FASTBACK

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The Case for School-Based Health Clinics

Dean F. Miller

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The Case for School-Based Health Clinics

by
Dean F. Miller

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Introduction

Angela is 15 and in the ninth grade at a large urban high school. She lives with her mother and two younger brothers in a two-bedroom high-rise apartment overlooking the busy expressway leading into the city. An average student in school, Angela hopes that someday she will have a job that pays more than her mother's minimum wage job at the local fast-food restaurant. Recently Angela has become sexually active with one of the older boys in her neighborhood. She is now concerned that she may be pregnant.

More than 1.1 million teenagers a year find themselves in the same circumstances as Angela. But she is more fortunate than most because the high school she attends has a school-based health clinic where she can receive some prenatal care and instruction. It will be easier for Angela to continue as a student during her pregnancy and not have to miss time or drop out of school.

Rodney is an active 13-year-old in junior high school. His passion is basketball. He can be found on the neighborhood playground shooting hoops by the hours. Last week Rodney injured the achilles tendon of the right leg. His father's employer has no health insurance plan, and his father's income as a laborer is just high enough to disqualify the family for Medicaid. They have no family doctor. However, Rodney's school has a school-based clinic where he is able to see a physician during school hours about his problem. There he received primary care and was referred to a specialist in the commu-

nity who would give him the treatment he needed. Without the initial care at the school-based clinic, Rodney's father would have had to take him across town to the county health department clinic, requiring taking a day off from work since his mother was home caring for three younger children. At the school-based clinic, Rodney received primary care and follow-up counseling from a nurse-practitioner who knew him and his family.

Maria, 16, is a new arrival in her school, having emigrated from El Salvador with her family within the past year. She is finding school hard because English is not her native language, but she is working diligently on her English in hopes of improving her school performance. Maria is overweight as the result of a diet high in carbohydrates and calories. Because she has no knowledge of basic nutrition, she often eats foods with little nutritional value. Like many adolescent girls, Maria is concerned about her weight; but because of language and cultural barriers, she would not seek help from any of the community weight reduction programs. Fortunately, the school Maria now attends has a school-based clinic. Once a week a dietitian comes to the clinic to provide instruction and counseling for students with weight problems. Maria has become involved in one of the weight reduction peer groups.

Each of these adolescents faced a specific health problem. Because of geographic, economic, or cultural factors, it is unlikely that their health needs would have been met had there not been a school-based clinic in their schools. The same could be said for thousands of other young people today. But the idea of having a health clinic located in a school raises many issues and concerns.

One issue is whether provision of primary health care is a responsibility the schools should assume. Many groups and individuals object to the idea of the schools, as an agent of the state, providing direct health care to individuals. Another issue raised is that the school-based health clinics usurp the authority and responsibility of parents to provide for the health care needs of their children. According to this view,

children should receive health care from a family physician or from an already existing public health clinic facility. Another set of issues concerns the financing of these clinics. Many question the justification of expending funds for these clinics when school budgets already are tight. Opponents view the presence of clinics in schools as an unnecessary duplication of services.

A final and highly controversial issue is that some school-based clinics are providing reproductive information and services to sexually active youth. Feelings run high about this issue, particularly with respect to providing contraceptives and abortion counseling.

Although the pros and cons of these issues will be addressed in this fastback, I will argue that school-based health clinics are needed and can be justified, especially in rural and inner-city communities.

The Need for School-Based Clinics

Just how good is the health of this nation's children and youth? Since we enjoy one of the highest standards of living in the world, many think the health status of our children is good. Various studies and reports indicate otherwise. National studies reveal that the overall level of physical fitness of school-age children is poor (U.S. Public Health Service 1986). Other reports note the poor nutritional status of many adolescents, with eating disorders a special concern. According to the most recent Surgeon General's Report on Smoking, the only population group experiencing an increase in cigarette smoking is adolescent females.

Other health problems are especially evident among disadvantaged minority children. Lack of primary health care in the early years is reflected in such problems as increased tooth decay, periodontal disease, and malnutrition. And malnutrition has been shown to impair not only physiological development but learning as well. (See fastback 147 *Nutrition and Learning*.) Some health problems are related to normal growth and development patterns, such as skin acne during adolescence. More serious, however, are the emotional problems associated with adolescence, such as depression, suicidal tendencies, and eating disorders.

Many children and adolescents become involved in behaviors that have negative effects on their health and well-being – substance abuse, tobacco use, and sexual activity. Teen pregnancy has reached an epi-

demic level in many communities, with more than a million teens becoming pregnant annually. These and other problems clearly indicate the need for health care services, but many students do not have ready access to these services.

Economic factors limit access to adequate health care for many Americans. Health care costs have risen dramatically in the past several years, from about $247 billion in 1980 to an estimated $600 billion annually in the early 1990s. This escalation in health care costs shows no sign of abating in the near future. Although many families have some type of health insurance, the most economically disadvantaged, the part-time employed, and those working at or near minimum wage levels are not covered by any type of health insurance. It is estimated that 37 million Americans have no health insurance.

The availability of health care providers and facilities varies widely from community to community. In particular, rural communities and inner cities often lack adequate health care personnel and facilities. As a result, the economically disadvantaged are most likely the ones without access to preventive health care, such as periodic physical examinations, immunizations, and basic health assessments.

For many children, the only time they come in contact with medical services is when there is an injury requiring a trip to the hospital emergency room or a serious illness requiring a visit to the local health department clinic. In these instances, medical services take care of the immediate problems, but neither effective follow-up nor primary health care is provided.

Another factor restricting children's access to health care is the conflict between school hours and the physician's office hours. Even weekend or evening appointments are difficult to schedule. As a result, the school child is not likely to go to the doctor's office or clinic unless there is a medical emergency.

Given children's need for health care (particularly of a preventive nature) and given the problems of access to such care, I believe a convincing case can be made for bringing health services to where

the children are – in the schools. While the idea of school-based health clinics is new to many, there are many precedents for the concept in the history of U.S. education.

A Brief History of School Health Services

As early as the late 1800s, school districts began to employ nurses to provide some health services. Also, physicians were employed to carry out various communicable disease control measures in several large city school districts. By 1920 most states had mandated that children have certain immunizations before they could be enrolled in the public schools. Also, many schools provided health screening procedures, such as hearing, vision, and height and weight measurements, as a part of the school health service program. Usually the school nurse carried out these screening procedures and made follow-up contacts with the parents and appropriate community agencies. However, it was assumed that parents, not the schools, had the responsibility for the primary health care of the child.

Following World War II there was increasing concern for improving nutrition, especially among disadvantaged children. This led to the establishment of the federal school lunch program. School districts were given funds and surplus foodstuffs to provide a hot lunch at school, which was provided free or at a nominal cost.

In the 1960s the federal government became increasingly involved in providing various social services for the disadvantaged, including health services. For instance, health examinations and screenings were an integral part of the Head Start program for preschool children. With the passage of P.L. 94-142, the Education for All Handicapped Children Act in 1975, public schools assumed responsibility for special

health needs of handicapped children. School nurses became increasingly involved in managing various medical regimens of children with physical handicaps now mainstreamed into regular classrooms.

By the 1970s the idea of providing health services in the school was clearly established, and the stage was set for the introduction of school-based health clinics.

School-based health clinics are located in or adjacent to school buildings for the purpose of providing primary health care and preventive services. This includes a comprehensive program of diagnostic, therapeutic, and follow-up support services. Equally important as medical services is the educational component of the clinic program devoted to developing attitudes and behaviors that will have a lifelong impact on the health and well-being of students.

The first school-based health clinics opened in the early 1970s. One of these, located in a Dallas high school, was operated by the Department of Pediatrics at the University of Texas Health Sciences Center. Another early clinic, which has come to be regarded as a model, was established in St. Paul, Minnesota. Known as the St. Paul Maternal and Infant Care Project, its school-based clinic opened in 1973 in an inner-city high school, where there was great concern about teenage pregnancy, childbearing, and high-risk births. This high school had many of the same problems found in most urban high schools. The dropout rate was double that of other high schools in the city. Absenteeism was high. Students rarely sought medical assistance except in an emergency.

The clinic was open five mornings a week and offered comprehensive health services. The clinic staff established a close working relationship with a local hospital for specialized procedures, tests, and consultations. Testing and treatment for sexually transmitted diseases was an important service provided by the clinic.

The clinic offered several educational programs, including prenatal classes for pregnant teenagers to give them a basic understanding of the maternity cycle. Also, these prospective mothers were enrolled

in the Supplemental Food Program for Women, Infants, and Children (WIC), a federally funded nutrition program for pregnant women and infants. In addition, there were weight reduction classes and a health communication series devoted to basic health issues. A day-care service at the clinic allowed teenage mothers to remain in school after the birth of their babies. And the clinic provided immunization shots for the infants as well as parenting education for the young mothers.

The clinic staff, which included a clinic attendant, social worker, and family planning nurse clinician, worked as an interdisciplinary team. Several health specialists were available on a part-time basis. These included a dental hygienist, health educator, nutritionist, and a maternity nurse clinician.

Evaluation of the clinic over a period of time showed that both male and female students made use of its services. Increased use of the clinic indicated that its services were well received by the students. Follow-up studies revealed a reduction in abortions by those who used the clinic as well as a decline in birth rates.

The number of school districts establishing school-based clinics has increased substantially. In 1990 there were more than 150 such clinics in 30 different states, and more are being planned throughout the nation. A majority of them are located in large inner-city schools.

Organizational Structure and Services of School-Based Clinics

According to Linda Edwards (1987), existing school-based clinics fall into four different organizational models. The first model is one that is established and administered by the school district. The clinic facility is located either in the school building or on school property, and the staff is employed by the school district. In this model a school nurse-practitioner often serves as director of the clinic and hires the full- and part-time staff who provide the medical and health services.

A second model is where the clinic is under the control of the local public health department. Clinic personnel are employed by the health department. The clinic site is located either in the school building or in close proximity to the school. Coordination between the school board and the local board of health is critical to the success of this model. Funding comes from various sources including contractual arrangements with the school district.

A third model is where the clinic is operated by an outside agency (other than the local health department), which contracts with the school district for its services. The most common contracting agencies are hospitals, medical schools, community health centers, and family planning clinics. Usually hospital personnel providing services in these clinics are specialists in pediatrics or obstetrics/gynecology.

A fourth model is one where the clinic is located adjacent to the school property and functions as an out-patient operation. As with the previous two models, the clinic personnel come from various med-

ical care agencies in the community. In this model the clinic services are available to others in the community, including families of the students as well as dropouts. In the last three models, where the clinic is not located on school property and the personnel are not school district employees, the school board has less control over the clinic.

Because community support is essential for the acceptance and success of a school-based clinic, most have citizen advisory committees that have responsibility for establishing goals and determining overall operating policies. Membership on these advisory committees draws heavily from persons representing educational, health, and social service organizations as well as from parents.

The location of clinics and the services provided should reflect the wishes of the community. For example, in 1988 there were five school-based clinics in Illinois. Three were located in high schools and two in junior high schools. The Chicago School Board approved dispensing birth control devices, while the East St. Louis School Board chose not to. In Kankakee, the clinic provided comprehensive services but excluded any contraceptive services. Decisions on such sensitive issues must rest with the individual community.

Clinics located in school buildings usually serve only their own students. One reason for this is that in many urban schools non-students are not permitted in the building for security reasons. Typically, the hours of operation are limited to when school is open.

Clinic Services

School-based clinics provide a comprehensive range of health care services, including general primary health care, health assessment, and screening procedures. Where health assessment indicates a need, the clinic makes referrals to community health care agencies or to physicians. At most clinics, students are able to obtain routine health examinations, required immunizations, and physical examinations required for participation in school athletics. Diagnosis and treatment is provided for minor injuries and illnesses in a majority of school-

based clinics. Where the health condition warrants it, medications are prescribed and dispensed.

Laboratory testing is a valuable service available at most school-based clinics. Such testing provides diagnosis of a variety of health problems. Testing for sexually transmitted diseases can be obtained without the student having to go to a private physician or to a local health department clinic. Some of the clinics provide pregnancy testing.

Other services provided in school-based clinics include preventive dental work, oral hygiene education, and nutrition education and counseling. Counseling regarding diet and weight control is especially important for teenagers. An increasing number of adolescent females experience serious eating disorders, particularly anorexia nervosa and bulimia. Early identification of these disorders can facilitate effective treatment and rehabilitation. Some school-based clinics incorporate weight reduction regimens among their services.

The management of adolescent chronic illnesses, such as diabetes and asthma, is another service provided in some school-based clinics. In some cases, clinic staff have identified cardiovascular problems in students during routine physical examinations. These, too, require a specific management regimen.

Educational programming is common in most school-based clinics. Topics covered include such basic health issues and concerns of adolescents as nutrition, dieting and weight reduction, parenting, sex education, and drug and alcohol abuse. Counseling is a vital component of these educational programs.

One of the important roles of the school-based clinic is its networking function among the various community agencies involved in health, social service, and education programs. Through information and referrals, the resources of these agencies are made available to students and their families.

Reproductive Health Services: A Controversial Area

Regardless of one's views on premarital sex, the reality is that a high percentage of teenagers in America today are sexually active. More than a million teenagers become pregnant every year. Most of these are unwanted pregnancies, the result of limited knowledge of the basic facts of human reproduction and of birth control.

Many school-based clinics have responded to the teenage pregnancy problem by providing reproductive health information and contraceptive services. Even though such services account for only a small percentage (about 15%) of student visits to the clinic, they have caused the most controversy.

The emphasis of reproductive health services is on prevention – attempting to reach young people before they become sexually active and to encourage them to delay sexual activity. The minimum reproductive health services provided in school-based clinics include contraceptive information and counseling, screening for sexually transmitted diseases, and gynecological examinations. Gynecological and pelvic examinations are a part of general health examinations in many clinics. Pregnancy testing and counseling are provided in some clinics. Some clinics offer information about human growth and development and human sexuality to groups of students. In schools that have no regular sex education program, these group sessions provide the only forum where students can receive accurate information about human sexuality. Other educational programs deal with the topic of parenting. Parenting classes are sometimes held in conjunction with in-school day-care programs for infants of teenage mothers. Also,

prenatal examinations and instruction are provided in some school-based clinics where there is a high incidence of teenage pregnancies.

Those who oppose reproductive health services in school-based clinics contend that it is not the school's role to provide contraceptive information, and especially not to prescribe and dispense contraceptives. This, they say, is tantamount to condoning and even encouraging sex among teenagers. This viewpoint was highlighted in 1987 when Florida Governor Bob Martinez turned down a grant for a school-based clinic in an inner-city high school in Miami, saying "government involvement in school-based clinics interferes with parental discretion and control over how and when they choose to discuss sex with their children." It was the position of the governor that parents or clergy, not state-paid medical personnel, should counsel teenagers about sex, morality, and family life.

According to the Center for Population Options, there is no evidence to indicate that the availability of contraception information and services increases sexual activity among adolescents. Nevertheless, adolescents are sexually active. The issue for policy makers to decide is whether to provide information, counseling, and services to help stem the teenage pregnancy epidemic and whether the school-based clinic is an effective means of delivering the services.

An even more volatile issue is abortion. Although no school-based clinics perform abortions, counselors in some clinics discuss abortion as one option when a pregnant teenager comes for help. A counselor might inform the teenager where she can obtain an abortion; some even go as far as to make an appointment for the teenager.

With efforts under way in many states to restrict access to abortion, school-based clinics offering abortion counseling are in an extremely vulnerable position. The other side of the coin is that the education and counseling provided in school-based clinics could help reduce the incidence of teenage abortion. Clearly we need well-designed studies to evaluate the effectiveness of school-based clinics on the sexual attitudes and behavior of adolescents using their services.

Staffing of School-Based Clinics

Staffing patterns in school-based clinics vary from one locality to another. Some clinics employ only one full-time paid professional; larger clinics may employ as many as 15 (Lovick 1988). Typically the clinic directors are nurse-practitioners, who are the primary care providers. Nurse-practitioners have specialized training beyond that required for the RN degree. Their training programs usually are about a year in length. Those working in school-based clinics are usually school nurse-practitioners or pediatric nurse-practitioners.

With their special training, nurse-practitioners are prepared to perform certain tasks that traditionally have been done by physicians. These include taking health histories, performing routine medical examinations (including some diagnostic procedures), assessing health status, and providing emergency medical care. Their training prepares them to identify health problems commonly found in school-aged children.

Physicians on the clinic staff usually work on a part-time basis. They may be employed by the local health department and assigned to work in the clinic at certain times or days, or they may be in private practice and work part time on a contractual basis. Physicians often are involved in developing the clinic's operational policies.

In addition to nurse-practitioners and physicians, a variety of specialists in related health and social service fields serve on the clinic staff. Social workers provide counseling and arrange referrals to ap-

propriate community agencies. Other contracted professionals include dental hygienists, nutritionists, and mental health workers. Since education is an important component of the clinic program, health educators often are available to plan and conduct educational programs for students.

The routine administrative tasks of the clinic are the responsibility of a full-time clerk-receptionist. This individual does appointment scheduling, maintains health records, sends follow-up communications to students and their families, and performs other administrative tasks.

The establishment of a clinic in a school raises some questions about the role of the traditional school nurse. Conflict can arise when tasks traditionally performed by the school nurse are taken over by the clinic staff. In fact, in some communities school nurses have opposed the clinic concept because they perceived it to be a threat to their role in the school health program.

At the outset there needs to be a clarification of specific roles of the school nurse and the clinic personnel. The school nurse should be a partner, not a competitor. She could be involved in the original planning of a school-based clinic and perhaps serve on its advisory board. With her knowledge of the school, she can serve as liaison to the school administration, faculty, parents, and community agencies. She may be involved with follow-up on students receiving services at the clinic. And certainly she can plan and carry out health education programs.

To support the development of school-based clinics while at the same time recognizing the important role of the school nurse, the American Nurses Association, the American School Health Association, and the NEA Department of School Nurses issued a joint statement in 1977 endorsing efforts to expand the traditional roles of school nurses to that of the school nurse-practitioner. In 1988 a joint statement from the American Nurses Association, the American Public Health Association, the American School Health Association, the Na-

tional Association of School Nurses, the National Association of State School Nurse Consultants, and the National Association of Pediatric Nurse Associates and Practitioners contained recommendations on how the school nurse could work in cooperation with the school-based clinic.

Funding School-Based Health Clinics

At a time when funding of education in general is critical, finding more financial resources to develop and operate school-based clinics will require considerable ingenuity. Currently the clinics operate with funding from a variety of sources from both the public and private sector.

In the public sector, funding has come from federal grant programs. For example, Maternal and Child Health and Social Services allocate block grant monies to the individual states. The states in turn establish their own priorities as to how the monies will be distributed to various state agencies, such as the department of public health. Some of these monies have been used for school-based clinics, but the amount varies widely among the states. Unfortunately, federal budget cutbacks during the late 1980s have reduced Maternal and Child Health block grant programs.

Funds to support school-based clinics also have come from Title X of the Public Health Service Act. For instance, funding is available for screening and testing of Medicaid eligible children under the age of 21 from the Early and Periodic Screening, Diagnosis and Treatment Program. In addition, Title X funds have been used for overall operational support of school-based clinics, including some reproductive health and education services.

The Adolescent and Family Life Act is another federal program providing funding. Under Title XX of this legislation, funds are avail-

able to community agencies to develop "abstinence based" sex education programs. More than 140 state and local health agencies as well as charitable and religious organizations have received funding under this legislation. The constitutionality of providing religious organizations funds for sex education was challenged in court. In June 1988 the U.S. Supreme Court ruled in the case of *Bowen* v. *Hendrick* that the Adolescent and Family Life Act was constitutional. However, school-based clinics receiving funds through the provisions of this legislation can not provide abortion counseling or make abortion referrals.

Other public sector funds for adolescent health services come from state and local governments. For example, in 1987 Connecticut provided funds to several communities for planning new school-based clinics. Also, state funded school-based clinics have received legislative support in Oregon.

In the private sector, several philanthropic foundations have taken an active role in the development and support of school-based clinics. Typically, foundation grants have provided for start-up costs, operational expenses for a limited time, and for evaluation. A notable example is the Robert Wood Johnson Foundation, which initiated its national School Health Services Program in 1978. Grants from this program have been used to establish school-based clinics, which provide basic and primary care, immunizations, and health screening.

In 1987 the Robert Wood Johnson Foundation launched its School-Based Adolescent Health Care Program, awarding 19 grants totaling $16.8 million for start-up costs and implementation of clinics in 23 large urban high schools throughout the nation. Each clinic provides comprehensive services to inner-city youth. Several of the clinics provide infant day-care services so that single teenage mothers can continue their education. A stipulation of the grants is that medical providers in the community operate the school-based clinic aided by a community advisory committee. Project staffing must include at least a part-time physician, a nurse-practitioner, a social worker, and a medical office assistant.

Other foundations supporting the development of school-based clinics include the Ford Foundation, the Rockefeller Foundation, the Grant Foundation, the Hewlett Foundation, the William Penn Foundation, and the Harris Foundation.

Financing of most school-based clinics comes from a combination of sources. For example, the clinic at DuSable High School in Chicago receives funds from the Illinois Department of Public Aid, the Robert Wood Johnson Foundation, the Commonwealth Fund, the Joyce Foundation, and Pittway Corporation Charitable Foundation. The Chicago school system provides space, maintenance, and security for the clinic. Funding for the clinic at Austin High School in Chicago comes from a grant from the Robert Wood Johnson Foundation and in-kind contributions from Cook County Hospital, the City of Chicago Department of Health, the Chicago Board of Education, and the Chicago Comprehensive Care Center.

Although most clinics provide services free of charge, some do charge a small fee. Some clinic administrators feel that charging a small fee helps young people to develop a sense of responsibility for their own heath care. However, fees should not become a barrier to using the clinic services.

Leaders of the school-based clinic movement will have to be aggressive in finding new funding sources. They cannot continue to rely on philanthropic foundations for ongoing support. Given the current political climate, it is unlikely that new federal funds will be forthcoming in the near future. Other kinds of community alliances must be pursued. With the growth of group prepaid health care plans (HMOs), possibly the school clinic could become a provider site for children and youth. In conjunction with local hospitals and public health departments, the school clinic might serve as a satellite health facility. The potential of school-based clinics for serving the health care needs of children calls for new and creative funding models.

The Role of Parents in the School-Based Health Clinic

Parental involvement is essential to the success of the school-based clinic. Through involvement, parents become supporters of the clinic and often are its strongest defenders when opposition arises. The clinic also provides a means for parents to become more directly involved in the health care of their children.

For example, in a Chicago school-based clinic, parents are required to participate in the initial clinic interview with the student patient. This gives the parent some familiarity with the services of the clinic and gives the clinic staff some information about the family background and home environment. Through this kind of parental involvement, there is likely to be better follow-up on the medical regimen the clinic has recommended.

For many parents the initial contact with the clinic comes at the beginning of the school year when they receive a parental consent form to sign before their child can receive services from the clinic. (Parental consent is necessary in most states before a minor can be rendered general medical care; only 12 states give minors the right to consent to their own medical care.) Often the consent form has a space for parents to indicate which clinic services they do not want their children to receive. Often the consent form is accompanied by a brochure describing the clinic program, the list of the services provided, and the name of a contact person.

Parents should be invited to visit the clinic during open house and at other times. Many school-based clinics have an open-door policy allowing parents to visit whenever they wish. In a number of cases parents have become interested in the clinic programs and volunteer to help with clerical and administrative tasks.

When parents serve on a clinic advisory council or planning committee, their insights can be especially helpful in policy development. For example, parents serving on the planning committee for a school-based clinic in Kansas City objected to including contraceptive counseling and services, and that became the policy. However, after the clinic had been operating for some time, the parents realized it provided an appropriate setting for adolescents to learn about contraception and to receive counseling. So they voted to institute these services for their school's clinic.

Conclusions

School-based clinics are not widespread, but the concept has received support from several professional organizations. In 1979 the American Public Health Association strongly endorsed the concept. In 1988 the president of the American School Health Association, in testimony before the Disease Prevention and Health Promotion Board of the U.S. Public Health Service, called for expanded primary health care services in the schools and recommended a goal of providing such services to 30% of K-12 students, with low-income children as the target population. Also, the Center for Population Options, located in Washington, D.C., operates a Support Center for School-Based Clinics that provides assistance to school systems and community agencies interested in developing clinics.

Although more research and evaluation studies are needed, there is already considerable evidence to document the contributions of school-based clinics to the overall health of children and youth. In schools with such clinics, more than 70% of the students have used clinic services for a variety of health-related problems within the course of a school year. Also, studies indicate that school-based clinics are cost effective when compared to cost for health care provided at hospitals and other outpatient facilities.

In testimony before a congressional committee in support of the School-Based Adolescent Health Services bill, it was reported that no student who had completed a school-based clinic alcohol and drug

abuse program in Kansas City had been cited again for disciplinary action. Also, no low-birthweight babies were born to teenage mothers enrolled in the clinic's prenatal program. In the same testimony, it was reported that in another clinic in Missouri, each teenage mother who had used the services of a school-based clinic continued in school and graduated with her class. Over a period of 10 years in schools with clinics in St. Paul, Minnesota, the birthrate among students declined from 79 per 1,000 to 35 per 1,000 (Kirby 1986). Several clinics reported an increase in the use of birth control methods among those who made use of the services of the school-based clinics.

Perhaps the strongest argument to justify school-based clinics is that of accessibility. Students are at school a major portion of the day. When access to health services is convenient, students are more likely to use them. In addition to easy accessibility, familiarity is an important factor. Once students know the clinic personnel and come to trust them, they feel comfortable going to the clinic and are more likely to accept the counsel and medical advice they receive.

Providing contraceptive information and dispensing contraceptives to sexually active students will continue to be a controversial issue. Those who oppose the school-based clinic concept on these grounds need to be reminded that most of the health care services provided by clinics are not in the area of reproductive health (Lovick 1988). The primary goal of school-based clinics is to improve the overall health of children and youth. However, clinic staff can play an important role by helping parents to deal with the sexuality and reproductive health of their children.

As the school-based clinic concept grows, more clinics should be established in elementary and midde schools with an emphasis on primary and preventive health care. Their operating hours should be expanded to after school, on weekends, and over the summer.

If we are to achieve the World Health Organization's goal of "Health for all by the year 2000," the school-based health clinic can play a key role in reaching that goal.

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