Guttmacher Policy Review
Winter 2015 | Vol. 18, No. 1
GPR

Meeting the Sexual and Reproductive Health Needs of Adolescents in School-Based Health Centers

By Heather D. Boonstra

Recognizing that many students have difficulty accessing needed health care services, many states and communities across the nation have established school-based health centers (SBHCs). SBHCs are located on school grounds, provide health care services regardless of one's ability to pay and offer a broader range of services than a school nurse generally provides. Almost all SBHCs provide primary care, and many also provide mental health services, nutritional counseling and dental care.

As part of this array of services, SBHCs provide a range of sexual and reproductive health services; however, since the inception of these centers, heated debates have raged in communities across the country over whether they should provide contraceptives on-site. At the same time, a number of SBHCs that are committed to reducing teen pregnancy are working within their communities to overcome opposition and provide contraceptive care.

HIGHLIGHTS

- *School-based health centers (SBHCs) are an important source of medical care for low-income and uninsured adolescents, and are a promising way of addressing unintended pregnancy and STIs.*
- *Controversy over teens and sex has had a significant impact on the provision of sexual and reproductive health services, and many SBHCs remain limited in their ability to meet the needs of adolescents by dispensing contraceptives on-site.*
- *Many SBHCs have overcome challenges and successfully integrated sexual and reproductive health services with other medical care. They can serve as models for other SBHCs.*

About School-Based Health Centers

Providing health services in schools is not a new concept. School nurses have long managed medical emergencies, helped students with chronic conditions, provided health education and immunizations, and screened students' vision and hearing.[1] Proposals to expand the scope of school health services to deliver primary and preventive care emerged in the 1970s, as health care professionals and children's advocates looked for new ways to reach adolescents who were not covered by Medicaid and otherwise did not have access to care.[2] These experts recognized that schools were trusted and familiar, could offer youth-friendly health services and could connect students with other services in their community.

The first SBHCs opened in the early 1970s. A decade later, funding provided by the Robert Wood Johnson Foundation spurred efforts to increase the number of SBHCs nationwide. Today, more than 1,900 of these SBHCs are in operation across the country in schools that enroll roughly two million students each year, according to the 2010–2011 national census of SBHCs conducted by School-Based Health Alliance.[3] Most SBHCs (54%) are located in urban communities, but 28% are in rural areas. Nearly 83% of SBHCs serve adolescents in grades 6–12. These students are disproportionately students of color and low-income, and many are uninsured or underinsured and have limited access to other sources of health care.

SBHCs provide care to adolescents, regardless of their ability to pay. They are typically staffed by

a midlevel provider such as a nurse practitioner or physician assistant. These providers are often joined by mental health professionals, such as a social worker or psychologist, and in many cases by a health educator, dentist or nutritionist as well.

By and large, which services an SBHC offers and under what terms are determined at the local level. Generally, these services include comprehensive health assessments, treatment for chronic and acute illnesses, prescription services, lab tests, vision and hearing screenings, sports physicals and nutrition counseling. Also, SBHCs typically offer education and health promotion services focusing on school safety, violence prevention and the prevention of tobacco, drug and alcohol use.

SBHCs are often sponsored by a health agency, such as a hospital, health department or federally qualified health center, and are satellites of those agencies' larger practice networks. Sponsors provide SBHCs with on-site staff, service coverage for students when schools are closed, and funding from grants and contracts. These partnerships have been particularly important as the medical home concept has evolved: Most SBHCs coordinate with their sponsoring agency to ensure that patients have access to primary care, either on-site or by referral, that is comprehensive, coordinated and culturally competent.[4,5]

In addition to the support they receive from sponsoring organizations, most SBHCs bill insurance programs—such as Medicaid, the Children's Health Insurance Program (CHIP) and private insurance—for the services they provide.[3] Most also assist adolescents and their families with on-site insurance eligibility and enrollment. To pay for services and patients not covered by insurance, many SBHCs also receive funds from local and state governments, as well as private foundations.

Certain federal grant programs have also been a source of funding for SBHCs. For example, some SBHCs receive funds through their sponsoring organization from the U.S. Department of Health and Human Service's Section 330 health center program or the Title X family planning program.[3,6] In addition, SBHCs may receive maternal and child health block grant funds either directly from the state or from their sponsoring organization. The Affordable Care Act (ACA) authorized two new federal grant programs targeted specifically to SBHCs. One of these programs authorized grants to renovate and expand existing SBHCs and build new centers and appropriated $50 million annually for fiscal years 2010–2013. For the second program, the ACA authorized grants for providing primary care services and managing and operating SBHCs. Congress, however, has never appropriated funds for this second program.

Sexual and Reproductive Health Services

SBHCs have long been seen as a promising way to address teen pregnancy and reach students most at risk of HIV and other STIs. Nationwide, nearly half of high school students have had sex,[7] and realistically they need information and services to avoid the negative consequences of sex. Furthermore, from a public health standpoint, students should be given information about and access to contraceptive and STI services before they begin to have sex, so that they are more likely to use protection when they do have sex. Although few younger teens have ever had sex, 30% of ninth graders and 64% of twelfth graders have had sex.

Over the last several decades, teen pregnancy, birth and abortion rates have declined dramatically in the United States.[8] In 2010, the pregnancy rate reached 57 per 1,000 women aged 15–19, its lowest level in nearly 40 years. This is overwhelmingly due to improved contraceptive use and use of more effective methods (see "What Is Behind the Declines in Teen Pregnancy Rates?" Summer 2014). Even with these encouraging trends, however, adolescent pregnancy remains a serious public health concern. Each year, nearly 615,000 U.S. women aged 15–19 become pregnant, and 82% report that their pregnancy was unplanned.[9] Moreover, adolescents have disproportionately high rates of STIs. For example, roughly 350,000 women aged 15–19 receive a diagnosis of chlamydia each year, and their rates of infection are among the highest of any age-group—second only to women aged 20–24.[10]

SBHCs serving adolescents provide varying ranges of sexual and reproductive health services. Most provide abstinence and contraceptive coun-

seling, pregnancy testing, vaccinations against human papillomavirus (HPV), and on-site diagnosis and treatment for STIs (see chart).[3] Many also offer programs on sexual orientation and gender identity, sexual assault, rape prevention and counseling, and intimate partner violence. More than half of SBHCs report providing HIV counseling and testing, although a significant proportion (19%) have policies that prohibit HIV testing.

Historically, however, the provision of contraceptive services on-site has been most commonly singled out and restricted. Although 37% of SBHCs that serve middle or high school students dispense contraceptives on-site, roughly half are prohibited from doing so. In a quarter of cases, this policy was set by the state. But most prohibitions on dispensing of contraceptives were imposed at the local level, by the school or school district. Moreover, an estimated 10–15% of SBHCs that do not dispense contraceptives are not driven by either state or local policies, but have adopted a policy voluntarily or are following a policy set by their sponsoring organization. Notably, in the last decade, the proportion of SBHCs prohibited from dispensing contraceptives on-site has declined; however, this change has not yet translated into substantial increases in the provision of contraceptives on-site. Although the provision of contraceptive pills and condoms has fluctuated over time, the levels in 2010–2011 were roughly the same as in 1998–1999 (see chart, page 24).

Although most SBHCs provide contraceptive counseling and referrals for services off-site, this situation is less than ideal from a public health perspective. Referrals alone cannot guarantee access to care. Students frequently do not follow through, either because they have concerns about confidentiality, lack the money or transportation to see a doctor, or simply may not prioritize doing so.[11]

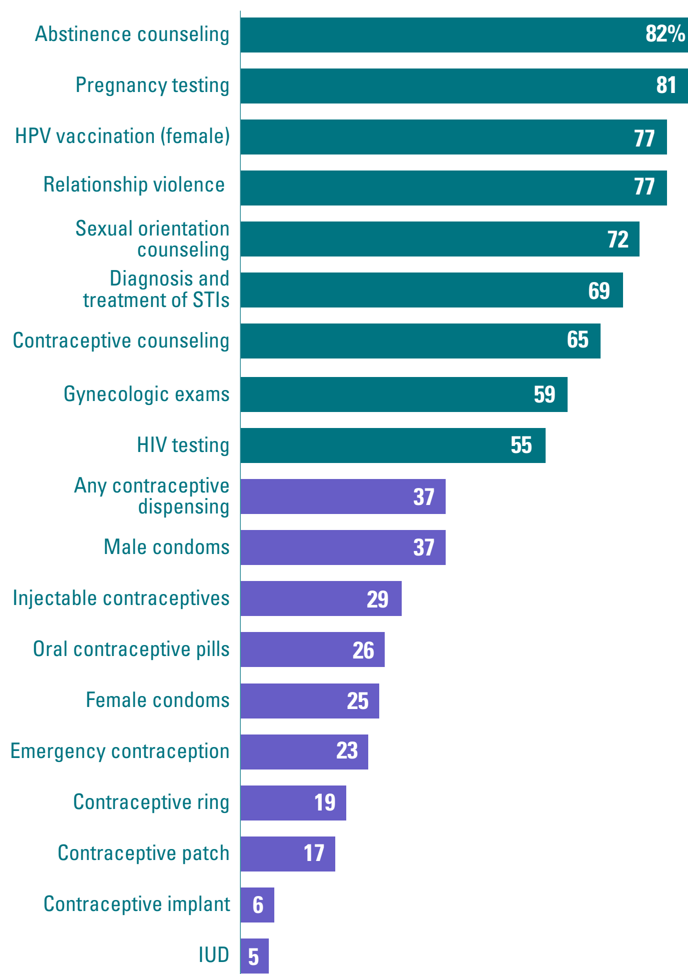
The evidence on the impact of SBHCs on adolescent sexual and reproductive health remains limited.[12] According to an analysis summarizing recent research, SBHCs that offer comprehensive reproductive health programs with community support "show promising results in improving adolescent sexual health."[11] In many cases, offering reproductive health care at SBHCs is associated with youth's delayed initiation of sexual intercourse, decreased number of sexual partners and increased contraceptive use. Nevertheless, not all studies have found significant relationships between SBHCs and adolescent sexual and reproductive health.[11–13] Such mixed results may reflect differences in the communities where SBHCs are located or in the scope of sexual and reproductive health services offered at SBHCs, which make comparisons across a range of settings difficult.

Political and Financial Challenges

Two persistent challenges have had an impact on the provision of a full array of sexual and reproductive health services at SBHCs. The first has to

NOT BROAD ENOUGH

School-based health centers provide a broad range of sexual and reproductive health services on-site, but just 37% dispense any contraceptives.



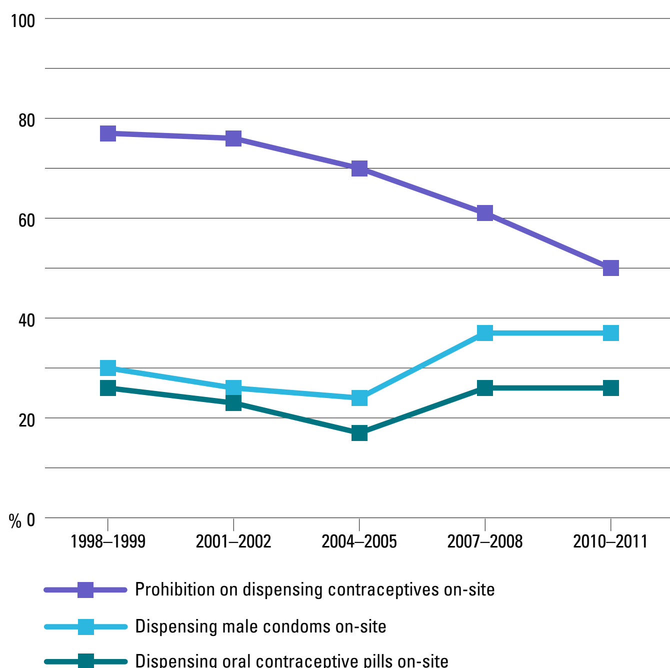
Note: Data are for 2010–2011. *Source:* School-Based Health Alliance.

do with the politics of teens and sex. Critics of SBHCs have long charged that, by offering contraceptives, these centers undermine parental rights; such accusations echo those made more broadly about the provision of sexual and reproductive health services and information to teenagers. To promote parental support for their programs around contraception and other services, most SBHCs go out of their way to involve parents in planning and oversight. All require parental consent for primary care, and six in 10 allow parents to restrict children's access to specific services.[3]

Critics also contend that SBHCs that dispense contraceptives increase rates of teen sexual activity, again echoing a charge made about access to services and information in classrooms, clinicians' offices, pharmacies and elsewhere. In truth, however, there is no evidence that providing teens with contraceptive information, education and services results in increased sexual risk-taking behaviors.[11,14]

POTENTIAL FOR PROGRESS

The proportion of SBHCs prohibited from dispensing contraceptives has dropped in recent years, but many SBHCs have not taken advantage of that trend to offer the pill and condoms on-site.



Note: For 1998–1999 and 2001–2002, SBHCs were asked about "providing" oral contraceptives and condoms on-site, which could include either dispensing the method or writing a prescription for it. *Source:* School-Based Health Alliance.

In addition, many critics accuse SBHCs of promoting abortion by funneling students to nearby family planning clinics. These clinics may indeed provide nondirective pregnancy counseling and referral, and abortion care as well as prenatal care. This same attack has been commonly used against publicly funded family planning services and providers in other contexts, and is designed to stigmatize and isolate those services and providers.

Unfortunately, because many policymakers, school districts, superintendents and principals—and even some health care providers—may not want to risk opposition or be perceived as infringing on parental rights or promoting sexual activity or abortion among adolescents, they may be reluctant to provide sexual and reproductive health information and services to students who need them. The good news is that a number of SBHCs are working within their communities to overcome opposition—and they are meeting with some success (see box, page 25).

The second major challenge that has had an impact on the provision of contraceptive services at SBHCs has to do with funding. Because SBHCs rely on a diverse funding portfolio, careful planning is required to generate enough revenue to match expenses, and finding adequate and consistent resources remains a challenge. This can affect any of the services that SBHCs provide, not just contraceptive services, but lack of consistent funding may make expanding the range of reproductive health services even more difficult. In addition, SBHCs—like other providers that serve low-income and medically underserved populations—struggle with the seemingly ever-rising cost of contraceptive supplies and other pharmaceuticals. But unlike many other safety-net providers, SBHCs do not necessarily have access to the federal government's 340B Drug Pricing Program. That program's discounts are only available to SBHCs that qualify, most often because they are a federally qualified health center or receive funding through such avenues as Title X or the Ryan White HIV/AIDS program. Being sponsored by an organization that qualifies for 340B is not sufficient.

Congress could certainly do more to support SBHCs. The only source of federal funding solely

dedicated to SBHCs—appropriated under the ACA—expired in September 2013. The School-Based Health Centers Program Reauthorization Act of 2013 put forth by Rep. Lois Capps (D-CA) would reauthorize funding through fiscal year 2019 and is expected to be reintroduced later this year. The legislation is supported by leading medical, teacher, child welfare and public health organizations, including the American Academy of Pediatrics, the American Federation of Teachers, the American Public Health Association and the Children's Defense Fund. But the political will for moving such legislation in the Republican-controlled Congress remains doubtful.

Moving Forward

SBHCs that are motivated to address the sexual and reproductive health needs of the students they serve may need to look to the experiences of more mature centers for a way forward.

Creating an Enabling Environment for the Provision of Contraceptive Services at SBHCs

The experience of two school districts—one located in Denver and the other in Portland, Oregon—are examples of successful advocacy for the inclusion of contraceptive services at SBHCs. Denver's SBHCs are among the oldest in the nation, and contraceptive services were not included in the array of services initially offered. In 2010, however, after a years-long community engagement process around teen pregnancy prevention, SBHCs in Denver public schools began dispensing contraceptives.[15] Similarly, when the first SBHCs opened in Portland public schools in the late 1980s, they excluded contraceptives; however, school administrators continued to engage community stakeholders about levels of teen pregnancy and STIs and the need for contraceptive services. In 1992, the school board granted permission to make condoms available to high school students, and in 1996, it granted permission to dispense all contraceptive methods.[16]

It is worth analyzing these experiences for broader lessons about the possibilities for meeting student's sexual and reproductive health care needs.

Seek political and societal leadership. Because SBHCs are guided by policies at multiple levels—from state laws to local school district guidelines to health center policies—political and societal leadership is needed at each level to support the provision of contraceptive services. For example, in one school in Denver, a school nurse and principal are credited with sparking community discussions and town hall meetings to engage parents on teen pregnancy prevention.[15] Eventually, a parent group was formed that began asking for contraceptives to be made available at the local SBHC, and as a result, the local SBHC expanded its services.

Engage parents. In advocating for contraceptive services at SBHCs, it is important to involve key stakeholders early and often. As the Denver experience shows, parents in particular need to be informed about the benefits of contraceptive services and to have the opportunity to express their thoughts and ideas. In Portland, parental involvement has been critical in garnering community support for adding contraceptive services.[16] Health care providers at SBHCs encourage teens to voluntarily talk to their parents, while also ensuring teens' confidentiality. Many school districts in Portland also employ parent liaisons or advocates, so parents have all the information they need about the services their child is receiving at SBHCs.

Use data to develop proposals and monitor progress. Findings on sexual activity, contraceptive use, teen pregnancy and childbearing are critical to building the case for the provision of contraceptive services at SBHCs. One reason communities in Denver and Portland rallied behind efforts to provide contraceptives is that they recognized the impact of pregnancies and births on teens' health, graduation rates and the economic well-being of the community.

Meaningfully involve adolescents. And finally, advocates for sexual and reproductive health services need to take into account the perspectives of young people themselves. Clearly, young people can play a vital role in advocating for their needs and in creating youth-friendly environments. In Denver, for example, a student petition led to a discussion with the parent-teacher association and principal about the provision of contraceptive services at the local SBHC.[15] Most SBHCs solicit feedback from the students they serve, and half ask adolescents to serve in an official capacity in the design and delivery of services as members of SBHC committees, advisory councils or boards.[3]

Interestingly, the older an SBHC is, the more likely it is to offer contraceptive services on-site. About 60% of SBHCs that have been in operation for more than 10 years dispense contraceptives, compared with only 40% of newer centers.[3] According to John Schlitt, president of the School-Based Health Alliance, older health centers were no more likely to offer contraceptive services from the start; rather, older centers have evolved. As SBHCs become more established, they also become more aware of the needs of the adolescents they serve and are more likely to have gained community support, which puts them in a much better position to advocate for contraceptive services.

Many SBHCs face strict prohibitions on the provision of contraceptives; however, for others, the restrictions are self-imposed. Both situations are unfortunate and self-defeating. If the drop in teen pregnancy rates over the last several decades has taught us anything, it is that contraceptive services are a crucial component of adolescent health and well-being and of helping teens fulfill their life goals. Public health and children's advocates must recognize that SBHCs are a critical access point to care for adolescents who are most at risk of unintended pregnancy and STIs, and that more must be done to ensure that students' sexual and reproductive health needs are met at SBHCs. ■

This article was made possible by a grant from the Brush Foundation. The conclusions and opinions expressed in this article, however, are those of the author and the Guttmacher Institute.

REFERENCES

1. School-Based Health Alliance and National Association of School Nurses, School-based health centers + school nurses = student success, 2010, <http://www.sbh4all.org/atf/cf/%7BB241D183-DA6F-443F-9588-3230D027D8DB%7D/SBHCS%20AND%20NURSES%20FINAL%202014.pdf>, accessed Apr. 3, 2015.

2. Gustafson EM, History and overview of school-based health centers in the US, *Nursing Clinics of North America,* 2005, 40(4):595–606.

3. Lofink H et al., *2010–2011 Census Report of School-Based Health Centers,* Washington, DC: School-Based Health Alliance, 2013, <http://www.sbh4all.org/site/c.ckLQKbOVLkK6E/b.8778055/k.F9F5/20102011_Census_Report.htm>, accessed Apr. 3, 2015.

4. Council on School Health, American Academy of Pediatrics, Policy statement: school-based health centers and pediatric practice, *Pediatrics*, 2012, 129(2):387–393, <http://pediatrics.aappublications.org/content/129/2/387.full>, accessed Apr. 3, 2015.

5. Reckling S, *School-Based Health Centers and Patient-Centered Medical Home: Study of Medicaid Policies and Practice,* Washington, DC: School-Based Health Alliance, 2013, <http://www.sbh4all.org/atf/cf/%7BB241D183-DA6F-443F-9588-3230D027D8DB%7D/PCMH%20Report%20FINAL%20PUBLICATION_10%2024%2013.pdf>, accessed Apr. 3, 2015.

6. U.S. Government Accountability Office (GAO), *School-Based Health Centers: Available Information on Federal Funding, GAO-11-18R,* Washington, DC: GAO, 2010, <http://www.gao.gov/products/GAO-11-18R>, accessed Apr. 3, 2015.

7. Kann L et al., Youth Risk Behavior Surveillance—United States, 2013, *MMWR,* 2014, 63(4):1–168, <http://www.cdc.gov/mmwr/pdf/ss/ss6304.pdf>, accessed Apr. 3, 2015.

8. Kost K and Henshaw S, *U.S. Teenage Pregnancies, Births and Abortions, 2010: National and State Trends and Trends by Age, Race and Ethnicity,* New York: Guttmacher Institute, 2014, <http://www.guttmacher.org/pubs/USTPtrends10.pdf>, accessed Apr. 3, 2015.

9. Finer LB and Zolna MR, Unintended pregnancy in the United States: incidence and disparities, 2006, *Contraception,* 2011, 84(5):478–485, <http://www.guttmacher.org/pubs/journals/j.contraception.2011.07.13.pdf>, accessed Apr. 3, 2015.

10. Centers for Disease Control and Prevention (CDC), *Sexually Transmitted Disease Surveillance 2010,* Atlanta: U.S. Department of Health and Human Services, 2011, <http://www.cdc.gov/std/stats10/surv2010.pdf>, accessed Apr. 3, 2015.

11. Section of Family Planning and Contraceptive Research, University of Chicago, School-based health centers: implications for adolescent reproductive health, *Policy Brief,* 2013, <http://familyplanning.uchicago.edu/policy/publications-resources/SBHCs%20abnd%20Reproductive%20Health%20Brief.pdf>, accessed Apr. 3, 2015.

12. Mason-Jones AJ et al., A systematic review of the role of school-based healthcare in adolescent sexual, reproductive, and mental health, *Systematic Reviews,* 2012, doi: 10.1186/2046-4053-1-49, <http://www.systematicreviewsjournal.com/content/1/1/49/>, accessed Apr. 3, 2015.

13. Minguez M et al., Reproductive health impact of a school health center, *Journal of Adolescent Health,* 2015, 56(3):338–344.

14. Kirby D, *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases,* Washington, DC: The National Campaign to Prevent Teen and Unplanned Pregnancy, 2007, <https://thenationalcampaign.org/sites/default/files/resource-primary-download/EA2007_full_0.pdf>, accessed Apr. 3, 2015.

15. Williamson J, Denver Public Schools, and Kuka K, Denver Health, Denver, personal communication, Mar. 17, 2015.

16. Lowell A, Multnomah County Health Department, Portland, personal communication, Mar. 10, 2015.

Guttmacher Policy Review

From the Guttmacher Institute's policy analysts

Editorial Office: Washington, DC
policyinfo@guttmacher.org

ISSN: 2163-0860 (online)
http:/www.guttmacher.org/archive/GPR.jsp
© 2015 Guttmacher Institute, Inc.