

**-- FOR DISCUSSION ONLY --
DRAFT DATE: JULY 13, 2006**

Milwaukee Alliance for Sexual Health
Author: Ann Kronser, M.Ed. & Lilly Irvin-Vitella, MCRP
Academic/Staff Mentor: Wendi Ehrman

Issue Paper Topic: Schools/School Based Health Services and Clinics

This inventory will specifically discuss school health programs and school based clinic services for teenagers attending middle and high schools, not necessarily residing in zip code areas 53205, 53206, 53208, 53209, 53210, 53212, 53216 and 53218 in Milwaukee, Wisconsin. This area is located in the near north/northwest side of the city, centered on zip code 53206.

Problem Description

This area of Milwaukee has the highest teen birth and STD rates in the city. The population is predominately African American. Opportunities to provide comprehensive reproductive health services to the school age population in this area ensures both continuity of care and increased access to STD and family planning supplies and services for Milwaukee youth engaging in high risk sexual behavior. Use of more effective methods of contraception, and more effective use of existing methods, is crucial to reducing the burden of unintended pregnancies.¹ Easy and confidential access to family planning services through clinics, school-linked health centers and condom availability programs have been found to help prevent unintended pregnancy.²

Sexually transmitted diseases (chlamydia, gonorrhea, and syphilis) and unintended pregnancies disproportionately impact African Americans in Milwaukee particularly African American youth ages 15-19. Milwaukee County has the highest reported STD case rates in the state, with 49.7% of all STDs reported in Milwaukee County. Among 63 selected large cities, Milwaukee ranks 10th highest in STD case rates.³ In the highest prevalence zip code in Milwaukee, over 20% of all 15-19 year olds had a reported STD in 2004. Rates of STDs among African Americans were 18-fold higher than rates for whites in Milwaukee. Milwaukee also has one of the highest percentages of adolescent births out of total births in the country. In 2004, the teen pregnancy rates for Milwaukee were 52.67 per thousand for 15-17yr old girls, for the entire United States the rate was 22.1 per thousand.⁴

A decline in repeat births to teens is also a factor in the reduction of Milwaukee's teen birth rate. In 2004, 25.2 % of Milwaukee's teen births (under age 20) were to women who have had a previous birth. Repeat teen births among Milwaukee racial/ethnic minorities are also a factor.⁵

Repeat Teen Birth Rates in Milwaukee 15-17 year olds, 1996-2004⁶

Non- Hispanic Black	Asian/Pacific Islander	Hispanic	Non-Hispanic White
38.2	28.1	26.8	6.9

¹ Henshaw, Stanley K. Unintended Pregnancy in the United States, Family Planning perspectives, 1998, 30 (1): 24-29 &46.

² Kahn, James G., et al. (1999) "Pregnancies Averted Among U.S. Teenagers by the Use of Contraceptives." Family Planning Perspectives, 31(1), 29-34.

³ WI DPH, Community Mobilization Initiative- Executive Summary, 2005

⁴ United Way of greater Milwaukee, If truth be told, teen pregnancy, public health and the cycle of poverty, 2006

⁵ City of Milwaukee Health Department

⁶ Ibid

-- FOR DISCUSSION ONLY --
DRAFT DATE: JULY 13, 2006

The City of Milwaukee Health Department released a High-Risk Sexual Behavior of Milwaukee Adolescent Survey in January of 2004. The results from student samples indicated⁷:

- 57% of Milwaukee Public School (MPS) high school students report having had sexual intercourse
- 40% of MPS high school students report having intercourse with 1 or more partners
- 29.5% of MPS students did not use a condom during their last sexual intercourse

The problem of both STDs and teen pregnancy differs from one neighborhood/ ethnic group to the next. In Milwaukee, Hispanics and non- Hispanic black teen girls get pregnant approximately three times more often than non-Hispanic white teens. The 2003 Big Cities Health Inventory ranked Milwaukee 2nd highest of 47 largest U.S. cities in percent of total births to African American teens under 20 years.⁸

Racial and ethnic disparities also impact other health outcomes in Milwaukee. High rates of infant deaths born to African American women have been 3-4 times more likely to occur, than in infants born to white women.⁹ In 2000-2001, Milwaukee zip code 53206 had the highest rate of infant deaths of 35.¹⁰

African American youth also have difficulty accessing health care; among youth ages 18-24 years of age in Wisconsin, 22% of whites, 37% of blacks, and 46% if Hispanics are uninsured.¹¹

Background

School-based health centers are an approach to delivering comprehensive medical and mental health screening and treatment to young people in their school settings. They are designed to serve the unique health needs of youth. One of the fundamental reasons healthcare needs go unmet is due to breakdowns in service delivery. Some of the barriers youth confront in accessing health care services are "lack of confidentiality or fear that confidentiality will not be maintained, transportation problems, fear that parents will be notified by the insurer, inconvenient appointment times, costs, and apprehension about discussing personal health problems."¹² As early as 1979, studies of school-based clinics were demonstrating their efficacy. In the 1985 Contraceptive Technology Update, authors wrote, "school-based clinics that provide contraception are proving two points: the more accessible birth control services are, the more young people will use them; and when those services are used, births among teenagers will decrease."¹³

However, in 1992, outside consultants to The Robert Wood Johnson Foundation evaluated the twenty-four school-based health centers supported by grants from the Foundation. The evaluation determined that the centers had increased the access of adolescents to health care. The report issued in 1993, found that school-based health centers had had little effect on high-risk behavior, such as unprotected sexual activity, or on teenage pregnancy rates. Indeed, the report estimated that one in four female students at the schools under study would become

⁷ MPS YRB Data Survey, Adolescent Pregnancy Prevention Workgroup (APPW) 2004 Annual Report

⁸ United Way, If truth be told, teen pregnancy, public health and the cycle of poverty, 2006, 12

⁹ WI DHFS, A Framework for Action to Eliminate Racial and Ethnic Disparities in Birth Outcomes-2006-2010

¹⁰ FIMR Status Report, Milwaukee 2001-2002

¹¹ US Census Data, 2000

¹² Foster, Nicole. The Facts © Advocates for Youth, February 1999

¹³ Contraceptive Technology Update. 1985 Apr;6(4):53-7.

-- FOR DISCUSSION ONLY --
DRAFT DATE: JULY 13, 2006

pregnant by their senior year, and that about half of the pregnant girls would bear children. The study suggests that school-based or linked health centers alone are not sufficient to change the high rates of teen pregnancy and STI /HIV infection rates.¹⁴ Rather SBHCs and SLHCs should be a component of a coordinated effort that includes intensive interventions based on best practices. Researchers who examined several successful pregnancy and STI prevention initiatives, outlined important components of a successful intervention. They include the use of social-learning and social cognitive theories to leverage behavior change; creation of a set of narrowly and clearly articulated behavioral goals; clear program components that are skill-based; use of a written curriculum and strong instructor training and feedback; relatively long duration and intensity; and have multiple component interventions.¹⁵

What's Currently Happening

To begin the discussion about school based health services, it's important to mention a few facts about the Human Growth and Development (HGD) curriculum. Currently, MPS requires .5 credits of Human Growth and Development for students to graduate. The district policy places each school principal in charge of this curriculum at his/her school, therefore offering more local control. The Wisconsin Statute 118.019 encourages school districts to provide a developmentally appropriate HGD instructional program in grades kindergarten to 12, to promote accurate and comprehensive knowledge and responsible decision making. The statute specifically identifies instructional topics, including self-esteem, responsible decision making, and personal responsibility; interpersonal relationships; discouragement of adolescent sexual activity, family life, and skills required of a parent; human sexuality; reproduction; family planning as defined in Wis. Stat. 253.07 (1) (a), including natural family planning; human immunodeficiency virus and acquired immunodeficiency syndrome; prenatal development, childbirth; adoption; available prenatal and postnatal support; and male and female responsibility; and sex stereotypes and protective behavior.¹⁶

New statues require that, if a school board provides instruction in human sexuality; reproduction; family planning as defined in Wis. Stat. 253.07 (1) (a), including natural family planning; human immunodeficiency virus and acquired immunodeficiency syndrome; prenatal development, childbirth; adoption; available prenatal and postnatal support; and male and female responsibility *it must also provide instruction in marriage and parental responsibility as part of the same course, during the same school year.*¹⁷ For example; a science teacher brings in the topic of HIV. That same teacher also has to teach a segment on marriage and parental responsibilities in the same class that school year. What science teacher is trained or even comfortable teaching marriage and parental responsibilities?

The designated Human Growth and Development curriculum currently used in the Milwaukee Public Schools is Making Proud Choices¹⁸ - for the middle schools and Reducing the Risk in high schools. Evidence-based research suggests moving away from knowledge based programs used alone, and recommends a combination of knowledge based programs and

¹⁴ Brodeur, Paul. To Improve Health and Health Care Volume III
Chapter One School-Based Health Clinics. 2000

¹⁵ Eisen, Marv; Pallitto, Christina; and Bradner, Carolyn. Problem Behavior Prevention and School-Based Health Centers: Programs and Prospects; An Urban Institute Project Report EXECUTIVE SUMMARY.

¹⁶ WI DPI Human Growth and Development: A resource Packet (4th edition) 2005

¹⁷ Ibid

¹⁸ Making Proud Choices and Reducing the Risk are evidence-based curricula that Dr. Doug Kirby, ETR Associates, has identified as Sex and HIV Education Programs that Positively Change Behavior.

-- FOR DISCUSSION ONLY --
DRAFT DATE: JULY 13, 2006

programs that build decision making skills focused on choices and self management. Full HGD evidence-based programs were added to Milwaukee Public Schools in 2003.

A MPS school structure change made in 2003 also impacts HGD curriculum implementation. At the end of 2002, MPS had 23 middle schools, currently there are only 16 middle schools. Movement toward K-8th schools has been implemented creating possible gaps in the health education curriculum in the new K-8 settings, where they may not have a designated health teacher as they did in the middle schools. These newly configured schools rely on classroom teachers to teach the HGD curriculum, who may not be trained or once again comfortable with presenting the material. MPS has not yet evaluated how the new K-8 schools are teaching the HGD curriculum and who is actually doing the teaching. This has been left up to the individual schools to figure out.

The Scope of Milwaukee School Population

Students residing in this eight zip code area don't necessarily attend school in their neighborhoods. With the Milwaukee Parental Choice program (MPCP) being in its' 15th year, many of them bus out to attend other schools. The MPCP program (or voucher program) provides state tuition vouchers to allow children from low-income families residing in MPS district to enroll in private schools within the city limits.¹⁹ Of the 22,859 students attending these 119 schools, 48% are African American. Of those 119 schools, 70 MPCP schools have enrollments with 90% or more of minority students.²⁰ Forming what is called "hyper-segregated" schools.

Many of the schools identified in this core zip code area of high risk behavior also indicate decreased academic engagement and success. Based on all Wisconsin school districts- Milwaukee Public Schools has the worst attendance rate at 88.6%, the highest habitual truancy rate at 45.4 %, and the highest suspension rate of 22.4%.²¹

The percent of students who utilize the free or reduced lunch program indicates the economic make-up of student enrollment at each of the schools and potentially the need for health services at the school.

School Health Services

Milwaukee Public Schools contract with various providers for health care services. The two models they use include; 1) The MPS nurse program and 2) The school- based health clinic model. The RN model of health care is used by the nurses employed by MPS. These services started out in K-5 schools, but currently provide services in K-8 schools. The RN model provides routine health care to students, immunizations, screenings and referrals to a home medical provider. The MPS nurses are currently also providing services in 8 MPS high schools. None of which are high schools located in the eight target zip code areas identified for this project. MPS school nurses are providing services in 3 middle/K-8 schools in these zip code areas. Because MPS nurses are employees of the school district, they do not require parental consent for services like the school based health clinics do. Children's' Hospital Foundation of Wisconsin (CHW) also funds a school nurse program providing services in 33 Milwaukee elementary schools.

¹⁹ Budget Brief 01-2 Legislative bulletin, September 2001.

²⁰ Public Policy Forum, Why not lift the cap? Research Brief, February, 2006

²¹ Regional report, 2003-2004, DPI, 11-12

**-- FOR DISCUSSION ONLY --
DRAFT DATE: JULY 13, 2006**

The charts below identifies Middle and K-8 schools in this area by grade, the economic need of students and the health services provided:

Schools located in 53205, 06, 08, 09,10,12,16 &18	Grades	Free/Reduced Lunch²²	Service Provider	Type of Provider
Middle:				
Edison Middle School	6-8	94%	MHD	RN
Malcom X	6-8	89%	MPS	RN
Milwaukee Education Center	6-8	92%	MPS	RN
Milwaukee Village School	6-8	95%		
Muir Middle School	6-8	93%	MPS	RN
Jackie Robinson Middle	6-8	85%		
Roosevelt Middle	6-8	55%	MHD	RN
Andrew Douglas Academy	6-8	93%		
Silver Spring	6-8	70%		

²² State of WI DPI -0224-2005 Enrollment Economic Status and Children's Hospital of WI

**-- FOR DISCUSSION ONLY --
DRAFT DATE: JULY 13, 2006**

School Name	Grades	Free/Reduced Lunch*	Service Provider	Type of Provider
K-8th Schools				
Auer	K4-8	84%	CHW	RN
Ben Carson Academy	K4-8	94%	CHW	RN
Clarke St	K4-8	100%	CHW	RN
Gaenslen	K4-8	87%		
Hopkins Elem.	K4-8	94%	CHW	RN
Humboldt Park	K-8	70%		
Keefe Ave.	K4-8	96%	CHW	RN
King Jr.	K4-7	105%	CHW	RN
Lee	K4-8	96%	CHW	RN
LaFollette	K4-8	93%	CHW	RN
Marion McLeod (37th St)	K4-7	92%	CHW	RN
Metcalf	K4-8	104%		
Sarah Scott (next to 53205)	K-8	84%	MPS	RN
Sherman Multicultural	K-8	84%	Aurora	NP
Starms Discovery	1-8	85%	CHW	RN
Story K-8	K5-8	97%		
Townsend	K-8	93%	CHW	RN
Urban Waldorf	K4-8	96%	CHW	RN
Westside Academy II	K4-8	96%	Froedtert	
Ac. of Learning and Leadership	K4-8	89%	CHW	RN
Atonement Lutheran	K4-8	24%	CHW	RN
Ceria M. Travis Academy	K4-8	100%	CHW	RN
Harambee Community	K4-8	99%	CHW	RN
Jared C. Bruce Academy	K4-9	100%	CHW	RN
Milwaukee College Preparatory Academy	K4-8	83%	CHW	RN
Mother of Good Counsel	K4-8	48%	CHW	RN
Mount Calvary Lutheran	K4-8	77%	CHW	RN
Hope Middle School	5-8			
St Catherine's Elementary	K4-8	95%	CHW	RN
Saint Sebastian School	K4-8	31%	CHW	RN
Young Leaders Academy	K4-8	83%	CHW	RN
Urban Day St. School	K-8		Aurora	NP

School based health clinic services are provided by both registered nurses and nurse practitioners from Aurora Healthcare, Milwaukee Adolescent Health Program (MAHP), Milwaukee Health Services (MHS) and the Milwaukee Health Department. These providers also offer routine and urgent health services, physicals, as well as provide information and education about contraception, pre-natal care, sexually transmitted diseases and reproductive health questions. Identified "at risk high schools are; North Division Complex, Messmer, Milwaukee Spectrum and Lady Pitts (Lady Pitts is a school specifically for pregnant or parenting teens). Pregnancy testing services are also provided, however STS screening and testing can

**-- FOR DISCUSSION ONLY --
DRAFT DATE: JULY 13, 2006**

only be provided by staff of Aurora, MAHP and MHS. Therefore, only Lady Pitts, Custer High School and the North Division- complex provide STD testing services. These sites also provide prescriptions for STD treatment and occasionally contraception. However, during interviews with school nurses, they indicated that contraception was provided only as a continuing prescription. MAHP can provide contraception services at both of its school clinics with parental permission if the teen is < 18.

Students hear about these confidential services from other students, school social workers, teachers and administrators. Referrals in the community for additional services are often made to community providers depending on the student's health insurance. Typically, they include a local Planned Parenthood clinic, Keenan STD clinic, 16th Street clinic, MAHP or MHS – some provide services on a sliding fee, some provide access to the MA family planning waiver and sign up uninsured teens for presumptive eligibility.

The Milwaukee Health Department's "No Condom No Way" program was developed in response to the reproductive health crisis for teens in Milwaukee. The program provides increased access to information on prevention of STDs and pregnancy and resources. Sites provide free condoms with no questions asked. Referrals in the MPS school based clinics can be made to "No condom, No way" program sites for free condoms. Condoms are not allowed to be dispensed in any MPS regardless of provider.

The chart below lists 24 Milwaukee high schools along with their respective health care providers. Sixteen of these schools are without health care services. A number of these 16 schools have a high rate of reduced or free lunch enrollments indicating a higher economic need among their students. Most middle and K-8 schools have nursing services provided by community partners (mainly Children's Hospital) but do not provide any type of reproductive health care services.

School Name	Free/Reduced Lunch%	Grades	Service Provider	Type of Provider	Hours per week	PG testing	STD testing
High Schools							
Custer	80%	9-12	MAHP	NP	8	Y	Y
Rufus King	40%	9-12	MHD	RN	8	Y	N
Madison	74%	9-12	MHD	RN	8	Y	N
Marshall-WEB & F/Williams	77%	9-12	MHD	RN	8	Y	N
Metro	87%	9-12					
Milw. School of Entre.	66%	9-12					
North Division-Multiplex	105%	9-12	MHS & Aurora	RN & NP	19	Y	Y
Alliance		9-12					
Milw. Aviation & Science		9-12					
Edison Career Ac		9-12					
Washington	63%	9-12					
Assata	70%	9-12					
Cornerstone	68%	9-12					

High Schools Continued;

**-- FOR DISCUSSION ONLY --
DRAFT DATE: JULY 13, 2006**

School Name	Free/Reduced Lunch%*	Grades	Service Provider	Type of Provider	Hours per week	PG testing	STD testing
HR -Middle & HS	51%	6-12					
Spotted Eagle	69%	9-12					
Milwaukee Spectrum	44%	9-12	MHD	RN	8	Y	N
NOVA (Middle & HS)	86%	7-12					
Shalom	40%	9-12					
Kilmer North		9-12					
Lady Pitts (Custer HS)	70%	6-12	MAHP/MPS	NP/RN	16	Y	Y
Messmer HS		9-12	MHD	RN	8	Y	N
Northside HS		9-12					
Messmer Prep		9-12	MHD	RN	8	Y	N
Marquette HS		9-12					

See attachment 1, for a map of Milwaukee zip code areas and the high schools listed above along with the median household income.

Key Research

This section of the paper outlines the role that School-Based Health Clinics and School-Linked Health Clinics play in improving access and delivery of reproductive health services, the challenges of this approach, and research about the successful use of this type of intervention. SBHCs have been supported by leaders in both education and healthcare. “The American Medical Association, the American Academy of Pediatrics, the Society for Adolescent Medicine, the American School Health Association, the Inspector General of the Department of Health and Human Services, the National Association of State Boards of Education, and Congress’ Office of Technology Assessment all affirm the unique potential of SBHCs to address teens’ unmet healthcare needs.”²³

Depending on the political climate in a community and school-district, SBHCs may overcome some barriers to access such as confidentiality and transportation while letting other barriers remain. For example, many SBHC are “prohibited from dispensing contraceptives. Rather, students must obtain contraceptives by prescription from an off-site source....”²⁴ This national trend is prevalent in Milwaukee as well where hormonal contraceptives and condoms are not routinely available in a school healthcare setting.

While there is an increase in reproductive and STI/HIV education and counseling due to SBHCs, barriers still exist in terms of getting condoms and hormonal contraceptives into the hands of youth. Without access to these services and supplies, changes in behavior are less likely. As Dr Kirby indicates in Emerging Answers, knowledge acquisition alone will not reduce unintended pregnancy or prevent of HIV or STI infections. Rather better health outcomes are dependant on changes in health beliefs, attitudes, and skills. In a survey of 250 school based

²³ Office of Inspector General. School-Based Health Centers and Managed Care: Examples of Coordination. (Washington, DC): U.S. Dept. of Health & Human Services, The Office 1993. National Commission on the Role of the School and Community in Improving Adolescent Health. Code Blue: Uniting Healthier Youth. Chicago, IL: American Medical Association; Alexandria, VA: National Association of State Boards of Education, 1990.

²⁴ Tiezzi, Lipshutz, Wroblewski, Vaughan, and McCarthy Pregnancy prevention Among Urban Adolescents Younger than 15: results of the ‘In Your Face’ Program Family Planning Perspectives, Volume 29 # 4 July/August 1997.

-- FOR DISCUSSION ONLY --
DRAFT DATE: JULY 13, 2006

health centers located in high schools around the United States, over 50% of the respondents indicated that their perception of the barriers to offering services were “concerns about parental objections, and the misperception that EC is an abortifacient. Others barriers included the belief that the use of EC would encourage youth taking behavior and that EC would undermine traditional contraceptive use.”²⁵ Although the concerns about EC being an abortion pill, the beliefs that the use of EC will increase risk-taking behavior, and the concern that use of EC will undermine the use of traditional contraceptives has been found to be untrue²⁶, the perceptions in the community create a real barrier to progressive policy change on this issue in SBHCs.

According to Advocates for Youth, only 7.6% of the services provided at reporting SBHCs were reproductive health services.²⁷ In 1998-1999, 77% of SBHCs who participated in the Advocates for Youth study were prohibited from dispensing contraceptives.²⁸ For those providing reproductive health services, 72% provided birth control counseling on-site. However, only 15% of those providing reproductive health services actually dispensed contraceptives at a SBHC. The majority provided off-site referrals to community-based clinics.

According to case studies done by Kirby, Waszak and Ziegler of SBHCs in Multnomah County, OR; St. Paul, MN; and Baltimore, MD with a combination of over 37 health centers, “SBHCs must emphasize that comprehensive care *is* quality care. SBHCs' role as health care providers means that they must provide a full range of services and match the community's standard of care. Failing to provide contraceptive services reduces the quality of SBHCs' care.”²⁹ In a cross-sectional survey of 949 sexually experienced students in 2 middle and 5 high schools in North Carolina in 1994 researchers found that most sexually experienced students report they would use their SBHC for reproductive/STI services if they were available. Absence of these services in SBHCs represents a missed opportunity to provide health care to adolescents who are at substantial risk of pregnancy and STIs.³⁰

Even within these limitations, there is value in the SBHC being a place for education and referrals for contraceptives. In fact, when 250 school based health centers located in high schools around the United States were surveyed³¹ regarding the benefits of providing education about emergency contraception pills, 75% of respondents indicated that a perceived benefit of

²⁵ McCarthy, Susan K.; Telljohann, Susan K.; Coventry, Barbara; and Price, James. Availability of Services for Emergency Contraceptive Pills at High School-Based Health Centers. *Perspective on Sexual and Reproductive Health* Volume 37, Number 2, June 2005.

²⁶ EC does not negatively impact the use of pills or condoms. See Gold MA et al., The effects of advance provision of emergency contraception on adolescent women's sexual and contraceptive behaviors, *Journal of Pediatric and Adolescent Gynecology*, 2004, 17(2):87-96.

EC is not an abortifacient. See ACOG — American College of Obstetricians and Gynecologists. (1998, July). *Statement on Contraceptive Methods*.

²⁷ Advocates for Youth 1998 *The Facts*

²⁸ Santelli JS et al., Reproductive Health in School-based Health Centers: Findings from the 1998-99 Census of School-based Health Centers, *Journal of Adolescent Health*, 2003, 32 (6):443-451

²⁹ Kate Fothergill Contraceptive Access at School-Based Health Centers: Three Case Studies. October 1999 © Advocates for Youth

³⁰ Tamera Coyne-Beasley, MD, MPH, Carol A. Ford, MD, Martha W. Waller, MA, Adaora A. Adimora, MD, MPH, and Michael D. Resnick, PhD Sexually Active Students' Willingness to Use School-Based Health Centers for Reproductive Health Care Services in North Carolina. *Ambulatory Pediatric Association* March 26, 2003.

³¹ McCarthy, Susan; Telljohann, Susan; Coventry, Barbara; and Price, James. Availability of Services for Emergency Contraceptive Pills at High School-Based Health Centers. *Perspective on Sexual and Reproductive Health* Volume 37, Number 2, June 2005.

-- FOR DISCUSSION ONLY --
DRAFT DATE: JULY 13, 2006

EC education was pregnancy prevention. Other benefits that were identified include an increased opportunity to assist students with traditional contraceptive methods (64-71%); increased access to EC pills (65-74%); and greater likelihood of using them when needed (59-71%).³²

Programs that Work

The 'In Your Face' pregnancy prevention program that was implemented in New York City School District 6 is an example of a successful reproductive health care intervention in a comprehensive school-based clinic. The program was designed to reduce the risk of unintended pregnancy by providing information, counseling, support and referral for reproductive healthcare. The population this program was designed to serve shares commonalities with Milwaukee, Wisconsin. The youth lived and attended school in an urban community. Minority youth were disproportionately represented among teenagers who give birth, and birth outcomes were poor in comparison with non minority teen births. Furthermore, unintended pregnancies among youth under age 15 were disproportionately represented among the state and national trends.³³

One of the programs objectives was to "encourage sexually active youth to consider abstinence." In the year that the program evaluation asked sexually active youth about their behavior around abstinence, 25% of the students in the program who had ever had sex indicated that they had chosen to become abstinent.³⁴

Another objective was to increase the consistent and correct use of contraceptives among youth who were sexually active. "Overall, among students referred to the clinic, the proportion who adopted a method increase from 11% in the year before the program began to 75% in the programs third year." The pregnancy rate in the junior highs served by the 'In Your Face' program "decreased from 8.8 per 100 in 1992-1993 to 5.3 per 1000 in 1993-1994 and 6.8% per 1000 in 1994-1995." The rate of pregnancy increased 19% for adolescents younger than 15 in Manhattan between 1990 and 1993. However, the rate in the schools operating the 'In Your Face' program declined by 34% between 1992 and 1996.

This program was implemented in four junior high schools. Each school had a health educator who was responsible for managing the program and providing direct service to youth. Some of the specific components of the program included forming groups of 5-10 students who met weekly through out the school year to learn about work together on sexual health issues; providing individual counseling; and creating peer groups, to reinforce positive messages. The group education was centered around a 15 lesson curriculum from "Reducing the Risk"³⁵ which focused on topics related to knowledge, behavior, and decision-making skills. The lessons were interactive rather than lecture oriented. Students learned to identify and assess their own risks.

³² Ibid

³³ Tiezzi, Lipshutz, Wroblewski, Vaughan, and McCarthy Pregnancy prevention Among Urban Adolescents Younger than 15: results of the 'In Your Face' Program Family Planning Perspectives, Volume 29 # 4 July/August 1997.

³⁴ Ibid

³⁵ This curricula has been evaluated and found to be effective in reducing teen pregnancy and HIV/STI infection rates. See Kirby, Emerging Answers published by the National Campaign to Prevent Teen Pregnancy in May 2001.

-- FOR DISCUSSION ONLY --
DRAFT DATE: JULY 13, 2006

Education about abstinence and contraceptives occurred in an “open, honest, non-judgmental way.”³⁶

Dispensing contraceptives and prescriptions in junior high was prohibited in NY City so the staff established a referral system with two clinics in the area that had overlapping staff. Students who needed to access contraceptives were likely to work with staff that they had already met and worked with through their SBHC. The health educator for the school took on a case management role when a young person needed outside services in order to provide the support necessary to overcome barriers to accessing an additional system.

The School-based Health Center collaborated very closely with the Columbia University School of Public Health and the Presbyterian Hospital in the City of NY to overcome policy barriers that prohibited schools from dispensing contraceptives.

The findings from evaluating this program suggest that “well-designed, well implemented programs may be able to lower pregnancy rates among very young, high risk adolescents.”³⁷ The “In Your Face” program used the following methods:

1. A population-based approach to diagnose and treat a given condition.
2. Collection of risk factor information from the majority of youth in the specified population.
3. Screening risk assessment data and referrals from other school staff to identify youth in need of services.
4. Inviting identified students to participate in the program.
5. Providing students with intensive case management and continuity of care.

Another related strategy for overcoming barriers to providing reproductive healthcare to adolescents is the creation of School-Linked Health Centers, SLHCs. Like SBHCs, SLHCs reflect an understanding that the barriers to health care that youth must confront in order to receive reproductive health services are unique. School-linked health centers tend to be organizations that serve schools, have formal collaborative relationships with schools and exist in close proximity to schools. However, they are not under the direction of a public school district or school board.

Kate Fothergill and Beth Orlick from the Support Center for School-based & School-Linked Health Care wrote in June 1997, “School-linked health centers maintain the advantage of accessing (and being accessible to) school populations, but are less restricted than school-based health centers.”³⁸ As indicated in the previous section about SBHCs, many schools are prohibited from providing reproductive health services and of those who are permitted to provide health services they are only permitted to do so in a limited way. To the extent that SLHCs are able to maintain their autonomy, they are better able to design, deliver, and sustain effective initiatives for addressing unintended pregnancy, HIV infection, and other STI infections.

³⁶ Tiezzi, Lipshutz, Wroblewski, Vaughan, and McCarthy. Pregnancy prevention Among Urban Adolescents Younger than 15: results of the ‘In Your Face’ Program Family Planning Perspectives, Volume 29 # 4 July/August 1997.

³⁷ Ibid

³⁸ Fothergill, Kate; Orlick, Beth. Support Center for School-Based and School-Linked Health Care, Advocates for Youth. Issues at a Glance: The School-Linked Health Center: A Promising Model of Community-Based Care for Adolescents. June 1997

http://www.advocatesforyouth.org/publications/iag/slhc_md1.htm

-- FOR DISCUSSION ONLY --
DRAFT DATE: JULY 13, 2006

School-Linked Health Centers have real opportunities to meet the needs of all youth. Fothergill and Orlick explain that “SLHCs appeal to young people because they respond to adolescent health and development issues and the providers are experienced in serving this population....By offering comprehensive services, SLHCs can respond to multiple problems at one time, and adolescents have one central place to go for all needs. In addition to offering a breadth of services, most SLHCs staff employ specific procedures to facilitate and encourage adolescent use of services, such as calling to remind them of appointments and to conduct follow-up.”³⁹ Not only are School-Linked Health Centers able to respond to the needs of students, they are able to address the needs of youth who are not enrolled in school. This component is absolutely essential given the rates of truancy, and drop-out evident in Milwaukee, WI.⁴⁰

One successful approach to implementing a School-Linked Model has been to do so in collaboration with School-Based Clinics. In 2004, the Center for Community Health and Education (The Center) in NYC served 2,775 students at school-based health clinics in two High Schools and 4, 136 students at school-based health clinics in Intermediate Schools. “The Center was the first community-based program in the US to provide continuity of services from intermediate school clinic to high school clinic to family planning center.” The Center’s mission is “to provide comprehensive women’s healthcare services, provide primary healthcare services to adolescents that include medical, mental health, health education, and HIV education and counseling services, prevent early childbearing, delay initiation of first intercourse, increase use of effective contraception among sexually active men and women who are not seeking pregnancy; and provide education to parents so that they can be effective advocates for themselves and their children.”

The Family Planning Center, FPC, which is linked to the school-based clinics serve both adolescents and adult women. It also has separate clinic hours at the same site for young men. Twenty percent of the FPC patients are age 19 or younger and services are completely confidential and require no parental consent. No patients are turned away because of inability to pay. No appointments are necessary for new patients and most services are offered on a walk-in basis. The location is accessible by public transportation. The clinic staff reflects the cultural and ethnic diversity of the patients themselves. Furthermore all professional staff are specially trained to work with confidential issues and with young people. The Center is very intentional in its initiatives to address issues of access for low income patients and minority patients.

The Young Men’s Clinic, which has specific clinic hours at the Family Planning Center, serves men ages 14-30. Their services include testing and treatment for STIs, HIV counseling and testing, physical exams for sports, school, and work, health education and referral for other services including social work. The YMC has placed health educators in the Center’s school-based health clinics in the High Schools. The services of the health educators “increased utilization by males, increased the YMC’s capacity to provide classroom health education programs, and promoted transition to YMC for graduating students. Health educators also organize extracurricular activities to help engage male students in SBHC services.”⁴¹

³⁹Ibid

⁴⁰ WI DPI Regional Report, 2003-2004, , 11-12 “Milwaukee Public Schools has the worst attendance rate at 88.6%, the highest habitual truancy rate at 45.4 %, and the highest suspension rate of 22.4%.”

⁴¹ www.mailman.hs.columbia.edu/cche/cche.html

-- FOR DISCUSSION ONLY --
DRAFT DATE: JULY 13, 2006

Clearly, the collaboration in this community is not a one way referral from SBHCs to SLHCs. Rather, the programming and service delivery is designed to meet the needs of clients by pooling resources to best respond to and meet the needs of patients through linkages back and forth between the school-based clinics and the community-based Family Planning Clinic.

Barriers and Gaps

Newly configured MPS K-8th schools may not have a designated health teacher. Teaching the HGD curriculum is left up to individual schools to figure out how and who will teach the HGD curriculum. This may result in less experienced educators teaching a subject they may not be comfortable or qualified to discuss.

The goal of providing health services in any public school is only to address health related issues or problems that provides a barriers to student learning. Can we not ensure a balance of what's good for the individual school, fulfilling the agency's goal of providing on-site urgent care, and the needs of the students?

How is it determined which schools receive school based health services? How are nurses placed in schools? Often this is arranged directly with the school principal and the provider (MAHP, MHD, etc). Is there a coordinated effort to place services in high risk middle, K-8 and high schools?

The level of services provided in schools also depends on the type of provider. There are clear differences between the care RN's and nurse practitioners can provide in school clinics. RN's cannot perform physicals and technically cannot diagnose and treat without the protocol and written orders from a physician. They also cannot dispense medication (contraception, EC or STD meds) without an order. Nurse practitioners can perform all of the above duties: assess, diagnose, treat and refer. Real school based clinics or school-linked clinics need "real" providers who can do more than pregnancy tests and first aid.

Lacking in both these school health programs is the staff time to provide case management services for students at risk of STDs and unintended pregnancy. Milwaukee school based health centers do not have their own social workers and must rely on assistance from school staff or their own limited resources to attempt patient follow-up. Barriers include truancy from school, frequent changing patient demographics and phone numbers and maintaining patient confidentiality.

Everyone interviewed for this paper spoke of the huge gap in services for Milwaukee homeless youth not attending school. Being homeless includes those living in shelters, group homes, hotels, with relatives, transitional centers or tripled up; living with two or more families.

Lesbian, Bisexual, and abused teens, as well as teens who are sexually active with older partners are more likely to experience pregnancy. Among women younger than 18, the pregnancy rate among those with a partner who is six or more years older is 3.7 times as high as the rate among those whose partner is no more than two years older.⁴² Programs that directly address issues of corrosion and poverty are lacking.

Services specifically targeted at males are lacking in all schools currently providing health care services.

⁴² Darroch, Jacqueline E., et. al. (1999). "Age Differences Between Sexual Partners in the United States". *Family Planning Perspectives*, 31 (4), 160-167.

-- FOR DISCUSSION ONLY --
DRAFT DATE: JULY 13, 2006

Recommendations

This section of the paper looks at three broad categories of recommendations for implementing school-based/school-linked interventions to reduce unintended pregnancy and STI/HIV infection rates. The categories are the structure of school-based/school-linked interventions, key program components, and best practices. Each broad category includes suggestions for next steps.

Structure of School-based/School-linked interventions

Use a healthcare delivery model that has the most capacity to meet the needs of youth balanced with the most flexibility to respond to changing healthcare needs. School-based clinics are limited in their efficacy due to lack of autonomy to provide reproductive services. However if this model was coupled with a commitment to change MPS policy and allow for comprehensive reproductive services or partner with community-based providers, then Milwaukee may see some of the positive changes that occurred in NY.

Build on the progress of current provider based services that will enhance the effectiveness and coordination of existing school-based clinic services by doing the following:

- 1) Take a more coordinated look at revising the current system of service delivery. Create a better infrastructure for determining which schools receive services and by whom. Track and evaluate services. Establish interschool referral systems for students needing school based clinic services but come from schools without them.
- 2) Increase the use of data to track and monitor program effectiveness and equality in access to services in order to address disparities.
- 3) Increase coordination among providers to facilitate on-going and up-to-date- training and technical assistance around science based practice methods. i.e. emergency contraception.
- 4) Provide a coordinated effort to work with funders to support best-practice interventions and the development of innovative strategies for hard-to-reach youth including youth who are not enrolled in schools or youth who have a weakened connection to schools because of homelessness and frequent moving.

Provide the infrastructure for assuring MPS students have access to contraception and STD testing and treatment, so that a referral is more than just "lip service."

- Infrastructure could include human resources and a space for the staff member. Having a space or place that students can go to in order to request services is essential to the utilization of this staff person.
- The use of a health educator/ case manager role within the highest risk MPS schools would provide a link between school and community services and would assist students in overcoming barriers to access much like the model used in the 'In Your Face' program.
- Infrastructure could also include Memorandums of understanding between schools and community healthcare providers about how to collaborate to meet youth needs. (including protocols for EC dispensing).

-- FOR DISCUSSION ONLY --
DRAFT DATE: JULY 13, 2006

- Collaboration with agencies such as PPW/MAHP/MHD/MHS to put a health educator/medical assistant/social worker on-site to make off-site referrals and dispense accurate health information.

Use Best Public Health Approaches

- Use a population-based approach to diagnose and treat a given condition.
- Collect risk factor information from the majority of youth in the specified population.
- Use the information gathered in the risk assessment to identify students in need of services and use referrals from other school staff to identify youth in need of services.
- Invite identified students to participate in effective programming.
- Provide students with intensive case management and continuity of care. Relationships between youth and adults are a key protective factor against high risk sexual behavior. Case management and continuity of care can create a relationship where youth have an adult resource person they can count on to help them get their needs met.

Key Program Components

Confidentiality- Wisconsin statutes provide for confidential treatment of minors in a family planning setting.⁴³ All staff should be trained specifically about the extent and limit of confidentiality as it pertains to reproductive healthcare and minors.

Affordability- No patients are turned away because of inability to pay. The MA Family Planning Waiver is a mechanism to overcome some (uninsured/undocumented) financial barriers.

Accessibility- In the NYC Family Planning Center, there policy is that no appointments are necessary for new patients and most services are offered on a walk-in basis. This insures that new patients will not be discouraged from using services due to long waits or missed appointments. Having clinics at school sites and clinics accessible by public transportation are essential.

Non-judgmental- In the interventions highlighted in the key research section, evaluators noted the significance of a non-judgmental approach as a key component of successful programming.

Cultural Competence- Having a clinic staff that reflects the cultural and ethnic diversity of the patients themselves. All professional staff are specially trained to work with confidential issues and with young people. The Center, in NYC, attributes part of their success to being very intentional in its initiatives to address issues of access for low income patients and minority patients.

⁴³ Withers, Richard. JD. Patient Rights and Provider Responsibilities: Privacy and Confidentiality Issues for Family Planning and Reproductive Health Services A Resource Guide for the Wisconsin Family Planning Program In the U.S. Supreme Court CAREY v. POPULATION SERVICESINTERNATIONAL, 431 U.S. 678 (1977), the court stated that: "(a) right to privacy in connection with decisions affecting procreation extends to minors as well as to adults. Moreover, there is substantial doubt whether limiting access to contraceptives will in fact substantially discourage early sexual behavior." Federal rules governing the Medicaid Program, which is a major source of family planning funds in Wisconsin, require that adolescents receive the same privacy rights as adults.

-- FOR DISCUSSION ONLY --
DRAFT DATE: JULY 13, 2006

Economic Competence- Pregnancy prevention programs need to directly address problems of poverty. Youth at risk need specialized programs to address their specific risk behaviors and to help them obtain services. Few programs directly address the root causes of teenage pregnancy as racism, sexism, disenfranchisement, or severely limited life options.⁴⁴

Coordination- A successful intervention requires not only a specific model of service delivery such as a school-based-clinic or a school-linked-clinic. The Key Research section highlighted interventions that used evidence-based curricula, school-based and school-linked models, and connections to university or community-based organizations to leverage resources for youth.

Best Clinical Practices

- Increase access to the Medicaid Family Planning Waiver, by providing enrollment opportunities at the school level. Train existing nurses and nurse practitioners on Waiver enrollment and services. By increasing access to the MA Family Planning Waiver, youth will be better able to afford sexual healthcare thus reducing a barrier to service.
- Increase access to emergency contraception for school students through school- based health clinics, school linked clinics or by using the Emergency Contraception/Family Planning Support Line. Improved access to emergency contraception includes EC in advance of need and immediate access to EC within 12 hours of unprotected sex. In the key research section, a cross-sectional study of sexually active youth indicated that they would use reproductive health services if they were available in their school-based health clinic.⁴⁵ Failing to provide EC at schools is a missed opportunity to reduce unintended pregnancies.
- Provide STD prevention, screening, and testing at school-based health clinics. Remove barriers to free condoms, by providing free condoms to students at school based health clinics and by MPS nurses. Again, research indicates that when services and supplies are available, students will utilize them.
- Provide pregnancy testing services and follow-up in all at risk MPS schools. Both in the middle, K-12 and high schools. The provision of pregnancy testing offers students an opportunity to turn a scary situation into a positive learning experience. A visit for a pregnancy test is a chance to learn about a range of options in a confidential setting. A visit also gives youth an opportunity to work with nurses or health educators to learn about how to protect against STIs and HIV as well as unintended pregnancy.
- Increase interventions aimed at meeting the needs of younger teens in MPS schools. Given the overrepresentation of births to females under age 15 in Milwaukee compared to the rest of WI and national rates, it is essential to implement programming and services that are targeted toward the specific needs of younger females.

⁴⁴ Kirby D. No Easy Answers; Research Findings on Programs to Reduce Teen Pregnancy, Washington, DC. National Campaign to Prevent Teen Pregnancy; 1997: 6-30.

⁴⁵ Coyne-Beasley, Tamera, MD, MPH; Ford, Carol A. MD; Waller, Martha W, MA; Adimora, Adaora A., MD, MPH; and Resnick, Michael D PhD. Sexually Active Students' Willingness to Use School-Based Health Centers for Reproductive Health Care Services in North Carolina. Ambulatory Pediatric Association March 26, 2003.

-- FOR DISCUSSION ONLY --
DRAFT DATE: JULY 13, 2006

- Increase interventions for young men, exemplified by the Young Men's Clinic, outlined in the Key Research section, demonstrates the importance and effectiveness of providing prevention interventions and services specifically for young men in order to address rising STI and HIV infection rates. The Young Men's Clinics were offered in addition to school-based and school-linked health clinics and were part of a coordinated set of services. The clinics had an active presence in public high schools as well as the community.

**-- FOR DISCUSSION ONLY --
DRAFT DATE: JULY 13, 2006**

Key Informants

Paul Akert, RN
School Nurse-
Milwaukee Health Department

Ann Rio Jas,
School Nurse Supervisor
Milwaukee Public Schools

Darryl Davidson
School Age Health Manager
City of Milwaukee Health Department

Ruby Robinson, NP
School Nurse- North Division HS
Milwaukee Health Services

Judy L. Gerrity, MS
Project Director
HIV/STD/Teen Pregnancy Prevention
Education
Milwaukee Public Schools

Vicky Robinson, RN
School Nurse
Milwaukee Health Department

Emily S. Holder, MA, CHES
Consultant- HIV/AIDS/STD Prevention
Program
Student Services/ Prevention & Wellness
Team
Wisconsin Department of Public Instruction

Joseph Schmidt
Researcher,
Public Policy Forum

Sara Siedenberg, RN
School Nursing Supervisor
Children's Hospital Of Wisconsin

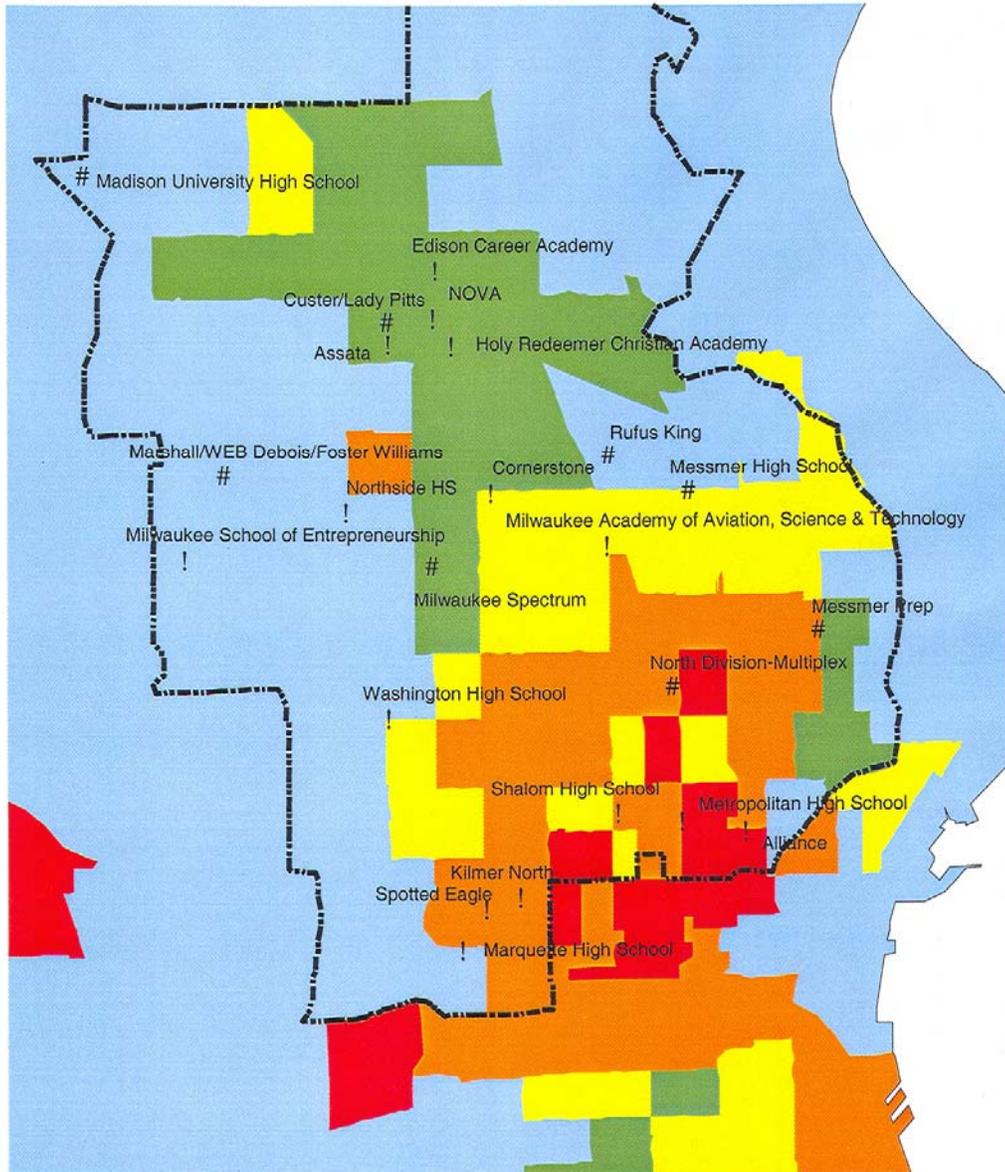
Kathleen Murphy RN, MSN, APRN-BC
Health Services Coordinator
Robert Wood Johnson Executive Nurse
Fellow
Milwaukee Public Schools

Lisa Tries
Associate Director of Community Impact
United Way of Greater Milwaukee

Melissa Vukovich, NP
Milwaukee Adolescent Health Program
Milwaukee College of Wisconsin

Victoria Carlson-Oehlers, MSN, RN, CPNP
Pediatric Nurse Practitioner
School Based Health/Community
Partnerships
Aurora Health Care

High Schools in zip code area, Milwaukee, Wisconsin



High schools

- # Schools with nurse
- ! Schools without nurse

Median household income by census tract, 2000 US Census

