Could We Do More?
The Argument for Inclusive
Sexual and Reproductive Healthcare in
Maryland School-Based Health Centers

NARAL Pro-Choice Maryland Fund
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Executive Summary

School-based health centers (SBHCs) have become an increasingly important source of sexual and reproductive healthcare for youth across the nation. NARAL Pro-Choice Maryland Fund (NPCMF) has begun an initiative to encourage existing high school SBHCs to expand their services, raise the standard of care for future SBHCs by requiring onsite comprehensive sexual and reproductive healthcare, and when requested care is not available, require that appropriate referrals be made to qualified and authentic community healthcare providers. To improve health and education outcomes, students who are sexually active or thinking of becoming sexually active should have access to proper services so they can make informed health and wellness decisions. If students are made aware of the available services through accurate and evidenced-based health communication, they can feel empowered to make responsible sexual and reproductive healthcare choices.

Of Maryland’s 24 school districts, 12 have SBHCs. Of these 12, nine have SBHCs located in high schools. Within these nine districts, only Baltimore City and Dorchester County have been found to offer a wide range of reproductive and sexual healthcare options. Others fail to provide even basic services, such as offering condoms. Based on results from the 2014 and 2016 Youth Based Risk Survey (YRBS) results in Maryland, students are reporting that they are sexually active, but not always engaged in sexually transmitted infection (STI) and pregnancy prevention behaviors. By looking at this data and recognizing the lack of family planning services in many counties, there is a need for SBHCs to offer a full range of reproductive and sexual healthcare for students. NPCMF has developed the following policy recommendations:

1. Provide a broader range of services at SBHCs in Maryland. This would include offering, without judgment, a variety of contraceptives and barrier methods onsite, pregnancy and STI/HIV testing, diagnosis and treatment related to sexual healthcare, and more.
2. Develop services that authentically address LGBTQ sexual and reproductive healthcare. A range of information sharing sessions and specific medical guidance are needed to support youth who have non-heterosexual sexual relationships or in gender transition.
3. Implement health education programs on how to decrease risk of STIs/HIV. SBHC staff should also be trained on advising use of the drugs pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) to reduce the risk of HIV infection.
4. Develop policies mandating screening for sexual abuse and exploitation across populations.
5. Require all adults who work with high school students to direct students to available SBHCs when seeking information about or access to birth control, STI and pregnancy testing, or any other information concerning reproductive and sexual healthcare.
6. Create and provide resource materials to students at schools without SBHCs appropriate referrals to qualified and authentic sexual and reproductive healthcare providers in or as close to their local communities as possible.
7. Offer basic onsite prenatal and postpartum healthcare to students to improve healthy pregnancy outcomes.
Introduction

According to advocates for youth across the nation, public school-based health centers (SBHCs) have become an increasingly important source of sexual and reproductive healthcare in areas where it is difficult for low-income families and disenfranchised youth to access such services. Of Maryland’s 24 school districts, 12 have a SBHC present in at least one of their schools, typically in an elementary school. Of these 12 school districts, nine have a SBHC located in at least one high school. These include Baltimore City, Baltimore County, Caroline County, Dorchester County, Howard County, Montgomery County, Prince George’s County, Talbot County, and Washington County. However, only Baltimore City and Dorchester County school districts currently offer a wide range of sexual and reproductive health care, from diagnosis and treatment of sexually transmitted infections (STIs) to providing long-acting reversible contraceptives (LARCs) to students. Unfortunately, the majority of high school SBHCs are doing the bare minimum, such as diagnosing and treating only STIs. The potential is great for SBHCs to meet the real needs of youth, such as offering STI or pregnancy prevention (i.e. providing condoms or birth control); pregnancy testing; providing basic prenatal care; offering relevant sexual education and healthcare for lesbian, gay, or bisexual youth; and assisting youth in gender transition. When youth are unable to easily access sexual and reproductive healthcare, they may choose to not seek care at all. Youth face numerous barriers accessing timely medical care, such as lack of transportation, family support, or health insurance.

NARAL Pro-Choice Maryland Fund (NPCMF) is a statewide nonprofit organization that seeks to protect and advance reproductive health, rights, and justice for all Marylanders. We work to ensure that every individual has the freedom to decide if, when, and how to form one’s family, and when parenting, to do so in good health, in safety, and with dignity. Access to accurate and comprehensive healthcare and information is essential in making informed decisions and acting in one’s best interest. In doing so, we support youth as they navigate the challenges of choosing when to form their families and completing their education to gain economic self-sufficiency.

We believe that in public schools fortunate enough to have SBHCs, timely access to care and information which serve the real needs of youth of any gender identity and sexual orientation will empower more students in realizing their goals. NPCMF has begun an initiative to encourage existing high school-based SBHCs to expand their services, raise the standard of care for future SBHCs, and when requested care is not available, require appropriate referrals be made to students of qualified and authentic community healthcare providers. Students who are sexually active or thinking of becoming sexually active should have access to proper services so they can make informed health and wellness decisions. If students are made aware of the available services through accurate and evidenced-based health communication, then they can feel empowered to make responsible sexual and reproductive health choices.

To better understand the call for increased access to sexual and reproductive healthcare among youth, it is useful to see what data is available. Maryland’s 2016 Youth Risk Behavior Survey (YRBS) results are broken down by each school district and reveal specific sexual risk behaviors of adolescents, including a startling percentage of students engaging in sex without using a method of birth control or STI prevention. Using available information from sources

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such as local health departments and the Guttmacher Institute, there appears to be a gap between need and access to available healthcare sites. In Montgomery County, for example, 11,280 young women under 20 reported needing publicly supported contraceptive services in 2010. Yet, the county has only four publicly funded clinics, leaving approximately 2,820 young women to utilize each clinic. Not only are clinics too few, but transportation is a barrier for too many.

To put this in perspective, below are maps of SBHCs in relation to Title X funded clinics.

SBHCs in Baltimore City and Closest Title X Funded Clinics

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SBHCs in Baltimore County and Closest Title X Funded Clinic

SBHCs in Caroline County and Closest Title X Funded Clinic

SBHCs in Dorchester County and Closest Title X Funded Clinic
SBHCs in Howard County and Closest Title X Funded Clinic

SBHCs in Montgomery County and Closest Title X Funded Clinics
SBHCs in Prince George’s County and Closest Title X Funded Clinics

SBHCs in Talbot County and Closest Title X Funded Clinic
SBHCs in Washington County and Closest Title X Funded Clinic

As shown in the maps, many Title X clinics are far enough away from schools to present a significant challenge to students without transportation. Asking students to go off site to access reproductive and sexual healthcare may also present a concern to those wishing to maintain confidentiality about their visits and needs. SBHCs should offer a full range of inclusive sexual and reproductive healthcare services that benefit all students regardless of their circumstances.

Maryland School-Based Health Center Policies

As shown in the table below, the Maryland Advisory Council’s School-Based Health Center Standards recommend but do not require that specific reproductive and sexual healthcare be offered. The standards have three levels ranging from what would be the basic services provided (core) to what would be ideal for each SBHC to offer (expanded or comprehensive). The standards also indicate when certain care may be offered on-campus, recommended to be provided onsite, or referred to off-campus medical providers for a SBHC to be in compliance. It should be noted that the table presents no specific mention of LGBTQ sexual and reproductive healthcare needs or how those needs should be addressed. The goal of our project is to assist existing high school SBHCs in increasing the number of recommended or referred reproductive health services to be authentically provided onsite. With each high school SBHC adopting more comprehensive policies and practices, we hope that in its planning and implementation, each new SBHC introduced in Maryland will include a fuller range of sexual and reproductive healthcare services that better address the real needs of today’s youth. There are currently 323 Maryland public high schools, 92% of which are without SBHCs.

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The Maryland Council on Advancement of School-Based Health Centers (CASCBC) is staffed to House Bill 221 of the 2017 legislative session (HB221), introduced by Delegate Bonnie Cullison. Maryland State Department of Education (MSDE) remains in control of policy, but staffing and oversight of CASBHC is now the purview of the Department of Health (MDH). Crucially, MSDE also currently holds control over the annual grants that fund the majority of SBHC operations. Some additional funding comes from the state and the Community Health Resources Committee, which also provides staffing for the Council.

### The Case for Expansion of SBHCs in Maryland: Demonstrated Need and Current Progress

There is a substantial need for publicly supported contraceptive services for youth in Maryland. Receiving these contraceptive services may be difficult to travel to from one’s home or even when referred off campus school, as illustrated by the distances between SBHCs and Title X funded clinics, but becomes challenging to access without insurance or other financial means. According to the Guttmacher Institute, between 2010 and 2014, Maryland experienced an over seven percent increase in the number of women needing publicly funded or accessible

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contraceptive services and supplies, with an estimated 3,840 uninsured women under 20 needing public contraceptive services. This number will arguably rise as reproductive healthcare costs increase and publicly funded services decline.

One of the best ways for us to learn more about the sexual behavior of high school students is by examining the results of the 2016 Youth Risk Behavior Survey (YRBS), a comprehensive study conducted across the nation every other year administered by the Centers for Disease Control (CDC). Originally created to track if youth engaged in health and safety habits, (i.e whether youth are eating carrots or wearing car seat belts), the survey questions have evolved over the years to capture real life concerns regarding sexual behavior. The following graph reflects the percent of students who are sexually active in Maryland, broken up by various categories, with data being drawn from the 2016 YRBS.

Survey results reveal that of those who were sexually active, 54% of seniors used a condom to prevent pregnancy or disease, and 33% used another form of hormonal birth control including a birth control pill, vaginal ring, or patch, or a long-acting reversible contraceptive (LARC) such as an IUD, implant, or injection. Of those who were sexually active, 13.5% of seniors did not use any form of birth control, as well as 15% of juniors and 18% of sophomores. Contraception use was also fairly varied. By county, the rate of condom use (in sexually active students’ last sexual encounter) ranges from 43.5% (Talbot County) to 68.3% (Baltimore City). Statewide, the average rate of condom use among sexually active students is 56.9%. Of these currently sexually active students, 27.7% of students statewide had used some form of birth control (oral birth control, IUD, implant, shot, patch, or ring) in their last encounter. Among the nine counties with SBHCs, this rate varied from 14.5% (Prince George’s County) to 43.5% (Talbot County). In these same students’ last sexual encounters, 15.8% of students statewide reported

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6 Frost, JJ et al.
7 Maryland Department of Health, "Youth Risk Behavior Survey," 2016

NOTE: As the Baltimore City Data for the 2016 YRBS has not been released yet, 2014 YRBS data has been substituted in its place for Baltimore City only
not using any form of birth control. Among the nine counties with SBHCs, this rate varied from 9.9% (Talbot County) to 20.8% (Dorchester County).7

In the table below, the data from the 2014 and 2016 YRBS shows the percentage of students in each county who used no method of birth control during their last sexual intercourse:

![Chart showing percentage of students using no method of birth control](image)

If only half of the state’s high school seniors are using some form of STI or pregnancy prevention, we should fear that an alarming percentage of students are failing to engage in preventive measures during every sexual encounter. Without sufficient access to contraceptive services, youth may be less likely to use condoms or various birth control methods when engaging in sex. This data does not account for whether or not students were properly trained in how to effectively use birth control, or identify risk factors. Such services could be offered by SBHC staff.

The table below, taken from the report Maryland’s 2016 YBRS Trend Report, outlines significant county drops in the percentage of sexually active teens using condoms during their last sexual encounter between 2014 and 2016.8 Causes for these declines were not accounted for, but it is important to note that drops in counties such as Talbot and Washington Counties occurred in which there are high school SBHCs, raising the question as to why condoms are not being made available to students onsite.

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Declining use of condoms or other barrier methods leave Maryland youth at increased risk for contraction of STIs and HIV. Data collected in 2017 by the Maryland Department of Health indicates that the highest and second highest reported cases and rates of gonorrhea and chlamydia are for youth ages 15-19, and young adults ages 20-24. In both cases, Baltimore City has the highest rates and reported cases of gonorrhea and chlamydia (942 and 2,372 cases respectively).9, 10, 11 Incident rates per county can be found in the following graphics as provided by the Maryland Department of Health.12, 13

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9 “Table of Gonorrhea Cases by Age Group, Maryland Counties and Baltimore City, 2017”
10 “Table of Chlamydia Cases by Age Group, Maryland Counties and Baltimore City, 2017”
11 “Chlamydia & Gonorrhea by Age-group, Maryland State 2017”
12 “County Map of Gonorrhea Incidence Rates, 2017.”
13 “County Map of Chlamydia Incidence Rates, 2017.”
When students do not have easy access to condoms and contraceptive materials, youth are also at an increased risk for unintended pregnancy. National data gathered in 2015 shows Maryland’s birth rate for female youth between 15 and 17 years of age is 8.4 per 1,000 women, and jumps drastically to 29.6 for youth ages 18 to 19. While this number decreased slightly in 2016, Maryland’s birth rate for youth remains relatively high - 29.1 - for those ages 18 to 19.

The Guttmacher Institute reports that in 2014 over 73,000 female contraception clients were served in Maryland, this only met 25% of Maryland’s overall need for contraceptive services and materials. Out of the 9 counties with SBHCs in Maryland (as detailed in the table below), 6 counties with SBHCs rank higher in terms of teen births than the state average rate of 17 per 1,000 teens. Baltimore City and Dorchester County School Districts do offer comprehensive sexual and reproductive health services, with the intention to meet the needs of students who are sexually active, knowing that the percentages of unintended pregnancy would be much higher than if they did not do so. In fact, increased access to IUDs and focused educational campaigns have cut Baltimore City’s teen pregnancy rate from 64.4/1,000 teens in 2009 to 43.04/1,000 teens in 2013. This is a 32% drop in the rate among teenagers 15 to 19 years of age.

<table>
<thead>
<tr>
<th>County</th>
<th>Number of births per 1,000 female population ages 15-19, 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baltimore City</td>
<td>37</td>
</tr>
<tr>
<td>Baltimore County</td>
<td>14.5</td>
</tr>
<tr>
<td>Caroline County</td>
<td>27.6</td>
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<tr>
<td>Dorchester County</td>
<td>40.6</td>
</tr>
<tr>
<td>Howard County</td>
<td>6.8</td>
</tr>
<tr>
<td>Montgomery County</td>
<td>11.7</td>
</tr>
</tbody>
</table>

16 Frost, JJ et al.
17 Khan D, et al.
18 Meredith Cohn and Andrea K McDaniels, “Teen Pregnancies in Baltimore Drop by a Third,” The Baltimore Sun, February 24 2015.
Prince George’s County 21.1  
Talbot County 18.1  
Washington County 27.1

There are also huge disparities in Maryland between the sexual risks taken by heterosexual and non-heterosexual high school students. Statewide, 12.8% of students surveyed reported that they identified as lesbian, gay or bisexual. Among the 9 counties with SBHCs, this varied from 8.8% (Talbot County) to 20.2% (Baltimore City). As the 2016 YRBS data shows, LGBTQ+ youth were overall more likely to be sexually active than their heterosexual peers (30.9% versus 21.1%) and were significantly more likely to not have used any form of birth control in their last sexual experience (32.9% versus 11.4%). These disparities are concerning as even in the absence of pregnancy risk in some cases of LGBTQ+ sexual experiences, barriers methods carry an important part of STI prevention, with some exploring their sexuality with others regardless of gender. Maryland youth would benefit from more inclusive health education including a focus on LGBTQ+ youth, and more comprehensive sexual and reproductive education and healthcare access including birth control. These identity groups are often tied to higher rates of behaviors and activities associated with health risks, and could benefit from improved and inclusive SBHC services.

To be clear, allies and advocates for youth are urging for more SBHCs in our schools, and for those high schools fortunate enough to have SBHCs, be allowed to offer the full range of healthcare not based on how adults wish youth would behave, but to meet youth where they really are in their lives. The data presented in the 2016 YRBS for the nine school districts that have high school SBHCs are quite telling:

Baltimore City*

- 48% of students reported that they had ever had sexual intercourse.
- 20.2% of students surveyed identified themselves as lesbian, gay, or bisexual.
- 68.3% of students surveyed had used a condom in their last sexual encounter (of students who were currently sexually active).
- 18.7% of sexually active students surveyed had used a form of birth control (oral birth control, IUD, implant, shot, patch, or ring) in their last encounter.
- 15.5% of sexually active students surveyed had used no form of method of birth control in their last sexual encounter.
- 9% of students surveyed reported that they had ever been physically forced to have sexual intercourse when they did not want to.
- 10.4% of students surveyed had experienced physical dating violence in the past year (among students who had dated or went out with someone in the past year).
- 7.8% of students surveyed had experienced sexual dating violence in the past year (among students who had dated or went out with someone in the past year).

* Data from the 2014 Youth Risk Behavior Survey due to lack of available data from 2016 Youth Risk Behavior Survey

Baltimore County

- 35.4% of students reported that they had ever had sexual intercourse.

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● 15.1% of students surveyed identified themselves as lesbian, gay, or bisexual.
● 57.8% of students surveyed had used a condom in their last sexual encounter (of students who were currently sexually active).
● 27.6% of sexually active students surveyed had used a form of birth control (oral birth control, IUD, implant, shot, patch, or ring) in their last encounter.
● 14.6% of sexually active students surveyed had used no form of method of birth control in their last sexual encounter.
● 9.3% of students surveyed reported that they had ever been physically forced to have sexual intercourse when they did not want to.
● 11.6% of students surveyed had experienced physical dating violence in the past year (among students who had dated or went out with someone in the past year).
● 5.4% of students surveyed had experienced sexual dating violence in the past year (among students who had dated or went out with someone in the past year).

Caroline County
● 40.7% of students reported that they had ever had sexual intercourse.
● 11% of students surveyed identified themselves as lesbian, gay, or bisexual.
● 55.3% of students surveyed had used a condom in their last sexual encounter (of students who were currently sexually active).
● 37.1% of sexually active students surveyed had used a form of birth control (oral birth control, IUD, implant, shot, patch, or ring) in their last encounter.
● 12.9% of sexually active students surveyed had used no form of method of birth control in their last sexual encounter.
● 12.3% of students surveyed reported that they had ever been physically forced to have sexual intercourse when they did not want to.
● 10.3% of students surveyed had experienced physical dating violence in the past year (among students who had dated or went out with someone in the past year).
● 7.3% of students surveyed had experienced sexual dating violence in the past year (among students who had dated or went out with someone in the past year).

Dorchester County
● 42.7% of students reported that they had ever had sexual intercourse.
● 17.3% of students surveyed identified themselves as lesbian, gay, or bisexual.
● 51.2% of students surveyed had used a condom in their last sexual encounter (of students who were currently sexually active).
● 33.5% of sexually active students surveyed had used a form of birth control (oral birth control, IUD, implant, shot, patch, or ring) in their last encounter.
● 20.8% of sexually active students surveyed had used no form of method of birth control in their last sexual encounter.
● 14.3% of students surveyed reported that they had ever been physically forced to have sexual intercourse when they did not want to.
● 17% of students surveyed had experienced physical dating violence in the past year (among students who had dated or went out with someone in the past year).
● 9.1% of students surveyed had experienced sexual dating violence in the past year (among students who had dated or went out with someone in the past year).
Howard County
- 22.4% of students reported that they had ever had sexual intercourse.
- 10% of students surveyed identified themselves as lesbian, gay, or bisexual.
- 67.1% of students surveyed had used a condom in their last sexual encounter (of students who were currently sexually active).
- 23.6% of sexually active students surveyed had used a form of birth control (oral birth control, IUD, implant, shot, patch, or ring) in their last encounter.
- 11.8% of sexually active students surveyed had used no form of method of birth control in their last sexual encounter.
- 7.2% of students surveyed reported that they had ever been physically forced to have sexual intercourse when they did not want to.
- 7.3% of students surveyed had experienced physical dating violence in the past year (among students who had dated or went out with someone in the past year).
- 6.1% of students surveyed had experienced sexual dating violence in the past year (among students who had dated or went out with someone in the past year).

Montgomery County
- 22.5% of students reported that they had ever had sexual intercourse.
- 11.2% of students surveyed identified themselves as lesbian, gay, or bisexual.
- 59.4% of students surveyed had used a condom in their last sexual encounter (of students who were currently sexually active).
- 25.1% of sexually active students surveyed had used a form of birth control (oral birth control, IUD, implant, shot, patch, or ring) in their last encounter.
- 17.1% of sexually active students surveyed had used no form of method of birth control in their last sexual encounter.
- 7.2% of students surveyed reported that they had ever been physically forced to have sexual intercourse when they did not want to.
- 6.3% of students surveyed had experienced physical dating violence in the past year (among students who had dated or went out with someone in the past year).
- 5.4% of students surveyed had experienced sexual dating violence in the past year (among students who had dated or went out with someone in the past year).

Prince George's County
- 29.3% of students reported that they had ever had sexual intercourse.
- 12.8% of students surveyed identified themselves as lesbian, gay, or bisexual.
- 62.8% of students surveyed had used a condom in their last sexual encounter (of students who were currently sexually active).
- 14.5% of sexually active students surveyed had used a form of birth control (oral birth control, IUD, implant, shot, patch, or ring) in their last encounter.
- 19.3% of sexually active students surveyed had used no form of method of birth control in their last sexual encounter.
- 9% of students surveyed reported that they had ever been physically forced to have sexual intercourse when they did not want to.
- 11.1% of students surveyed had experienced physical dating violence in the past year (among students who had dated or went out with someone in the past year).
- 5.5% of students surveyed had experienced sexual dating violence in the past year (among students who had dated or went out with someone in the past year).

Talbot County
- 35% of students reported that they had ever had sexual intercourse.
- 8.8% of students surveyed identified themselves as lesbian, gay, or bisexual.
- 48.9% of students surveyed had used a condom in their last sexual encounter (of students who were currently sexually active).
- 43.5% of sexually active students surveyed had used a form of birth control (oral birth control, IUD, implant, shot, patch, or ring) in their last encounter.
- 9.9% of sexually active students surveyed had used no form of method of birth control in their last sexual encounter.
- 10.9% of students surveyed reported that they had ever been physically forced to have sexual intercourse when they did not want to.
- 8.1% of students surveyed had experienced physical dating violence in the past year (among students who had dated or went out with someone in the past year).
- 5.6% of students surveyed had experienced sexual dating violence in the past year (among students who had dated or went out with someone in the past year).

Washington County
- 32.7% of students reported that they had ever had sexual intercourse.
- 12.9% of students surveyed identified themselves as lesbian, gay, or bisexual.
- 51.2% of students surveyed had used a condom in their last sexual encounter (of students who were currently sexually active).
- 36.5% of sexually active students surveyed had used a form of birth control (oral birth control, IUD, implant, shot, patch, or ring) in their last encounter.
- 14.6% of sexually active students surveyed had used no form of method of birth control in their last sexual encounter.
- 9.8% of students surveyed reported that they had ever been physically forced to have sexual intercourse when they did not want to.
- 10.6% of students surveyed had experienced physical dating violence in the past year (among students who had dated or went out with someone in the past year).
- 6.5% of students surveyed had experienced sexual dating violence in the past year (among students who had dated or went out with someone in the past year).

SBHC Policies in Other States

The use of SBHCs as holistic, accessible health centers is a relatively new practice, but research has already been conducted on reproductive health access through SBHCs. Health counseling, STI/HIV testing, and other forms of care are broadly used throughout the country, but only 37% offer any form of birth control as of 2015.20 Of those SBHCs that do offer contraceptives, 96.8% offer barrier methods, 82.9% offer hormonal contraceptives, 73.3% offer emergency contraception, and 39.8% offer implantable devices or LARCs.21

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The benefits of providing birth control onsite are clear. A study compared two high schools in the same urban Southwestern school district, one of which administered birth control on site and the other which referred students off campus for care. The SBHC that offered onsite contraception was partially funded by Title X and provided students free and confidential hormonal and barrier methods, as well as emergency contraception. Results reveal that at the school with onsite access, girls in particular were more likely to select and continue with a contraceptive method, and accessed emergency contraception much more frequently when compared to students who were referred off-campus. **Unsurprisingly, the rate of first-time pregnancies and the overall pregnancy rates were significantly higher in the school that referred students off-campus.**

Further, there is no evidence that birth control services are being accessed by very young students (11-12 years-old) at SBHCs offering onsite birth control. Moving forward, the NARAL Pro-Choice Maryland Fund aims to research the relationship between SBHCs and Title X, since SBHCs in Maryland receive Title X funds in some capacity, to further and better understand funding through Title X for SBHCs that do not provide the full spectrum of healthcare needs. This research will also explore if funding differs from SBHCs that provide the full spectrum of sexual and reproductive healthcare.

While all populations in a school stand to benefit from broader healthcare access, there are certain groups of youth that would likely utilize more, and therefore benefit more from, SBHCs with more comprehensive sexual and reproductive healthcare. Young women are both the most targeted and most affected by access to such healthcare measures. In a study of 12 California high schools, half of which had onsite SBHCs, there was no evidence of an overall difference in student reproductive healthcare usage. Despite this, when SBHCs were onsite, sexually active females were more likely to: receive preventive healthcare and testing, have used hormonal birth control during the last time they had sexual intercourse, and access emergency contraception. There is also evidence to suggest that high-risk populations benefit most from access to healthcare within schools, including low-income students, those without insurance, and students who live far from health centers.

Another notable case is the New York City public schools (NYPS) school-based wellness center program run through a contract with Montefiore that serves 22 locations and reaches a total of 74 schools. Despite NYCPs’ abstinence-first health curriculum, Montefiore’s school health centers offer onsite dispensing of short and long-term birth control methods as well as other reproductive healthcare like STI testing and treatment, HIV and pregnancy testing, and family planning counseling. The health centers’ work in providing comprehensive care does not supersede or override public school curriculum.

**SBHC Policies in Maryland**

23. Urist.
Baltimore City Public Schools do allow pregnancy prevention and other forms of sexual and reproductive healthcare in high school wellness centers, with contractors including Baltimore Medical System. Care includes SBHCs offering IUDs and other LARCs. Increased access to IUDs and a high priority on educational campaigns have cut Baltimore City’s teen pregnancy rate from 64.4/1,000 teens in 2009 to 43.04/1,000 teens in 2013. This is a 32% drop in the rate among teenagers 15 to 19 years of age.

The Dorchester County School-Based Wellness Center program is another successful example in Maryland. Dorchester County has two high school SBHCs at North Dorchester and Cambridge South Dorchester High Schools. Both SBHCs dispense birth control, administer pregnancy tests, and provide STI testing and treatment. The scope of care includes providing emergency contraception/Plan B, condoms, birth control pills, IUDs, and prescription birth control, delivered as needed from the pharmacy to the SBHC; HIV/STI testing; and counseling on each of these issues as well as anatomy, physiology, safe sex, contraception options, and abstinence education. Policy in Dorchester reflects the adoption of reproductive health education standards “in accordance with state laws, program policy, community acceptance and documented need” and lists their services as follows:

- Abstinence Education
- Responsibility - male and female
- Screening for sexual development
- Preventive education and screening
- Pregnancy Testing and appropriate referral
- Testing and treatment for Sexually Transmitted Infections
- Contraceptive initiation and management.

Like other SBHCs, wellness center enrollment is required to access the care in Dorchester County. However, students do not need to be enrolled to receive a pregnancy test or an STI test/counseling session. While originally parents were given an opt-out for their children to receive sexual and reproductive healthcare services, in the past two years this option has been rolled back and all family planning services are offered to students 13 years or older, with parental notice required for students under 13. The family planning services are confidential. The school district’s SBHC is a model of a balance between confidentiality, scope of care, and SBHC responsibility:

V. Family planning services are available to students enrolled in the Wellness Center Program.

A. Students 13 years of age and older may access family planning services without further parental notification, although students are always encouraged to include their parent/guardian in such decisions.

29 Meredith Cohn and Andrea K McDaniels, "Teen Pregnancies in Baltimore Drop by a Third," The Baltimore Sun, February 24 2015.
30 Dorchester County School-Based Wellness Center Program: Policies and Procedures, pg. 27-30. Obtained and obtainable with permission from Dorchester County Board of Education.
31 Dorchester County School-Based Wellness Center Program: Policies and Procedures, pg. 27
32 Dorchester County School-Based Wellness Center Program: Policies and Procedures, pg. 3
33 Information following a conversation with Dorchester County School Based Wellness Centers Program Director Beth Spencer, LCSW-C, July 08, 2017.
B. Parents of students under 13 years of age will be included in discussion and decision-making regarding contraception.

C. Students younger than 13 years old who want to access birth control without parental notification will be referred to the Family Planning clinic at the main Health Department.

D. Although minors may access birth control without parental consent under State Law (Health General Article §20-102) the SBWC Program’s primary mission is to provide health care services. Parents may be reluctant to enroll their younger children in the program if they are opposed to their child receiving birth control at school. In order to preserve the mission of the SBWC program, family planning services will not be provided to students under 13 years old without parental notification.34

**Desired Outcomes & Policy Recommendations**

Despite record low birth rates in young people, teen pregnancy is still a massive and costly issue for the State of Maryland and the country as a whole. Youth 15-19 years of age account for 99% of teen births, meaning that many of these occur during their high school years.35 There has been a steady decline of teen births, down to 553,000 in 2011 in the country, though racial disparities are still prevalent.36 Maryland’s teen pregnancy rate is currently 17 per 1,000 teens, though racial disparity remains: 9 per 1,000 White/Anglo, 23 per 1,000 Black, and 43 per 1,000 Latina youth in 2015.37 Researchers agree the drop in sexual activity among young people is attributable to increased knowledge about and access to a variety of contraceptive methods. There has also been a corresponding decrease in the number of abortions among youth.38

Keeping in mind the successes of other SBHCs that are offering more comprehensive reproductive healthcare, it should become a priority for the Maryland Department of Health to implement a broader range of services at SBHCs in Maryland. This should ideally include offering a range of birth control onsite including barrier, hormonal, emergency, and long-acting reversible contraceptives. This policy would not only remove transportation, financial, and confidentially barriers to students’ access, but should also help reduce the rate of teen pregnancy in Maryland. Additionally, SBHCs should consistently offer pregnancy and STI/HIV testing and be transparent about that access. SBHCs should communicate the offered services clearly and in a nonjudgmental way, to ensure that all students know what services they can access. This information should be made available in school and/or on the SBHC website and students should be encouraged to make use of the variety of SBHC services. If students do not know that they can receive comprehensive sexual and reproductive healthcare in their SBHCs, then having those services available is not going to make a significant difference. Dorchester County School District serves as a good model in terms of scope of care and balance of confidentiality protocols among parents, primary care providers, and students. Similar policy

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34 ‘Dorchester County School-Based Wellness Center Program: Policies and Procedures,’ pg. 3
37 “The National Campaign: National and State Data”.
38 “U.S. Teen Pregnancy, Birth and Abortion Rates Reach the Lowest Levels in Almost Four Decades”.
and procedure language should be incorporated in SBHC policies to provide the greatest access and healthcare provision to students while remaining within age-appropriate, legal, and practical boundaries.

Another recommended policy change is requiring adults who work with high school students to direct students to the SBHCs when seeking information about or access to birth control, STI and pregnancy testing, etc. While it is policy for nurses to link students directly to Title X-funded sites where they can access birth control, there are no policies definitively requiring school employees to create a clear information and referral system. This means that while school teachers, staff, and administers are expected to provide a “network of trusted adults for students,” they are not allowed to explicitly tell students where to access different types of birth control, and do not require teachers to direct students to the SBHC staff or school nurses. Teachers are allowed, but not required, to refer students to the school nurses, with the expected outcome of an offsite referral for healthcare.39 This may necessitate a broader conversation between each county’s Department of Health and the Department of Education to push for policy that requires open information to students.

In addition, specific policies should be implemented regarding LGBTQ sexual and reproductive healthcare. According to Jamal Hailey, the Director of Programs at University of Maryland’s STAR TRACK (Special Teens At-Risk, Together Reaching Access, Care, and Knowledge) program, which focuses on HIV-positive youth in Baltimore City, a range of counseling and specific medical guidance is needed to support youth who have non-heterosexual sexual relationships. Open discussions on sexual and gender identity is the first step to this counseling as it would help SBHC staff understand what type of sexual encounters each individual student may be having, and therefore what types of behaviors and risks may be associated with each student. It is also necessary to screen for sexual abuse and exploitation across populations, and provide counseling on how to decrease risk of STIs/HIV. SBHC staff should be trained on advising use of the drugs pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) to reduce the risk of HIV infection.

**Challenges to Policy Implementation**

**I. Implementation and Training**

Implementation in other areas of Maryland would be overseen differently depending on the county. In Baltimore City for example, Johns Hopkins University Hospital is the medical oversight staff for certain SBHCs in the city, which means that staff members are trained by the hospital in areas like cultural competency, best standards of care, and practical applications of treatments (i.e. LARC and IUD implementation, PEP, etc.).

Implementation of a policy that permits the dispensing of birth control would depend on the safe-sex methods deemed most appropriate and effective for each county’s public high schools. This should include contraceptives and STI-prevention devices that can be tailored to students’ sexual partners and practices. For example, it will be necessary to offer dental dams in addition to condoms, hormonal birth control pills, etc. to effectively provide for students of all sexual orientations and for all different sexual activities. Training for students in effective method use is also necessary. This could be done through classroom demonstrations, hands-on workshops,

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39 from the recording of the joint HHS and Education committees in July 2016 meeting on teen pregnancy:  

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consultations with students, or in depth explanations on the SBHC website. Ideally, contraceptive measures should include the ability to dispense long-acting reversible contraceptives (LARCs). However, additional staff training would be necessary to 1) lessen common biases towards LARC usage relative to other contraceptives for youth, and 2) learn how to safely and effectively insert and remove a LARC device. In Seattle, Washington, a grant from the National Campaign to Prevent Teen and Unplanned Pregnancy allowed the local SBHC staff to receive training, which included shadowing trained staff from Public Health Seattle and King County, which oversees the SBHCs for the area. Baltimore City incorporated LARCs as a contraceptive option in its high school SBHCs through a partnership with Johns Hopkins University Hospital and the Abell Foundation. A multi-stage rollout of birth control options, with LARCs offered later on, could accommodate immediate need for some students while still promising the greatest scope of care for the future.

In addition, questions of whether or not to directly enroll students or require parental consent like most SBHCs would need to be answered, as well as confidentiality parameters of the student seeking sexual and reproductive healthcare. Privacy measures relating to students who receive Medicaid, private insurance, or who cannot pay must be fully ensured and students should be given the option to access reproductive health care without parental notice if necessary.

Implementation should include staff training on the full range of sexual and reproductive healthcare issues for LGBTQ students, as well as the cultural competency around those issues. Baltimore City’s STAR TRACK is a potential and willing future partner for this type of training. Further, increased attention must be given to adequately addressing the needs of transgender students seeking accurate and comprehensive care and information about sexual and reproductive health. For other needs, SBHC staff may benefit from partnerships with local medical centers.

II. Cost
Local health department and SBHC budgets will need to be revised to support increased contraceptive access, including the purchase and distribution of commodities as well as support and training for staff. Prescription medication can be dispensed onsite provided the location either has an established pharmacy or the practitioner’s license includes prescriptive authority. The financial burden of birth control could be alleviated in part if enrollers could prescribe using requirements under the 340B Drug Pricing Program under the Public Health Service Act, which could reduce costs by 15-60%, or those under the Medicaid drug rebate program. However, even if SBHCs could enroll in these programs, or if insurance of students covered some costs, expanded SBHC services would require additional costs. Grants like the Abell Foundation Grant ($30,000) that Baltimore City received for its LARC access efforts could also be explored. Costs for contraceptives especially would need to be budgeted in a way that the SBHC would not need to rely on funding from students’ insurance plans, in order to maintain the confidentiality of the service. This presents a separate challenge for Medicaid recipients.

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42 Ibid., 3-4.
regarding separately or selectively reporting what services are provided in the benefits documentation sent to a Medicaid recipient’s family/parent’s home. Although there is a simple form that can be completed by the youth to not have the benefits document be mailed home, it may take weeks to process, and not many are aware of that option.

III. Parent/Public Opposition

We anticipate that the most aggressive barrier to increased sexual and reproductive healthcare access in high school SBHCs may come from opposition from parents, elected officials, and the general public. If this is the case, there would need to be a targeted approach to ensure buy-in among these groups. Organizing students and their family members, as well as supportive school staff and community advocates, can be done to argue for making access to these services a priority. Connections should be made between the proposed sex education curriculum and the corresponding healthcare needs of students in each grade. Currently the sex education curriculum in Maryland is abstinence plus, with further regulation provided by each county. While this curriculum can remain, it is important to discuss with parents, school board members, school staff, and community members the potential benefits of increased sexual and reproductive health access to assist all youth in realizing their education goals. Lastly, any public awareness or advocacy campaign must be led by youth seeking that these services be established in their SBHCs in order to inform priorities in scope of care and services.

Conclusion

Although Maryland has the reputation of being a progressive, pro-choice state, meaningful access to basic sexual and reproductive healthcare remains limited for too many of our youth. In the past couple decades, school-based health centers (SBHCs) have emerged as a way to deliver accessible, confidential, and comprehensive healthcare to students.44 Growing in numbers, they have been successful in reducing absenteeism and dropout rates45, increasing health knowledge and use of care, and decreasing use of emergency rooms.46 SBHCs have the potential to deliver quality care; improve the social, emotional, and behavioral health of students; and minimize the effects of poverty and other adverse experiences on school success.47 One crucial way SBHCs can improve the health and future potential of students is by offering sexual and reproductive healthcare, as well as by providing education and tools for preventative care.48 These wellness centers can assist adolescents during a time when they might otherwise avoid seeking care,49 and have already proven successful in yielding positive results for their students.50

46 Kate Fothergill, Contraceptive Access at School-Based Health Centers: Three Case Studies, Advocates for Youth (October 1999), http://www.advocatesforyouth.org/publications/publications-a-z/513-contraceptive-access-at-school-based-health-centers-three-case-studies
47 About School-Based Health Centers, School-Based Health Alliance, www.sbh4all.org/school-health-care/aboutsbhcs/ (last visited January 19, 2016).
50 Fothergill, supra note 12.
There are only 124 publicly funded clinics in Maryland, located disproportionately throughout the counties and leaving one-third of the counties with only one each.\textsuperscript{51} Accessing sexual and reproductive healthcare can be difficult for youth challenged with additional obstacles such as transportation and confidentiality. Timely information is critical when trying to reduce teen pregnancy, especially when many students are not using an effective method of birth control, if any method at all.\textsuperscript{52} In addition to the state’s lack of reproductive health services within their SBHCs, sex education within its schools has little correlation with reductions in teen pregnancy or delays in the initiation of sexual activity\textsuperscript{53}, and its programs for pregnant or parenting students are scarce.\textsuperscript{54} Poor attention to these issues results in increased dropout by students or pushout from schools, leaving youth without a high school education and forcing taxpayers in the community to compensate in other ways. The population most affected by the inability to access these services is low-income, minority students. We must look at the problem not merely as a health, education, or financial issue, but also as a social justice issue. We cannot better our community without bettering our youth, and doing so equitably.

We believe that our public high school students want and deserve more sexual and reproductive healthcare in the available SBHCs. By offering a wide-range of onsite contraceptive services, ensuring confidentiality, making students aware of these services through evidence-based health communication, and allowing students to self-consent for their health services in high schools, Maryland has the opportunity to address risk behaviors to positively impact adolescent health. These services are a simple way to significantly better not only the health and educational outcomes of our youth, but also the community as a whole. Again, school districts must stop setting healthcare policies based on how adults wish youth would behave, but on ways to meet youth where they really are in their lives.

\textsuperscript{51} Id. at Table 3.
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