Politics and Practice: Introducing Norplant into a School-Based Health Center in Baltimore

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Introduction

The city of Baltimore has long had one of the nation's highest adolescent birth rates. The emotional, social, and economic costs of this problem are significant. In 1990, 10% of all 15- to 17-year-olds living in Baltimore gave birth, with direct costs of teenage births to the government (through Aid to Families with Dependent Children [AFDC]; the special supplemental food program for Women, Infants, and Children [WIC]; food stamps; and Medicaid) of $222 million. Health risks to adolescent mothers and their children are well documented, ranging from pregnancy complications such as preeclampsia to low-birthweight babies. In addition, there are the long-term consequences of lower levels of educational and job attainment for the mothers and higher rates of living in poverty for their offspring.

Over the past decade, many different approaches have been attempted to combat the problem of adolescent pregnancy and birth in Baltimore. These approaches include (1) the development of an inner-city, mall-based comprehensive health clinic that provides a host of services, including family planning, to over 5000 adolescents each year; (2) a citywide media campaign promoting abstinence; (3) school-based efforts, including peer-taught and teacher-taught abstinence curricula in middle schools, male outreach activities, and sex education; and (4) the development of family planning services in two middle and six high school-based comprehensive primary care centers. These activities have resulted in some success. After several years of increasing rates, Baltimore's adolescent birth rate has stabilized (Baltimore City Health Department, unpublished natality statistics, 1992). However, it remains among the highest in the country, and further approaches are being considered.

One widely discussed approach is making the implantable contraceptive Norplant more readily accessible to adolescents. Norplant has been available to adolescents in Baltimore City Health Department family planning clinics since the summer of 1992. However, clinicians working in the health department's school-based health centers, after hearing requests for Norplant from students and parents, felt that these centers would be the best setting for adolescent Norplant insertions and would provide the best access to this contraceptive.

The Baltimore City Health Department operates school-based health centers that provide comprehensive primary and preventive health care to enrolled students at eight secondary schools. These schools are all in locations where there is a particular need for accessible adolescent health care.

Family planning counseling and exams have been available on site at the school-based health centers since their inception in 1985. Vouchers for contraceptives, to be redeemed at off-site locations, were given to students who desired them. However, this voucher system did not work well because students rarely followed up to obtain contraceptives. To alleviate this problem, the health department decided to make oral contraceptives, foam, and condoms available in the health centers at the start of the 1990/91 school year. However, the number of students using them remained low. In a small pilot program, Norplant was inserted into a small number of students, and these results suggested that the implant was a viable option for adolescent women.

One consequence of the implant's high initial cost was that the number of adolescents able to use it was limited. One approach to decreasing the cost was to combine it with a second contraceptive, the foam. A small pilot study suggested that the two contraceptives could be used together. However, combining Norplant with the foam added complexity to the procedure, increasing the number of steps, and possibly the risk of infection. Because of these concerns, the authors decided to use Norplant alone in these adolescent clients.

As one element of Baltimore's effort to combat its high rate of teenage pregnancy, the Baltimore City Health Department added the implantable contraceptive Norplant to the array of services offered at one of its school-based health centers in early 1993. The initial findings with the adolescents who received this contraceptive at the school were favorable, particularly regarding condom use, parental involvement, and patient acceptance of the contraceptive. This new policy garnered a significant amount of attention, both nationally and locally. It attempts to address problems that have complicated etiologies as well as diverse clinical, social, and ethical ramifications, all complicated by political realities. The Norplant experience offers useful lessons regarding controversial health initiatives that address problems facing public health practitioners today. (Am J Public Health, 1995;85:309–311)
Commentary

school year. The decision became policy only after an extensive survey of parents of students enrolled in the clinics demonstrated strong support (75% in favor) for offering contraceptives on site.6 The contraceptive availability policy has been very well accepted by students, staff, and parents. A follow-up survey in the second year of this policy revealed no parental complaints about the availability of contraceptives on site (P. Beilenson, unpublished data, 1991).

The Decision and the Reaction

As Norplant began to be discussed in the general media, health care professionals in the school-based health centers were asked by students and parents about its availability in these sites. These requests, combined with the fact that the current contraceptive policy was so well accepted by parents, led the commissioner of health to decide to make Norplant available on a pilot basis at one of the health department's school-based health centers in the 1992/93 school year.

The school chosen as the pilot site, a combined middle and high school for pregnant and parenting teens, was selected for two reasons. First, adolescents who have already given birth are at even higher risk of pregnancy than other adolescents.7 Second, the principal of this school was very supportive of the program.

In December 1992, as the health department's Bureau of School Health began to develop the structure for this pilot program, the media learned that Baltimore would be the first city in the nation offering Norplant at a school-based health center. The media coverage—local, national, and international—was almost universally favorable and plans for implementing the pilot program were finalized.

However, in late January 1993, shortly after the first Norplant was inserted at the school, a small but vocal group of citizens spoke out in opposition to the program. This group contended that the Norplant policy targeted inner-city African-American teenagers (some argued that this amounted to "genocide"); that Norplant had not been tested in this population; that Norplant users would be less likely to practice safer sex and therefore would be at higher risk for human immunodeficiency virus (HIV) and other sexually transmitted infections; that the health department was promoting the use of this contraceptive over abstinence; that Norplant had dangerous side effects; and that the program excluded families from the decision-making process of their adolescents.8,9

The strategies used by the opposition were similar to those used nationally against other school health programs instituting reproductive care. These strategies included misinformation, manipulation of public meetings, preying on fears of parents, intimidation and pressure tactics, and accusations of racism.10

To ensure that these concerns got a public airing, a city councilman introduced legislation calling for a hearing on the health department's policy of offering Norplant in the schools. The hearing, held in early February 1993, was contentious. The opponents' claims were refuted (Appendix) and their public opposition to the program subsided as it became obvious that the general public was in favor of making Norplant available as long as it was not promoted and no coercion was involved. The Norplant program continued during the hearing process and Norplant continues to be available to students in the school-based health center.

Outcomes

In the first semester after the new policy was implemented, 11 of the approximately 100 pregnant students in the school received Norplant from the school-based health center. Before receiving Norplant, each of these 11 students attended a counseling session at the school, accompanied by a parent or guardian; in most instances, a relative was also present during the insertion procedure. All of the students have tolerated Norplant well; there have been no requests for removal and no students have exhibited any but minor side effects. All of these students reported using condoms at least as frequently as they did before receiving Norplant (with follow-up of 5 to 12 months), and most reported using condoms significantly more frequently since getting the implant. As support for these students' self-reports on condom use, we know of only a single case of a sexually transmitted disease among these Norplant recipients. One possible explanation for this increased use of condoms is the intensive counseling on condom use all students receive before getting the implant, combined with extensive follow-up counseling.

Plans for the Future

With the successful implementation of this policy, the health department has expanded the availability of Norplant to three more high schools, with plans to expand to the remaining two high schools that have school-based health centers over the next year. (The implant will not be available in the two middle school health centers.) In light of the controversy the initial proposal generated, however, the health department educated various segments of the community about Norplant before this expansion. The health department (1) discussed the issue with religious groups and a city-wide community health advisory group; (2) discussed the issue with interested parents in each school; (3) educated the teaching and administrative staffs of the schools; and (4) made presentations to student groups about postponing parenting, including a discussion of abstinence, Norplant, and other contraceptive methods.

Discussion

If community acceptance can be obtained, school-based health centers are ideal places to offer contraceptive services. They are readily accessible to students, a well-recognized advantage in delivering any kind of health care to adolescents. This accessibility is also important for the health care staff, who can locate the students easily when follow-up and compliance are important. In addition, the close, trusting relationship that typically develops between school-based health center staff and individual adolescents is critical to the success of efforts to provide effective health care to teens.

One important lesson our experience teaches is that the community may not immediately accept measures that make good public health sense. Extensive education of all involved, including community members, elected officials, and religious groups as well as all pertinent staff (who might not be knowledgeable about the proposed intervention), is essential to the successful and smooth implementation of controversial policies. The lead time necessary for doing this important groundwork is rarely appreciated by funders or program managers as a sound investment.

There is a real need for affected communities to be in on the development of public health policies from the beginning, playing a major role in identifying the community's important health problems, suggesting intervention strategies, and working with health experts to implement them. However, any progressive public health initiative, from family planning to violence and substance abuse
prevention, is likely to arouse opposition; fear and anger may make rational discourse difficult. If progress is ever to be made against the major public health and social problems affecting us, public health leaders must be willing to stand up to confrontation and to point out ignorance and misconceptions.

Although some public health advances in the past were controversial (e.g., fluoridation of public water supplies), many were less so, in part because they primarily dealt strictly with health issues. For example, many of the epidemic diseases of the past were curtailed or eradicated either by simple changes in hygiene or by the introduction of effective antibiotics. In contrast, many of today's public health initiatives are controversial because they attempt to address issues that are both social and medical in nature. As an example, the Norplant issue touches on adolescent sexuality and the social and ethical questions of coercion vs choice.

In addition, Norplant raises concerns in some about genocide or selective use. Because some minority communities distrust the health care system, they view Norplant as a means of controlling certain populations. The negative consequences of the infamous Tuskegee syphilis study on the practice of public health cannot be overestimated; the study's strong repercussions in the Black community continue today.

Consequently, with any public health initiative that might be perceived as having a disproportionate impact on minorities (another example would be needle exchange programs for intravenous drug users), public health practitioners must educate the affected community about the scope of the problem and about the specific initiative as a potential solution. How this is done depends on the specific locale. First, local public health practitioners need to know their community and which community leaders must be involved. In Baltimore, for example, religious leaders and their organizations are very influential forces in the city. With the Norplant issue, the opinions of teachers and principals of the affected schools must be considered. Obviously, parents of adolescents in the schools must also be involved. In addition, formal and informal leaders should be sought out and involved: recreation center directors, school volunteers, neighborhood librarians—all those who have grassroots knowledge of the needs and perceptions of the community. It is with the involvement of all these members of a community that the likelihood of successful implementation of progressive, controversial public health policies will be the greatest.

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**APPENDIX—Opposition Claims and Baltimore City Health Department Responses about the Health Department's School-Based Norplant Policy**

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<th>Opposition Claim</th>
<th>Health Department Response</th>
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<tr>
<td>Targeting inner-city African-American teens is genocide.</td>
<td>The policy is simply one of equity: making all contraceptives available in school-based health centers to those who would not otherwise be able to get them.</td>
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<td>Insufficient testing of Norplant has been done on African-American adolescents.</td>
<td>(1) Food and Drug Administration trials of Norplant did include similar populations in Newark and San Francisco. (2) Norgestrel (the hormone found in Norplant) has been used in oral contraceptives by hundreds of thousands of African-American adolescents over the past 25 years, with no known differences in efficacy or side effects from those experienced by the rest of the population.</td>
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<td>The new policy will lead to higher rates of sexually transmitted diseases and HIV infections in teenaged Norplant users because they will feel protected against pregnancy and will thus neglect to use condoms.</td>
<td>(1) The students will receive extensive counseling on the importance of condom use in conjunction with Norplant. (2) Norplant recipients in the first school-based site will be evaluated to ascertain the efficacy of this counseling.</td>
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<td>The health department is promoting Norplant and sexual promiscuity over abstinence.</td>
<td>Abstinence is the only method of contraception that the health department promotes; the school system also has an abstinence curriculum. Norplant is simply another contraceptive option available to sexually active teenagers in the school-based health centers.</td>
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<td>Norplant has dangerous side effects.</td>
<td>Norplant's side effects are primarily &quot;nuisance&quot; side effects; a stringent follow-up protocol will be observed to identify patients who need to have the implant removed or who need further counseling about side effects.</td>
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<td>The program excludes families from adolescents' decisions about contraception.</td>
<td>Families are strongly encouraged to be present both for counseling sessions and for the actual insertion procedure.</td>
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