

School-Based Health Centers and the Birth Control Debate

With their numbers on the rise, school-based health centers are an important source of counseling and medical care for low-income and uninsured youth. Controversy over family planning services has had a significant impact, however, and many centers remain limited in their ability to meet the needs of sexually active teens by dispensing contraceptives to them on-site. At the same time, a number of school-based health centers that are committed to reducing teenage pregnancy and improving teens' reproductive health are working within their communities to overcome opposition to the provision of contraceptive care—and they are meeting with some success.

By Cynthia Dailard

School-based health centers increasingly are becoming part of mainstream health care, providing an important source of primary and preventive medical services to young people in the United States. Research shows that while adolescents have significant unmet health needs, those with access to a school-based health center are more likely than their peers who do not to obtain

needed services. Since their inception, however, the question of whether school-based health centers should provide family planning services has sparked heated debates in many communities across the nation. With the number of school-based health centers on the rise, this controversy is likely to spread as parents, educators and health care professionals grapple with the appropriate role of school-based health centers in meeting the family planning needs of sexually active teenagers.

Profiling the Centers

According to a 1998–1999 survey conducted by the National Assembly on School-Based Health Care (NASBHC), there are currently 1,135 school-based health centers across the country, up from only 200 in 1990. Much of this growth is recent: Six in 10 of the centers have been in operation for four years or less (see chart). The centers are located in 45 states—all but Idaho, Nevada, North Dakota, South Dakota and Wyoming—and the District of Columbia and can be found in urban, rural and suburban areas where children have significant unmet health care needs because they are low-income or uninsured. Three in 10 are located on-site at elementary schools, and the rest in middle schools and high schools. By and large, they are sponsored by a larger health agency, such as a hospital, health department or community health center (see chart).

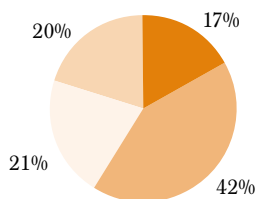
States are the largest source of funding for school-based health centers, contributing almost \$30 million in general revenues during the 1997–1998 school year, reports Making the Grade, a national grant program of the Robert Wood Johnson Foundation that assists states in developing the long-term financing policies necessary to sustain school-based health centers. Historically, federal support for school-based health centers came primarily from the maternal and child health block grant and the

CENTERS AT A GLANCE

Most school-based health centers were established recently...

Years:

- Fewer than 2
- 2–4
- 5–9
- 10 or more

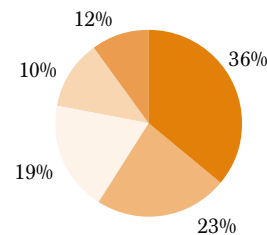


NUMBER OF YEARS ESTABLISHED

...and are sponsored by a larger health agency

Sponsor:

- Hospital or university/medical school
- Local health department
- Community health center
- School system
- Other



TYPE OF AGENCY

Note: Based on 1998–1999 school year. *Source:* National Assembly on School-Based Health Care (NASBHC), *Creating Access to Care for Children and Youth: School-Based Health Center Census 1998–1999*, NASBHC: Washington DC, 2000.

Healthy Schools/Healthy Communities program (providing \$9 million and \$8 million, respectively). However, with school-based health centers increasingly seeking third-party reimbursement, Medicaid has also become an important source of support, contributing almost \$9 million in 1997–1998.

According to NASBHC, school-based health centers provide a broad range of primary and preventive health services on-site to almost one million students, often at no cost to the students or their families. In accordance with state law, local communities determine what services a center will offer and under what terms. Generally, these services include treatment for chronic and acute illnesses; prescription services; lab tests; sports physicals and general health assessments; vision and hearing screenings; and mental health services. School-based health centers also typically offer education and health promotion services focusing on the prevention of tobacco, drug and alcohol use; sexually transmitted disease (STD), including HIV, infection; pregnancy; injuries; and violence. More than nine in 10 school-based health centers require parental consent for services when students enroll in the school, and almost two-thirds allow parents to give consent but restrict their children’s access to specific services.

Reproductive Health Services

According to NASBHC, centers located in middle or high schools typically provide a range of reproductive health services on-site (see chart). Almost nine in 10 of these school-based health centers provide pregnancy testing; seven in 10 offer testing and treatment for STDs, gynecologic

logic exams and Pap smears; almost six in 10 provide HIV testing; and two in 10 offer prenatal care. These services, moreover, are in demand: Studies show that when reproductive health services are available, they account for anywhere between 10% and 17% of health center visits.

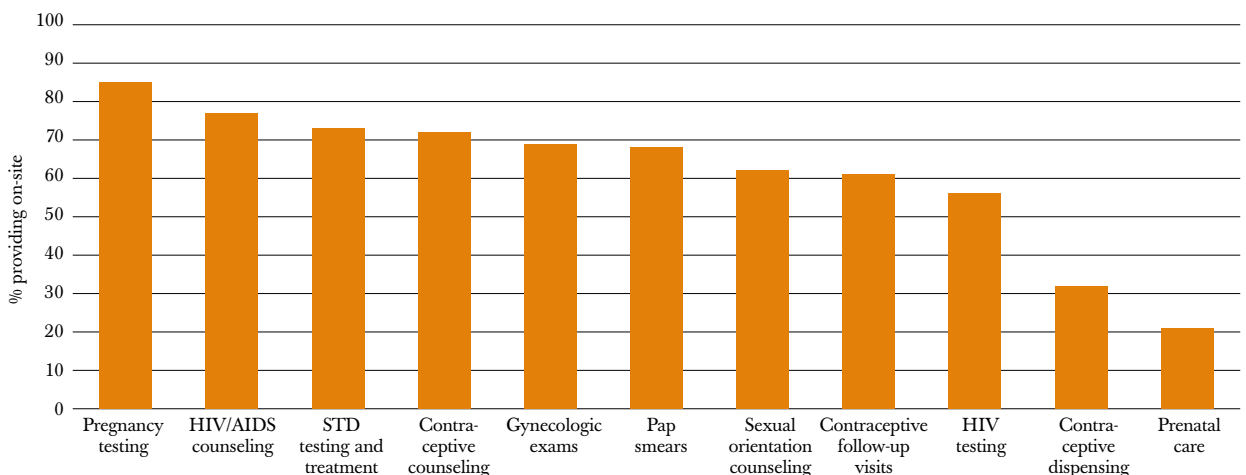
Contraceptive services, however, are often treated differently from other reproductive health services. In fact, three out of four (77%) school-based health centers located in middle or high schools are prohibited from dispensing contraceptives on-site (although not all of those prohibitions include condoms). Only 4% of health centers that do not dispense contraceptives adopted the policy voluntarily; in most cases, the policy was set by the school district (73%), the school (29%) or the state (12%). The most common methods dispensed in school-based health centers are condoms (30%) and oral contraceptives (25%); emergency contraceptives are dispensed in only 15% of centers.

John Schlitt, NASBHC’s executive director, notes that while relatively few school-based health centers are allowed to actually dispense contraceptives directly to students, seven in 10 provide birth control counseling, and most provide referrals for services off-site. Still, Schlitt acknowledges that this situation is less than ideal from a public health perspective—particularly given the high rates of sexual activity and unintended pregnancy among teenagers in this country. Referrals alone are often inadequate, he says. Students frequently do not follow through, because they either lack transportation, have concerns about confidentiality or simply may not regard doing so as an urgent priority.

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CENTERS AND REPRODUCTIVE HEALTH CARE

Centers in middle and high schools provide a range of reproductive health services, but few dispense contraceptives on-site.



Source: See chart, page 5.

Advocating for Family Planning Services in School-Based Health Centers: Two Success Stories

The experiences of two school-based health centers—one located outside of Chicago and one in the Portland, Oregon area—are examples of successful advocacy by health care professionals for the inclusion of contraceptive services in school-based health centers. Their efforts provide models for health care providers in other communities hoping to expand their student-oriented services to include family planning.

When the Evanston Township High School Health Center, located in a suburb of Chicago, opened in February 1996, its planning group decided to exclude contraceptive services in response to perceived opposition from the community. However, the group stipulated that after one year of operation, the center would conduct a formal assessment to measure community sentiment about adding such services.

Family nurse practitioners and site managers Kathy Swartwout and Julianne Russell began by reviewing more than 800 student charts and compiling data on how many clinic clients were sexually active and on their contraceptive practices. They included this information in fact sheets and other materials that also featured national, state and local statistics on teen pregnancy and a review of research showing that offering contraceptives in schools does not increase sexual activity.

Next, they surveyed the parents of students registered to receive health services to determine their level of support. They also surveyed teachers, conducted faculty focus groups, met with local clergy and conducted a second survey, which included the parents of all students enrolled in the school, not just those enrolled in the health center. Citing findings that approximately seven in 10 of all those surveyed supported the move,

an advisory board composed of representatives from the local hospital, health department, high school and health center then developed a proposal to make contraceptive services available to students who had prior written consent from their parents. The proposal also stressed that abstinence would continue to be emphasized first and foremost with all students. Two well-publicized and high-profile community forums followed for parents, teachers and residents to obtain information and provide feedback. This culminated in a 6–1 vote by the school board allowing the center to provide contraceptive services beginning July 1998.

Two years later, Swartwout attributes the center's success to a "carefully considered strategy for garnering community support" and the methodical manner in which its staff gathered information, used data to develop their proposals, and talked and listened to individuals in the community. The way they went about it, she says, "is very applicable to other communities across the nation."

Jill Daniels, clinical program manager at the Multnomah County Health Department, based in Portland, Oregon, tells a similar story. Because of community opposition to the provision of family planning services when the first school-based health center opened in the Portland area in 1986, center administrators declined to offer any prescription drugs, rather than offer all prescription drugs except contraceptives. After a few weeks of operation, however, they realized that this approach was untenable, given the significant prescription-drug needs of their students. Shortly thereafter, they began offering prescription drugs but excluded contraceptives.

Over time, center administrators continued to engage in a dialogue

with stakeholders in the community, conveying anecdotal information about the need for family planning, levels of sexual activity and the incidence of teen pregnancy among high school students. In 1992, the school board granted them permission to make condoms available to high school students. Daniels notes, "This was the era of Magic Johnson. The time was right for the school board to make such a decision. But the decision also reflects the effort we put into developing a detailed policy that would require teens requesting condoms to provide a health history and receive counseling about abstinence and responsible sexual behavior." Discussions with the school board and the community continued, and in 1994, a survey conducted by center administrators showed that parents overwhelmingly supported the addition of contraceptive services. As a result, the school board in 1996 granted the center permission to dispense all methods of contraceptives in high schools.

Daniels believes that one reason the community has rallied behind the center and its effort to provide family planning services is that parental involvement is one of the core values of the program. "Providers at our school health centers are wonderful at helping students to see how parental involvement in their health care decisions is beneficial." She notes that as part of their strong emphasis on teenage pregnancy prevention, the centers are equally committed to encouraging abstinence and to encouraging effective contraceptive use. Says Daniels, "We give abstinence just as much energy as using any method of birth control. Just as we will follow up with students who are using birth control, we will follow up with students who are abstinent to make sure that continues to be the case and, if not, to meet their birth control needs."

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Navigating the Waters

Since the early 1970s, when the first school-based health centers were established, critics have charged that they exist primarily to provide birth control. Other health services, they contend, are provided only to lure students into the centers and to provide a front for the centers' reproductive health activities. And despite research to the contrary, critics argue that by offering contraceptives, school-based health centers increase rates of sexual activity among teens.

In 1994, a report by the General Accounting Office (GAO) concluded that the controversy over family planning services constrained the ability of school-based health centers to meet some adolescents' health needs. According to GAO, "opposition to some reproductive health services expressed by groups of citizens, elected officials and religious leaders has led some centers to limit or eliminate family planning services, move their operations off the school campus, or not open. Other sites have had their funding withheld."

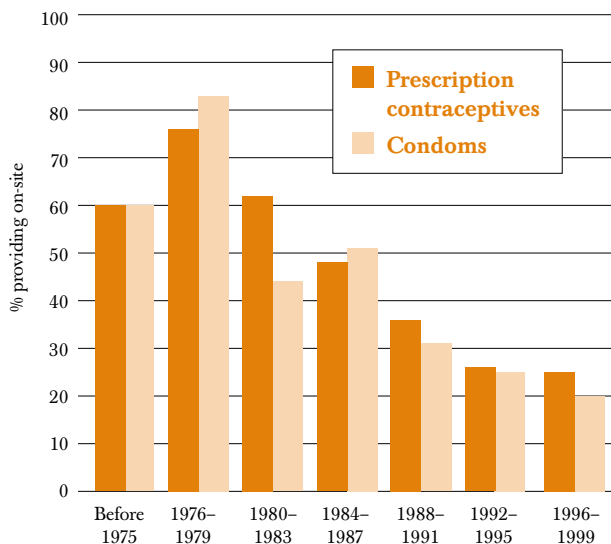
The GAO report also noted, however, that some school-based health centers were taking steps to mitigate the potential effects of opposition and controversy. NASBHC's Schlitt agrees, pointing out that the older a school-based health center is, the more likely it is to offer contraceptive services on-site (see chart). In fact, 41% of school-based health centers that have been in

operation for more than 10 years dispense contraceptives, compared with only 21% of newer centers. This has to do, he says, not with the fact that older health centers were more likely to offer family planning services from the start, but with the "evolutionary quality" of school-based health centers. "As these centers become more established, they gain community support and a buy-in from parents. At the same time, the needs of students become better known. This places centers in a much better position to advocate for birth control services."

Julia Graham Lear, program director of Making the Grade, adds that HIV/AIDS has played a major role in changing the views of parents and residents in some communities. According to Lear, "In the early days of school-based health centers—back in the 1970s and early 1980s—the idea of providing family planning services on-site was extremely controversial. The headlines in the paper would read, 'The Pill Goes to School.'" Lear continues, "While echoes of that still linger on in the minds of some people today—largely those who aren't very familiar with school-based health centers or the communities they serve—HIV/AIDS significantly altered the equation." Lear explains, "The price was too high in many communities for parents and educators to ignore the changing norms. More students were becoming sexually active, and it became apparent that there was an increasing need to bring reproductive health services to high school students in a way that addressed their very real problems."

POWER OF AGE

Long-established centers are more likely than newer ones to provide contraceptives on-site.



Source: Unpublished data from NASBHC, school year 1998-1999.

In spite of these changing norms, Schlitt acknowledges that acceptance of family planning in school-based health centers remains the exception, not the rule. Says Schlitt, "Yes, prohibitions compromise the health centers' scope of service, but for many, the center simply could not operate under any other condition." Schlitt hastens to add that those prohibitions are not always permanent. "School and parental attitudes have been known to shift over time, particularly as the school-based health center builds trust, comfort and familiarity, as well as the data" underscoring the need for such services (see box, page 7). Schlitt continues, "These providers are committed to meeting *all* the various health care needs of the students they serve. And it often doesn't take long for a school or community to realize that school-based health centers play an enormous role in meeting students' health care needs and for the providers to say we can do even more."

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