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The National Campaign
to Prevent Teen and Unplanned Pregnancy

WHAT HELPS

WHAT HELPS

in Providing Contraceptive Services for Teens

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What Helps in Providing Contraceptive Services for Teens?

Over the years, The National Campaign has produced and disseminated a number of detailed reports and publications designed to answer this question. Here, in shorthand form, is an overview of what is known about carefully evaluated clinic interventions that help prevent teen pregnancy.

We encourage those who want to learn more to review materials on this topic at www.TheNationalCampaign.org

WHAT HELPS

Sixteen recent studies (all reviewed for this report) of teen clinics have shown that clinics can increase the use of contraception by teens, (Orr et al., 1996; Boekeloo et al., 1999; Danielson et al., 1990; Zabin et al., 1986; Brindis et al., 2005), reduce teen pregnancy (Foster et al., 2004; Zabin et al., 1986), and increase teen knowledge about sex, reproduction, and related issues (Boekeloo et al., 1999).

The studies of these program effects vary in their quality and included experimental designs, quasi-experimental designs, or some other design to measure the impact of the clinic-based intervention. Studies using an experimental design randomly assign participants to either a 'treatment' or a control group, and these types of studies provide the strongest evidence of success. Those with a quasi-experimental design compared the intervention group to a comparison group, but the participants were not randomly assigned to the different groups. Some interventions that have been measured using other, weaker designs show some promise, however, their results should be received with caution. These programs and their evaluations are presented and summarized in the charts. The tables also include information about the study sample, the specific behavioral impacts, and other details about the programs and the evaluation. Experimentally evaluated programs have been noted with an asterisk.

In addition to providing information about specific clinic-based programs, this monograph reviews some of the critical policies and/or practices that may contribute to an intervention's success. These are based on a review of effective programs and an assessment of the elements that are common among them. Please note that this assessment is merely suggestive of key elements. This is because the evaluations of these interventions were structured to measure the effect of an entire program and not specific aspects within a program. Thus, even when a study may show a particular intervention to be effective, one cannot say definitively how much specific aspects of that program contributed to its success. Even so, the fact that the eleven factors noted below are common to a number of successful programs and that they are consistent with the literature on providing clinical services in the most effective way, suggests they are promising elements for clinic providers to be aware of when focusing on adolescents.

The most effective teen clinic programs can be placed into one of three categories:

1. **CLINIC-BASED INTERVENTIONS** offer family planning and sexually transmitted infection (STI) prevention services to teenagers. Some of these programs have been developed for adult and teen clients while others are specifically designed for teens. These interventions can take many forms. Some are developed to offer low (or no) cost, confidential, comprehensive family planning and reproductive health services to teenagers who might not otherwise have access to them. Other programs offer pregnancy and STI prevention interventions (e.g., videos, literature, classes) in addition to, or as a part of, standard health care visits (Henshaw & Torres, 1994). The actual services that are provided can vary widely based on the type of agency that operates the clinic (e.g., health departments, Planned Parenthood affiliates, and independent agencies). A 2003 survey of publicly funded clinics showed that more than 90% of clinics offer oral contraceptives, injectables, and condoms and 80% offer some type of emergency contraception. Further, three-quarters offer the contraceptive patch and four out of ten offer the vaginal ring (Lindberg et al., 2006). These agencies also provide other routine tests and procedures, the most common of which are pelvic exams, STI screening and treatment, breast examinations, and Pap smears (Henshaw & Torres, 1994; Lindberg et al., 2006). Another common feature of family planning clinics is that they may offer several important programs for teenagers including school outreach and education programs that focus on postponing sexual intercourse (Henshaw & Torres, 1994).

2. **SCHOOL-BASED AND SCHOOL-LINKED INTERVENTIONS** consist of clinics that are either located within a school or within close proximity to a school. Research has consistently shown that school-based and school-linked clinics do not increase the proportion of teens who are sexually experienced. The most effective of these programs provide information about both abstinence and contraception and they focus on behavior (Kirby, 2001; Kirby 2007). Kirby notes that school-based and school-linked clinics offer several advantages over traditional clinics, including: they provide easy access for youth, they serve both boys and girls, they offer a wide range of services, their services are confidential and often free, and their staff is skilled at working with youth (Kirby, 2002). In addition, school-based and school-linked clinics have greater access to students for follow up and for providing educational programs. The primary disadvantage of school-based clinics is that they only serve those teens who are actually in school. In addition, though some reproductive health services are available at most of these clinics, school policy prevents many from giving out contraceptives (Fothergill & Feijoo, 2000).

3. **INTERVENTIONS THAT INCLUDE PEER PROVIDERS** offer family planning and reproductive health services to teenagers. Their key attribute is that the non-medical portion of health visits are provided by teenagers themselves within a healthcare setting. These teenage "providers" are trained to offer such services as patient intakes, counseling about reproductive health and contraception, and outreach services. In this model, teenage and adult staff are treated equally and are offered similar training and compensation. Clients receive services in a confidential, non-judgmental environment that has been designed with teenagers in mind. The rationale behind peer provider models is that teenagers may feel more comfortable talking about reproductive health issues with other teenagers and may be more likely to absorb and attend to these messages (Brindis et al., 2005). In fact, some research has shown that peer health educators can be equally or more effective than adult educators (Siegel et al., 1998).

How do *you* define effective?

SPECIFIC CLINIC PROTOCOLS FOR TEENS

Within any of these three basic models, special protocols for teens appear to improve teen contraceptive use. The list of characteristics of successful teen clinics that follows was created after examining the independent service components of the effective interventions found in the literature. None of the interventions that we reviewed contained all of the components listed below and, as mentioned earlier, the evaluations did not attempt to determine which specific components of the interventions provoked change in the participants. However, most of the protocol characteristics listed below have been described as important both in the literature on teen pregnancy prevention and in the evaluations of the successful interventions themselves.

CHARACTERISTICS OF SUCCESSFUL TEEN CLINICS

Successful teen clinics provide their clients with:

LONGER APPOINTMENT TIMES AND INDIVIDUAL COUNSELING ABOUT THE ADOLESCENT'S OWN BEHAVIOR. One common change that effective teen clinic interventions have employed is to increase counseling time or offer longer appointment times. This counseling often covers such topics as abstinence, contraceptive use, and the individual's own behavior (Kirby, 2001; Kirby 2007). For example, the Self Center, a school-linked health clinic, offered in depth individual and group counseling to patients during certain hours of the day (Zabin, 1986). Similarly, many clinic-based interventions have offered longer appointment times for teens to allow for individual counseling (Danielson et al., 1990; Orr et al., 1996; Roye et al., 2006; Winter & Breckenmaker, 1991). A survey of public family planning agencies indicates that most routinely provide teenagers and adolescents with counseling about abstinence and talking to parents about sex (Lindberg et al., 2006).

EDUCATIONAL PROGRAMS. Nearly half of public family planning clinics have put in place some sort of education program either on site or at other facilities that adolescents frequent. Many of these clinics have programs that focus on delaying sexual activity. A few of these agencies even provide incentives to encourage teenagers not to become pregnant (Frost & Bolzan, 1997; Lindberg et al., 2006). Many of the effective clinic-based interventions reviewed for this report offer supplemental resources, workshops or activities related to reproductive health for their teen patients. Some programs offered brochures (Boekeloo et al., 1995) and/or video or audiotaped programs as a part of regular office visits (Boekeloo et al., 1999; Danielson et al., 1990; Roye et al., 2006). Other clinic-based interventions offered supplemental workshops for their patients that met weekly for several weeks (DiClemente et al., 2004; Shain et al., 1999). These workshops often included role playing and skill building activities and they covered such topics as ways to reduce certain risks, abstinence, and condom use.

A WIDE RANGE OF SERVICES. Many family planning clinics provide more than just family planning services. Clients can often receive reproductive and family health services at these clinics as well (Frost & Bolzan, 1997). The location and focus of the clinic (e.g., school-based, family planning clinic, hospital) may have an impact on whether it is possible to make a wide range of medical services available for teens. School-based health centers, in particular, often offer a wide range of medical services and do not focus solely on reproductive health (Ricketts & Guernsey, 2006; Zabin et al., 1986).

CONFIDENTIAL SERVICES. Confidentiality is particularly important for teenagers and can have a large impact on teenagers' use of reproductive health services. A recent study of adolescent females found that 59 percent of teen girls under age 18 who were seeking services at a Planned Parenthood clinic would refuse family planning services and delay STI and HIV testing and treatment if their parents were informed that they were being prescribed oral contraceptives (Reddy et al., 2002). Family PACT, a series of state funded clinics in California, was able to assure confidentiality to teen patients because by law, parental consent for these services was not necessary (Foster et al., 2004). Likewise, Jemmott and colleagues (2005) evaluated an effective HIV risk reduction program for African-American and Latina girls that took place in an adolescent medicine clinic and that offered confidential reproductive health services to clients. The evaluation results indicated that the incidence of unprotected sex over the last ninety days was significantly lower for participants in the intervention. In addition, intervention participants reported fewer sex partners and had a lower incidence of STIs. Similarly, in an effort to tailor its intervention to the special needs of adolescents, one program made confidentiality a core component of its program. That intervention succeeded in increasing contraceptive use and reducing teen pregnancy (Winter & Breckenmaker, 1991). Most clinics that report data on confidential services indicate that parental consent is not required for their adolescent and teen patients to receive prescriptions for contraceptives (Lindberg et al., 2006).

CONTRACEPTIVES. Even though many of the evaluations of clinic-based interventions did not specify whether contraceptives or prescriptions for contraceptives were offered on-site, it is the case that many clinics offer both services. For example, the clinics involved in Family PACT offered patients a choice of all U.S. FDA approved methods of contraception (Foster et al., 2004). One intervention, tailored to the special needs of adolescents, offered patients a prescription for their contraceptive of choice as well as a follow up appointment six weeks later to provide counseling on any difficulties that the teen was having with their chosen contraceptive (Winter & Breckenmaker, 1991). Most school-based health centers are restricted by district policy from dispensing contraceptives and/or prescriptions for contraceptives on site (Fothergill & Feijoo, 2000). However, many of the school-based health centers, such as those in the Denver public schools, offer referrals for students to receive contraceptives off site (Ricketts & Guernsey, 2006).

How do *you* educate teens?

FREE OR LOW COST SERVICES. Many of the clinic-based programs offer services to teens at little or no cost. For example, Family PACT, which was created by the California State Assembly, provided reproductive health services through public sector and private provider clinics to California residents (including teens) whose income was at or below 200% of the federal poverty level and who did not have access to these types of services through other means. In addition, teens' income was calculated independent of their parents' income level which increased the likelihood of eligibility (Foster et al., 2004). Similarly, an HIV risk reduction intervention for African-American and Latina adolescent women that took place in an adolescent medicine clinic offered free family planning services to teens (Jemmott et al., 2005). Finally, the Self Center, a school-linked health center, offered reproductive and contraceptive health care at no cost to junior and senior high school students (Zabin et al., 1986). These programs were successful at reducing the frequency of unprotected sex (Jemmott et al., 2005; Zabin et al., 1986), increasing contraceptive use (Zabin et al., 1986), and reducing teen pregnancy rates (Foster et al., 2004.; Zabin et al., 1986). Although the specific role of free/low cost contraceptives in achieving these reductions was not determined, it is reasonable to conclude that it was part of the explanation.

CONVENIENT SERVICES. Convenience should play a large part in determining where clinics that serve teens are located (e.g., in or near schools, in target neighborhoods) and in their hours of operation. Some of the most effective interventions provided special or extended hours to make their services more convenient for their teenage clients.

FLEXIBLE MEDICAL PROTOCOLS. As a part of their comprehensive effort to make teens more comfortable during their clinic visits, one intervention spread the initial visit over two appointments spaced two weeks apart. During the first visit, the teen was counseled about contraception. During the second visit, the teen received a pelvic exam and any other needed medical services. This intervention increased contraceptive use and decreased teen pregnancy (Winter & Breckenmaker, 1991). Additional flexible medical protocols used in successful programs were the advance provision of emergency contraceptives (Raine et al., 2005, Raymond et al., 2006) and quick start for oral contraceptives (Westhoff, 2007).

EDUCATION ABOUT IMPORTANT REPRODUCTIVE HEALTH SKILLS. Many interventions also taught patients specific skills such as how to correctly use a condom and how to negotiate with a partner about contraceptive use (Boekeloo et al., 1991, DiClemente et al., 2004, Jemmott et al., 2005; Orr et al., 1996), how to avoid risky sexual encounters (Boekeloo et al., 1991), and how to communicate with partners (DiClemente et al., 2004).

REFERRALS FOR NEEDED SERVICES. Teens often have needs that cannot be met by a clinic, such as services for mental health or substance abuse. Many of the effective interventions such as Family PACT and the Self Center provided referrals to their teen patients for those services (Foster et al., 2004; Zabin et al., 1986). In addition, as a part of their intervention, ASSESS offered patients a brochure that contained community resources available to their patients (Boekeloo et al., 1999).

ACTIVE OUTREACH. Two of the major challenges faced by clinics that provide reproductive health services for teens are: (1) getting teenagers in the door and, (2) making sure the right services are offered. Based on this review of effective programs, there are several common sense things that clinics can do to improve in both areas. In order to reach teenagers who are most in need, clinics should pay attention to location, visibility, and outreach. Clinics should be located in areas that are convenient and accessible to the teens who are most at risk for teen pregnancy. Finding the right location, however, is not enough to get teens into the clinic. Clinics should be prepared to identify the teens at greatest risk in their communities and actively recruit them by advertising, forming partnerships with other organizations (e.g., schools, community centers), and asking for referrals. The clinic itself should be well marked and easily identifiable by teens on the street. Other practical suggestions include:

- Place a sign on the clinic that can be easily seen on the street,
- Maintain a presence at community events, and
- Invite teens to refer their peers to the clinic (Hogue & Baden, 1996).

EFFECTIVE PROGRAM CHART

As this report has indicated, a number of teen clinic interventions have been identified through research and evaluation to have a positive effect on teen sexual behavior. The list that follows is comprised of the programs that have been identified as most effective. More information about each program is provided on the charts that follow. If you would like more detail about any of these programs, please read the associated publications listed in the following chart.

In order to be included in this review, programs had to have been evaluated and to have met the following criteria[1]:

- The studies had to be completed (or published) in 1980 or later.
- The intervention had to have taken place in the United States.
- Research had to be conducted on the impact of the program on teenagers or adolescents.
- The evaluation had to include information on the impact of the intervention on sexual behavior.

[1] Note, these criteria were adapted from the *What Works* in curriculum-based programs to prevent teen pregnancy report.

How do *you* reach teens?

AT-A-GLANCE

LIST OF EFFECTIVE PROGRAMS

CLINIC-BASED INTERVENTIONS

1 Family PACT (Foster et al., 2004)

2 ★ Untitled study (Orr et al., 1996)

3 ★ ASSESS (Boekeloo et al., 1999)

4 ★ Reproductive Health Counseling for Young Men (Danielson et al., 1990)

5 ★ SiHLE Sistering, informing, healing, living, and empowering (DiClemente et al., 2004)

6 Tailoring family planning services to the special needs of adolescents (Winter & Breckenmaker, 1991)

7 ★ Sisters Saving Sisters (Jemmott, et al., 2005)

8 ★ Project Safe & Project Safe-2 (Shain et al., 1999; Shain et al., 2004)

9 ★ Untitled intervention for Black and Latina female adolescents (Roye, et al., 2007)

10 ★ Advance provision of emergency contraceptives (Raine et al., 2005)

11 ★ Increased access to emergency contraceptives (Raymond et al., 2006)

12 ★ Quick start oral contraception (Westhoff et al., 2007)

13 ★ HORIZONS (DiClemente, et. al 2009)

SCHOOL-BASED/SCHOOL-LINKED INTERVENTIONS

14 Self Center (Zabin, et al., 1986)

15 Denver School Health Centers (Ricketts & Guernsey, 2006)

PEER PROVIDER MODELS

16 Peer Providers of Reproductive Health Services (Brindis et al., 2005)

★ As a general matter, programs and interventions that have been evaluated using an experimental design provide stronger evidence of effectiveness than those evaluated using other evaluation designs. Programs that have been evaluated using an experimental design are noted with a star.

	1	2 ★	3 ★	4 ★	5 ★
NAME OF PROGRAM	Family PACT	Untitled (Orr, *et al.*)	ASSESS	Reproductive Health Counseling for Young Men	SiHLE (Sistering, Informing, Healing, Living, and Empowering)
DESCRIPTION	A state funded program in California to make family planning services available to families	Behavioral intervention targeting condom use in high-risk adolescent females	A social-cognitive intervention that provided adolescents with information about STI/HIV prevention	Clinic-based intervention that includes a slide presentation with a healthcare practitioner	Clinic-based STI/HIV prevention intervention given during four consecutive Saturday workshops
IMPROVED CONTRACEPTIVE USE	Not Measured (NM)	Yes	Yes (short-term)	Yes	Yes
REDUCED TEEN PREGNANCY	Yes	NM	No	NM	Yes
SETTING	Public sector and private, for-profit providers	Urban family planning and STI clinic	Managed Care Clinics	Health Maintenance Organization	Community health clinic
SAMPLE	491,569 female patients (20% were adolescent females)	Female adolescents between the age of 15 and 19 who were treated for Chlamydia	Adolescents between the ages of 12 and 15	Adolescent males aged 15 – 18	Sexually active, African American, adolescent, girls age 14 – 18
SELECTED EFFECTS	Researchers estimate that as a result of the program, 24,000 teen pregnancies were averted.	Adolescents who received the behavioral intervention were more likely to use condoms than adolescents who received standard education.	At the three-month follow up, adolescents who received the intervention were more likely than adolescents who received usual care to have used a condom at last intercourse. No difference was found at the nine month follow up.	Adolescents who received the intervention were more likely than those adolescents who did not receive reproductive counseling to report that their last sexual encounter was protected by the pill and that their main method of contraception in the last year was the pill.	Participants showed increased condom use at 30 days, six months and 12 months. Participants were less likely than controls to be pregnant at the six and 12-month follow ups.
SERVICES OFFERED	All US FDA approved methods of contraception, male and female sterilization, HIV testing, STI screening and treatment, limited cancer screening and infertility services	Discussion with nurse about Chlamydia, condom demonstration, and role-plays	Audio taped risk assessment, a discussion ice breaker, educational, brochures, discussion about sexual behavior with a physician	Education about reproductive health and sexual behavior as well as a visit with a physician to discuss contraception	Four Saturday workshops that covered ethnic and gender pride, HIV education, increasing communication skills around sex, and healthy relationships
EXPERIMENTAL DESIGN	No; other	Yes	Yes	Yes	Yes
CITATION	Foster, *et al.*, 2004	Orr, *et al.*, 1996	Boekeloo, *et al.*, 1999	Danielson, *et al.*, 1990	DiClemente, *et al.*, 2004
FOR MORE INFORMATION	www.Familypact.org	Emerging Answers 2007*	Emerging Answers 2007* PASHA Archive www.socio.com/srch/summary/pasha/passt18.htm Effective Programs Database**	Emerging Answers 2007* PASHA Archive www.socio.com/srch/summary/pasha/pasppo8.htm Effective Programs Database**	Emerging Answers 2007* PASHA Archive www.socio.com/srch/summary/pasha/passt23.htm Effective Programs Database**

* and ** see page 22

	6	7 ★	8 ★	9 ★
NAME OF PROGRAM	Tailoring Family Planning Services to the Special Needs of Adolescents	Sisters Saving Sisters	Project SAFE & Project SAFE-2	Untitled intervention for Black and Latina female adolescents
DESCRIPTION	Clinic-based intervention designed for teens that included a two-part initial visit, education, counseling, and contraceptive services	Clinic-based intervention that focuses on teaching HIV and STI risk reduction skills	Three 4-hour, culture-specific group sessions that include education, discussion, modeling of behaviors, and role plays given over three consecutive weeks	A clinic-based intervention based, in part, on Project RESPECT
IMPROVED CONTRACEPTIVE USE	Yes	Yes	Yes	Yes (short-term)
REDUCED TEEN PREGNANCY	Yes	NM	NM	NM
SETTING	Family planning clinics	Adolescent medicine clinic	Public health clinics	Medical clinic
SAMPLE	Caucasian adolescent girls under age 17 (some of whom were developmentally delayed)	Urban African-American and Latina adolescent females age 12 – 19	African-American and Mexican American women age 14 – 24 diagnosed with non-viral STI	African-American and Latina female adolescents
SELECTED EFFECTS	Participants were significantly more likely than controls (who received standard care) to report using contraception at the six-month follow up.	At the 12-month follow up participants in the skills-based intervention reported less occurrence of sex without a condom over the previous three months than participants who received an information-only intervention and those participants in a health promotion control group.	In Project SAFE, fewer women who received the intervention than women who received standard STI counseling reported multiple unprotected sexual encounters.	At the three (but not 12) month follow up, participants who watched the video and had the counseling were more likely to have used a condom at last intercourse than were those participants who received usual care.
SERVICES OFFERED	A six week intervention that included a two visit initial appointment with a longer counseling and education session in visit one and medical services and contraceptive prescriptions in visit two, as well as follow up visits	A four hour and 15 minute group session that provided education as well as instruction on correct condom use and negotiating condom use with a partner. The group was designed to be culturally appropriate for these groups	Three to four hour intervention sessions held for three consecutive weeks covering abstinence, monogamy, correct condom use, and STIs, optional support groups, STI screening and treatment, and follow up appointments	A brief video, a 15 – 20 minute individual counseling session, as well as routine medical care
EXPERIMENTAL DESIGN	No; Quasi-experimental	Yes	Yes	Yes
CITATION	Winter & Breckenmaker, 1991	Jemmott, *et al.,* 2005	Shain, *et al.,* 1999 Shain, *et al.,* 2004	Roye, *et al.,* 2007
FOR MORE INFORMATION	Emerging Answers 2007* PASHA Archive www.socio.com/srch/summary/pasha/pasppo5.htm Effective Programs Database**	Emerging Answers 2007* Select Media www.selectmedia.org/customer-service/evidence-based-curricula/sister-saving-sister/ Effective Programs Database**	PASHA Archive www.socio.com/srch/summary/happa/hap10.htm Effective Programs Database**	Emerging Answers 2007*

	10	11	12	13
NAME OF PROGRAM	Advance Access to Emergency Contraception	Increased Access to Emergency Contraception	Quick Start Oral Contraception	HORIZONS
DESCRIPTION	Clinic patients were provided with three packs of Emergency Contraceptives	Patients were given two packs of emergency contraceptives with unlimited refills at no charge	Patients are instructed to take their first pill during their clinic visit	HORIZONS is a clinic-based, small group intervention culturally tailored to female, African-American adolescents age 15 – 21. The intervention was based on the Social Cognitive Theory and the Theory of Gender Power. It consists of 2, 4-hour group sessions on consecutive Saturdays and 4 follow-up phone calls every 2.5 months.
IMPROVED CONTRACEPTIVE USE	Yes (emergency contraceptive use only)	Yes (emergency contraceptive use only)	Yes	Yes
REDUCED TEEN PREGNANCY	No	No	Yes	NM
SETTING	Clinic	Clinic	Clinic	Clinic
SAMPLE	Women between the ages of 15 and 24	Women ages 14 – 24	Women younger than age 25	Sexually active, African-American women age 15–21
SELECTED EFFECTS	Women who received emergency contraception in advance were more likely to have used emergency contraceptives than women in the control group.	The increased access group was more likely to use emergency contraception—and to use it quicker—than was the control group.	Women in the quick start group were more likely to start a second pack of oral contraceptives than women in the control group. In addition, women in the quick start group were less likely to become pregnant within six months of starting the pill.	Participants in the program were significantly more likely to report using condoms and using condoms consistently compared to women in the control group (at 6 months and 12 months follow-up). There were also significantly fewer Chlamydial infections among women in the intervention group compared to those in the control group.
SERVICES OFFERED	Advance provision of emergency contraceptives	Participants were given two packs of emergency contraceptives to start and were given free refills as soon as a pack was used so that each woman always had at least two packs in her possession.	Patient's took their first oral contraceptive pill during their clinic visit.	Two, four hour workshops on consecutive Saturdays and 4 follow-up telephone calls every 2.5 months.
EXPERIMENTAL DESIGN	Yes	Yes	Yes	Yes
CITATION	Raine et al., 2005	Raymond et al., 2006	Westhoff et al., 2007	DiClemente, et. al 2009
FOR MORE INFORMATION	Emerging Answers 2007*	Emerging Answers 2007*		Effective Programs Database**

CLINIC-BASED INTERVENTIONS AND PROTOCOLS (CONT.)

	14	15
NAME OF PROGRAM	Self Center	Denver School-Based Health Centers
DESCRIPTION	Nurses and social workers made presentations in the schools and reproductive health services were available in the clinic	Denver school-based health centers offered a wide range of health maintenance services
IMPROVED CONTRACEPTIVE USE	Yes	NM
REDUCED TEEN PREGNANCY	Yes	Yes
SETTING	The clinic was located within close proximity to a high school and a junior high school	School-based health clinics located in Denver high schools
SAMPLE	Adolescents in grades 7 to 12	African-American females age 15 – 17 (though the centers were open to all students)
SELECTED EFFECTS	The program reduced unprotected sex and increased use of contraception.	The fertility rate of African-American females at Denver schools with health centers showed a bigger decrease than the fertility rate of African-American females at Denver schools without health centers.
SERVICES OFFERED	Classroom presentations and reproductive health services (including distribution of contraceptives)	Centers offered medical services, counseling for behavioral risk reduction, abstinence and birth control, STI diagnosis and treatment, as well as mental health and substance abuse services. Clinics did not dispense contraceptives nor did they provide prescriptions for contraceptives on site
EXPERIMENTAL DESIGN	No; Quasi-Experimental	No; Quasi-Experimental
CITATION	Zabin, *et al.*, 1986	Ricketts & Guernsey, 2006
FOR MORE INFORMATION	Emerging Answers 2007* PASHA Archive www.socio.com/srch/summary/pasha/pasppo6.htm	Emerging Answers 2007*

SCHOOL-BASED/SCHOOL-LINKED INTERVENTIONS

	16
NAME OF PROGRAM	Peer Providers of Reproductive Health
DESCRIPTION	Teenage "providers" are trained to provide other teens with non-medical family planning services
IMPROVED CONTRACEPTIVE USE	Yes (girls only)
REDUCED TEEN PREGNANCY	NM
SETTING	A designated peer provider clinic often located within a family planning clinic
SAMPLE	Adolescent males and females age 15 – 20
SELECTED EFFECTS	Female patients were more likely to have used birth control at last intercourse and to have used an effective birth control method at follow up appointments than at initial visits. No such results were found for males.
SERVICES OFFERED	Peer providers conduct intake assessments and follow up phone calls. In addition, peer providers are trained to conduct health education outreach work and staff the toll free Adolescent Teen-line. Female patients are able to choose between having family planning visits, limited exams, or pregnancy test only visits. Male patients were able to choose between having a male medical exam, a male supply visit or an STI-only visit
EXPERIMENTAL DESIGN	No; Correlational (pre-test/posttest design)
CITATION	Brindis, *et al.*, 2005
FOR MORE INFORMATION	www.healthpolicyguide.org/doc.asp?id=6421

PEER PROVIDER MODEL

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The National Campaign
to Prevent Teen and Unplanned Pregnancy

ABOUT THE NATIONAL CAMPAIGN TO PREVENT TEEN AND UNPLANNED PREGNANCY

The National Campaign is a nonprofit, nonpartisan organization supported largely by private donations. The National Campaign seeks to improve the lives and future prospects of children and families and, in particular, to help ensure that children are born into stable families who are committed to and ready for the demanding task of raising the next generation. Our specific strategy is to prevent teen pregnancy and unplanned pregnancy among single, young adults. We support a combination of responsible values and behavior by both men and women and responsible policies in both the public and private sectors.

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* Emerging Answers 2007:
www.thenationalcampaign.org/ea2007

** Effective Programs Database:
www.thenationalcampaign.org/resources/programs.aspx

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