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Barbara A. Rienzo, PhD, is Professor of Health Science Education at the University of Florida in Gainesville. Her expertise is in the areas of human sexuality and health education. She has published numerous scholarly articles and book chapters and has consulted extensively with school districts nationally on teacher training and sexuality education program implementation. She has been awarded some $420,000 in grant funds that have supported both research and the development of health promotion materials for schools. She was one of 30 initial recipients of University of Florida Research Professorship Awards (1997-2000).

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Preface

"Seesaw Battle Goes on Over School Clinic in Gadsden"; "Neighborhood Clinic Praised; Teenage Pregnancies Reduced by Approximately 75 Percent"; "Clinic Is Moved Back to Campus After Three Years Across the Street"—such were the headlines in north Florida newspapers that grabbed our attention more than ten years ago and precipitated this study. With the authors' expertise in human sexuality education (BR) and politics of social change (JB), we were uniquely prepared to attend to the question: what are the crucial political factors that affect controversial yet successful public health programs such as school-based health clinics? We knew, for example, that almost 11 million children (one in six) lacked medical insurance, and millions more were uninsured for parts of the year. School-based health centers (SBHCs) began as an innovative grassroots effort to fill this void in the nation's health care delivery system. Another basic goal of SBHCs was to address issues of reproductive health care, particularly the high rates of teenage pregnancy and sexually transmitted diseases. Moreover, children in poverty (approximately 20 percent of American youths) have greater and more frequent health problems that in turn have a notable impact on their school performance. SBHCs contribute directly to improving the academic achievement and social behavior of students by ameliorating some of the causes of poor performance. Thus we embarked upon what turned out to be a decade-long look at the political process that influences the establishment, growth, and ultimate success of this important education and health care innovation.

Our intent in writing this book is threefold. First, we want to make information relevant to the politics of health accessible to those dedicated medical, education, and social service professionals in the field. All too often the crucial skills involved in building support and dealing with resistance (i.e., "politics") are missing from professional preparation. As a result, promising programs are not often given a chance to succeed due to the inability of schools and communities to get beyond initial hurdles. Second, we hope this study con-

tributes to the body of knowledge that scholars of school and health politics need to optimize chances for implementing innovation to improve the health of youth (and their families). School health centers have often encountered substantial political resistance, and scholars have considered the emerging conflicts as one example of current culture war issues confronting schools. Third and last, we hope that our research contributes to the public's vision of the possible—that important changes can be instituted through "politics" as usual. This study analyzes not only the nature and extent of political barriers but, more important, what strategies have proved most successful in overcoming these barriers.

Some of the more technical aspects of this study have been reported in scholarly journal articles. Thus scholars and students can access the specific research findings and analyses in those sources (cited throughout this book). The information presented herein focuses mainly on the details regarding how and why innovations such as school health centers occur and continue. We have deliberately limited tables, figures, and statistics. Instead, we include descriptions of the people and the methods they used and whenever possible use their words to give voice to the important lessons learned.

This study is unique not only in that the political process underlying the effective implementation of an important school health innovation is revealed but also because it presents information on how programs maintain and grow over time. We began our investigation in 1991-1992 and revisited school-based clinics in 1998-1999. At both junctures, two types of research methods were utilized: we employed a national survey that provided the overall picture in time and the quantitative data necessary to explore contextual factors; and we conducted case studies of five representative school communities, which provided a rich source of qualitative information that described and explained basic findings.

We are very grateful to the Spencer Foundation (Chicago), a national organization that supports research on programs in education, and to the University of Florida Division of Sponsored Research for funding this study. We also express our utmost appreciation to the variety of respondents considered knowledgeable about clinic evolution and politics in each community whom we interviewed in both the early and late 1990s. Those interviewed typically included clinic coordinators and staff, school administrators, teachers, parents, school

board members, leaders of community and political groups both supportive and in opposition to clinics, and media representatives. Local newspapers and available clinic records added further depth. The research assistance we received from our students, especially Seth McKee, was crucial. To our colleague and good friend, Ken Wald, goes our utmost regard and appreciation. Ken's insights, especially related to research design and his contributions to the research analysis, were invaluable.

Finally, we must acknowledge with deepest gratitude the contributions of our families and friends. They are our abiding supporters and our loyal readership. They form our sacred circle.

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Chapter 1

Evolution of Health Services in Schools

> Angela is an 18-year-old Hispanic high school student in Prince George's County, Maryland, who suffers from asthma, disabling migraines, and worries about getting pregnant. She comes from a poor family that she has left, works two jobs to support herself, and has no health insurance.
>
> *Washington Post,* February 1, 1994

> Sam, an eleventh-grade African-American student in Jersey City, New Jersey, lost his mother last year and faces so many problems at home that he almost left. He's very depressed; he has no easy access to condoms, and he thinks that his girlfriend may be pregnant and that he has an STD.
>
> Interview, May 19, 1999

In the last several decades youth in American society have undergone dramatic changes. Among all age groups, children and adolescents now have the highest rates of poverty. Today 25 percent of youth live in families with only one parent, more than double the rate of two decades ago. More than 50 percent of these single-parent children live in poverty. For growing numbers of African-American and Hispanic youth, all of these figures depicting rates of poverty and social and economic disadvantage are much higher. Amid the deteriorating conditions for youth, health care and housing costs have increased significantly. At the same time, budget crises and antigovernment rhetoric at all levels have produced drastic cuts in health and social services. These contending forces—the increased needs of children and deep concerns over public spending—have exacerbated

a serious crisis for many of America's youth. All of this has contributed to the explosion of the "new morbidities"—unprotected sexual behavior, substance abuse, depression, and violence—that continually threaten the well-being of today's children and tomorrow's adults.

At the community and school level, a number of innovative approaches have been discussed and a few implemented to confront this growing crisis. One of the most unique and successful interventions has combined health and social services within educational institutions in what are called school-based health centers (SBHCs). Beginning almost three decades ago, community health agencies and schools in Dallas, Texas, and St. Paul, Minnesota, implemented plans to provide health care to underserved youth through their schools, especially services to combat high teen pregnancy rates. This partnership between health and education seemed an inexpensive and expedient way to meet the pressing physical and social problems affecting students in low-income families. School-based health centers proved to be so successful that today more than 1,000 communities across the country have adopted this school and health care reform in one or more of their schools—a reform that now involves national and local foundations, every level of government, health care institutions, universities, and many professional organizations. From serving poor and minority youth, SBHCs increasingly have grown to provide health services to children and teens in more middle-class neighborhoods.

Our primary goal is to reveal the history, nature, and political dynamics involved in building and sustaining this important innovation in delivering health and social care to youth and, increasingly, their families. Clearly it is important to understand why and how SBHCs began and how they have persisted amid budget concerns, growing health care demands, and frequent criticisms of the schools. Despite their dramatic increase in numbers, SBHCs have nonetheless confronted a number of issues that have ultimately limited the development and growth of this unique program of health care. Among the most important barriers have been consistent and continuous funding, lack of full parental and community support, misunderstanding and poor communication between health professionals and educators, conflicts with some physicians in the community and with school nurses, and, most significant, the politically controversial na-

ture of some services, especially the provision of reproductive health care for teens. Because of these highly controversial services, clinics have often encountered substantial political resistance, and many observers have considered the emerging conflicts as one example of current culture war issues confronting U.S. schools. These and other political conflicts have limited the growth and funding of SBHCs. We shall not only analyze the nature and extent of such political issues and controversies but also discuss what strategies have proved most successful in overcoming these barriers. Since the American educational system is decentralized, initiating and sustaining such reform involves building local support and overcoming the opposition. This is the "politics" of school-based health care, or of any school innovation, and it is an essential but often neglected aspect of reform.

HEALTH STATUS AND CARE OF AMERICAN YOUTH

Access to health care is a significant issue for America's youth. This is largely due to the fact that the poverty rate for those under age eighteen (approximately 20 percent) is much higher than for the rest of the population. Living in poverty is also a function of race and ethnicity, with almost 40 percent of African-American and Hispanic youth in this category. About 12 million American youth are medically uninsured and millions of others have inadequate insurance that fails, for example, to cover even basic immunizations necessary for school attendance. Studies also show that schools with poorer students report high rates of unsafe school environments, another significant health risk for these children. Finally, according to a 1997 Institute of Medicine report (Eng and Butler, 1997), even adolescents with access to care rarely get help for problems of greatest importance, because most physicians are untrained and feel unqualified to address these issues. Those with mental health and dental problems, which comprise a significant number of youth, go largely untreated (Allensworth et al., 1997).

Youth in lower socioeconomic levels suffer disproportionate rates of all types of risks associated with morbidity and mortality. In the 1980s it was found that these risk behaviors (substance abuse, sexual activity, delinquency, depression, and school problems) were inter-

related and that approximately 25 percent of America's youth were at high risk for the problems that resulted from these behaviors. Today the estimated numbers of youth who are at "high risk" or "very high risk" have increased to approximately 35 percent (Dryfoos, 1998).

Youth sexual behavior, in particular, has caused professionals to create school-based programs to help adolescents avoid the plethora of problems resulting from unintended pregnancies and sexually transmitted diseases. Almost 80 percent of males and 66 percent of females initiated sexual intercourse during their teenage years. Studies also have shown that teens wait at least a year or more after initiating intercourse before acquiring a medical form of contraception. More than 1 million teenage females become pregnant each year. Four in ten become pregnant at least once before age twenty. Of these, about 40 percent of pregnancies are terminated through elective abortion, and nearly 500,000 infants are born to mothers age nineteen or younger. Most teens do not use condoms at all or use them inconsistently. Thus, their vulnerability to sexually transmitted diseases, including HIV, also becomes a cause of concern. Adolescents account for at least 25 percent of the more than 15 million cases of STDs that occur annually in the United States. Moreover, STDs among adolescents are causally related to HIV, infertility, cervical cancers, spontaneous abortion, and low-birth-weight infants (Bar-Cohen, Lia-Hoagberg, and Edwards, 1990; Crosby and Lawrence, 2000).

SCHOOLS AND HEALTH CARE

Health problems suffered by these youth are clearly related to difficulties in learning and poor school achievement. Recognizing this, the American Academy of Pediatrics has supported comprehensive school health programs due to the conviction that such interventions increase the "health and educational outcomes of youth" (1993:4). The "comprehensive school health program," a concept introduced in the 1980s, includes a broad range of school-based and community-based activities all designed to prevent disease, promote health, and minimize the complications of health problems of school-age children. Of the seven primary goals of comprehensive school health programs, four involve school-based medical care services and personnel: assuring access to primary care, providing a system for dealing with medical crises, providing medical screening and immuniza-

tions, and identifying and resolving students' health and educational problems. In addition to medical care, school services that are part of this model include health education, healthful environment, health promotion, physical education, nutrition, and mental health counseling. Unfortunately, very few schools have implemented a truly comprehensive school health program.

Nonetheless, schools have been central in efforts to provide a wide range of health and social services for American children since the inception of compulsory education in the mid-1800s. At the turn of the nineteenth century, schools in large urban areas were used to deliver health and social services to children, particularly those children of immigrants. Controlling smallpox and other communicable diseases was a major concern among medical and public health officials, and schools were recognized as the logical place of access to children. Medical "inspections" of youth in schools by health personnel were initiated in Boston, New York, Philadelphia, Chicago, and other major cities. School nurses soon assumed the role of inspecting students, treating minor ailments at school, and referring major problems to physicians. Yet the number of schools that had nurses or medical personnel was few, and the focus was limited to youth with recognized needs (Means, 1975).

World War I had a decided impact on school health programs. The poor physical condition of many war draftees, especially those living in poverty, led to a greater emphasis on health care for youth. Immediately after the war, almost all states enacted legislation calling for health and physical education for schoolchildren. Yet schools were reluctant to provide comprehensive health services. School nurses, or sometimes nurses' aides, focused on first aid, health screenings, and preventive health care. It was assumed that most youth had family doctors for primary care, and the appropriate role of schools was to inform parents of health problems or refer students to community health services (Allensworth et al., 1997; Kort, 1984).

The advent of the War on Poverty and Great Society programs of the 1960s marked another watershed for education and health care. Federal legislation established Head Start, Medicaid, free or reduced school lunch programs, and Title I of the Elementary and Secondary Education Act of 1965, all of which provided new funds for and emphasis on school health and social services. Recognizing and meeting the needs of poverty-ridden students was a primary concern. As a re-

sult, health and school officials became more aware of the issues of drug abuse, teen pregnancy, sexually transmitted diseases, emotional health, and malnutrition that affected significant numbers of children and adolescents. With the influx of public funding for schools and health care, a number of programs were instituted that focused on the potential for schools to meet the special needs of the young.

Another factor that influenced the development and focus of health care was the black civil rights movement in the 1960s. The focus of this movement was on equal rights for African Americans, and these rights included health care and education. The mass mobilization and protests of blacks, first in the South and later in the urban ghettos of the North, highlighted the poverty and social disadvantages of African-American youth as well as adults. Compared to white youth, black children were much more likely to live in a single-parent household, often with an adolescent mother, and to have parents who had not completed high school. Almost half of all African-American youth lived in poverty (Jaynes and Williams, 1989). The black movement, and somewhat later the Hispanic movement, focused greater attention on the morbidities of black and Latino youth, and education and health professionals sought more government funding and new approaches to deal with what had been an "invisible" minority population. Thus, events of the 1960s elevated issues of race, ethnicity, and poverty, including their effects on youth, to the national political agenda.

More recently, pressures have been mounting for schools to expand health care for youth, particularly due to the realization that certain health behaviors are responsible for 70 percent of adolescent mortality and morbidity. According to the Centers for Disease Control and Prevention, these health behaviors include unintentional and intentional injuries, drug and alcohol abuse, sexually transmitted diseases and unintended pregnancies, diseases associated with tobacco use, illnesses resulting from inadequate physical activity, mental disorders, and problems due to inadequate dietary patterns (Allensworth et al., 1997). Along with the recognition of the growing need for services, especially among poorer youth, has been the understanding that schools are the primary venue where children may be reached.

A further impetus for providing health care for youth was the National Education Goals initiative, which originated at a national governors' summit in 1989, and emphasized that students begin school