services and prevention of teen and unintended pregnancy. Access to family planning services, including both privately and publicly funded services, is one necessary component to reducing unintended pregnancies, and more importantly, to ensuring women and families in DC have the ability to plan if and when to have a child.

Research Methods

The family planning community needs assessment included four major components and utilized both qualitative and quantitative methods: 1) a quantitative web-based survey of 53 family planning clinic/practice administrators; 2) 23 in-depth interviews with family planning providers; 3) a quantitative community survey with a purposive non-random stratified sample of 1,573 adolescents and women aged 15–29 living in or receiving health care services across all eight DC Wards; and 4) nine qualitative focus groups with 40 women aged 15–29. All study protocols were reviewed and approved by the George Washington University Institutional Review Board (#081702).

Clinic Survey

Study Design: A database of 76 family planning clinics/practices was created in consultation with the DCFPP Community Advisory Board, Internet searches, and through consultations with Title X family planning clinics, Federally Qualified Health Centers (FQHCs), and hospital outpatient services.¹ A cross-sectional quantitative survey was administered to each site to examine the structural and organizational landscape of family planning services in DC.

Clinic Survey Instrument and Measures: The survey included questions on patient demographics; organizational structure; clinic practices and protocols; services and accessibility; funding sources and insurance policies; communications and outreach; and facilitators and barriers to providing services.

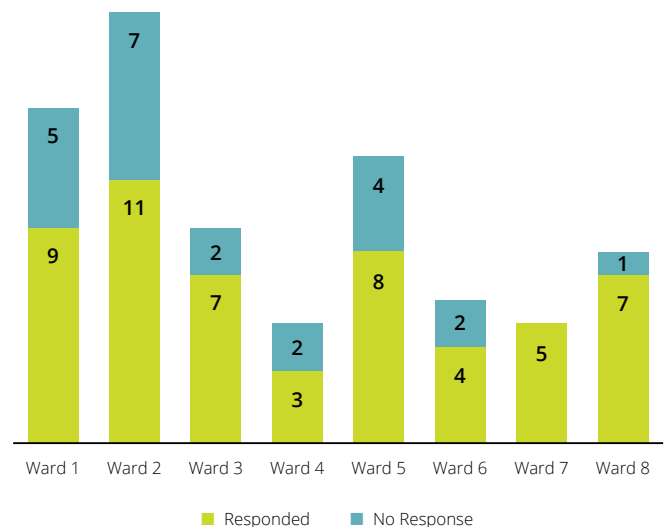
Data Collection Process: Clinic managers/administrators at all clinics (n = 76) were contacted via email addresses through a web-based tool, REDCap (Research Electronic Data Capture). The survey was sent through REDCap to clinics during September–November 2017. An introductory email with a link to the survey was sent to all clinics. For clinics with multiple sites, an

individual survey was completed for each site. One week after the initial survey was administered, clinics received a follow-up email reminder, and thereafter weekly reminder emails were sent to all non-respondents.

Data Analysis: Descriptive quantitative analysis was conducted, including examining differences by Ward and Title X status.

Description of the Clinic Sample: The final clinic sample included 53 clinics across Wards 1–8. The largest representation of clinics was found in Ward 2, which contained 20.4% (n = 11) of the sites surveyed, followed by Ward 1 (n = 9; 16.7%) and Ward 5 (n = 8; 14.8%). Clinics in Wards 3 and 8 were equally represented (n = 7; 13.0%), followed by Wards 7 (n = 5; 9.3%), 6 (n = 4; 7.4%), and 4 (n = 3; 5.6%). One survey was filled out for a clinic with locations in two separate wards (Ward 1 and 8).

FIGURE 3.1: CLINIC SURVEY COMPLETION BY WARD (N = 76; RESPONSE RATE = 69.7%)



Note: One clinic responded for two sites in different wards (1 and 8), and it is counted in each ward.

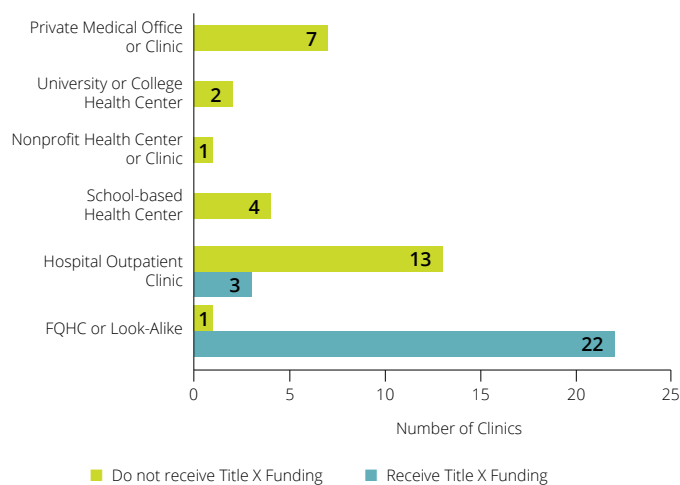
¹ Special emphasis was placed on identifying clinics/practices that serve low-income and publicly insured adolescents/women

As presented in Figure 3.1, the final sample represents a 69.7% response rate. It is important to examine the results with the understanding that despite all efforts, not all clinics responded to the survey, and therefore it is not fully comprehensive within each Ward.

A majority of sites surveyed (n = 23; 43.4%) identified as an FQHC or “look-alike.” Hospital outpatient clinics were the second most prevalent health center type (n = 16; 30.2%), followed by private medical clinics (n = 7; 13.2%). 7.5% of sites identified as a school-based health center (SBHC) (n = 4); 3.8% as a university or college health center (n = 2), and 1.9% as a nonprofit health center or clinic (n = 1).

The Title X family planning program is the only federal program focused on providing affordable, comprehensive, and confidential family planning services. Many of the FQHCs in DC which provide comprehensive primary care, are also Title X grantees, and have expanded their family planning services at their clinic sites. As shown in Figure 3.2, there is significant overlap between the clinics that have both of these major funding sources.

FIGURE 3.2: TYPES OF HEALTH CENTERS RECEIVING TITLE X FUNDING



Note: One clinic responded for two sites in different wards (1 and 8), and it is counted in each ward.

Provider Interviews

Study Design: In-depth semi-structured interviews were conducted with health care providers to understand their experiences providing family planning services to women and girls, and their perceptions surrounding barriers to contraceptive use, particularly LARCs.

Study Sample: A list of providers was developed in consultation with the DCFPP Community Advisory Board, and further snowball sampling identified additional providers. One-on-one interviews with family planning providers were conducted from October–December 2017. To achieve diversity for geography, clinic type, and provider type, providers were purposefully selected for an interview. Providers in Wards 4, 5, 7 and 8 were oversampled to ensure representation of areas of the city that have higher teen pregnancy rates and poorer birth outcomes. The final sample (n = 23) included providers from all eight DC Wards, and clinic types included FQHCs, SBHCs, non-profit Title X clinics, hospital outpatient clinics, and private practices. Interview participants included a variety of clinicians, including obstetrician-gynecologists (Ob-Gyns), advanced practice nurses, pediatricians and general practitioners, as well as a few individuals working with family planning and reproductive health programs in non-clinical roles.

Interview Guide and Measures: A qualitative interview guide was developed and included questions and probes regarding family planning needs and challenges of clinic patients, family planning services offered, insurance and funding issues, family planning education and counseling, staff/provider training, and barriers/facilitators women face when accessing family planning services.

Data Collection Process: Potential participants were invited via email with subsequent follow-up emails as needed. If a provider did not respond after the third email, another provider in a similar setting/location was contacted to take his/her place. Providers who responded to the email were given a detailed description of the study and verbal consent was obtained before beginning each interview. The telephone interviews each lasted between 45 and 75

minutes. All interviews were audio-recorded via WebEx software and subsequently transcribed for thematic analysis.

Data Analysis: Interview transcripts were coded based on a codebook with categories developed from the interview guide, and emergent categories/codes were added as they appeared in the data. A comparative grid was developed to compare and contrast providers' experiences and perceptions, and to identify common themes in the interviews.

Community Quantitative Survey

Study Design: An anonymous cross-sectional quantitative survey was conducted with a purposive non-random stratified sample of adolescents and women aged 15–29 either 1) living in DC, or 2) not living in DC but accessing health services in DC.

Study Sample and Sample Size/Power: The sample size was calculated based on the sufficiency of the study design to detect the current prevalence of contraceptive use among sexually active 15–29 year-olds in DC. A conservative estimate for contraceptive prevalence of 0.5 among sexually active females was chosen to yield a sample size sufficient to detect differences between age and Ward. Other sample size parameters included a margin of error of 2.5%, power of 80%, and an alpha level of 0.05. A purposive non-random sample with 24 strata (i.e., three, five-year age categories and eight DC Wards) was created based on the 2010 District of Columbia Census data. Additionally, women in the 15–24 age groups were oversampled by 50%, yielding a final target sample size of 876 sexually active 15–29 year-olds across the 24 strata.

Survey Instrument and Measures: The survey instrument was developed using previously tested and validated survey questions from studies the team has conducted with similar populations. Participants could choose to take the survey in either Spanish or English, and the survey took approximately 10–15 minutes for adolescents and women to complete. The survey included questions on socio-demographics, sexual behavior, contraceptive use, perceptions and knowledge

regarding safety and efficacy of contraceptive methods, sources of health information, and satisfaction with and priorities for high quality health care and family planning services.

Data Collection Process: Study participants were recruited at sentinel sites in all eight Wards, and via email listservs and social media sites. First, a list of sentinel sites by Ward was developed, including places where the target population is likely to be present such as shopping malls, retail stores, community centers, faith based centers and organizations, housing associations, youth associations, DC youth employment programs, and at neighborhood and cultural events. Data collection was conducted with trained graduate students and occurred between November 2017 and April 2018. The in-person survey was administered via mobile tablets. Second, a list of email listservs and social media sites (e.g., Facebook pages and Twitter) that cater to adolescents/women in this age group was developed. A short recruitment email containing an electronic link to the survey was sent to the moderators/administrators for these sites, and if permitted, posted to their members/followers. All survey respondents were entered into a raffle and/or given a \$5 Starbucks gift card for their participation.

Data Analysis: Descriptive and bivariate quantitative analysis was conducted, including examining statistically significant differences by age group (15–19, 20–24, 25–29); Ward (1–8, other); and race/ethnicity (non-Hispanic black, non-Hispanic white, non-Hispanic other, Hispanic).

Description of the Study Sample: The total sample size yielded was 1,573 with 1,029 adolescents/women who have ever had sex. Although a stratified sampling method was used to ensure representativeness by both age and Ward, the total sample recruited was not fully representative of DC demographics by race. Thus, the final analytic sample was weighted for subsequent analyses. (Table 3.1).

TABLE 3.1: DEMOGRAPHIC CHARACTERISTICS OF STUDY PARTICIPANTS (N = 1,573)

	Total N (%)	Total Weighted (%)	Ever Sex N (%)	Ever Sex Weighted (%)
Age group				
15-19	633 (40.2)	45.6	233 (37.5)	36.7
20-24	594 (37.8)	33.0	486 (82.5)	83.6
25-29	346 (22.0)	21.4	310 (89.6)	90.9
Ward				
1	180 (11.4)	12.1	140 (78.2)	80.6
2	241 (15.3)	10.9	173 (72.1)	70.5
3	219 (13.9)	11.2	156 (71.2)	75.6
4	114 (7.2)	11.2	63 (56.8)	57.6
5	159 (10.1)	10.1	91 (57.6)	49.4
6	128 (8.1)	10.0	96 (75.6)	74.5
7	108 (6.9)	9.3	49 (45.8)	39.6
8	123 (7.8)	9.5	59 (49.2)	49.3
Other	261 (16.6)	15.8	178 (69.0)	68.2



TABLE 3.2: DEMOGRAPHIC CHARACTERISTICS OF STUDY SAMPLE BY AGE GROUP (N = 1,573)

	Total %	% of 15–19	% of 20–24	% of 25–29
Race*				
American Indian or Alaskan Native	0.8	1.4	0.4	0.1
Asian	5.9	3.9	8.4	6.1
Black or African American	43.5	76.0	15.1	18.0
Native Hawaiian or Other Pacific Islander	0.3	0.5	0.2	0
White	45.1	15.4	71.6	67.0
Other	7.5	4.6	8.1	12.4
Hispanic/Latina	10.0	8.6	10.2	12.7
Marital Status				
Married	7.0	2.3	3.0	15.4
Living with someone	15.9	2.7	15.1	23.1
Not married/single	77.1	95.0	81.9	61.5
Household Income				
Less than \$25,000	28.8	47.8	35.6	9.8
\$25,000 – \$34,999	7.0	8.8	6.7	6.8
\$35,000 – \$49,999	11.2	10.6	10.6	12.5
\$50,000 – \$74,999	20.0	10.0	16.7	29.5
\$75,000 – \$99,999	10.3	7.4	11.0	10.6
\$100,000 – \$149,999	14.9	9.2	13.8	19.1
\$150,000 or more	7.8	6.2	5.7	11.8
Highest Level of Education				
Less than high school	3.5	18.3	1.3	0
High school graduate or equivalent (GED)	14.3	48.9	11.3	3.2
Some college credit but no degree	16.1	28.3	19.7	5.0
Associate degree	2.0	3.5	1.2	2.5
Bachelor's degree	47.8	0.4	60.5	49.9
Master's degree	14.3	0.5	5.4	34.2
Professional degree	1.4	0	0.7	3.1
Doctorate degree	0.7	0	0	2.0
Insurance Status*				
None	5.1	7.8	2.9	3.01
Private through employer	43.0	20.0	56.0	69.0
Medicaid	19.5	32.1	10.1	8.3
A health plan through DC Health Link or healthcare.gov	4.7	4.4	2.1	9.2
DC Healthcare Alliance	2.1	3.3	0.8	1.9
Medicare	3.3	7.0	0.4	0.3
Other private health insurance plan that you bought yourself	4.5	5.4	3.8	3.6
Other private insurance purchased by someone else	18.0	14.1	31.0	6.0
Don't know	12.5	26.7	1.2	1.2

* The total for this category exceeds 100% because respondents could select more than one option (i.e. respondents could choose all options that applied).

Table 3.2 presents the weighted demographic characteristics by age. As shown, a little less than half of the sample identified as white (45.1%) or as black (43.5%), with 10% reporting Hispanic/Latina ethnicity. The majority of the sample was single/not married across all age categories (77.1%). More than one-third of the sample is 15–17 years old. 94.1% of 15–17 year-olds are enrolled in school (data not shown). Excluding the 15–17 year olds, this is a fairly educated sample with more than 60% receiving a Bachelor’s degree or higher. This is consistent with the 2010 District of Columbia Census Data that reports 55% of the population has received at least a Bachelor’s degree. Income level was asked of survey participants 18 and older, whereas 15–17 year-olds were asked about receiving free/reduced lunch at school, which is a proxy measure for income-level. 73.2% of those enrolled in school receive free and reduced lunch (data not shown). Total uninsured (5.1%) is low, which is in line with the overall uninsured rate in DC (5.2%). It is important to note that 7.8% of adolescents and young adults aged 15–19 years-old report not having insurance which may reflect adolescents not knowing their health insurance status, and therefore, the uninsured prevalence in the sample may in fact be lower. The majority of adolescents reported Medicaid as their type of health insurance (32.1%) compared to the majority of 20–24 and 25–29 year-olds who report private insurance through an employer (56.0% and 69.0%, respectively).



Community Focus Groups

Study Design: Focus groups were conducted to better understand the following: 1) experiences and preferences related to birth control/family planning; 2) communication and satisfaction with family planning providers; 3) perceptions about contraceptive methods; and 4) barriers to utilizing contraception and family planning services. The research team developed a focus group guide and DCFPP Community Advisory Board members reviewed the guide for appropriateness, relevance, and comprehension.

Recruitment and Data Collection: The research team worked with staff members at FQHCs, SBHCs, and a peer education group active in DC public high schools to pass out flyers and invitation cards to adolescent girls and women in the community. Nine focus group discussions were conducted from January 2018–April 2018. Focus groups were held in two DC public libraries (n = 6), an FQHC (n = 2) and an SBHC (n = 1). Two research team members served as moderator and note-taker for each discussion. Discussions ranged from 90 to 120 minutes in length and were audio recorded. Additional summary notes were recorded by the co-facilitator. Focus group participants were informed of the purpose of the project, the voluntary nature of participation, as well as the risks and benefits of participating. Informed consent was obtained prior to the start of the focus group. Participants received a \$25 gift card for their participation.

Focus Group Participants: There were four groups with adolescent girls (ages 15–19) and five groups with adult women (ages 20–29); eight focus groups were in English and one in Spanish. Eligibility criteria included adolescents and women ages 15–29, living and/or receiving health care services in DC, and being willing to engage in a group discussion about contraception and reproductive health care services. A total of 40 individuals participated in the focus group discussions. Adolescents and women from all eight Wards of DC participated in the discussions. (Table 3.3).

TABLE 3.3: DEMOGRAPHIC CHARACTERISTICS OF FOCUS GROUP PARTICIPANTS (N = 40)

	n	%
Age		
15-17	16	40.0
18-21	10	25.0
22-25	9	22.5
26-29	5	12.5
Education		
Eighth grade or less	1	2.5
High school (ninth-twelfth grade)	23	57.5
Some college or 2-year degree	5	12.5
Bachelor's degree or higher	11	27.5
Race/ethnicity		
Asian	1	2.5
Black or African American	24	60.0
Other (Hispanic)	3	7.5
Other (Mexican American)	1	2.5
White	8	20.0
Mixed Race	1	7.5
Household income		
Less than \$25,000	6	15.0
Between \$25,000 and \$49,000	10	25.0
Between \$50,000 and \$74,000	1	2.5
Between \$75,000 and \$99,000	2	5.0
More than \$100,000	4	10.0
Don't know	16	40.0
Type of health insurance		
Medicaid	17	42.5
Private, commercial	14	35.0
Other (school-based)	1	2.5
Don't know	8	20.0



Data Analysis: The focus group transcripts were manually analyzed for themes using a set of predetermined codes based on the focus group guide. Revisions were made to the codebook as new themes emerged from the data, and a comparative grid was used to compare participants' experiences and identify common themes.

Limitations

It is important to note the following limitations when interpreting the findings in this report. First, the 69.7% response rate for the clinic survey means that one must be cautious not to make broad generalizations about gaps in services within a particular Ward when interpreting the analysis by Ward. In addition, clinic responses are self-reported and not verified by the investigators. Second, the focus groups potentially yielded a biased sample as the adolescents and women had to have been willing to discuss sexual and reproductive health and may not represent adolescents and women most in need. And finally, the needs assessment was conceptualized to focus on LARC methods and therefore greater depth of knowledge/perceptions with respect to other methods was not captured in the study.

Key Findings

There are several key findings from this needs assessment that provide insights for both service delivery sites as well as for direct outreach to the community. The key findings presented stem from synthesis of the data across all of the study components and have been categorized into four areas:

- A) Access to contraception;
- B) Facilitators and barriers to contraceptive access and use;
- C) Knowledge/education of adolescents and women in the community and clinic outreach; and
- D) Perceptions, perspectives, and behaviors related to contraceptive methods and services.

Access to Contraception

Key Finding 1: Contraceptive Methods are Widely Available in DC

Overall, most clinics surveyed provide a wide range of contraceptive methods on-site, and the majority of surveyed clinics prescribe *and* dispense Depo Provera, IUDs, and implants. Further, these methods are usually available on the same day *at the same appointment*.

- 82.0% of surveyed clinics prescribe and dispense Depo Provera.
- Over 70% of surveyed clinics provide and insert/place IUDs.
- Nearly 90% of surveyed clinics provide and insert/place contraceptive implants.

However, there is some variability across Wards, with Ward 3 generally having lower on-site availability, and Wards 5–8 having higher on-site availability of methods. Overall, more than three-quarters of all clinics surveyed provide same-day appointments, and most provide

after-hours access as well. In Wards 1, 4, 6, 7 and 8, all clinics surveyed provide same day appointments for established patients, and all clinics surveyed in Wards 4, 6, 7 and 8 provide same day appointments for new patients seeking an initial contraceptive visit.

Clinics also reported on how often they utilize specific protocols and practices known to enhance contraceptive availability, and the majority of clinics report that they adhere to the following best practices:

- Prescribing of oral contraceptives using the ‘Quick Start’ methodⁱⁱ (61.2%);
- No requirement of a pelvic exam for prescribing oral contraception (68.0%);
- Provision of IUDs and implants to adolescents and young adults (78.3%); and
- Provision of IUDs to nulliparous women (77.6%).

However, clinics are less likely to offer emergency contraception:

- Emergency contraception medication is not usually prescribed or dispensed ahead of time (16.7%).
- The copper IUD is rarely provided as emergency contraception (4.4%).

Most clinics also reported that they provide materials and translation/interpretation services and provide low/no cost services:

- A large majority of health clinics report that they are providing multilingual educational materials and translation/interpretation services either by clinic staff or by the health care provider. Less than 6% of surveyed clinics reported that they do not provide interpretation services.
- Most Wards have clinics that will provide services on a sliding scale, with the majority offering no-cost service.

ⁱⁱ A method involving initiation of the contraceptive method on any day of the menstrual cycle

“Teens said—and this really stuck with me—when you’re doing something new you need to have all of your courage because you don’t know what’s going to happen. And sometimes you have your courage and then a small thing happens and ruins it—[for example] at the check in desk they ask to confirm parent’s address and phone number and then the teen thinks ‘oh no, my parents are going to find out.’”

Reproductive Health Program Coordinator

Key Finding 2: Adolescent-Specific Services are Available, but Limited

Many clinics surveyed, especially those in Wards 4, 7 and 8, reported offering adolescent-friendly services such as:

- Services tailored specifically for adolescents (65.3%);
- Collaboration with other organizations on teen outreach (62.2%); and
- Confidentiality through separate contact information (65.3%).

However, clinics across DC are less likely to offer adolescent-only hours or days for services (30.0%). Available services appear to address some, but not all, of the factors identified by 15–19 year-olds as being “very important” in choosing a family planning provider:

- Approximately 60% of survey participants reported that confidential services are very important.
- Close to 50% of survey participants reported that clinic hours that fit their schedules are very important.

Likewise, providers who were interviewed identified confidentiality as a concern for their younger patients and stated that teens frequently indicate that “fear of their parents finding out” can stop them from accessing services, or can motivate them to seek family planning methods that are difficult for parents to detect. Further, scenarios such as processing insurance claims and coordination with other providers (e.g. pharmacies and labs) also raise concerns that parents could find out about adolescents’ use of family planning services.

Finally and importantly, providers who worked with school-based health centers (SBHCs) noted that the uneven access for teens with and without access to SBHCs is a significant barrier to the provision of family planning services to all teens in DC.

Facilitators and Barriers to Contraceptive Access and Use

Clinic administrators and adolescents/women were asked about a variety of factors that either facilitated access to contraception (“facilitators”) or created barriers to accessing contraception (“barriers”). The survey options available to clinic administrators for rating the various facilitators and barriers were: “major facilitator/barrier,” “minor facilitator/barrier,” or “not a facilitator/barrier.” Additionally, provider interviews and focus group discussions with adolescents and women identified additional facilitators and barriers. The following information summarizes facilitators and barriers identified through all of these study components (i.e. surveys, interviews, and focus groups).

Key Finding 3: Public Funding of Health Care Services, and Insurance Coverage are Greatest Payment-Related Facilitators to Contraceptive Access

- 47.2% of surveyed clinics receive Title X family planning funding, and 43.4% are Federally Qualified Health Centers (FQHCs) with Section 330 funding. Only 7.5% receive DC family planning-specific funds. When examining access to methods by Title X status, it is clear that Title X family planning funding is associated with higher on-site availability of all methods.

- DC is unique for its low uninsured rate (less than 4% in 2016) and generous Medicaid eligibility criteria, so clinics encounter relatively few patients without health insurance coverage.
- No copay coverage of contraception facilitates access, particularly for clinics that do not receive Title X family planning funding.

Key Finding 4: Inadequate Reimbursement and Confidentiality Concerns are Major Payment-Related Barriers

- Clinic administrators consistently identified an inadequate level of insurance reimbursements/ payments as a major (43.2%) or minor (27.3%) barrier. This concern was particularly highlighted by Title X funded clinics (70.0% considered it a major barrier). FQHCs also reported reimbursement barriers related to how the Medicaid Prospective Payment System (PPS) rates work, and the need to cover medical devices separately. This creates a barrier to stocking and inserting IUDs.
- Additional major barriers identified by clinics include lack of insurance by patients (20.4% major barrier) and high out-of-pocket costs (14.0% major barrier) for patients, which may reflect an inability to bill insurance due to confidentiality concerns, rather than actual lack of insurance.
- Interviewed providers indicated that confidentiality concerns often preclude school-based health centers (SBHCs) from billing for reproductive health care services, thus creating a financial barrier. (Note: SBHCs see patients regardless of ability to pay; however, absent the aforementioned confidentiality concerns, they generally bill insurance companies for services provided to insured patients).
- Providers reported that some insurance plans cover some birth control pills but not others.
- Medicaid has removed pre-authorization requirements, but some private insurance plans still require pre-authorization for certain services.



Key Finding 5: Method Availability and Trained Staff are Major Practice-Related Facilitators

- Many clinics report that the increased availability of LARCs and other hormonal methods is a major (59.1%) or minor (25.0%) facilitator in meeting the family planning and reproductive health needs of their patients.
- A large majority of clinic administrators identified having staff members who are trained in insertion of implants (65.3%) and IUDs (58.3%) as a major facilitator.
- To a lesser extent, clinic administrators perceive that patient awareness of methods, dedicated clinic hours for special populations, and increased in-house systems to improve efficiency of provision of LARCs are facilitators.
- The approaches most likely to be identified as “not a facilitator” were use of ‘Electronic Health Record’ (EHR) clinician prompts regarding postpartum contraception (70.0%), dedicated hours for specific populations such as adolescents (51.2%), and comprehensive sex education in schools (46.9%).

Key Finding 6: Clinical Time Constraints are Major Practice-Related Barriers

- Providers indicated that clinical time constraints create the following limitations:
 - limit providers' ability to provide in-depth counseling and education of patients about their options, causing some providers to worry that patients could feel pressured or coerced to choose a method before they are ready.
 - often make it impossible to offer same day IUD insertions, especially for patients who need lengthy counseling sessions.
 - make it difficult for providers who are learning to insert IUDs to be trained and to practice insertions with supervision from other clinicians.
- Interviewed providers indicated that the limited skill, comfort and confidence of internal medicine physicians, family practice physicians, and pediatricians is a barrier. Although these providers may be trained in IUD insertion and removal, they are less experienced with providing these services and have varying interest in expanding their knowledge of and experience providing them.
- Nevertheless, only 16.0% of clinic administrators surveyed identified lack of staff training in IUD procedures as a major barrier.
- Those issues identified as “not a barrier” include lack of space for stocking (89.8%), religious or moral concerns (89.6%), and lack of culturally or linguistically appropriate materials or services (83.7%).

“I would say more generally... but just in general the biggest barrier to effective family planning in the broader context of health care is that we don't have enough time to counsel patients. Providers are on this treadmill to get them in, get them out, get them in, get them out, especially as reimbursements have fallen. So we don't have 20 minutes to really talk about benefits and risks and really understand what their reproductive priorities are, and what kind of adverse effects profile is going to be something that they can live with, and go through the entire consent form and make sure they get every piece of it.”

Hospital-affiliated and SBHC CNM/NP



Key Finding 7: Providers Identified Patient Perceptions, Safety Concerns, and Suspicions as Major Patient-Related Barriers to Care

- Providers reported that some patients have significant concerns about the safety of contraceptive methods.
- Patient perceptions and concerns about side effects, and about the long-term impact of family planning methods on their health and future fertility, impact patients’ willingness to use these methods. Such perceptions are particularly prevalent regarding hormonal methods that alter menstrual cycles.

- Providers report that patients sometimes are reluctant to try certain family planning methods because of negative stories they have heard about the experiences of friends, family members, and others on social media, etc.
- Some patients are uncomfortable with the idea of having IUDs and other devices inserted in their bodies and being unable to remove them without going back to a provider.
- Providers indicated that patients’ ambivalence regarding pregnancy intention or desire influences contraceptive counseling and shapes provider likelihood to recommend specific methods.

“They say the pill makes you real big. And I’m already big and I don’t need to be bigger.”
Teen participant

“I heard that you shouldn’t start too young because you don’t want to be on birth control for too long.”
Teen participant

“I heard that Depo gives you cancer.” *Teen participant*

Key Finding 8: Adolescents/Women Identify Access to “The Birth Control I Want” and to Respectful, Attentive, Confidential Services as Important Factors in Choosing Providers

FIGURE 4.1: FACILITATORS AND BARRIERS, PROVIDER/STAFF CHARACTERISTICS

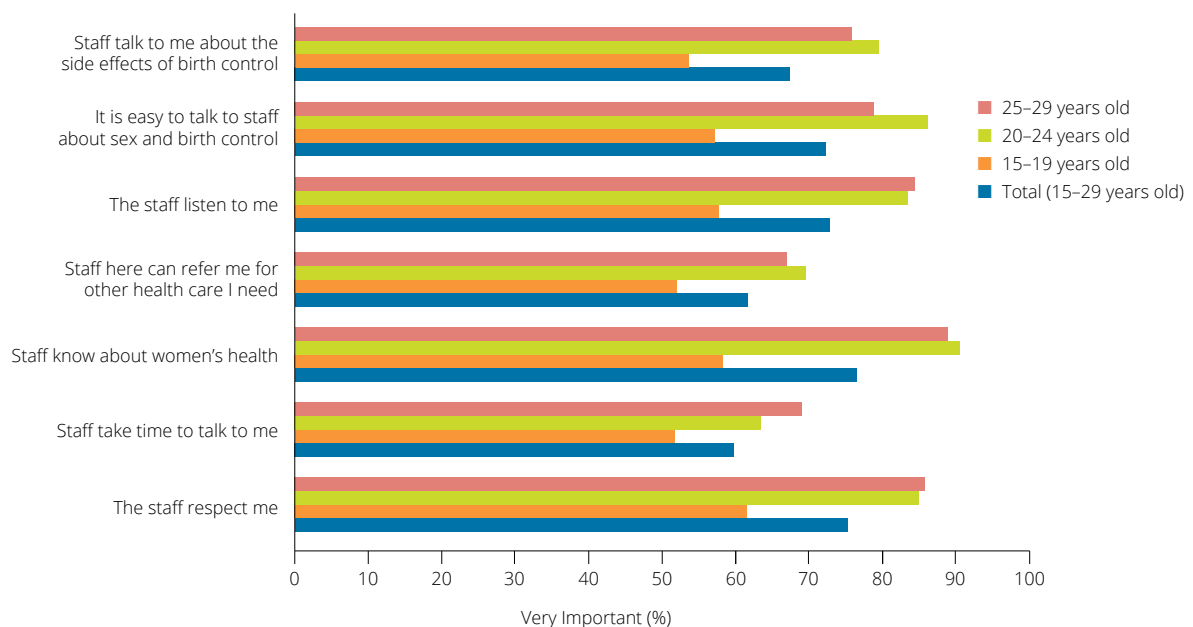
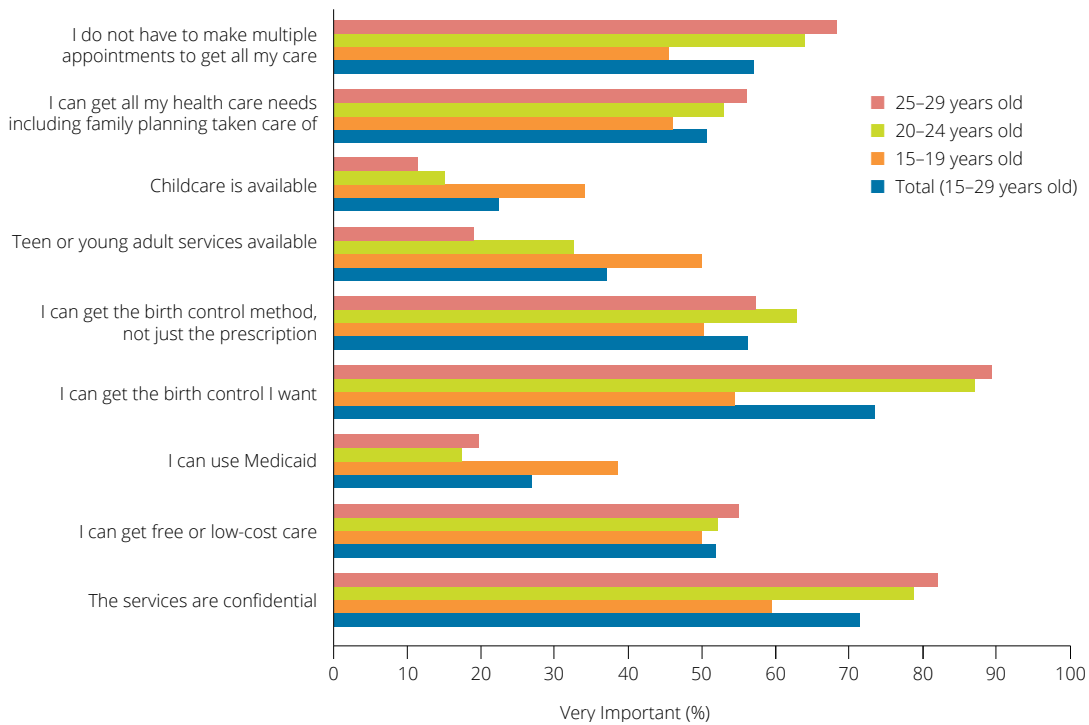


FIGURE 4.2: FACILITATORS AND BARRIERS, CLINIC ENVIRONMENT AND SERVICES



- Nearly 75% of adolescents/women reported that obtaining “the birth control I want” is a very important factor for choosing a provider.
- One of the most important factors for 15–19 year-olds was “services are confidential.”
- Provider and staff interactions were reported as important factors to patients, including “staff talk to me about the side effects of birth control,” “the staff listen to me,” and “the staff respect me.”
- Appointment wait times, hours, and location were reported as very important factors for choosing a family planning provider.
- Focus group participants reported that providers discussed the range of birth control methods with them but often recommended a specific option based on a patient’s age, medical history, and current life situation. Participants expressed feeling “pressure” and indicated that they would prefer that providers pay more attention to patient preferences.

“I started off on birth control and I was horrible at taking it every day. And my doctor at the time was kind of judgy. I like admitted that I would sometimes take 2 or 3 pills at a time because I missed a day and she kind of like pressured me into getting a long-term birth control that I wouldn’t have to think about which makes sense and was logical from a medical standpoint. But I kind of felt this pressure from all my peers who had Mirena that was the best thing in the world.”

Teen participant

Key Finding 9: Negative Perceptions, Concerns about Side Effects, and Perceived Expense Identified by Adolescents/Women as Top Barriers to Uptake of LARC

- With respect to perceptions of LARC methods:
 - 15–19 year-olds reported significantly higher perceptions of infertility associated with IUDs and implants compared to both the 20–24 and 25–29 year-old age groups.
 - For both IUDs and implants, 15–19 year-olds reported believing that these methods are “best for women who are older, married, and already have kids.”
 - 20–24 and 25–29 year-old age groups reported more negative perceptions of IUDs and implants as compared to 15–19 year-olds, with respect to IUDs being painful, implant insertion being painful, a pap smear being required before IUD insertion, and IUDs damaging the uterus.
- The top barriers to contraceptive use, as reported by adolescents and women about their own or other “girls/women your age” concerns, included the following:
 - Bad effects from birth control methods they tried;
 - Hard to remember to take or use birth control;
 - Birth control is too expensive;
 - Birth control causes weight gain;
 - Should not use birth control for religious or personal reasons; and
 - Lack of understanding of the consequences of unprotected sex.
- Additional challenges identified by many adult women included long wait times to schedule an appointment and their health insurance not covering the full cost of birth control.
- Many adolescents also mentioned that it was difficult to obtain family planning services at hospital-based clinics because they did not want to involve their parents’ insurance due to privacy concerns.

Knowledge/Education of Adolescents and Women in the Community and Clinic Outreach

Key Finding 10: Friends and Family Are Important Sources of Contraception Information for Adolescents and Women

Survey participants were asked about how they usually get their information about contraception:

- 30.9% reported receiving the information from a personal doctor or health care provider.
- The second highest source of information was friends at 12.6%.
- Adolescents 15–19 years old reported a higher percentage of seeking information about contraception from parents (10.5%) and school health centers (14.7%).
- Adolescents and women in Wards 7 and 8 reported higher percentages for “no source” of information about contraception, and lower percentages for seeking information from health websites.

“For adults to be more open. It would be more comfortable for us to like talk about it if adults address it to us...We don’t like being looked down upon so we go to our friends. And that’s really not helpful because y’all are my age so you are learning as I go so it’s like I’m going based off what you’re saying and you might not even know what you’re talking about. Yeah, I trust you because you are my friend but I need somebody older or somebody who has been through it.”

Teen participant

“My mother had a lot of fertility issues and she had me by mistake, and she kind of credits it to different birth control methods when she was younger and different things. So I think she’s happy that I choose not to take it every day. She’s more like natural body...she thinks any interference [isn’t healthy]—that’s probably misguided... She also says ‘you guys are lucky to have plan B’, which is my choice if I have a mistake or a slipup. She also thinks, oh, you’ll be more likely to use a condom, great. And it’s true. She’s more worried about an STD than an accidental pregnancy—she’s not opposed to any alternative options there. So that’s my experience. I think that’s why I have not really seriously considered taking birth control day to day or [an] IUD. She definitely influenced that. I think if she had been the mom who says ‘no, take something now, I don’t want you to get pregnant’ that I would have gotten on it.”

Adult participant



Focus group participants also identified friends and family members as a vital source of contraceptive information and also a potential barrier to use. Many participants did not use the IUD because of misconceptions and myths shared within their social networks. Participants expressed a desire for health care providers to discuss the potential complications and side effects associated with birth control methods in greater detail.

Many women in the focus groups shared that their partners were supportive of their decisions, accompanied them to medical appointments, and split the cost of birth control. However, it is important to note that both women and adolescent girls reported that partners attempted to dissuade them from using a condom during sexual intercourse because they were on birth control.

Key Finding 11: Knowledge about LARCs is Lowest amongst 15–19 year-olds; Adolescents/Women Living in Wards 4, 5, 7 and 8; and non-Hispanic Black Adolescents/Women

TABLE 4.1: LARC KNOWLEDGE MEAN SCORES BY AGE GROUP

	Total	15–19	20–24	25–29
Mean knowledge score (range 0–8)	4.0	2.4	5.1	5.5

TABLE 4.2: LARC KNOWLEDGE MEAN SCORES BY WARD

	Ward 1	Ward 2	Ward 3	Ward 4	Ward 5	Ward 6	Ward 7	Ward 8	Other
Mean knowledge score (range 0–8)	5.0	4.9	5.3	3.3	2.9	4.5	2.6	1.8	4.5

TABLE 4.3: LARC KNOWLEDGE MEAN SCORES BY RACE/ETHNICITY

	Non-Hispanic White	Non-Hispanic Black	Non-Hispanic Other	Hispanic
Mean knowledge score (range 0–8)	5.6	2.4	4.6	4.1

Knowledge about contraceptive methods, specifically related to LARCs, was assessed through the survey. The following findings were identified:

- The overall mean knowledge score about contraceptive methods is 4.0 on a scale of 0–8.
- 15–19 year-olds have the lowest mean score (2.4). Further, bivariate analysis found that 20–24 and 25–29 year-olds have significantly higher mean knowledge scores (Mean=5.1 and 5.5, respectively) compared to 15–19 year-olds ($p<.001$).
- Analysis by Ward found that adolescents/women in Wards 7 and 8 have the lowest knowledge scores (2.6 and 1.8, respectively), and those in Wards 4, 5, 7 and 8 have significantly lower knowledge scores compared to Ward 1 ($p<.001$).
- Analyses of LARC knowledge scores by race/ethnicity found that non-Hispanic black adolescents/women had significantly lower LARC knowledge scores (M=2.4) compared to non-Hispanic white (M=5.6), non-Hispanic other (M=4.6), and Hispanic (M=4.1) adolescents/women ($p<.001$).
- 15–19 year-olds reported significantly higher perceptions of infertility associated with implants (23.2%) compared to 20–24 (15.4%) and 25–29 (19.1%) age groups ($p<.001$).
- 15–19 year-olds also reported significantly higher perceptions of infertility associated with IUDs (25.1%) compared to both the 20–24 (15.8%) and 25–29 (13.4%) age groups ($p<.001$).

“With the IUD thing, I don’t have any friends that have done that. What I have heard is that they can break and come out, and I heard that it can be kind of painful. But yeah, that’s all I know about it. I know it goes in and it’s a little plastic T looking thing and it can stay there for a long time.”

Teen participant

Key Finding 12: Many Adolescents and Women Have Negative Perceptions Regarding the Safety and Comfort of LARC Methods

As previously stated in Key Finding 9, a number of women reported negative perceptions regarding pain associated with IUDs and implants, as well as concern that IUDs can damage the uterus. Additionally, the survey and focus group discussions revealed the following negative perceptions:

- Across all age groups, nearly 25% of adolescents and women “strongly agreed” or “agreed” that IUDs could be “felt and make sex uncomfortable.”
- Overall, oral contraceptives are perceived as a safer method compared to other hormonal methods, with emergency contraception, the patch, and the ring perceived as the *least* safe methods.
- 15–19 year-olds reported lower perceptions of safety across all methods compared to 20–29 year-olds.
- Adolescents and women in Wards 7 and 8 reported significantly lower perceptions of safety across almost all methods, including IUDs and implants.
- Non-Hispanic black respondents reported significantly lower perceptions of safety across all methods with the exception of the patch and emergency contraception compared to the three other race/ethnicity categories. Hispanic respondents also had significantly lower perceptions of safety compared to non-Hispanic white and non-Hispanic other respondents.
- Fear of infertility as a consequence of contraceptive use also emerged as a theme in the focus group discussions.

“I heard that even with the shot, you have to be a certain age...it can do something to your ability to have kids.”

Teen participant

Key Finding 13: Current Community Outreach by Clinics is Largely Passive

The findings on clinic outreach are especially important given this study's findings of low levels of knowledge concerning LARC methods, the significant number of sexually active adolescents and young women who are not accessing family planning care, and the need for extensive education and outreach to women in the community.

Clinic survey responses found that most sites did not engage in many types of *active* outreach activities, and the most common forms of outreach were passive or involved reaching out through those already connected with the health care system, including:

- Current patients (family or friend referrals) (49.1%);
- Websites (43.4%);
- Community health fairs (43.4%);
- Social media advertising (20.8%);
- Internet advertising (9.4%);
- Newspaper or magazines (7.4%);
- Places of worship (5.7%); and
- TV advertising (3.8%)

There also was limited access to clinic services through online systems, particularly if seeking an initial prescription for contraception via telemedicine. The most common electronic form of outreach was the use of text messaging for appointment reminders.

Several interviewed providers indicated that their organizations (especially in FQHCs or hospital-affiliated practices) conducted community outreach activities including teen days or nights to facilitate family planning access and education for adolescents. Most of these events include group education and counseling sessions—run by case managers, health educators and/or clinicians—as well as opportunities for teens to make appointments for family planning and sexually transmitted infection testing services.

Perceptions, Perspectives, and Behaviors Related to Contraceptive Methods and Services

Key Finding 14: 15–19 year-olds, Adolescents/Women in Wards 7 & 8, and non-Hispanic Black Women Are Less Likely to Be Using a LARC or Other Hormonal Method of Contraception

- Slightly more than 80% of respondents who have been sexually active in the *last 12 months* are using a LARC or other hormonal method of contraception (LARC and hormonal methods have been proven to be the most effective methods of contraception).
- Sexually active 15–19 year-olds are less likely to be using *any* method of contraception, and only 66.4% are using a LARC or other hormonal method compared to 87.5% of 20–24 year-olds ($p<.001$) and 79.7% of 25–29 year-olds ($p<.05$).
- Adolescents and women in Wards 7 and 8 reported the lowest utilization for LARCs (22.2%, $p<.01$ and 17.6%, $p<.01$) compared to other Wards.
- Non-Hispanic black respondents reported higher levels of *not* using any method (14.4%) compared to the other racial/ethnic groups.

Key Finding 15: Low Pregnancy Wantedness is Seemingly at Odds with Uncertainty about Likelihood of Pregnancy among 15–19 year-olds, non-Hispanic Black Adolescents/Women, and Hispanic Adolescents/Women

- Although overall level of pregnancy wantedness is low (1.8 on a scale of 1–5), 13.1% of respondents reported “not sure” for *future* pregnancy intentions, and close to 15% reported “maybe” or “don’t know” with respect to how *likely* they are to become pregnant in the next year. This may indicate a lack of ability to recognize the risk of pregnancy.
- Approximately 22% of 15–19 year-olds reported “maybe” or “don’t know” for pregnancy likelihood, which is much higher than for other age groups.
- “Maybe” and “don’t know” for likelihood of becoming pregnant in the next year is significantly higher among non-Hispanic black adolescents/women (24.6%, $p<.001$) and Hispanic adolescents/women (18.5%, $p<.05$) compared to non-Hispanic white (4.2%) and non-Hispanic “other” (12.2%).
- 76.4% of sexually active respondents who are not using any method of contraception reported “no” to the likelihood of becoming pregnant in the next year, again possibly reflecting a lack of understanding of the risk of pregnancy when not using effective forms of contraception. (Table 4.4).

“...Some girls I know, like they’re with this boy for like 2–3 years so they really got a really good trust system and they had this talk about having kids...it’s my cousin and she’s been with her boyfriend for 5 years...she’ll be telling how they sometimes don’t use a condom. And I’m like what? And she’ll say at the end of the day that’s my dude. So...she really trusts him. And sometimes it does come up in conversation they both agree they don’t want them, but if it were to happen what would be the next step? And her family kind of already has a history for having babies young, so I guess it doesn’t bother her? But she knows she doesn’t want them. So if anything she’d say, oh it’s not that bad.”

Teen participant

- Pregnancy ambivalence combined with a perception of limited risk of pregnancy was identified as a common theme in the focus group discussions, with participants sharing that pregnancy ambivalence shapes decisions about using contraception. In particular, those adolescents and women in trusting relationships might not use a method consistently if they are not sure about their pregnancy intentions or risk of pregnancy.



TABLE 4.4: PREGNANCY WANTEDNESS, INTENTIONS, AND LIKELIHOOD BY CONTRACEPTIVE USE IN THE LAST 12 MONTHS

	None	Barrier	LARC	Other hormonal
Pregnancy Wantedness Mean (range 1–5)	2.1	1.8	1.6	1.8
Pregnancy Intentions (%)				
In the next year	3.4	7.0	0.8	1.0
In the next 2 years	10.4	5.4	3.3	7.3
In the next 5 years	19.0	28.5	23.9	25.9
5 or more years	34.6	41.0	48.8	48.3
Never	16.1	5.9	11.3	8.4
Not sure	16.5	12.1	11.8	9.2
Pregnancy likelihood in the next year (%)				
Yes	6.1	8.9	1.7	1.3
No	76.4	79.2	91.2	84.0
Maybe	5.7	7.0	4.7	11.5
Don't Know	11.8	4.9	2.5	3.1

“I’ll have a teenager who is in love with her boyfriend and kind of wants a baby because her sister is pregnant but kind of doesn’t want a baby. We see that all the time. That’s where the contraceptive coercion comes in. I think so many of us are telling them you need birth control, you need birth control, you’re young, and you’re a teenager. And part of them wants to be pregnant and they’ll say I don’t want that. And if you really dig deeper some of them will admit to wanting to get pregnant.”

Hospital-affiliated Ob-Gyn

Key Finding 16: Family Planning-Specific Visits Appear to be Highly Correlated with Use of a LARC or other Hormonal Method of Contraception; Almost Half of 15–19 year-olds Have Never Had a Family Planning Visit

Among all survey participants, close to 49% of respondents reported visiting a provider for family planning services in the last 12 months. Family planning-specific visits appear to be highly correlated to use of a LARC or other hormonal method of contraception (which are considered to be the most effective contraceptive methods).

Adolescents (15–19 year-olds)

- Among all 15–19 year-olds, 41.6% have never been to a provider for birth control, significantly higher compared to 20–24 and 25–29 year-olds (13.9% and 8.1% respectively, $p < .001$).
- Nearly 30% of sexually active 15–19 year-olds who have *never* been to a provider for birth control are not using any method.
- A little over 68% of those who are sexually active and have *never* been to a provider for birth control are using only barrier methods.
- Among sexually active 15–19 year-olds who have visited a provider for birth control in the last 12 months, nearly 85% are using an effective method (25.8% LARCs; 58.6% other hormonal method). (Table 4.5).

TABLE 4.5: PROVIDER VISIT FOR FAMILY PLANNING SERVICES BY CONTRACEPTIVE USE AMONG 15–19 YEAR OLDS SEXUALLY ACTIVE IN THE LAST 12 MONTHS

	None	Barrier	LARC	Other hormonal
Last time visited a health care provider				
Never	29.8	68.6	1.6	0
More than 3 years ago	7.8	43.4	0	48.8
1–3 years ago	33.1	10.9	36.2	19.9
Within the last 12 months	3.5	12.2	25.8	58.6



Women in Wards 5, 7 & 8

- Respondents in Wards 5, 7 and 8 reported the highest percentages for “never” visiting a provider for birth control services (33.0%, 32.8%, and 36.8%, respectively; $p < .001$). (Table 4.6).
- With respect to satisfaction, respondents in Ward 8 have slightly lower levels of satisfaction with their last family planning visit compared to the other Wards, and 19.9% report that the information they received was not useful, again higher compared to the other Wards. (Table 4.6).

TABLE 4.6: PROVIDER VISIT FOR FAMILY PLANNING SERVICES BY WARD

	Ward 1	Ward 2	Ward 3	Ward 4	Ward 5	Ward 6	Ward 7	Ward 8	Other
Last time visited a provider for family planning									
Never	13.2	21.7	18.4	28.6	33.0	22.0	32.8	36.8	25.4
More than 3 years ago	10.4	5.9	4.7	15.3	11.2	7.7	7.1	7.0	5.8
1–3 years ago	20.7	19.8	18.9	16.3	12.0	19.7	19.8	11.5	18.6
Within the last 12 months	55.8	52.6	58.1	39.8	43.8	40.6	40.3	44.7	50.2
Satisfaction with last family planning visit									
Very satisfied	71.7	69.7	61.9	58.1	66.0	63.3	68	50.2	67.4
Somewhat satisfied	22.1	15.3	26.7	14.5	11.3	23.0	16.1	21.3	19.1
Neither satisfied nor dissatisfied	3.8	7.2	8.3	22.1	17.8	11.0	12.3	20.4	6.8
Somewhat dissatisfied	2.5	6.0	3.1	5.2	2.5	2.7	0	2.7	4.8
Very dissatisfied	0	1.8	0	0	2.5	0	3.6	5.4	2.0
Useful information received at last family planning visit									
Not at all useful	0.8	6.1	3.2	12.8	6.3	10.4	0.4	20.0	5.4
Somewhat useful	32.3	22.7	30.5	27.9	29.0	28.1	32.7	18.5	38.8
Very useful	66.9	71.2	66.4	59.3	64.7	61.6	66.9	61.6	55.8

Non-Hispanic Black Women

- Non-Hispanic black respondents reported higher percentages of never visiting a provider for birth control (34.3%) compared to non-Hispanic white (13.1%), Hispanic (26.1%), and non-Hispanic other (29.7%).
- Non-Hispanic black respondents had a higher level of dissatisfaction (6.7%) with reproductive health services based on the total of their responses of “somewhat dissatisfied” (3.1%) and “very dissatisfied” (3.6%) compared to non-Hispanic white (4.1% and 0.6%, respectively), Hispanic (3.4% and 0%, respectively), and non-Hispanic other (1.6% and 1.0%, respectively).

Implications and Recommendations

The quantitative and qualitative findings provide key insights and implications at multiple levels: A) clinic and provider needs and roles; B) community/public outreach and education needs; C) priorities for policy and advocacy organizations; and D) research and evaluation needs. Further, the results of this needs assessment provide support for five primary goals to address the reproductive health needs of adolescents and women aged 15–29 in DC:

Goal 1: Improve knowledge about contraceptive methods and increase awareness and use of existing services by adolescents/women in need of reproductive health services who are not in care.

Goal 2: Improve access to, awareness of, and use of reproductive health services for and by adolescents.

Goal 3: Gain a better understanding of the interplay between pregnancy wantedness and likelihood of pregnancy, and of the role of family planning in helping women and families to reach their educational, economic, and social goals.

Goal 4: Reduce provider barriers to providing family planning services.

Goal 5: Evaluate interventions to learn what works and what does not.

The following recommendations stem from the key findings, as well as broader discussions with the DCFPP Community Advisory Board to identify potential next steps for improving reproductive health and reducing unintended pregnancy in DC.

Clinic and Provider Needs and Roles

1. Increase proactive clinic/provider outreach to the community in innovative, non-traditional settings to increase awareness of the availability of contraceptive methods and services across DC. Developing active outreach tools, including social media marketing and media advertising beyond existing networks, can assist health care providers and clinics in reaching women in the community.
2. Develop and make available more adolescent-friendly and adolescent-specific programs. Additional adolescent-only services, sites and hours of access can help health centers reach this underserved population. Partnerships between health care provider clinics, youth serving organizations, schools, and public health agencies can create innovative sites and access points for adolescents to receive reproductive health services.
3. Expand development and implementation of confidentiality best practices and standards. Ensuring confidentiality and improving adolescents' and women's' awareness of the confidential nature of these services and other sensitive services is needed.

“Yeah, we’re also not completely aware of all the ways that parents get provider information. For example, I had an IUD patient who was going to an outside clinic so I had to order that IUD to [be] delivered to our pharmacy at the main hospital and it was going to [be] delivered to the clinic but the pharmacy themselves called the parents to confirm.”

Hospital-affiliated pediatrician

“For example, there is an initiative that is coming out of the emergency department where the ED would like to place Nexplanon. And the follow-up would be in outpatient. There is a DC law that says if the patient wants to keep it confidential she can do that with initiation of contraception, but there is no clarity on follow up. How do we maintain confidentiality with the follow up? We know that we tell our patients that the benefit of insurance goes to your parents and they may find out you had a Nexplanon placed. So what instructions can we give to our patients and say call your insurance company and say these words and they won’t send the explanation of benefits. It’s a very grey area.”

Hospital-affiliated pediatrician

4. Develop and implement new professional provider mentorship programs to assist primary care providers, including pediatricians, to develop more advanced skills and confidence in gynecologic procedures, such as IUD insertion and removal.
5. Develop, support, and evaluate sustainable sexual and reproductive health counseling strategies that can improve understanding and facilitate fully informed decision-making by women seeking contraception, while making efficient use of clinician time. Strategies for non-clinician counselors, including peer counseling, need to be established and/or expanded.



Community/Public Outreach and Education Needs

1. Develop and implement a broad-based education and outreach campaign focused on increasing knowledge among adolescents and women about the range of contraceptive choices available to them, and also providing the community with information on the benefits, risks and effectiveness of all methods. A focus on adolescents/women being able to get the method that is right for them (“what I want”) is critical. Include a significant focus on partners, parents, and on other family and community members as an important component (target audience) of the campaign. Advocacy organizations, community organizations, schools and public health organizations can work together to develop community wide education and outreach programs. Such a campaign needs to be culturally and linguistically appropriate and engage community members in development and implementation.
2. Build a community coalition to explore ways to acknowledge and address the role of race/racism, reproductive rights abuses, implicit bias, myths, misperceptions, and mistrust of the medical community on reproductive health care decision-making and outcomes. Engage youth and young women to identify needs and barriers, and to implement strategies to improve communication and trust.

Priorities for Policy and Advocacy Organizations

1. Improve and support expanded sexual health education in schools, including a focus on the range of effective methods of contraception, other reproductive health needs, risks of unprotected sexual activity including pregnancy, and methods of accessing appropriate health care for adolescents and young women and men.
2. Expand ability of school-based health centers (SBHCs) to offer health care, including reproductive health services, to youth and young adults beyond the students enrolled in the schools housing SBHCs, and increase capacity and utilization of this community resource.

“If I could change anything about the SBHCs it would be that more youth could access the services. I really feel like SBHCs should be open to anyone of school age that lives in the community. And unfortunately that’s not the way that they run in DC, and it really ought to be.”

Hospital-affiliated NP

3. Support expanded Medicaid reimbursement levels for reproductive health services. Advocates and provider organizations should continue to work with public and private insurers to improve reimbursement rates, and to ensure coverage of procedures and devices that will lower barriers to utilization of methods selected by the patient. This should include coverage of non-clinician counseling and education activities.
4. Advocate for and support the addition of reproductive health training, including counseling approaches, to area physician primary care residency programs and other provider training programs, including programs for pediatric/ adolescent health providers.

Research and Evaluation Needs

1. Expand upon and support current research to better understand young women’s reproductive goals and behaviors, including pregnancy ambivalence and perceptions of likelihood of future pregnancy. Research should incorporate the diverse cultural and social norms and expectations of adolescents and young women in DC, as well as the need to expand educational and economic opportunities for young people across all Wards of DC. Develop, pilot, and evaluate innovative interventions to support decisions on contraception, pregnancy, and family formation.
2. Establish a rigorous evaluation program to measure both short- and long-term outcomes of interventions and campaigns. Short term measures include contraceptive use, knowledge levels, behaviors, and shifts in attitudes, perceptions, expectations, and norms. Longer term outcomes such as teen or unintended pregnancy and birth rates, and their impacts on educational and economic outcomes also need to be measured and evaluated.



Endnotes

- ¹ Kost K, *Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends Since 2002*, New York: Guttmacher Institute, 2015, <https://www.guttmacher.org/report/unintended-pregnancy-rates-state-level-estimates-2010-and-trends-2002>
- ² Sonfield A and Kost K, *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010*, New York: Guttmacher Institute, 2015, https://www.guttmacher.org/sites/default/files/report_pdf/public-costs-of-up-2010.pdf
- ³ Guttmacher Institute, 2016. <https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states>
- ⁴ Statistical Note: Reported Pregnancies and Pregnancy Rates in the District of Columbia 2011–2015, Dept. of Health, Center for Policy Planning and Evaluation, State Center for Health Statistics, Oct 31, 2017. <https://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/Pregnancy%20Outcomes%202011-2015%20%28Final%29%20%2810.31.17%29.pdf>
- ⁵ Martin JA, Hamilton BE, Osterman MJK, et al. Births: Final data for 2015. National vital statistics report; vol 66, no 1. Hyattsville, MD: National Center for Health Statistics. 2017, https://www.cdc.gov/nchs/data/nvsr/nvsr66/nvsr66_01.pdf
- ⁶ Statistical Note: Reported Pregnancies and Pregnancy Rates in the District of Columbia 2011–2015, Dept. of Health, Center for Policy Planning and Evaluation, State Center for Health Statistics, Oct 31, 2017. <https://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/Pregnancy%20Outcomes%202011-2015%20%28Final%29%20%2810.31.17%29.pdf>
- ⁷ Sonfield A et al., *The Social and Economic Benefits of Women's Ability to Determine Whether and When to Have Children*, New York: Guttmacher Institute, 2013 <https://www.guttmacher.org/report/socialand-economic-benefits-womens-ability-determine-whether-and-when-have-children>
- ⁸ *Id.*
- ⁹ Kost K, *Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends Since 2002*, New York: Guttmacher Institute, 2015, <https://www.guttmacher.org/report/unintended-pregnancy-rates-state-level-estimates-2010-and-trends-2002>
- ¹⁰ Unintended Pregnancy in the United States Fact Sheet, Guttmacher Institute, 2016. <https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states>
- ¹¹ Finer LB and Zolna MR, Declines in unintended pregnancy in the United States, 2008–2011, *New England Journal of Medicine*, 2016, 374(9):843–852,
- ¹² Unintended Pregnancy in the United States Fact Sheet, Guttmacher Institute, 2016. <https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states>
- ¹³ State Facts About Unintended Pregnancy, Guttmacher Institute, 2017, <https://www.guttmacher.org/fact-sheet/state-facts-about-unintended-pregnancy>
- ¹⁴ Sonfield A et al., *The Social and Economic Benefits of Women's Ability to Determine Whether and When to Have Children*, New York: Guttmacher Institute, 2013 <https://www.guttmacher.org/report/socialand-economic-benefits-womens-ability-determine-whether-and-when-have-children>
- ¹⁵ *Id.*
- ¹⁶ Kost K, *Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends Since 2002*, New York: Guttmacher Institute, 2015, <https://www.guttmacher.org/report/unintended-pregnancy-rates-state-level-estimates-2010-and-trends-2002>
- ¹⁷ Unintended Pregnancy in the United States, Fact Sheet, Guttmacher Institute, 2016. <https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states>
- ¹⁸ Sonfield A and Kost K, *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010*, New York: Guttmacher Institute, 2015, https://www.guttmacher.org/sites/default/files/report_pdf/public-costs-of-up-2010.pdf
- ¹⁹ Statistical Note: Reported Pregnancy Rates in the District of Columbia, 2011–2015; DC Department of Health, 2017
- ²⁰ *Id.*
- ²¹ *Id.*
- ²² *Id.*
- ²³ *Id.*
- ²⁴ *Id.*
- ²⁵ Martin JA, Hamilton BE, Osterman MJK, et al. Births: Final data for 2015. National vital statistics report; vol 66, no 1. Hyattsville, MD: National Center for Health Statistics. 2017, https://www.cdc.gov/nchs/data/nvsr/nvsr66/nvsr66_01.pdf
- ²⁶ Statistical Note: Reported Pregnancy Rates in the District of Columbia, 2011–2015; DC Department of Health, 2017
- ²⁷ Unintended Pregnancy in the United States Fact Sheet, Guttmacher Institute, 2016. <https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states>
- ²⁸ Frost JJ, Singh S, Finer LB, Factors Associated with Contraceptive Use and Nonuse, United States, 2004, New York: Guttmacher Institute, 2007, https://www.guttmacher.org/sites/default/files/article_files/3909007.pdf
- ²⁹ Sonfield A et al., *The Social and Economic Benefits of Women's Ability to Determine Whether and When to Have Children*, New York: Guttmacher Institute, 2013, <https://www.guttmacher.org/report/social-and-economic-benefits-womens-ability-determine-whether-and-when-have-children>
- ³⁰ Daniels K, Mosher WD and Jones J, Contraceptive methods women have ever used: United States, 1982–2010, *National Health Statistics Reports*, 2013, No. 62, <https://pdfs.semanticscholar.org/1cfe/9a5b9a1fd9c75acee82612c4b38294ebf937.pdf>; Kavanaugh ML and Jerman J, Contraceptive method use in the United States: trends and characteristics between 2008, 2012 and 2014, *Contraception*, 2018 Jan;97(1):14–21, doi: 10.106/j.contraception.2017.10.003. Epub 2017 Oct. 13. <https://www.ncbi.nlm.nih.gov/pubmed/29038071>
- ³¹ Contraceptive Use in the United States Fact Sheet, Guttmacher Institute, July 2018, <https://www.guttmacher.org/fact-sheet/contraceptive-use-united-states>
- ³² Frost JJ, Frohwirth L and Zolna MR, Contraceptive Needs and Services, 2014 Update, New York: Guttmacher Institute, 2016, <https://www.guttmacher.org/report/contraceptive-needs-and-services-2014-update>



1331 H Street, NW, Suite 1000 | Washington, DC 20005 | 202.347.7737 | info@wawf.org | thewomensfoundation.org



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