# Delaware stakeholder perceptions of the provision of reproductive health services by school-based health centers: Executive Summary

*Judith W. Herrman, PhD, RN, ANEF (jherrman@udel.edu)*

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**http://dhmic.healthywomende.com/**

Currently reproductive health services (RHS) are provided by 14 of the 28 schools in Delaware. Delaware teens sustain some of the highest rates of sexual activity, pregnancy, births, STIs, and HIV in the nation. Despite scientific evidence supporting youth access to RHS as a means to prevent pregnancy, STIs and HIV, opposition exists relative to the expansion of reproductive and preventative services, and controversy persists in schools related to such practices. This study was designed to clarify Delaware adult stakeholder views on adolescent sexual activity, teen pregnancy prevention, and the role of the school-based health centers (SBHCs) in providing RHS. Adult participants were also asked to consider teens' perspectives on these issues.

A comprehensive review of the literature revealed myriad benefits associated with the provision of RHS in SBHCs and provided a strong foundation upon which to build supportive efforts. This review also provided the framework for the development of a qualitative study designed to explore adult perceptions of the provision of RHS in SBHCs. Fifty interviews were conducted with key informants throughout the state of Delaware. Effort was made to represent each of the three counties and the snowball technique of sampling, wherein each participant was asked to suggest subsequent candidates, allowed for a broad representation of perspectives. The final sample included SBHC personnel, school board members, school administrators, parents, reproductive health experts, and youth advocates. Interviews spanned 25-70 minutes and were conducted by the Principal Investigator from September 7 to November 5, 2012. Data were analyzed using classical qualitative techniques and yielded ten themes:

1. *Teens in Delaware are highly sexually active, secondary to myriad influences, and access to RHS does not increase the rate of sexual activity.*
2. *Education of all stakeholders, most importantly teens and parents, is a critical element of effective contraception and prevention of teen pregnancy.*
3. *Parents have a critical role in healthy sexual behavior and educating their children; other resources are vital for families when parents' capacities are limited.*
4. *Teens see sexuality and RHS as a routine part of their healthcare.*
5. *Access to RHS is limited for teens, with transportation serving as the greatest obstacle to teens' accessing RHS.*
6. *Access is not the only reason sexually active teens do not use contraception, but it is an important reason.*
7. *SBHCs, in addition to other settings, are logical, accessible, and appropriate sites to provide RHS that teens perceive as confidential and teen-friendly.*
8. *Key decision makers, including school board members and others, about RHS in SBHC may or may not represent the perspectives of other stakeholders, including parents, school administrators, healthcare providers, advocates, and teens.*
9. *RHS provided by SBHC at this time are perceived as effective at reducing rates of teen pregnancy, STI's, HIV, and economic costs and these services have encountered very few issues in implementation.*
10. *The addition of RHS to SBHCs is one of the many changes impacting perceptions about SBHC at this time.*

This report provides important insights into each of the themes by including exemplar quotes and analysis. The interview findings clearly demonstrated support of RHS provision, as part of health promotion efforts, by SBHCs. Many participants discussed their desire for broader services, potentially including emergency contraception, long acting reversible contraceptives, HIV testing and referral, and other contraceptive agents. Those agencies currently providing RHS reported few problems associated with the initiation of this policy and also noted that actual dispensing has been for a small, but steady, number of teens. The teens receiving such services, according to the adults interviewed, reported satisfaction with the services and often considered it part of their routine care, rather than a subject of controversy. Stakeholders perceived that these teens represented a critical population to receive services and voiced the need for teens who seek such services to be able to access RHS at readily available settings without significant barriers. From a developmental perspective, the provision of RHS by SBHCs demonstrates an evidence-based practice rooted in understanding of adolescent sexual decision-making and the developmental traits of teens. From that perspective, interventions designed to support responsible sexual decision-making need to include assessments of individual teens' abilities for mature decision-making and social and emotional maturity; gradual exposure to opportunities to test decision-making skills; guidance from responsible and respected adults; and ongoing support in decision-making experiences. This sample voiced that SBHCs were optimal sites to provide these supports and services.

Opposition to RHS in SBHCs appeared to be related to three perspectives, including those related to: 1) religious or personal opposition to adolescent sexual activity and, therefore, accessible contraception; 2) the ideology that schools are for education, not healthcare, and that bringing RHS to the SBHCs would raise concerns about SBHCs in general, causing public scrutiny associated with religious, conservative beliefs or question public/private funding of such services; and 3) parental rights and the perceived threats to these rights offered by the SBHC consent process, the Delaware state law offering healthcare to children 12 and over without parental consent, and the perceptions that SBHCs confound family communication and parental responsibilities. In seeking progress in this issue, it is important to appreciate the perspectives of those who oppose the provision of RHS by SBHCs while also attending to medically accurate, evidence-based, and sought after services that adhere to the needs, preferences, and values of the students, parents, healthcare providers, and other advocates.

One framework that may inform next steps in the expansion of RHS in additional SBHCs is the advocacy action process. The steps of this process include: education of stakeholders about the issues, consequences, and potential revisions; recruitment of committed, well placed champions; obtaining diverse and bipartisan support; avoiding and managing controversy; providing timely information on successes; and openness to compromise while staying focused on the objective.

A discussion of the findings and a model for viewing ideological issues, recommendations, limitations, and conclusions are provided to inform the expansion of RHS at SBHCs and better the health of teens in Delaware. This study offered a glimpse into the perceptions of key adult stakeholders. It will be critical to use these findings to shape future policy and to explore the perspectives of teens to ensure their voice is heard while adults as parents, policy-makers, school board members, healthcare providers, school administrators, and advocates argue for their case in the discussion concerning the provision of RHS by SBHCs in Delaware.