Contraceptive Dispensing and Selection in School-based Health Centers

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Purpose: To determine whether initiation of on-site dispensing of hormonal contraceptives (oral contraceptive pill, Depo-provera, and Norplant) in six urban school-based health centers reduced time to initial selection, and increased their consistent use among sexually active females.

Methods: Participants were sexually active females who received family planning care in a school year before (1994–1995 cohort) or after (1996–1997 cohort) the initiation of on-site dispensing. Data on contraception and sexual behavior were collected at each family planning visit. Cohorts were compared using Student's t-tests and Chi-square tests, analysis of covariance, and logistic regression.

Results: About 59% of the 1994–1995 cohort selected hormonal contraceptives at the first or second visit; this increased to 72% of the 1996–1997 cohort ($X^2 = 11.3; p < .001$). After adjustment for cohort differences, the 1996–1997 cohort consistently selected hormonal contraceptives a longer period of time, although the difference did not reach statistical significance (adjusted means: 1994–1995 cohort = 73 days, 1996–1997 cohort = 81 days; $t = 1.6, p < .10$).

Conclusion: Sexually active females receiving family planning care select methods of hormonal contraception sooner and somewhat more consistently when the clinics in their high schools can dispense contraceptives on-site. © Society for Adolescent Medicine, 2001
accessing contraceptives and improve consistency of contraceptive use \[8,9\]. Yet, there is little empirical evidence to support this claim. Few studies have examined whether dispensing of contraception on-site in SBHCs affects adolescent contraceptive use. In one study, Brindis et al. \[8\] completed chart reviews at two sites that dispensed contraceptives and two sites that were limited to providing prescriptions for contraceptives. When comparing clients at these SBHC sites, there was no difference in the average contraceptive use ratio (the number of months that a sexually active client reported having used a contraceptive method at every act of intercourse divided by the number of months in SBHC family planning care services). A second study by Bearss et al. \[9\] evaluated a program designed to improve contraceptive continuation by dispensing hormonal contraceptives in Baltimore SBHCs. Patterns of contraceptive use after initiation of dispensing were compared with patterns the month before dispensing. Use of the oral contraceptive pill increased, but dropout of the program was high.

**Research Questions**

Overall, few studies have investigated whether on-site dispensing of contraceptives in SBHCs can affect adolescents' use of contraceptives. The goal of this study was to investigate this question further. We determined whether a policy to begin dispensing hormonal contraceptives, including oral contraceptive pills (OCPs), depot medroxyprogesterone acetate (DMPA; marketed as Depo-Provera), and levonorgestrel implants (Norplant), in SBHCs was associated with earlier and more consistent selection of hormonal contraceptives. We had two research questions. Compared with females who received family planning care at SBHCs in a school year before on-site dispensing of hormonal contraceptives, did females who received care in the same SBHCs in a school year after the initiation of dispensing: (a) select methods of hormonal contraception sooner during family planning care, and (b) select methods of hormonal contraception more consistently? Therefore, two cohorts of females were compared. The first cohort received family planning care at SBHCs in a school year before on-site contraceptive dispensing in SBHCs. The second cohort received family planning care in a school year after dispensing began. Hormonal contraception included OCPs, DMPA, and Norplant. We did not examine the switching of hormonal contraceptive methods. Research questions were focused on selecting hormonal contraceptives more quickly and more consistently rather than use of contraceptives because data on ingestion of OCPs were not available and 66% of females selected OCPs at least one time.

Before February 1996, providers at the SBHCs included in this study were unable to dispense methods of hormonal contraception on-site. Instead, clients received a prescription for birth control that they were instructed to fill at other locations such as county clinics or private pharmacies. Health care providers at SBHCs reported that many young women were not filling their prescriptions and described four primary barriers to contraceptive access. The first barrier was the distance of clinics and pharmacies from schools. Clinic and pharmacy sites were between 1 and 5 miles from the SBHCs. SBHC providers reported that many of their clients had no transportation apart from the bus system, and the trip from school to some clinics or pharmacies required a bus change. SBHC providers also described adolescents' lack of planning as a second barrier. The most common reason that adolescents do not access a contraceptive clinic is procrastination \[10\]. SBHC providers reported that some students procrastinated or did not complete the steps needed to acquire contraception from another site.

A third barrier was adolescents' lack of time after school or difficulty finding time after school. Upon follow-up of family planning clients, SBHC providers found that adolescents had difficulty finding travel time after school and students could not be excused from school to go to the clinic or pharmacy. Students also had difficulty seeking care after school hours without the knowledge of their parents. This deterred some young people from receiving services because, as Zabin et al. reported \[10\], about 30% of adolescents do not seek family planning services because of fear of discovery by parents. A final barrier was the difficulties young females had approaching unknown adult clinic settings. Young people can be embarrassed to seek family planning care \[11\], especially when care involves the use of an unfamiliar clinic or pharmacy.

**Methods**

**Setting**

Females who received family planning care at six high school SBHCs in an urban area of the northwestern United States were included. Because of the reported barriers to contraceptive access, a policy
was implemented in February 1996 that allowed SBHC providers to dispense contraceptive foam and hormonal methods of contraception (including OCPs, DMPA, and Norplant). There were no changes in other family planning policies. Three-month supplies of contraceptives were provided at no cost before and after on-site dispensing in SBHCs.

A tickler system to prompt SBHC care providers to follow-up about every 3 months with family planning clients was in place both before and after on-site dispensing. The tickler system also prompted staff to contact new users of contraception for a 1-month check-in. The average wait for a family planning visit before and after on-site dispensing was <1 week and was usually within 24–48 h.

**Data Source**

Health Department Health Information System (HIS) data based on the client visit record (CVR) developed by Ahlers and Associates were the source of information. This study was exempt from Internal Review Board approval because it used a portion of this existing data source that contained no information that identified patients. As part of the CVR, each family planning visit included two codes to indicate methods of contraception. The first code indicated a contraceptive method reported to be used by the patient at the beginning of a family planning visit. The second code indicated a contraceptive method selected by the patient at the end of a family planning visit. If more than one method was reported at the beginning or was selected at the end of a single visit (e.g., OCPs and condoms), the method most likely to prevent pregnancy was coded. Codes included “none,” “sterilization,” “oral,” “intrauterine device (IUD),” “diaphragm/cap,” “foam and condom,” “condom,” “spermicide,” “natural rhythm,” “hormone implant,” “hormone injection,” “abstinence,” or “other.” As a result of this coding method, we were unable to determine rates of selection of more than one method of birth control. In addition, observed rates of condom selection were likely to be much lower than actual rates because SBHC personnel almost always encouraged the selection of hormonal methods in combination with the use of condoms.

**Sample**

Female students who had at least one family planning visit at SBHCs early in the school years of interest (between September 1, 1994 and December 1, 1994, or between September 1, 1996 and December 1, 1996 were identified in the HIS to select participants who were most likely to have received family planning care throughout the entire school year. Data on all family planning visits for these two cohorts of females were then selected from the HIS for the entire years of interest (July 1, 1994 to June 30, 1995, or July 1, 1996 to June 30, 1997). About 80% of all first family planning visits were between September 1 and November 31.

The data were then matched on client identification number and merged to develop a set of person-level data that included a history of all family planning visits for each SBHC client selected. Overall, 804 females were identified who received a family planning visit early in the school year before on-site dispensing in SBHCs and 915 females were identified in the school year after the initiation of on-site dispensing.

We selected the subgroup of females who were most likely new users of hormonal contraception and who received at least two family planning visits during the school year. This included 355 clients from the 1994–1995 school year (44%, “1994–1995 cohort”) and 378 clients from the 1996–1997 school year (41%, “1996–1997 cohort”).

Students who reported use of hormonal contraceptives at their first family planning visit in the study years (38% of family planning clients in 1994–1995 and 39% of family planning clients in 1996–1997, \( \chi^2 = .21, p = .58 \)) had only one family planning visit (18% of family planning clients in 1994–1995 and 18% of family planning clients in 1996–1997, \( \chi^2 = .06, p = .81 \)) and/or were abstinent were excluded. Females were considered abstinent if they were coded as not selecting a method of birth control because of abstinence or because they were not sexually active at every family planning visit. Yet, most abstinent females (72%) had only one family planning visit. A higher proportion of females who received family planning services were classified as abstinent in 1996–1997 than in 1994–1995 (6.0% of family planning clients in 1994–1995 vs. 9.8% of family planning clients in 1996–1997; \( \chi^2 = 8.7, p < .01 \)). Finally, about 3.6% of females (n = 27) were excluded because they had received family planning care in 1994–1995 and 1996–1997.

The mean age of females included in the study was 16.3 [standard deviation (SD) = 1.2] years. Excluded females were just slightly older (mean age = 16.6 years, \( t = 5.0, p < .001 \)). Fifty-eight percent of participants were white, 26% were black,
7% were of Asian descent, 5% were Hispanic, 2% were Native American, and 2% did not have a race/ethnicity recorded. Excluded females were somewhat more likely to be white (64% vs. 58%) and slightly less likely to be black (20% vs. 26%, $\chi^2 = 12.2, p = .03$).

### Analytic Strategies

Time to initiation of hormonal contraception was operationalized as the number of days and visits until the first selection of hormonal contraception. We also determined the proportion of students who selected hormonal contraception at their first or second family planning visit. To measure consistent selection of hormonal contraception, the number of days of consistent selection were counted starting with the first selection of any of the three hormonal methods of contraception at a family planning visit. Counting continued as long as either OCPs, DMPA, or Norplant were reported to be used at the beginning and selected at the end of subsequent family planning visits. Inconsistency was defined as a skip in this pattern and counting was stopped. The proportion of days each female consistently selected hormonal contraception was calculated as the number of days of consistent selection divided by the total number of days in family planning care. Time to initiation, and consistent selection, of hormonal contraception between cohorts were first compared using Student’s $t$-tests and Chi-square tests. Because there were students who never selected hormonal contraceptives, we compared cohorts excluding these females. We repeated the cohort comparisons of time to initiation of hormonal contraception after including these students by assigning them the maximum value possible (described below).

Because we relied on information gathered at each family planning visit to determine consistency of selection of hormonal contraception, these cohort differences might have been confounded with con-

### Table 1. Cohort Comparisons of Demographic Characteristics and Use of Family Planning Care

<table>
<thead>
<tr>
<th>Characteristics and Use of Care</th>
<th>1994–1995 Cohort $(N = 335)$</th>
<th>1996–1997 Cohort $(N = 378)$</th>
<th>$t$ or $\chi^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age [mean (SD) years]</td>
<td>16.3 (1.2)</td>
<td>16.2 (1.2)</td>
<td>1.1</td>
</tr>
<tr>
<td>Race/ethnicity [$n (%)$]</td>
<td></td>
<td></td>
<td>8.1</td>
</tr>
<tr>
<td>American Indian/Alaskan native</td>
<td>11 (3.1)</td>
<td>3 (0.8)</td>
<td></td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>25 (7.0)</td>
<td>26 (6.9)</td>
<td></td>
</tr>
<tr>
<td>Black/African-American</td>
<td>92 (25.9)</td>
<td>99 (26.2)</td>
<td></td>
</tr>
<tr>
<td>Hispanic/Latina</td>
<td>19 (5.4)</td>
<td>18 (4.8)</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>204 (57.5)</td>
<td>221 (58.5)</td>
<td></td>
</tr>
<tr>
<td>Total number of family planning visits [mean (SD)]</td>
<td>4.7 (2.5)</td>
<td>4.8 (2.6)</td>
<td>0.4</td>
</tr>
<tr>
<td>Days from first to last family planning visits [mean (SD)]</td>
<td>157.3 (84.0)</td>
<td>151.8 (82.5)</td>
<td>-0.9</td>
</tr>
<tr>
<td>Days from first to second family planning visit [mean (SD)]</td>
<td>48.3 (55.3)</td>
<td>39.7 (49.6)</td>
<td>-2.2‡</td>
</tr>
<tr>
<td>Visit within 90 days from first selection of hormonal contraception [$n (%)$]</td>
<td>179 (50.4)</td>
<td>230 (60.9)</td>
<td>8.1†</td>
</tr>
<tr>
<td>Visit between 90 and 180 days from first selection of hormonal contraception [$n (%)$]</td>
<td>139 (39.2)</td>
<td>173 (45.8)</td>
<td>3.3§</td>
</tr>
</tbody>
</table>

* $p < .05$.  
† $p < .10$.  
‡ $p < .01$.  

### Table 2. Methods of Contraceptives Selected by Cohorts

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No method of contraception selected</td>
<td>147 (41.4)</td>
<td>111 (29.4)</td>
<td>11.64‡</td>
</tr>
<tr>
<td>Oral contraceptive pill</td>
<td>184 (51.8)</td>
<td>201 (53.2)</td>
<td>0.13</td>
</tr>
<tr>
<td>Injection of hormones (Depo-provera)</td>
<td>115 (32.4)</td>
<td>146 (38.6)</td>
<td>3.10</td>
</tr>
<tr>
<td>Hormone implants (Norplant)</td>
<td>4 (1.1)</td>
<td>1 (0.3)</td>
<td></td>
</tr>
</tbody>
</table>

* Percentages add to more than 100% because females could select different methods (including no method) at different family planning visits.

† Includes not selecting any method of hormonal contraception, condom, spermicide, or any other form of contraception.  
‡ $p < .001$.  
Blank indicates no statistical test completed owing to small cell size.
consistent selection of hormonal contraceptives. Hence, we also used analysis of covariance and multiple logistic regression to compare consistent selection between cohorts using two indicator variables to adjust for these differences. The first indicator variable identified females who returned for another family planning visit within 90 days after they first selected hormonal contraception. The second variable indicated whether females had a return family planning visit between 90 and 180 days after they first selected hormonal contraceptives.

Results

Demographic Characteristics and Family Planning Services

The two cohorts were drawn from the same schools 1 year apart. In general, demographic characteristics, numbers of family planning visits, and numbers of days from first to last family planning visit did not differ between cohorts (Table 1). Females in the 1996–1997 cohort received their second visits sooner. On average, the number of days between the first and second family planning visit was shorter among the 1996–1997 cohort. In addition, a higher proportion of females in the 1996–1997 cohort returned to SBHCs for another family planning visit within 90 days of their first selection of hormonal contraception. Accordingly, analyses of consistent selection of hormonal contraception are reported both before and after controlling for these significant differences between cohorts.

Types of Hormonal Contraceptive Methods Selected

Table 2 summarizes the types of hormonal contraception selected in the 1994–1995 cohort and the 1996–1997 cohort. Among the 1994–1995 cohort, 52% of females selected OCPs at the end of at least one of
their family planning visits, 32% selected DMPA, and about 1% selected Norplant. Overall, 147 females (41%) selected no method of contraception at the end of at least one of their family planning visits.

Compared with the 1994–1995 cohort, there was no significant difference in the proportion of females in the 1996–1997 cohort who selected OCPs at the end of at least one of their family planning visits (53%) or DMPA (39%). Only 1 female in the 1996–1997 cohort selected Norplant. Nevertheless, the 1996–1997 cohort was significantly less likely than the 1994–1995 cohort to select no method of contraception at the end of at least one of their family planning visits (29%).

Selection of Hormonal Contraception by Visit

Figure 1 displays proportions of females within each cohort who first selected hormonal contraception, had not selected hormonal contraception, and who were consistent and inconsistent selectors of hormonal contraception for up to six family planning visits. This figure illustrates that, compared with the 1994–1995 cohort, a higher proportion of females in the 1996–1997 cohort selected hormonal contraceptives at their first visit (23% vs. 16%), and regardless of the number of family planning visits received, a larger proportion of females had consistently selected hormonal contraception.

First Selection of Hormonal Contraceptives

After on-site dispensing of hormonal contraceptives in SBHCs it took fewer days and visits for females to first select hormonal contraception. On average, the 1994–1995 cohort took 57 days (2.5 visits) to first select hormonal contraception, whereas the 1996–1997 cohort took 40 days (Table 3) \((t = -3.2; p < .001; 2.2 \text{ visits}, t = -3.3, p < .001)\). Overall, 59% of family planning clients in the 1994–1995 cohort selected hormonal contraceptives at the first or second visit compared with 72% of the 1996–1997 cohort \(\chi^2 = 11.3; p < .001)\).

Because there was a group of females who never selected hormonal contraceptives (24% of the 1994–1995 cohort and 22% of the 1996–1997 cohort), we repeated these analyses after assigning these females the total number of days (or visits) from their first family planning visits to their last visits. These analyses produced similar results but, as expected, the average numbers of days and visits until first selection of hormonal contraceptives increased in both cohorts and the proportion of each cohort who selected hormonal contraception at the first or second family planning visit declined (proportions shown in Figure 1).

Consistent Selection of Hormonal Contraceptives

Females in the 1996–1997 cohort who received family planning services were also expected to select hormonal methods of contraception more consistently compared with females in the 1994–1995 cohort. Females in both cohorts who never selected any method of hormonal contraception were excluded because these females had no potential to be consistent. Therefore, we compared consistent selection of any of the three hormonal methods of contraception before and after a policy to dispense these methods among those females who selected hormonal contraception at least one time during family planning care.

### Table 3. First Selection and Consistent Selection of Hormonal Contraceptive Methods by Cohort

<table>
<thead>
<tr>
<th>Cohort Comparisons of Contraceptive Selection (^a)</th>
<th>1994–1995 Cohort (N = 270)</th>
<th>1996–1997 Cohort (N = 293)</th>
<th>(t) or (\chi^2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time to first selection of hormonal contraception methods</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days to first selection [mean (SD)]</td>
<td>57.3 (67.5)</td>
<td>39.8 (60.0)</td>
<td>(-3.2^{**})</td>
</tr>
<tr>
<td>Selection at first or second family planning visits [(n) (%)]</td>
<td>158 (59)</td>
<td>211 (72)</td>
<td>11.3^{**}</td>
</tr>
<tr>
<td>Consistent selection of hormonal contraception methods, unadjusted</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days of consistent selection [mean (SD)]</td>
<td>80.3 (86.6)</td>
<td>94.6 (81.8)</td>
<td>2.0*</td>
</tr>
<tr>
<td>Proportion of days in family planning care with consistent selection [mean (SD)]</td>
<td>0.41 (.39)</td>
<td>0.53 (.39)</td>
<td>3.7^{**}</td>
</tr>
<tr>
<td>Consistent selection for (\geq 90) days [(n) (%)]</td>
<td>103 (38)</td>
<td>138 (47)</td>
<td>4.6*</td>
</tr>
</tbody>
</table>

\(a\) Includes oral contraceptive pill, Depo-provera injections, and Norplant. Excludes females who never selected hormonal contraception.

\(p < .05.\)

\(* p < .001.\)
Simple Cohort Comparisons

Table 3 also summarizes the results of comparing consistent selection of hormonal contraception between cohorts. On average, females who received family planning care after on-site dispensing consistently selected hormonal methods of contraception for more days overall compared with females who received family planning care the year before on-site dispensing in SBHCs. The 1994–1995 cohort of females consistently selected hormonal birth control an average of 41% of the days that they received family planning care. In the 1996–1997 cohort of females, this had significantly increased to an average of 53%. Finally, a significantly higher proportion of females in the 1996–1997 cohort consistently selected hormonal contraceptives for 90 days or more at some time during family planning care.

Adjustment for Patterns of Repeat Family Planning Visits

Table 1 shows the cohort differences in proportions of females who returned for repeat family planning visits within 90 days, and between 90 and 180 days, of their first selection of hormonal contraceptives. After adjustment for these differences, the 1996–1997 cohort consistently selected hormonal contraceptives a longer period of time although the difference did not reach statistical significance (adjusted means: 1994–1995 cohort = 73 days, 1996–1997 cohort = 81 days; t = 1.6, p < .10). After adjustment, the 1996–1997 cohort was 1.5 times as likely to have consistently selected hormonal contraceptives for 90 days or more compared with females in the 1994–1995 cohort (odds ratio = 1.5, \( \chi^2 = 4.3, p < .10 \)).

Use of DMPA

Although there were no significant differences in the use of DMPA when comparing the 1994–1995 cohort and the 1996–1997 cohort (Table 1), there was a slight increase in the popularity of this method among the 1996–1997 cohort. Because DMPA results in consistent use of hormonal contraception for 3 months, any increase in popularity could account for some of the increase in consistent selection of hormonal contraception found among the 1996–1997 cohort. Therefore, analyses were conducted adjusting for the use of DMPA by including a variable that indicated whether females had or had not selected DMPA during at least one of their family planning visits. Again, the 1996–1997 cohort selected methods of hormonal contraception for a longer period of time but the difference was not significant (\( p = .11 \)).

Discussion

Our findings indicate that, among females who receive more than one family planning visit at SBHCs and who choose hormonal contraceptives at least one time during family planning care, on-site dispensing of hormonal contraceptives in SBHCs is associated with earlier selection of hormonal contraceptives and a longer period of selection of hormonal contraceptives after accessing family planning care. On-site dispensing of hormonal contraceptives in SBHCs does not, however, appear to increase the proportion of females who select hormonal contraceptives at some time during family planning care, and does not reduce the proportion of abstinent females.

Although on-site dispensing of hormonal contraceptives in SBHCs is associated with earlier first selection of hormonal contraception and an increase in the number of days of consistent selection of hormonal contraception, cohort differences were not large. Nevertheless, these small improvements in selection of hormonal contraception may delay or eliminate some unintended pregnancies by reducing periods of intermittent use. Inconsistent use of contraception is common among adolescents [2–6], and young women are more likely to stop using methods of contraception that require preparation (such as OCPs) during periods of sexual abstinence and switch to methods which do not require preparation (such as withdrawal) when sexual activity is reinitiated. This places adolescents at risk of unintended pregnancies when abstinence ends [3]. In addition, partner switching is common among adolescents [9] possibly resulting in multiple short periods of abstinence and increased risk of intermittent use of methods of birth control that require preparation. Not having a steady romantic relationship or having infrequent sexual intercourse is associated with inconsistent birth control use among adolescents [12–14]. In addition, it has been difficult to identify school programs that increase contraceptive use or decrease pregnancy among young people [15,16]. Therefore, it is necessary to identify programs and policies that, when averaged across a large group of young people, appear to make small improvements in contraceptive access and use, while also developing and identifying programs that have a more significant effect on a smaller but higher-risk group of adolescents. In this study we could not determine whether...
on-site dispensing of hormonal contraceptives in SBHCs results in delays in, or reduced rates of, unintended pregnancy. This remains an important question to investigate in the future.

In addition, we could not determine whether on-site dispensing of hormonal contraceptives in SBHCs was associated with shorter intervals from first intercourse to seeking family planning services. National surveys indicate that females wait an extended period of time from their first experiences of sexual intercourse before seeking family planning services [2], but may use condoms in the interim. However, adolescents report embarrassment and other barriers to purchasing condoms [11]. Therefore, additional goals of on-site dispensing in SBHCs are to improve the proportion of adolescents who use planned methods of birth control when they first have intercourse, reduce the proportion of adolescents who rely on withdrawal, and reduce the time from first intercourse to use of planned contraceptive methods.

The results of this study appear promising and suggest that on-site dispensing of hormonal contraception improves the contraceptive selection practices of young females. Yet, this study had limitations that primarily stem from questions of the validity and reliability of using an existing administrative database for research and evaluation. In particular, we were careful to stress that the analyses focused on improvements in females’ patterns of selecting hormonal methods of contraception rather than claiming that use of birth control had improved. There is evidence that selecting birth control pills as a contraceptive method cannot be equated with actual use of contraceptives [17].

The reliance on multiple health care providers to record data consistently must also be addressed. There were nine changes in health care provider personnel in the SBHCs included in this study from the 1994–1995 school year to the 1996–1997 school year. However, all providers had experience with the same Ahlers client visit record.

In summary, this study demonstrates that a subset of female high school students select hormonal contraception sooner and consistently select these methods for a longer period of time when the SBHCs in their schools dispense hormonal contraceptives on-site. It seems that on-site dispensing removes some of the logistic barriers to contraceptive access for these young women.

There are at least two populations of females who were identified in this study that require further study. First, there is a group of females (over 20%) who seek family planning care but never select hormonal contraceptives. This group includes females who consistently select condoms or condoms and foam, but also includes those females who choose no method of birth control at their family planning visits. We need more information on if and why this group of sexually active females is ambivalent or resistant to the use of hormonal contraceptives. Second, as previous studies report [9], dropout from SBHC family planning services is fairly high. About 18% of females had only one family planning visit at SBHCs early in the school year. It will be important to understand the reasons.

Overall, fewer than one-fourth of SBHCs currently provide condoms on-site, dispense OCPs, or dispense DMPA [18,19]. In some locations SBHCs are prohibited from dispensing contraception by state law, but most often SBHCs are restricted by school districts’ policies. The results of this study indicate that on-site dispensing of hormonal contraception in SBHCs does not increase the proportion of females who access family planning care and select hormonal contraceptives. Yet, dispensing of hormonal birth control methods in SBHCs is associated with earlier and more consistent selection of hormonal contraception among sexually active females. It may be beneficial for school district administrators to determine whether the young women who receive care from SBHCs or health care providers perceive barriers to consistent use of contraception with present policies. If barriers exist, school districts might rely on evidence of effective provision of family planning services to make modifications that could improve contraceptive access.

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References


