POSITION STATEMENT

PROVIDING REPRODUCTIVE HEALTH SERVICES IN COLORADO SCHOOL-BASED HEALTH CENTERS

July 2011

COLORADO ASSOCIATION FOR
SCHOOL-BASED HEALTH CARE

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INTRODUCTION

The Colorado Association for School-Based Health Care (CASBHC) promotes access to comprehensive health services for adolescents. Where there is a significant documented need to reduce the prevalence of at-risk behaviors, sexually transmitted infections and pregnancy among adolescents, school-based health centers (SBHCs) should meet that need by providing preventive and primary reproductive health services. These services include human sexuality education, behavioral risk assessment, counseling, pregnancy testing, contraception or referral for contraception, and diagnosis and treatment of sexually transmitted infection. Ultimately, the goal is to keep students healthy, in school, and ready to learn.

DOCUMENTING THE NEED FOR REPRODUCTIVE HEALTH SERVICES

TEEN SEXUAL ACTIVITY

In 2009, the Centers for Disease Control and Prevention (CDC) conducted a nationwide Youth Risk Behavior Survey to monitor risk behaviors among students in grades nine to 12. Regarding reproductive health nationwide, 46 percent of students surveyed reported having had sexual intercourse. When broken down by ethnicity, 65 percent of Black students, 49 percent of Hispanic students, and 42 percent of White students reported having had sexual intercourse.[1] Nationwide, 34 percent of students reported having had sexual intercourse with at least one person in the last three months prior to the survey. Of that 34 percent, 61 percent reported that they or their partner used a condom during the last sexual intercourse and 23 percent reported that they or their partner used birth control pills or Depo-Provera before the last sexual intercourse.[2]

In Colorado, 40 percent of students surveyed reported having had sexual intercourse and 27 percent reported being currently sexually active. Among the students reporting current sexual activity, 63 percent reported condom use during their last sexual intercourse. Twenty six percent reported using birth control pills or Depo-Provera before their last sexual intercourse.[3]

PREGNANCY AND TEEN BIRTH RATES

Approximately 80 percent of teen pregnancies are unintended.[4] When teens use contraception during their first sexual experience, they are less likely to get pregnant during their teen years. Forty-three percent of sexually experienced teen girls who did not use contraception during their first sexual experience reported pregnancy during their teen years versus 27 percent of teen girls who used contraception during the first sexual experience. Likewise, 18 percent of sexually experienced teen boys who did not use contraception at first intercourse reported involvement in a pregnancy as a teen versus 12 percent who used contraception.[5] According to the National Campaign to Prevent Teen and Unintended Pregnancy, many teens do not use contraceptives consistently and correctly. Of girls aged 15 through 19 years who use oral contraceptives, only 70 percent take a pill every day.[6]

It is important to note research has consistently shown that the availability of condoms and contraception in school-based health centers does not increase frequency of sexual activity, nor does it hasten the onset of sexual intercourse. Additionally, when contraception is available in school-based health centers, sexually active students do obtain contraception, thus decreasing risk of unintended pregnancy.[7]

Nationally and across Colorado, teen birth rates declined between 1991 and 2005 by 34 percent. However, between 2005 and 2007 there was a 5 percent increase in teen birth rates nationally.[8] A partial reversal of the two year increase occurred between 2007 and 2008, making the overall national decline in teen birth rates 33 percent between 1991 and 2008.[9] Despite the decline, the teen birth rate in the United States is still the highest among western nations. The 2007 U.S. birth rate was one and a half times as high as England, two and a half times as high as Australia and Canada, and eight times as high as Switzerland, Japan, and the Netherlands.[10]

Compared to the nation, Colorado saw a larger decline in teen birth rates. Between 1991 and 2008 Colorado's teen birth rate declined 33 percent among 15 through19 year olds. Although there has been a decline, many teens in Colorado are giving birth. On average, more than 18 babies were born to teens in Colorado every day—or about one baby born every ninety minutes.[11] Additionally, although there was a decline in teen birth rates between 2005 and 2008, nearly half of all Colorado counties experienced increases, including the populous counties of Arapahoe (4 percent increase), Pueblo (7 percent increase), Jefferson (5 percent increase), and Weld (7 percent increase).[12]

Colorado has the twenty-first highest teen birth rate among the 50 states.[13] The statewide teen fertility rate is 38 births per thousand 15 through 19 year old females. Colorado Youth Matter (CYM) broke down Colorado's teen fertility rate by county. Averaged between 2006 and 2008, San Juan County had the highest fertility rate among female 15 through 19 year olds at 105 per thousand, Rio Grande was second at 81 per thousand, and Prowers was third with 79 per thousand. The top ten also included Morgan with 69 per thousand, Otero with 69 per thousand, Bent with 65 per thousand, Lake with 65 per thousand, Moffat with 62 per thousand, Denver with 62 per thousand, and Adams with 61 per thousand.[14]

The calculation of birth rates can be deceptive when the population being measured is small, as it is in many rural counties in Colorado. Therefore, CYM created a list of the state's most populated counties having the highest teen fertility rates in 2008. Populous counties with rates above the statewide teen fertility rate include Pueblo with 58 per thousand, followed by Denver with 57, Adams with 57, Weld with 46, and Mesa with 42. Populous counties with rates below that of the state include Arapahoe with 37, El Paso with 39, Jefferson with 23, Boulder with 16, and Douglas with 7.[15]

SEXUALLY TRANSMITTED INFECTIONS

Studies show that persons who engage in sexual activity at a young age often have multiple sexual partners and frequent sexual encounters. Both behaviors can be attributed to increased risk of contracting sexually transmitted infections (STIs). Additionally, adolescent females may be more susceptible to STIs than older women because they have fewer antibodies to STIs and may have a higher risk of cervical infections.[16] A recent study demonstrated that 50 percent of urban female teens will be infected with at least one sexually transmitted infection within two years of initiating sexual activity.[17]

ACCESS TO REPRODUCTIVE HEALTH CARE

The number of women in need of contraceptive services and supplies increased 6 percent between 2006 and 2008. Of the 17.4 million women in need of contraceptive services, 29 percent (5 million) were younger than 20 years old.[18] Additionally, evidence to date suggests that youth in the United States are much more likely to encounter barriers to access than their peers in the United Kingdom and other western European countries.[19]

IMPACT OF TEEN PREGNANCY

Economic Impact

According to the National Campaign to Prevent Teen Pregnancy, children of teens born in Colorado cost taxpayers at least $167 million in 2006 ($9.1 billion nationally). Included in the taxpayer costs are medical care for the child, child welfare, and lost tax revenue due to decreased earnings and spending of the parents. The average annual public cost associated with a child born to a mother 17 years of age and younger was $4,056 in 2006.[20]

Educational Impact

Parenting is the main reason adolescent girls drop out of school.[21,22] Young mothers are less likely to graduate.[23,24] Although little research has been completed on adolescent fathers, it is known that, should they decide to support their child, they too are more likely to drop out of school.[25]

Health and Social Welfare Impact

Pregnancy disrupts adolescence which is a time of transition between childhood and adulthood. There are several negative health and social impacts on a teenage parent. Pregnant teens are more likely to experience higher rates of pregnancy-related complications such as toxemia and anemia; and, they are more likely to deliver low birth weight, premature,[26] and developmentally disabled babies.[27] Additionally, teen mothers are more likely to be single parents, have a greater reliance on public assistance, and have multiple children over a short time frame.[28]

While teen mothers face difficulties, their children face even more hardships. Children of teen mothers often have poorer health, more developmental delays,[29,30] and are more likely to be abused and/or neglected.[31] When children of teen mothers reach the age at which their mother became pregnant, they are predisposed to dropping out of school, obtaining low-skilled employment, being incarcerated,[32] and becoming teen parents themselves.[33] According to the National Campaign to Prevent Teen and Unplanned Pregnancy, if a child's mother gave birth as a teen, if the child's parents were unmarried when the child was born, and if the mother did not receive a high school diploma or GED, the child is nine times more likely to grow up in poverty compared to if none of these factors existed.[34]

IMPACT OF SEXUALLY TRANSMITTED INFECTIONS

The most common STIs are chlamydia, human papillomavirus (HPV), genital herpes, gonorrhea, syphilis, and human immunodeficiency virus (HIV). Some STIs have painful and long-term consequences including blindness, cancer, heart disease, and death. STIs can also lead to infertility, ectopic pregnancy and birth defects.[35]

Chlamydia and Gonorrhea

According to the CDC, in 2008, 1,210,523 cases of chlamydia were reported from 50 states and the District of Columbia. Chlamydia often has no symptoms. Nationally, young women aged 15 through 19 years continue to experience the highest rate of both chlamydia and gonorrhea.[36] In Colorado, the chlamydia rate is 1645 per 100,000 for females aged 15 through 19 years.[37] Gonorrhea, like chlamydia, often presents with no symptoms; however, symptoms may occur within thirty days but be mistaken for other infections. In 2008, gonorrhea rates continued to be the highest among adolescents and young adults. Additionally, the rate of gonorrhea among African Americans continues to be 20.2 times greater than that of Whites.[38] In Colorado, among 15 through 19 year olds the gonorrhea rate is 128 per 100,000.[39]

Pelvic Inflammatory Disease (PID)

Left untreated, both chlamydia and gonorrhea can lead to pelvic inflammatory disease (PID).[40] Approximately 750,000 women develop PID each year in the United States. Sexually active women in their child bearing years are most at risk, and those under 25 are more likely to develop PID than women over 25. This is partly because the cervix of teenage girls and young women is not fully matured, increasing their susceptibility to STIs that are linked to PID. PID usually goes undetected and untreated due to its mild symptoms. Additionally, there are no precise tests to identify PID. However, untreated PID can damage the female reproductive system leading to infertility. One in eight women with PID becomes infertile.[41]

Human Papillomavirus (HPV)

HPV is the most common STI in the United States affecting approximately 20 million people. Roughly 50 percent of sexually active men and women will acquire genital HPV infection at some point in their lives. By age 50, approximately 80 percent of women will have acquired genital HPV infection.[42] HPV often presents with no symptoms for both men and women. Some people get genital warts and some may have precancerous changes in their reproductive tract. According to the CDC, "Human papillomavirus is the name of a group of viruses that have more than 100 different strains. More than 40 of these viruses are sexually transmitted."[43]

Currently, there is no cure for HPV infection. For most men, the virus will never cause any symptoms or health problems,[44] and for most women, the body's immune system will clear HPV naturally. For 90 percent of women, cervical HPV infection becomes undetectable within two years.[45] However, for those women who do not clear the infection, HPV is generally the root cause of cervical cancer. Therefore, in 2006, the Food and Drug Administration approved the Gardasil vaccine, which prevents infection from four common types of HPV, including HPV 16 and 18, which are responsible for 70 percent of cervical cancers in the United States.[46]

STIs and HIV

According to the CDC, having an STI increases a person's susceptibility to HIV. Individuals who are infected with STIs are at least two to five times more likely than uninfected individuals to acquire HIV infection if they are exposed to the virus through sexual contact. Additionally, if a person is infected with HIV and also infected with another STI, they are more likely to transmit HIV.[47]

STIs and Pregnancy

STIs also pose consequences for pregnant women who can pass on an STI to their babies, before, during, or after birth. STI in babies can cause stillbirth, low birth weight, conjunctivitis (pink eye), pneumonia, neonatal sepsis (infections of the baby's blood stream), neurological damage, blindness, deafness, acute hepatitis, meningitis, chronic liver disease and cirrhosis. Most of these complications can be prevented with routine prenatal care, which includes testing and treatment of STIs.[48]

DEFINING PREVENTIVE AND PRIMARY REPRODUCTIVE HEALTH SERVICES OFFERED IN A SCHOOL-BASED HEALTH CENTER

Preventive and primary reproductive health services may be offered at school-based health centers in order to reduce the incidence of disease and prevalence of at-risk behaviors among adolescents. Although

the services vary among centers, the most common include human sexuality education, a comprehensive behavioral risk assessment, counseling, pregnancy testing, contraception or referral for contraception, and diagnosis and treatment of sexually transmitted infections.

The services provided by SBHCs vary based on the age of students served, student need, community resources, available funding, and local school district policy. Most SBHCs located in high schools include a comprehensive behavioral risk assessment as part of a well-adolescent exam, and follow up with health education and counseling when a need is identified. Sexually active students are counseled about risk of pregnancy and sexually transmitted infections and informed about methods of prevention. Some SBHCs provide contraception, while others refer students to another provider in the community. Most SBHCs provide pregnancy testing upon request. If a diagnosis is made, SBHCs provide non-directive counseling, support, and referral as needed. However, in rural areas of Colorado, lack of community resources and inadequate transportation may make referrals impractical and limit access to comprehensive reproductive health services.

HUMAN SEXUALITY EDUCATION

Desired Outcome: *Adolescents make healthy, informed decisions to delay sexual activity*.

A law passed by the Colorado General Assembly in 2007 (HB07-1292) requires that a school district or charter school that offers instruction in human sexuality base the content on scientific research and encourage parental involvement and family communication. The law states, in part, that "comprehensive sex education programs that complement the involvement and instruction of parents and respect the diversity and values of the state provide Colorado's youth with a foundation of information to help them make responsible, healthy, informed decisions."[49]

The standards for human sexuality education outlined in HB07-1292 are implemented in the SBHC, ensuring that classroom-based education compliments clinic-based education. In schools where no human sexuality education is taught in the classroom, SBHCs provide patient education as needed during clinic visits.

COMPREHENSIVE BEHAVIORAL RISK ASSESSMENT

Desired Outcome: Reduce the incidence of risk-taking behavior by collecting information about the type of behaviors in which the adolescent is engaged and educating the adolescent as part of the well-adolescent exam.

Comprehensive behavioral risk assessments are administered for the purpose of identifying unhealthy behaviors and providing appropriate interventions. One of the most widely used risk assessment tools is the Guidelines for Adolescent Preventive Services (GAPS). GAPS was developed by the American Medical Association (AMA) to organize, restructure, and redefine health care delivery for adolescents. GAPS provides twenty-four recommendations to physicians and other health providers on how to best deliver preventive services.[50,51] "The goal of GAPS is to improve health care delivery to adolescents using primary and secondary interventions to prevent and reduce adolescent morbidity and mortality."[52]

COUNSELING

Desired Outcome: *To support students in making healthy choices around reproductive health issues; to increase positive communication with parents, guardians, and partners around reproductive health issues.*

Counseling is an important aspect of providing reproductive health services as it is vital to understanding the motivating factors behind adolescent choices to become sexually active. Clinicians and health educators encourage adolescents to involve their parents in reproductive health decisions. Within the scope of services at SBHCs, staff may counsel adolescents regarding their developmental and/or emotional preparedness for having sex, peer influences, parental values, and self-esteem. If the adolescent is in a relationship, discussions may address the components of a healthy relationship.

CONTRACEPTION AND PREGNANCY TESTING

*Desired Outcomes***:** *To reduce the number of unintended pregnancies; to increase knowledge around ways to prevent unintended pregnancies and sexually transmitted infections; to encourage early prenatal care and improve the health of babies born to adolescent women*.

Pregnancy testing is performed in SBHCs upon request or as indicated by medical history. If an adolescent has a negative pregnancy test, the clinician provides education and counseling, and, if the adolescent indicates continuing sexual activity, contraception or referral for contraception is also provided. If the pregnancy test is positive, the adolescent is strongly encouraged to inform and involve parents or other trusted adults in decision-making, and non-directive, family-centered counseling is initiated.

DIAGNOSIS AND TREATMENT OF SEXUALLY TRANSMITTED INFECTIONS

*Desired Outcome***:** *Early intervention to lower complications*.

Adolescents are screened for sexually transmitted infections upon request or as indicated by medical history. Some SBHCs have the capacity to provide treatment for STIs; others refer to providers in the community. In addition to treatment, SBHCs provide education and counseling to address at-risk behaviors.

Antibiotics are most often used to treat bacterial infections such as gonorrhea, chlamydia, and syphilis. Viral infections are commonly treated with antiviral medication as needed. Self-care can relieve some painful symptoms related to genital herpes.

SCHOOL-BASED HEALTH CENTERS AND THE LAW

In the State of Colorado, a minor may consent to the following services: contraceptive services, STI services, prenatal care, and general medical care for the minor's child.[53] According to Colorado Revised Statute 13-22-105, a minor may consent to contraceptive services and information.[54] Additionally, according to Colorado Revised Statute 25-4-402, a minor may consent to examination and treatment of a venereal disease without the consent or notification of a parent.[55]

Additionally, according to Colorado Revised Statute 19-3-304[56], SBHC providers are required to report abuse and neglect to local law enforcement agencies or departments of social services. Therefore, a SBHC provider who suspects sexual abuse is mandated to report the information to appropriate officials.

Privacy and confidentiality are of the utmost importance in providing medical care to adolescents. Teens are more likely to share important health-related information with trusted adults. SBHCs are bound by the federal Health Insurance Portability and Accountability Act (HIPAA). HIPAA guidelines regulate who can access medical records and personal health information and what information can be disclosed. SBHC

clinicians encourage adolescents to engage in open dialogue with their parents/guardians about all aspects of their health care.

CONCLUSION

The services provided in each school-based health center depend upon the age of the students served, documented need, community resources, available funding, and local school district policy. Where there is a significant documented need among adolescents for comprehensive reproductive health services, school-based health centers should meet those needs by providing human sexuality education, behavioral risk assessment, counseling, pregnancy testing, contraception or referral for contraception, and diagnosis and treatment of sexually transmitted infection.

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