Sexual and Reproductive Health: 90-99

90.

Parental Consent for Adolescent Sexual Health Research: Whom Do We Leave Out?
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**Purpose:** Although adolescents are typically empowered to consent to clinical care for sexual health concerns, many institutional review boards (IRBs) do not permit adolescents to participate in sexual health research without explicit parental consent. Prior studies suggest this may exclude more vulnerable youth from research participation. The Teen Video Study (TVS) is a randomized controlled trial of a behavioral intervention for sexually active females, with a unique IRB-approved consent protocol pertaining to minors (age 14-17). Minors presenting alone for care at clinical visits may enroll in TVS without parental consent. However, parental consent is required if a parent is present. Here we compare the characteristics of teen participants with and without parental consent.

**Methods:** Youth were recruited from urban academic adolescent health clinics and rural family planning clinics across Ohio, Pennsylvania, and West Virginia. Gonorrhea (GC) and Chlamydia (CT) infection were determined by vaginal self-swab. A family income proxy was based on median income for home zip code. All other data were self-report. We conducted a multivariate linear regression predicting parental consent among enrolled minor participants.

**Results:** Among 280 minors (mean age 16.5), 54% were white, 9% had a prior pregnancy (current pregnancy was an exclusion criterion for enrollment), 9% had CT, and 3% GC. About half (51%) had a recent (past 3 months) sexual partner, with 9% having more than one. Forty-five percent had parental consent to participate. The overall model predicting parental consent was significant, \(F(11,242)=8.50, \ p<.001\). Adolescents enrolled through family planning sites were less likely to provide parental consent (\(\beta=-.438, p<.001\)). Parental consent was 15% less likely for girls who were non-white, (\(\beta=-.151, p=.030\)), 10% less likely with each year of age, (\(\beta=-.106, p<.001\)), and 5% more likely per $10,000 additional level of mean income for home zip code (\(\beta=.057, p<.01\)). Those who tested positive for GC were far less likely to provide parental consent (\(\beta=-.445, p=.027\)). However, it should be noted that there were only 7 positive GC test results so this finding may not be reliable. Those with positive CT infections were not significantly less likely to provide parental consent (\(\beta=.042, p=.677\)), nor were those with previous pregnancies (\(\beta=-.117, p=.269\)), or who had more sexual partners in the past 3 months (\(\beta=.062, p=.096\)).

**Conclusions:** Older, lower income, non-white teens and those attending family planning clinics were more likely to have been recruited into TVS without parental consent, indicating parents were not present at the time they sought care. Studies that require multiple in-person visits may have more opportunities to request parent presence for consent. However, for studies that have one face-to-face recruitment visit and collect post-enrollment data by mail and Internet, failure to obtain a waiver of parental consent could result in systematic exclusion of minority and less affluent adolescents.
Investigators and IRB members must continue to work collaboratively to ensure that the youth at highest risk for the outcomes being studied are included in sexual health research.

**Sources of Support:** Office of Adolescent Health, DHHS: 1TP1AH0000400100

91.

**Fertility Preservation After a Childhood Cancer Diagnosis: A Systematic Review of Adolescents’ and Young Adults’, Parents’, and Providers’ Knowledge, Beliefs, and Attitudes**

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**Purpose:** Survival into adulthood is now a reality for many children and adolescents facing cancer. Fertility preservation (i.e., sperm banking, ovarian tissue cryopreservation, testicular tissue preservation) for pubertal and pre-pubertal oncology patients is a rapidly advancing field. Our objective was to review and summarize the available data regarding the knowledge, attitudes, and beliefs of adolescents and young adults with a history of childhood cancer, parents, and pediatric oncology providers about fertility preservation after a childhood cancer diagnosis.

**Methods:** Five electronic databases (PubMed, Embase, Web of Knowledge, CINAHL, PsychInfo) were systematically searched to retrieve relevant studies published between January 1999 and July 2013. The following MESH terms and their synonyms were combined “fertility” (“infertility”, “fertility preservation”, “cryopreservation”, “oncofertility”), “cancer” (oncology, oncologic, cancer survivor), “pediatric” (child, youth, adolescent, teen, childhood, “parent” (parental), “information” (communication, attitudes, beliefs, decision making)), Additional studies were identified from reference lists, expert consultation, and conference abstracts. Eligible studies focused on pediatric and adolescent oncology patients or survivors, their parents, and/or pediatric oncology providers and their knowledge of, beliefs about, or attitudes toward fertility preservation after a cancer diagnosis. Studies were assessed for methodological quality, data was extracted using a standardized form, and synthesized using the Cochrane guidelines for multi-level, simultaneous syntheses of quantitative and qualitative data.

**Results:** 1233 papers were identified and 36 were included in the final review. 24 studies provided quantitative data (patients: 8, parents: 4, providers: 7, multiple perspectives: 5). 11 studies were qualitative (patients: 7, parents: 0, providers: 3, multiple perspectives: 2). The majority of cancer patients wanted information about treatment related fertility effects and fertility preservation options early in their course of their cancer treatment. Patients recalled receiving this information 30-87% of the time. A higher proportion of patients had heard about fertility issues before treatment in later studies. Many patients (35-64%) were dissatisfied with the information received and identified ways of improving the provision of fertility preservation information. Examples include offering options for parental involvement in initial discussions and offering continued support for fertility preservation decision-making before, during, and after cancer treatment. Parents of pubertal and pre-pubertal cancer patients find many fertility preservation options acceptable despite being experimental,
especially if they do not cause a delay in treatment. Providers are aware of the importance of fertility issues for their patients and their families, they are knowledgeable about fertility preservation options, and identify age, pubertal status, critical illness, and uncertainty as potential barriers to communication about and referral for fertility preservation services.

**Conclusions:** Adolescent oncology patients and their parents desire candid and timely fertility preservation related information and referral for fertility preservation procedures. Providers are aware of fertility preservation options and resources, but identify system-related and personal barriers to discussions with adolescent patients and families regarding fertility preservation. Future research should focus on patients and families to determine the optimal setting, method, and delivery of fertility preservation related information.

**Sources of Support:** None

92.

**Sexual Health Assessments of a High Risk Population: Adolescent Inpatients on a Mental Health Unit**

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**Purpose:** Teens with psychiatric diagnoses have higher risk sexual behaviors — they are more likely to be sexually active, have an earlier age of first intercourse, have a greater number of sexual partners, have unintended pregnancies and engage in riskier and unprotected sex. Insufficient data exists regarding the sexual health of Canadian adolescent mental health inpatients. There are no guidelines regarding how best to meet sexual health needs of this high-risk population. We sought to review baseline characteristics of the teens referred for assessment to our clinic and to determine if there were differences in this group compared to other Canadian teens.

**Methods:** We first established a new consultative and collaborative service between Child and Adolescent Psychiatry and Adolescent Medicine (AM) at our institution. Referrals were facilitated by Advanced Practice Nurse (APN) who provides initial assessment and psycho-education. Patients were assessed while still inpatients (with APN present for support). We conducted a retrospective chart review of patients seen over a 2-year period. After analyzing our own data we compared our results with published data on sexual health of other Canadian teens.

**Results:** 32 charts reviewed. The results from our study suggest that Canadian teens on an adolescent inpatient mental health unit have riskier behaviours related to sexual health. Just over 1/3 of our sample had a sexual health issue requiring treatment or referral (2 PID, 2 trichomonas, 2 BV, 1 hymen septum, 1 candida infection, 2 pregnancies). This cohort had an average age of 1st intercourse which was 3 years younger than the reported Canadian average for teens. Our patients had, on average, a much higher reported number of lifetime partners (21.4). Compared to the general population, a much higher
proportion of our sample identified themselves as LGBTQ (25%). Finally, the reported frequency of abuse was a staggering 75% (most of these were cases of sexual assault).

**Conclusions:** There is some data to suggest that teens with mental illness are more likely to engage in riskier sexual behaviors, which may impact their health in a negative way. There is a paucity of Canadian data on this issue. Our study is the first that we are aware of to describe the sexual health of Canadian teens on an inpatient mental health unit and supports that their behaviours related to sexual health are higher risk than other Canadian teens. A significant proportions of these teens (1/3) had a sexual health issue requiring treatment or referral. Sexual health interventions, including education, screening, treatment and follow-up should target this high-risk population. Sexual health problems in this high-risk population require comprehensive and timely assessment. Admission to an adolescent mental health unit provides an opportunity for exploring sexual health issues.

**Sources of Support:** none

93.

**Evaluation of the OSOM BVBlue Test for Diagnosis of Bacterial Vaginosis in an Adolescent, Young Adult Population**

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**Purpose:** Bacterial vaginosis (BV) is the most common etiology of vaginal discharge in sexually active females. BV is not considered a sexually transmitted infection but may increase the risk of acquiring chlamydia, gonorrhea, and HIV. The risk of pregnancy complications such as preterm delivery is also increased in women with BV. Sialidase is an enzyme liberated by known BV pathogens including Gardnerella vaginalis, Bacteroides, and Prevotella sp. The OSOM BVBlue Test is a point of care test (POCT) that measures sialidase activity in vaginal fluid and yields a colorimetric result when positive. The purpose of this study is to compare the clinical performance of the OSOM BVBlue Test, a rapid POCT, to a scored Gram stain (Nugent score) and Amsel Criteria for the diagnosis of BV in adolescents.

**Methods:** Data were collected from female patients, ages 12-21 years, presenting to an urban adolescent clinic with a vaginal complaint requiring vaginal swab testing. Eligible patients were enrolled as a convenience sample from August 2012 to August 2013. Demographic data including age and sexual activity were obtained. Exclusion criteria included patients who douched or used other vaginal products within 72 hours of testing. All swabs were provider-collected. A clinical diagnosis of BV was made using Amsel Criteria, as interpreted by Adolescent Medicine specialists. Microbiology laboratory personnel ran BVBlue, performed Gram stains on vaginal fluid remnants and determined Nugent scores. The performance of BVBlue was compared to the Nugent score (gold standard), and Amsel Criteria. The IRB deemed this a quality improvement study and did not require written consent.
**Results:** 104 samples were collected and 100 used for final analysis. 4 samples were excluded due to insufficient data. Average age was 17.5 years; 93% of participants were sexually experienced. 61% patients (61/100) had a Nugent score consistent with BV (7-10). Of these, 38 were BVBlue positive and 23 were BVBlue negative, correlating with a sensitivity and specificity of 62% and 100% respectively and a positive predictive value of 100% compared to Nugent score. BV was diagnosed in 45 patients using Amsel Criteria; 35 were BVBlue positive and 10 were BVBlue negative, correlating with sensitivity of 78%, specificity of 95%, and a positive predictive value of 92% compared to the Amsel Criteria. Trichomonas and yeast were diagnosed by physician microscopy in 3/100 and 11/100 patients, respectively.

**Conclusions:** The OSOM BVBlue Test provides a straightforward and rapid means of diagnosing BV that is more feasible than a Nugent Score or the Amsel Criteria in many settings. The test was found to be highly specific. Sensitivity was low compared to the Nugent Score, but better when compared to the more commonly-used Amsel criteria. The OSOM BVBlue Test may be utilized to diagnose BV in an adolescent/young adult population when microscopy is not practical.

**Sources of Support:** Sekisui Diagnostics provided test kits.

94.

**Talk with Tiff: Teen’s Inquiries to a Sexual Health Website**
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**Purpose:** Because of its availability, anonymity, and low cost of access, the Internet is an increasingly common way for adolescents to find information about sensitive issues. Sexual health website question portals are an important way for adolescents to seek personalized information tailored to their individualized needs. Few studies have examined the content within anonymous emails sent to these question portals. The purpose of this qualitative evaluation was to analyze thematic content of anonymous emails sent through a question portal on a comprehensive sexual health clinic website for an adolescent family planning clinic in a large city in the southwest United States.

**Methods:** Between August 2009 and June 2012, the email server received questions from 484 individuals who were seeking sexual health-related information. A content analysis was utilized to identify recurrent themes in the questions submitted.

**Results:** The most common questions among users pertained to cost of sexual health services, sexually transmitted infections testing, birth control, and general health issues. Some of the questions indicated users were worried about service costs, insurance requirements, and the need for parental consent. Questions regarding detailed personal health problems evidenced a limited understanding of sexual risk and the negative health outcomes associated with sexual behavior. The questions also revealed that adolescents hold many misconceptions regarding sexual health.
Conclusions: The findings support the usefulness of online question portals as effective venues for teens to quickly and anonymously obtain accurate information on sensitive issues.

Sources of Support: Spirit Golf Association

Patterns and Disparities in Sexual Health Service Utilization among Adolescent Males: A Report From a National Teen Pregnancy Prevention Initiative
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Purpose: Male adolescents have higher rates of risky sexual behaviors compared to females, including earlier age of first sexual intercourse, higher rates of sexual experience, unprotected intercourse, and sex while high on drugs and/or alcohol. However, compared to females, male adolescents are less likely to receive routine primary care, disease screenings, sexual health counseling, and pregnancy prevention service. Although gender disparities in sexual and reproductive healthcare (SRH) have been well documented, there has been little research on racial/ethnic disparities in adolescent male utilization of SRH services. The current report aims to address this gap in research using data from a national initiative to reduce teen pregnancy in communities with the highest rates.

Methods: Health center data was collected in 2011 for 59 health centers via a Clinical Partner Needs Assessment (CPNA). CPNA data included information describing health center practice setting, number of unduplicated adolescents clients, and utilization of SRH services by adolescent clients, stratified by age, gender, race and ethnicity. Basic descriptive statistics were calculated on the proportion of adolescent male SRH visits, and disaggregated by age, race, and ethnicity. Patterns in utilization of services were compared across age, race, and ethnic categories to identify disparities. All data was analyzed using Stata statistical analytic software.

Results: Out of the 59 partner health centers, only 37 (63%) reported valid data. Collectively, these 37 health centers reported serving 27,683 adolescent clients, of which 19,917 (72%) were female and 7,766 (28%) were male. Among all the male client-visits, 19.9% were SRH visits whereas among all the female client-visits, 55.3% were SRH visits. The proportion of adolescent males accessing SRH care services varies considerably across race/ethnic groups. Hispanic males have the lowest proportion of SRH visits compared to the other racial/ethnic groups (6.7%). In contrast, black males have the highest proportion of SRH visits (39.3%). The frequency of visits per client varies substantially among racial/ethnic groups as well. On average, Hispanic male adolescents have the highest frequency of visit per client (2.4) whereas black males have the lowest frequency of visits per client (1.7).

Conclusions: Analysis of data point to persistent disparities in access of SRH utilization for adolescent clients, with adolescent males significantly less likely to access SRH services as compared to their female peers. Among adolescent males, black males have the lowest frequency of visits per client. While
Hispanic male adolescents visit health centers in a more recurrent manner compared to other racial/ethnic groups, they are less likely to receive SRH services compared to their non-Hispanic peers. Despite efforts to achieve health equity in teen pregnancy prevention efforts, considerable work needs to be done to address disparities in provision of SRH services for male adolescents. Future efforts should focus on addressing barriers to sexual and reproductive healthcare for black and Hispanic adolescent males in particular.

Sources of Support: Centers for Disease Control and Prevention

96.

The Effects of Family Monitoring on Sexual Partnership Characteristics of African-American Adolescent Females: Implications for HIV/STI prevention
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Purpose: Sexually transmitted infections (STIs) among adolescents are a major public health problem. Greater parental monitoring is associated with decreased sexual risk behavior and STI acquisition among adolescents. However, little is known about the pathways through which parental monitoring is related to adolescent sexual behavior. Moreover, although older siblings and extended family often help rear children in low-income African American families, few studies have examined the role of family monitoring on sexual risk behavior among African American adolescent females, who are disproportionally affected by STIs. The objective of this study was to examine associations between African American adolescent females’ perceptions of family monitoring frequency and engagement in risky sexual partnerships.

Methods: The analytic sample included 284 African American adolescent females 14-17 years participating in an HIV/STI prevention trial who reported living with family. Baseline data collected via audio computer-assisted self-interviews were used to assess associations between perceived frequent family monitoring (defined as the resident family member with the most knowledge about the participant’s activities usually knew where she was and who she was with) and risky sexual partnerships (having a boyfriend with concurrent sexual partners, casual partner, casual partner with concurrent sexual partners, partner who used alcohol or drugs before sex in the past 90 days, partner recently released from incarceration, and partners =4 years older). Chi-square and t-tests compared selected baseline characteristics among participants who reported frequent and infrequent family monitoring. Logistic regression models examined associations between perceived family monitoring frequency and each partnership characteristic; adjusted models controlled for age and bivariate differences significant at p<0.1.

Results: The majority of participants, 57% (n=162) reported their mother as the person with whom they lived who knew the most about their activities; 26% (n= 73) reported a brother or sister; 8% (n=23) a grandmother, 6% (n=18) an aunt and 3% (n=8) their father. Most, 57% (n=161), reported frequent family
monitoring. Adolescents who reported frequent monitoring were less likely to report a history of physical abuse (34.2% vs. 45.5%, p=0.052) and alcohol use in the past 90 days (32.9% vs. 43.9%, p=0.058). They also reported higher levels of parental communication about sex (p=0.010). In adjusted analyses, frequent family monitoring was associated with a reduced likelihood of having a casual partner (AOR= 0.49, 95% CI=0.29, 0.82) but was not significantly associated with other risky partnership characteristics.

Conclusions: Frequent family monitoring appears to protect African American adolescent females from having a casual sexual partner. Monitoring by parents and other family members may protect against STIs, in part, by influencing adolescents’ engagement in casual sexual partnerships. Family-level interventions that promote monitoring of African American female adolescents may decrease their involvement in sexual partnerships associated with elevated STI risk.

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Examining the State of Communication about Sexual & Reproductive Health Information Between Youth with Disability and Healthcare Providers
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Purpose: To support the normative tasks of pubertal progression, sexual expression, and romantic relationship development, it is recommended that physicians offer preventative sexual health care to all patients. The purpose of this study was to (1) describe the source and extent of sexual and reproductive health information (SRHI) received by youth with and without mobility limitations (ML), and (2) examine the relationship between the extent of SRHI received from providers and the patient-provider relationship.

Methods: This study utilizes data from wave 4 (18-month follow-up) of the MyPath study, a longitudinal survey study of youth (ages 16-24) with and without ML over the course of the transition to adulthood. The MyPath sample is community based and drawn from upper Midwest USA, with nearly even representation of youth with and without ML. Measures: Degree of ML was dichotomized to No ML or ML for these analyses. Demographics (age, gender), overall health (5pt Likert, poor to excellent), extent of SRHI (4pt Likert, dichotomized to Low or High) from each source (providers, parents, friends, partners, media, sex education classes). The patient-provider relationship was assessed as follows: provider spent enough time with you (4pt Likert, never to always), talked to provider privately (n/y), Youth-Centered Communication (YCC) (4 items, a=0.83), Autonomy Support for Healthcare (AS) (5 items, a=0.91), and
Self-efficacy Communicating with Physicians (SECP) (3 items, a=0.86). Descriptive statistics, student t-tests, and logistic regression analyses were conducted in STATA, findings significant at p<0.05.

**Results:** 360 youth (72% of eligible) completed the survey. Demographics did not differ between No ML (n=207, 41% male, mean age 20.1 yrs), and ML (n=162, 42.6% male, mean age 20.0 years). Participants with No ML were more likely to report excellent or very good health compared to ML (67.6% vs. 58.0%; p= 0.005). Overall, participants identified friends (69.7%) most often as providing High SRHI, followed by sex education classes (64.0%), the media (61.8%), parents (52.2%), partners (51.1%), and providers (45.0%). ML were less likely than No ML to report receiving High SRHI from all sources, except parents (59.4% ML and 47.0% No ML, p<.05). Only 33.1% ML and 53.2% No ML reported High SRHI from providers (p<.05).

Enough time with provider, and YCC, AS, and SECP scores did not differ between ML and No ML. However, ML were less likely than No ML to spend time alone with their provider (86.8% vs. 58.3%, p<.05). Time alone with provider, higher AS and SECP are associated with receiving higher levels of SRHI from providers while level of YCC was not.

**Conclusions:** The majority of SRHI comes from media and friends which are potentially inaccurate sources. Despite similar patient-provider relationships, youth with ML are less likely to receive SRHI from providers, though spending time alone with the provider is a key strategy for improving SRHI. Interventions focused on clinical systems change and youth communication skills building may be effective in improving SRH education in the clinic setting.

**Sources of Support:** CDC #1U48DP001939-01 SIP 09-023

98.

**Gender Differences in Sexting Behaviors Among Chlamydia Positive Adolescents and Young Adults**

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**Purpose:** To identify behaviors correlated with sexting as well as gender differences in attitudes toward and motivation for sexting.

**Methods:** A cohort of chlamydia positive patients participating in the CHARM (Chlamydia Reproductive Management) study completed a computerized questionnaire that assessed demographic information, sexual practices, sexting behaviors, and symptoms of depression. Chi squared analysis and logistic regression were used for comparison. STATA was used for analysis.

**Results:** Sexting was reported in 23% of the 217 CHARM participants. Patients who reported engaging in sexting were more likely to be male (OR 2.2: CI 1.1, 4.2), report using drugs (OR 2.4: CI 1.3, 4.6) and alcohol (OR 2.8: CI 1.4, 5.4), and report signs and symptoms of depression (OR 2.1: CI 1.1, 4.1) There
were no differences in age of first sexual intercourse, number of partners in the past 3 months, education, smoking, or self image. Females were more likely to engage in sexting due to pressure from a partner (OR 9.7, CI 1.0, 90.4) and to understand the potential consequences (OR 5.2: CI 1.5 – 18.2). Among females, those who reported no symptoms of depression were less likely than those with symptoms of depression to engage in sexting (OR 0.1: 0.0, 0.5).

**Conclusions:** Sexting is a common practice among adolescents. Although sexting does not appear to be related to risky sexual behaviors, there is a correlation to symptoms of depression as well as alcohol and drug use. These results suggest that there may be important gender differences in the motivation to engage in sexting.

**Sources of Support:** Benotsch E, Snipes D, Martin A, Bull S. Sexting, substance use, and sexual risk behavior in young adults. Journal of Adolescent Health 2013: 52: 307-313. Lenhart A. Teens and sexting: How and why minor teens are sending sexually suggestive nude or nea

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**Contraceptive Initiation in Black and White Adolescents**

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**Purpose:** Despite declines in teen pregnancy rates, disparities among races continue with Black females 15-19 years old more than 2 times higher than Whites. This may be due to differences in contraceptive use, method knowledge, and reproductive characteristics and attitudes. The purpose of this study was to explore differences in contraceptive uptake between Black and White adolescents.

**Methods:** Females 12-24 years old seen for an initial contraceptive visit in an adolescent Title X clinic were eligible to participate in the study. Prior to seeing the provider, patients were asked to participate; minor patients were allowed to consent for themselves due to the low-risk nature of the study and because the questions were related to reproductive healthcare. Participants completed a pre-visit Computer Assisted Self-Interview (CASI) survey regarding reproductive characteristics, contraceptive knowledge, attitudes, and preferences and a post-visit survey regarding method selection. The primary outcome variable was contraceptive method initiated at that visit of short-acting reversible contraception (SARC) - oral contraceptive pills (OCPs), DMPA, vaginal ring, or patch- vs long-acting reversible contraception (LARC) –IUDs or etonogestrel implant. T-tests and chi-squares were used to compare White and Black participants and contraceptive initiated.

**Results:** A total of 644 participants were surveyed, 91 Black and 553 White. On average Black participants were younger (19.4 ± 2.5 vs 20.6 ± 2.4, p<0.001) and less likely to be nulligravid (85.7% vs. 93.5%, p=0.010). Black females had used fewer methods (1.2±1.1 vs 1.8±1.2, p<0.001) and were more likely to report knowing very little/nothing about contraceptive methods (53.8% vs 30.6%, p<0.001.) Blacks were more likely to leave with a SARC (37.9% vs 22.6 %, p<0.001), mostly attributable to their
initiation of DMPA (18.7% vs 3.3%). Blacks were more likely to know someone who uses DMPA (61.5% vs 42.0%, p=0.002) and more likely to report knowing someone who got pregnant on DMPA (16.5% vs 6.5%), but were equally likely to report knowing someone that got pregnant using OCPs (48.4% vs 50.0%) or IUD (8.8% vs 8.1%).

Conclusions: While the majority of participants across both groups initiated a LARC method, Black females were more likely to initiate a SARC method. Interestingly, they were more likely to initiate DMPA even though they were more likely to report that they knew someone that became pregnant using that method, indicating that they may not perceive this as a negative feature of DMPA or perceive their own pregnancy risk. Black females presenting to the clinic were younger, more likely to report having little or no knowledge about contraceptives, and had used fewer prior methods which suggests they may be more comfortable with methods with which they are more familiar. Despite receiving contraceptive counseling regarding all available methods, Black females have higher rates of SARC initiation. Future study design should further explore factors that influence Black females to initiate short-acting methods.

Sources of Support: No financial sources of support