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# Family Planning for Teens: Strategies for Improving Outreach and Service Delivery in Public Health Settings

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## Synopsis.....

*The persistent underuse of family planning services by inner-city, low-income, sexually active youth underscores the importance of testing inno-*

*vative programs that maximize participation. Presented in this paper is an analysis of a Chicago public health clinic's special program for adolescents that originated from the staff's observations of the scheduling, educational, and support needs of teens seeking family planning services from a traditionally managed public health facility.*

*Between December 1982, when the special program—the Teen Clinic—was implemented, and March 1985, more than 600 adolescents sought social support and contraceptive services—an 82 percent increase in new-patient registration compared with the enrollment before the program began. In contrast, two neighboring public health department facilities without special family planning programs for teens experienced either a small increase, 4 percent, or a modest decrease, 17 percent, in utilization by teenagers during the same period. The increased use of the study facility by teens, coupled with patients' self-reported nonuse of alternative sources of care and referral patterns, suggests that the new program was successful in recruiting sexually active teens who had previously been inadequately protected against pregnancy. The perceived institutional and interpersonal factors influencing 153 teens' initial and repeated use of the Teen Clinic, as measured by a structured survey, echo the findings of previous research. Strategies suggested by the study's findings for improving outreach and service delivery are described.*

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**T**HE PREVENTION OF ADOLESCENT PREGNANCY remains a major concern in the United States. Birth rates among adolescent females (births per 1,000 females of ages less than 20 years) declined during the late 1970s (1). Still, in 1984, 13 percent of all births were among adolescent females, with approximately 480,000 teenagers giving birth that year (2).

Maximizing the availability of family planning services as a direct means of preventing teenage pregnancy is an ongoing challenge to public health care providers. Approximately one-third of teen women who were at risk of pregnancy were served by organized family planning clinics in 1983; an equal proportion were seen by private physicians (3). Within the public sector, health departments

are a major provider of contraceptive-related care to low-income women and teenagers. In 1983, such agencies represented 6 of 10 family planning programs in the United States and served 40 percent of all clients seeking contraception (4). The most recently available data show that among teenagers who seek care from organized family planning providers, 39 percent receive services through public health departments, 28.6 percent from Planned Parenthood facilities, 10.7 percent through hospital-based programs, and 20.8 percent from a combination of other agencies (3).

Why teenagers choose or do not choose different sources of clinic care for their contraceptive needs remains unclear. A related question is why they continue to use, or drop out of, a clinic program.

Studies examining the incentives for and barriers to the use of family planning services, and the patient characteristics that are associated with continuing or dropping out of the program, have typically analyzed (a) institutional or access factors and (b) social or interpersonal variables.

Consistent and straightforward findings emerge from studies of the institutional or access incentives and disincentives for choosing specific contraceptive care providers. Convenience of hours and location are commonly cited as important in determining what clinic is chosen (5-9). The cost of service is another barrier for many teens (5-8; see reference 6 for one exception).

A variety of social or interpersonal factors have also been found to influence clinic use. Parental involvement in adolescents' contraceptive use has been widely discussed. Forty to 60 percent of teens report that their parents know of their clinic attendance (5,10). Further, 12 percent of teenage patients report that they use a family planning clinic at their parents' suggestion (7,11). On the other hand, confidentiality is often quite important and frequently sought by first-time patients and younger teens (7-9,11).

Positive provider-client interactions in terms of staff friendliness and concern for the patient also influence clinic attendance (7,8). One study has demonstrated that the mean levels of birth control use rise when adolescent female clients of family planning clinics expect, and the nursing staff provide, authoritative or directive guidance in helping clients choose a contraceptive (12).

The salience of a clinic's location, hours of operation, and attitudes of staff in influencing teenagers' use of family planning services suggests that utilization could be further increased if clinics specially tailor their services to the interpersonal and logistical needs of adolescents. However, the evidence concerning the effectiveness of special teen clinics in increasing the use of family planning services is generally equivocal (6-9). Zabin and Clark (1983) note that although few teens cite special teen hours or "rap" groups as important for attendance, such features in a clinic may attract teens before or soon after they become sexually active. Early care is in turn associated with increased compliance over time and reduced pregnancy risk among teens. In the Zabin and Clark study, a higher proportion of virgins and teens who had only begun having intercourse chose clinics with special teen hours or rap groups (32.3 to 33.5 percent) than chose clinics without such specialized services (16.7 to 21.3 percent). Such

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programming may create an atmosphere that shows that the staff is concerned about and responds to the needs of adolescents.

How best to offer family planning services in a manner that is both effective and attractive to adolescents and that will lead to early and consistent contraceptive use remains unclear. These uncertainties support the need for additional research. The evaluation of the effectiveness of marketing strategies for family planning services offered by public health departments is particularly important, given that these programs serve the greatest number of teenagers seeking publicly supported services. However, no systematic information exists regarding the variations in the service protocols and outreach strategies of public health facilities. (No published information on this topic was available from the Public Health Service's Office of Population Affairs, according to personal communication with Lucy Eddinger, Information Specialist, November 1985.)

This article presents an analysis of a Chicago public health clinic's implementation of a special family planning program for inner-city, low-income youth. Information on clinic use and survey data are used in this study. Analyses of the utilization data compare (a) the within-facility change in the registration of new adolescent family planning patients before and after initiation of the special teen program, and (b) the change in the number of teens registering for family planning at the study facility versus similar changes at two other nearby public health department facilities without special teen family planning programs. The survey data describe the perceived institutional and interpersonal factors influencing the teen clients' choice of the study facility. Clients' responses to questions on their use of alternative

sources of care for contraception and source of referral to the Teen Clinic are also presented. The utilization and self-report data are combined to estimate the success of the special teen clinic program in the recruitment of adolescent patients. Overall, the data provide several suggestions for strategies to improve outreach and service delivery to adolescents in public health facilities.

## Method

This section is divided into two parts: a description of the development and operation of the Teen Clinic in the study facility and an outline of data collection instruments and procedures.

**Teen Clinic.** The study facility serves a black, low-income community at high risk for teenage pregnancy. In 1982, the year preceding the opening of the Teen Clinic, 34 percent of all births in the surrounding areas were to women 19 years and younger (13). Although other family planning providers exist in the area, the high number of pregnant adolescents in the community led the Chicago Department of Health (CDOH) staff to plan a special family planning clinic for teenagers to be located in the study facility.

For the purposes of this study, traditional clinic management was defined as the status quo prior to implementation of the Teen Clinic. Before this program was introduced, the facility was open 5 days a week from 8 a.m. to 4 p.m. Family planning services were offered daily, either by appointment or on a walk-in basis. Teenagers coming to the facility for birth control services were included in the regular family planning program, with no particular attention given to the fact that they were adolescents.

The CDOH staff used the flexibility available under the Maternal and Child Health Block Grant Program to develop and implement a program tailored for area teens. Many program features found to influence clinic use in previous research were incorporated into the special program. No charge is required for the services. The Teen Clinic is operated one afternoon a week for 4 hours, from 2 p.m. to 6 p.m., to facilitate after-school attendance. (The latest students in Chicago public schools are dismissed is 3 p.m.) The clinic is staffed by nurses, health educators, obstetricians-gynecologists, and mental health professionals. A rap group is also part of the Teen Clinic, offering patients a forum to discuss human sexuality, birth control, interpersonal relationships, and related

topics. Regular clinic facilities are available for gynecologic examinations as well as a large conference room for the rap sessions.

Typical outreach and recruitment strategies were used by the facility's health educators. Flyers were posted in the neighborhood, and presentations were given in the local schools. One health educator tried to establish strong relationships with a few key teens who she believed would be able to influence other teens to attend. In addition, staff at the two traditionally managed health department clinics near the study facility were encouraged to refer teens to the Teen Clinic. In the study facility, the staff was instructed to give appointments for adolescents during Teen Clinic hours, whenever possible.

**Measurement of utilization trends.** Utilization was measured by examining new-patient registration trends. The study facility's patient registration log was used to obtain utilization information. When a new patient registered for services, the clinic's staff recorded the date of registration and the patient's birth date in the log. Patients were defined as teens if they were ages 19 or younger at the time of registration. The number of new adolescent patients registering for family planning at the study facility was tallied quarterly, beginning in the second quarter of 1982 through the fourth quarter of 1985. (The Teen Clinic was implemented in mid-December of 1982.)

For comparison, registration data for the same period was also obtained from two nearby public health department facilities that had no special teen family planning program. During the study period, these facilities were open 5 days a week, from 8 a.m. to 4 p.m. Family planning services were offered daily, by appointment or on a walk-in basis. No special services were provided for adolescents. These comparison sites are located in the same service catchment area of Chicago as the study facility. Administratively, the facilities function as a triad with one regional supervisor. Informal observation indicates that the patient populations at all three facilities are more than 90 percent low-income blacks.

**Demographics and visit information.** In the study facility, a card file maintained by the clinic's staff provided information concerning the demographic characteristics of clients, as well as the dates and types of services requested at each visit. The staff recorded these data on 3- by 5-inch index cards at each visit; the data were abstracted onto a stan-

standardized coding form by research assistants. This form allowed the recording of information for up to a maximum of 15 visits. Less than 15 percent of all patients had more than 15 visits during the data collection period—December 1982 to March 1985. These demographic and visit data were restricted to information about adolescents seen at the Teen Clinic during that interval. (Data concerning adolescents seen during hours when the Teen Clinic was closed were excluded.)

**Teen Clinic survey.** Perceptions of the Teen Clinic were measured by surveying Teen Clinic patients on a cross-sectional basis. The instrument was designed to assess reasons for coming to that clinic, as opposed to other sources of care, and to ask what changes in service clients would recommend. Two almost identical versions of the survey were developed, one for first-time patients and one for return clients. All patients were asked why they had come to the clinic the first time (“today” for new clients) instead of going elsewhere. Further, return patients were asked why they had continued to go to the clinic, rather than going elsewhere. For both questions, 13 categories were presented; respondents were to choose from those categories the three most important reasons for their attendance.

A total of 153 respondents completed the survey between March and June 1985. At the beginning of each Teen Clinic session, all clients seeking contraceptive services were approached by a research assistant who explained the purpose of the project and asked them to complete a survey, anonymously. Less than 10 percent (approximately 15 clients) refused to participate. Although an exact tally was not maintained, the refusers resembled participants in terms of race and gender (black females). The surveys were completed on a self-administered basis while patients were waiting to receive services or during rap sessions. Each respondent completed the survey only once.

## Results

**Characteristics of Teen Clinic users.** Between December 1982 and March 1985, a total of 622 persons 19 years old or younger received services at the Teen Clinic. Most of those participants were female (87.8 percent). The average age was 16.4 years—standard deviation (SD)=1.7, range=11–19 years. During the study period, more than half (55.5 percent) of the Teen Clinic patients returned at least once after their first visit. The number of

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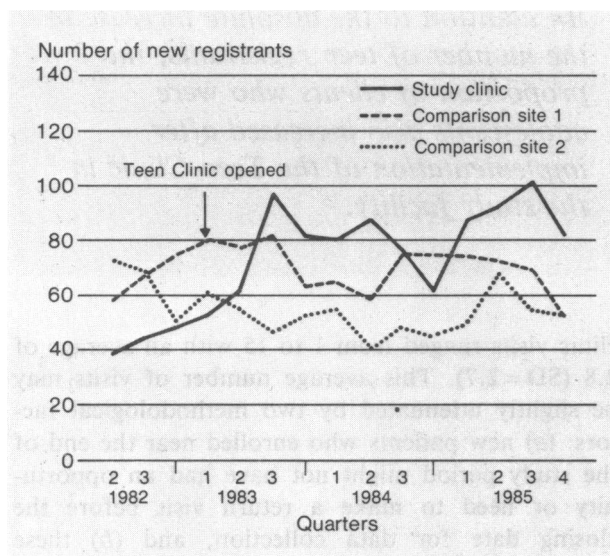
clinic visits ranged from 1 to 15 with an average of 2.8 (SD=2.7). This average number of visits may be slightly attenuated by two methodological factors: (a) new patients who enrolled near the end of the study period might not have had an opportunity or need to make a return visit before the closing date for data collection, and (b) these utilization figures do not include visits made to the facility when the Teen Clinic was closed.

A review of the Teen Clinic’s records showed that teen participants attended 138 different schools throughout Chicago (52 public and private high schools and 86 public and private middle or grammar schools). The majority of participants (58 percent) came from nine nearby public schools. Twenty percent of the participants failed to list a school. Based on the survey’s results described subsequently, an estimated 4 percent of Teen Clinic patients were school dropouts. Approximately 75 percent of the participants were in high school at the time of their enrollment in the Teen Clinic; another 21 percent of participants were enrolled in a grammar or middle school.

A minority of participants (22.4 percent) explicitly requested that they not be contacted at home by clinic staff. There was no difference in the willingness to be contacted at home by sex or age.

**Utilization trends.** The chart depicts the number of new female adolescent family planning registrants at the three CDOH facilities both before and after implementation of the Teen Clinic at the study site. It is assumed that the implementation of the special program influenced adolescents to use the study facility at all times of operation, not just during Teen Clinic hours. Thus, the post-implementation figures for the study facility include Teen Clinic registrants as well as all those who enrolled for family planning during the hours when the Teen Clinic was closed.

Enrollment rates for adolescents showed a greater increase in the study facility than in either



of the comparison sites. In the study facility, the average number of new teen registrants per quarter for the three-quarter period prior to implementation of the Teen Clinic was 44. For the twelve-quarter period after program implementation, the average number of new registrants per quarter was 80. Thus, following implementation of the program in late 1982, there was an average 82 percent increase in the number of new teen registrants during the post-implementation quarters in the study facility. In contrast, comparison site 1 experienced a 4 percent increase, whereas comparison site 2 showed a decrease of 17 percent in the number of new adolescent female patients.

Adult registration rates did not change markedly during the study period in any of the facilities. The number of adults who registered for family planning services at the study facility increased an average of 22 percent during the same time interval, compared with an increase of 16 and 2 percent, respectively, at comparison sites 1 and 2 (data not shown). These data suggest there was not a general increase in overall family planning use that could account for the observed changes in enrollment rates among adolescents.

In addition to the absolute increase in the number of teen registrants, the proportion of clients who were adolescents also increased after implementation of the Teen Clinic in the study facility. In the three-quarter period before startup, adolescents accounted for 47 percent of all new family planning registrants. Following introduction of the Teen Clinic, the proportion of adolescent

family planning registrants was 57 percent, representing a 21 percent increase overall.

The observed increase in teen family planning patients is, of course, not necessarily attributable to implementation of the Teen Clinic. A variety of alternative explanations can be offered to explain the change. The most plausible alternative explanation for the upswing in the number and proportion of teens seeking contraceptive services at the study facility is referral of teen patients from neighboring clinics. This alternative hypothesis is particularly strong in light of the explicit CDOH policy that encouraged clinic staff at the two comparison sites to refer teen family planning patients to the new Teen Clinic at the study facility. If such a transfer occurred, a decrease in the proportion of patients who were teens would be expected at those two facilities. At comparison site 2, the percent of family planning patients who were adolescents dropped from 55 to 46 percent after the Teen Clinic was implemented. At comparison site 1, the rate stayed the same at 52 percent. These data indicate that some transfer of patients might have been responsible for the increase in new teen family planning patients at the study facility. However, additional evidence from the cross-sectional survey described subsequently suggests that very few patients transferred. Thus, the marginal increase in adolescent family planning patients at the study facility most likely represents new rather than relocated clients.

**Survey findings.** The major demographic characteristics of the 153 respondents to the Teen Clinic survey were virtually identical to the Teen Clinic client population overall, that is, young, black females. About one-third (30.1 percent) of the respondents were making their first visit to the clinic at the time of the survey, while the remainder (69.9 percent) were return patients. Of the respondents 22, or 14.6 percent, were already parents, and 96 percent were enrolled in school. The majority of teenagers (69.3 percent) lived with only one parent, their mother. One-third of these mothers worked full-time (32.4 percent); half (48.6 percent) were unemployed. Almost half of the participants' fathers (44.9 percent) worked full-time; about one-fourth (28.6 percent) did not know their father's employment status.

Travel time, as an indicator of distance to the clinic, was relatively short for most participants. Eighty-seven percent of the teenagers surveyed traveled a maximum of 30 minutes to the clinic, and of the total group, 57.1 percent reported that

they had to travel 15 minutes or less to come to the clinic. Mode of transportation was split almost equally between public transit (43.1 percent) and walking (51.0 percent). Reported travel time and mode are consistent with the finding that over half of the participants came from nearby schools.

**Knowledge of other sources of care and referrals.** With regard to the availability of birth control, 69.9 percent of the teenagers surveyed knew of other places where they could obtain contraceptives. In descending order of the frequency of responses, these other places were neighborhood clinics (67.5 percent), hospitals (52.5 percent), private doctors (27.5 percent), and drug-stores (11.7 percent). Despite the apparent knowledge of alternative sources, only 13.8 percent of the respondents said they had actually used a provider other than the Teen Clinic for birth control.

The sources of referral for the adolescents coming to the Teen Clinic varied. Friends were by far the most common source of information about the clinic (47 percent), followed by mothers (28 percent), other relatives (15 percent), and other people (10 percent). Additionally, 67 percent of the respondents stated that they had a friend or relative who also used the Teen Clinic.

**Reasons for clinic attendance.** Both new and return patients were asked to indicate their most important reasons for initially choosing the Teen Clinic, as opposed to another source of care. Frequencies of the responses are shown in the first column of table 1, grouped into two major conceptual categories suggested by previous research (plus an "other" category). One institutional ("services are free") and one interpersonal factor ("clinic is for teens only") were cited most frequently as important in motivating initial attendance. Other factors cited by at least one-fifth of the participants included (a) convenience of scheduling and location ("open in the afternoon," "easy to get here"), (b) staff factors ("staff friendly," "comfortable talking to staff"), (c) peer factors ("friends come here"), and (d) confidentiality ("no parental consent required," "staff won't tell").

Return patients were also asked to indicate why they kept coming back to the Teen Clinic, rather than going elsewhere for services. Frequencies of the responses are shown in the second column of table 1. For the most part, these responses closely mirror those selected as important reasons for first

Table 1. Reasons why adolescents visited the Teen Clinic the first and subsequent times

Response category	Percent of cases	
	First visit	Return visit
Total respondents .....	150	102
<i>Institutional-access factors</i>		
Money-cost: "services are free" ....	36.0	39.2
Time: "open in afternoon" .....	19.3	27.5
Location:		
"easy to get here" .....	24.0	33.3
"safe from gangs" .....	2.7	0.0
<i>Social-interpersonal factors</i>		
Staff:		
"staff friendly" .....	28.7	32.4
"comfortable talking to staff" .....	27.3	35.3
Peers:		
"friends come here" .....	22.0	15.7
"clinic is for teens only" .....	34.7	35.3
Confidentiality:		
"no parental consent required" ...	26.7	12.7
"staff won't tell anyone" .....	24.0	15.7
Special services:		
"to go to info session" .....	6.7	8.8
"to go to rap group" .....	14.0	20.6
Other .....	8.7	4.9

NOTE: All survey respondents were asked to indicate why they had come to the Teen Clinic the first time ("today" for new patients) rather than going elsewhere for services. Respondents who had made 2 or more visits were also asked to indicate why they kept coming back to the clinic. Thus, the return patients answered both questions and are included in the calculations for both columns of the table. Percents do not add to 100 because of multiple responses.

visits. The fact that services are free leads the list of important reasons. At least one-third of the respondents indicated that location ("easy to get here"), staff factors ("staff friendly," "comfortable talking to staff"), and peer factors ("clinic is for teens only") were important considerations. Availability of services in terms of scheduling ("open in the afternoon") was also judged as important by over one-fourth of the return patients.

**Strategies for improving services and outreach.** Suggestions for improving the Teen Clinic and recruiting new patients were solicited through two open-ended questions. When asked about what, if anything, they would change about the clinic, almost half of the respondents reported that they would make no changes or that everything was "okay as it is" (see table 2). The most frequent suggestions for change included a desire for faster service (15 percent) and more or different hours (6 percent).

Suggestions for improving outreach and recruiting new patients are shown in table 3. One-fourth of the clients believed that having current patients bring in their friends would increase utilization by

Table 2. What 121 participants would change about the Teen Clinic

<i>Suggested changes</i>	<i>Frequency of response</i>	<i>Percent of cases</i>
Nothing, "okay as it is" . . . . .	53	44
Faster service . . . . .	18	15
More or different hours . . . . .	7	6
More positive staff attitudes . . . . .	5	4
More staff . . . . .	4	3
Increase or change rap group . . . . .	6	5
Do not require rap group . . . . .	4	3
Other . . . . .	17	14
No comment . . . . .	11	9

Table 3. Suggestions from 122 participants for recruiting new patients to the Teen Clinic

<i>Recruitment methods</i>	<i>Frequency of response</i>	<i>Percent of cases</i>
Tell participants to bring friends . . . .	32	26
Advertise . . . . .	30	25
Advertise with flyers, signs, and posters . . . . .	16	13
Advertise through schools . . . . .	13	11
Advertise through mass media . . . . .	11	9
Other . . . . .	6	5
No comment . . . . .	23	19

area teens. A similar proportion suggested that advertising in general would help. More specific methods of advertising (for example, posting written notices, giving presentations in local schools, and utilizing radio and television) were mentioned by smaller proportions of respondents.

### Conclusions

The results of this study demonstrate that public health facilities can successfully implement services designed to meet the needs of inner-city, high-risk adolescents and thereby increase registration for family planning services. Data on the use of the clinic document an 82 percent increase in teen family planning registrants at the study facility after the implementation of the special teen services. Figures for comparison were obtained for two traditionally managed public health facilities whose staff were instructed to refer adolescents to the Teen Clinic. In one comparison site, a 4 percent increase in teen family planning registrants was found; in the other site, a 17 percent decrease was observed.

Overall, the evidence suggests that the Teen Clinic was successful in attracting new adolescent

family planning patients. The plausibility of the causal role of the new program in attracting teen clients is enhanced by consideration of alternative explanations for the observed increase in the number of teens registering for family planning services. Among the possible alternative reasons for this increase, the most salient is referrals from neighboring public health clinics that are related both geographically and administratively to the study facility.

Although a referral network among health department facilities was encouraged, the available evidence suggests that such referrals did not occur frequently. Only 14 percent of the survey participants who knew of other places where they could obtain birth control services reported having gone elsewhere. Likewise, when asked to report the source of referral, only 10 percent cited a source other than a friend or relative. Overall, it appears that the Teen Clinic attracted adolescents who were first-time users of medically prescribed forms of birth control. They were not simply referrals from one clinic provider to another. Informal referral networks, especially friends and other relatives, played a major role in recruiting patients.

The upswing in the use of services was achieved at basically no financial cost to the management of the clinic. Staff time was staggered so that the extension of clinic hours did not incur overtime. Of course, some additional resources were consumed because of an increased distribution of family planning methods. However, because at the time of the study the CDOH paid only 10 cents per packet of birth control pills, these new expenditures were modest and easily absorbed by the clinic's budget. Perhaps the most important ingredients in the teen program, namely, positive staff attitude and commitment to youth, were completely free.

Another factor that also might have contributed to clinic use is the apparent family support in the surrounding community for pregnancy prevention. Most of the Teen Clinic clients indicated they could be contacted at home if necessary; many had initially heard of the clinic from their mother. In some communities, parents and other concerned adults may thus represent an underutilized resource for the recruitment of teens into family planning programs. More effort should be expended to garner adult support for teen pregnancy prevention through school- and church-based parent groups, local tenant and public housing organizations, and other adult organizations. Making parents aware of available community resources and helping



them learn to communicate with their teenagers may contribute to timely and effective use of contraception (11).

A second good source of referral is the current clinic patients. Most new patients in this study had heard of the clinic from their friends. Many Teen Clinic clients believed that having current patients bring in a friend would be a successful outreach strategy—a conclusion shared by other investigators (5,8).

Patient retention presents a different problem for family planning clinics. The return rate in this study (56 percent) was fairly similar to the rate observed in one inner-city hospital-based teen program (52 percent) (14). In this study, logistical considerations and staff-patient interactions were viewed as important reasons for clinic use by more return clients than new patients (who were more concerned with issues of confidentiality). Concern about waiting time is common (7); however, the alleviation of this problem will, in many cases, require additional staff. Free or subsidized services also are important, as is convenience of scheduling (for example, after-school hours). Clearly, further experimentation with methods to retain adolescent family planning patients is warranted.

The use of specialized teen services—special hours, education and counseling sessions, rap groups—has received mixed support in the literature. Such settings enable clinic administrators to employ staff who are sensitive to the special needs of teens. Additionally, these programs may provide an important source of peer support and create a “caring” atmosphere (8,15). On the other hand, some studies have found that the presence of special teen services is not an important predictor of patient satisfaction or retention and may, in fact, adversely affect clinic use by increasing a patient’s time with educators-counselors, which is viewed as undesirable by teens (6).

Results from this study support the implementation of specialized teen services in public health facilities. Special hours and the fact that the clinic was only for teens were frequently cited as important reasons for first and return clinic visits by a group of adolescents who, for the most part, had never gone elsewhere for contraceptive care. Although the rap groups were not exceptionally important compared with other clinic features, one-fifth of the clients who used the clinic more than once cited them as an important reason for continuing to use the clinic. Perhaps the strongest evidence supporting the provision of specialized teen services is suggested by the utilization data.

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As previously noted, registration at the clinic by female teens increased by 82 percent after the Teen Clinic was implemented in the study facility. In contrast, utilization at two other traditionally managed facilities decreased or remained basically the same.

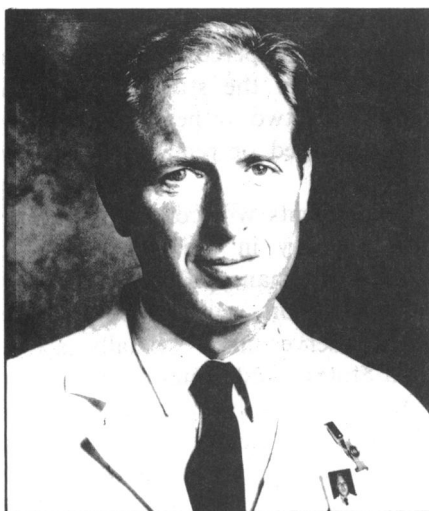
Public health departments will continue to have an important role to play in the prevention of unintended adolescent pregnancy. Because of their wide geographic dispersion, such facilities are uniquely situated to serve many sexually active teens in the United States. Additionally, in this era of fiscal constraint, it will become increasingly important to demonstrate whether such programs are cost-effective compared with more traditional service models, as well as other initiatives (for example, school-based clinics). Special clinics for adolescents provided through public health department facilities may be one successful model of contraceptive service delivery for teens in low-income, inner-city black communities.

#### References. . . . .

1. Baldwin, W.: Trends in adolescent contraception, pregnancy and childbearing. *In* *Premature adolescent pregnancy and parenthood*, edited by E. McAnarney. Grune and Stratton, Orlando, FL, 1982, pp. 3-19.
2. Center for Population Research, National Institute of Child Health and Development: Adolescent pregnancy and childbearing—Rates, trends and research findings from CPR, NICHD. August 1986.
3. Alan Guttmacher Institute. Current functioning and future priorities in family planning services delivery. New York, December 1983.
4. Torres, A., and Forrest, J.: Family planning clinic services in the United States, 1983. *Fam Plann Perspect*, 17: 30-35 (1985).
5. Swartz, D., and Darabi, K.: Why did you come to the clinic tonight? Motivations for adolescents’ first visits to



- birth control clinics. Presented at APHA, November 1984.
6. Kisker, E.: The effectiveness of family planning clinics in serving adolescents. *Fam Plann Perspect*, 16: 212-218 (1984).
  7. Chamie, M., et al.: Factors affecting adolescents' use of family planning clinics. *Fam Plann Perspect*, 14: 126-139 (1982).
  8. Zabin, L., and Clark, S.: Institutional factors affecting teenagers' choice and reasons for delay in attending a family planning clinic. *Fam Plann Perspect*, 15: 25-29 (1983).
  9. Dryfoos, J., and Heisler, T.: Contraceptive services for adolescents: an overview. *In* *Teenage sexuality, pregnancy and childbearing*, edited by F. Furstenberg, et al. University of Pennsylvania Press, Philadelphia, 1981, pp. 394-408.
  10. Moore, K., and Burt, M.: Private crisis, public cost: policy perspectives on teenage childbearing. The Urban Institute Press, Washington, DC, 1982.
  11. Zabin, L., and Clark, S.: Why they delay: a study of teenage family planning clinic patients. *Fam Plann Perspect* 13: 205-217 (1981).
  12. Nathanson, C., and Becker, M.: The influence of client-provider relationships on teenage women's subsequent use of contraception. *Am J Public Health* 75: 33-38 (1985).
  13. Illinois Department of Public Health: Teenage pregnancy statistics for Chicago community areas, 1982.
  14. Jones, J., Namerow, P., and Philliber, S.: Adolescents' use of a hospital-based contraceptive program. *Fam Plann Perspect* 14: 224-231 (1982).
  15. Jekel, J.: Evaluation of programs for adolescents. Birth defects: original article series, Vol. 17. March of Dimes Birth Defects Foundation, White Plains, NY, 1981, pp. 139-153.



*"AIDS is a fatal disease, but it can be prevented. If we know how to protect ourselves and our children, we can stop this disease in its tracks."*

- Dr. Samuel Perry  
A researcher working on  
identifying the symptoms  
of AIDS



Call the AIDS Information line,  
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An Important Message from the U.S. Public Health Service Centers for Disease Control