REPRODUCTIVE HEALTH AT SCHOOL-BASED HEALTH CENTERS: TWO CASE STUDIES IN CRISIS COMMUNICATIONS

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Abstract

Controversy surrounding reproductive health issues at school-based health centers (SBHCs) arises frequently at the community level and in the news media, and can have lasting repercussions for the strength and sustainability of the movement. In this thesis I present two case studies of reproductive health communications crises at SBHCs. The case studies feature in-depth interviews of key stakeholders involved in the crisis, as well as textual analysis of internal and external communications documents and news media coverage. In both cases no one was harmed, the law was on the side of the SBHC, and the SBHC eventually had the support of the community – including parents and students. In both cases the media incited much of the crisis, and the interviewees perceived the resulting coverage – particularly at the national level – as highly sensationalized. The first case had much more extensive and negative coverage than the second case, with more serious repercussions on national SBHC policy. It is possible that the manner in which SBHC stakeholders managed the crisis had some impact on the tenor and duration of the news coverage, as well as the resulting political backlash (or lack thereof). A surprising finding of this study is the extent to which, in retrospect, the interview participants viewed the crises as positive events for themselves personally and for school-based health care.

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Reproductive Health at School-Based Health Centers: Two Case Studies in Crisis Communications

This study will present two case studies of reproductive health-related incidents at school-based health centers (SBHCs). I chose both cases because the incidents resulted in a large amount of media attention that threatened the ability of the SBHCs to function, their reputation, and financial sustainability – thus making it a communications crisis. In the context of crisis communications, a crisis is defined as “a significant threat to operations that can have negative consequences if not handled properly” (Coombs, 2007).

School-based health care is broadly defined as comprehensive preventive and primary care provided, regardless of students’ ability to pay, at or near school – where students spend a majority of their time (Ammerman, 2010). According to the National Assembly on School-Based Health Care (NASBHC), there are nearly 2,000 SBHCs in 44 states and the District of Columbia (Strozer, Juszczak, & Ammerman, 2010). They provide a range of culturally-competent primary and preventive health care services, including routine physicals, eye exams, mental health counseling, and more (Strozer et al., 2010).

Reproductive health is a critical component of adolescent health and wellbeing (American Academy of Family Physicians, 2004). A majority of SBHCs serving at least one grade of adolescents provide access to some form of reproductive health care, most commonly abstinence counseling (84%) but also including pregnancy testing (80%) and counseling for birth control (70%). More than half (60%) of SBHCs are barred from dispensing birth control or condoms – a prohibition set most commonly by the school district (57%) (Strozer et al., 2010).
SBHCs encourage adolescents to communicate with their parents about issues related to reproductive health and sexuality, and most SBHCs require parents or guardians to sign a general consent form for their child to access services. However, in some states minor consent laws free SBHCs (and other service providers) from the legal requirement to inform parents when their children seek services deemed confidential by law, such as substance abuse counseling and reproductive health care. According to Jones et al (2005):

All 50 states and the District of Columbia allow most minors to consent to STD testing and treatment. Twenty-one states and the District of Columbia explicitly allow all minors to consent to contraceptive services, and another 14 confirm the right for certain categories of minors, such as those who have had a previous birth. Where the law is silent, the decision of whether to allow minors to consent to services is left to the discretion of the clinician.

Controversy surrounding reproductive health issues at SBHCs arises frequently at the community level and in the news media, and can have lasting repercussions for the strength and sustainability of the school-based health care movement. As early as 1988, an article described growing support for the SBHC model as a potential tool for reducing teen pregnancy, but also acknowledged increased opposition from conservative political and religious groups at the local and national levels (Dryfoos, 1988). The author noted that, even though only a minority of SBHCs provided contraceptive services at the time of publication, the opposition frequently gained coverage in the news media – in some documented cases even resulting in the failure to launch SBHC programs (1988). In addition, many new SBHCs have voluntarily chosen not to provide reproductive health services to avoid controversy (Santelli et al, 1992).
In order to survive during times of crisis, SBHC stakeholders must learn from past incidents. For this reason, I conducted case studies of communications efforts to manage reproductive health crises at two SBHCs on opposite sides of the country – one in 2007, the other in 2010. Case study analysis of past crises can yield insights to help the SBHC movement better manage its communications strategy in future crises. This study may be used by school-based health care stakeholders to learn best practices in how to manage communications before, during, and after a crisis. Best practices are “a general set of standards, guidelines, norms, reference points, or benchmarks that inform practice and are designed to improve performance” (Seeger, 2006).

In addition to SBHC stakeholders, this study will be useful to other organizations that provide and/or advocate for reproductive health services and provide education to school-aged youth. This study may also be of interest to communications experts who wish to learn from crisis communications research in the non-profit context, as opposed to the more frequently studied business context.
Literature Review

Before conducting an in-depth look at reproductive health communications crises in SBHCs, it is helpful to explore existing analysis of reproductive health services provided in SBHCs, parents’ views of these services, and best practices for managing communications crises. Research shows that many SBHCs provide access to reproductive health services, with inconsistent impact on contraceptive use and teen pregnancy rates. Research on parents’ views of either offering or restricting access to reproductive health services and education for adolescents finds that parents have complex opinions, but are generally supportive of offering access. To protect an organization’s reputation and prevent fall-out, best practices in crisis communications theory, research, and operations suggest that there are critical steps that should be taken to plan pre-crisis, to manage communications as the crisis unfolds, and to rebuild post-crisis.

Reproductive Health Services at SBHCs

Many school-based health centers provide access to a range of reproductive health services, to varying degrees – but research finds that they have inconsistent impact on contraceptive use and teen pregnancy rates. Santelli et al. (2003) studied survey data related to reproductive health services at 551 SBHCs in schools with middle or high school students. A wide range of reproductive health services were available in these SBHCs, either onsite or by referral, including gynecological examinations (95%), pregnancy testing (96%), testing and treatment for STDs (95%), and HIV counseling (94%). Three quarters (76%) of SBHCs reported that they were barred from providing contraceptive services onsite, although a majority provided referrals for off-site services. Many SBHCs reported that they allowed adolescents to access reproductive health
services, including STD care (48%) and family planning (40%), without having to seek prior parental consent.

In an earlier study, Kirby, Waszak, and Ziegler (1991) found that the type of contraceptive services available at the SBHC impacted the ability of the SBHC to increase adolescent contraceptive use. The authors conducted a student survey at six schools with SBHCs and four comparison sites to evaluate the reproductive health services offered and their affect on contraceptive use and sexual activity. The researchers found that providing reproductive health services did not appear to encourage adolescents to have sex earlier or more frequently. The authors were not able to find a consistent relationship between access to contraceptive services and contraceptive use; however, it appeared that condoms and birth control needed to be provided onsite in addition to supplemental offerings (health education in one site, vouchers for contraceptives in another) to have a significant increase in contraceptive use over the comparison sites. The authors noted that it was unlikely that the clinics significantly lowered pregnancy rates.

Kisker and Brown (1996) came to the same conclusion in their study of students at 19 schools with SBHCs. The authors conducted a survey that measured self-reported use of the SBHC and other factors. The results showed that students who used the SBHC services had increased health knowledge and access to health services as compared to a comparison sample of urban youth without access to an SBHC. For example, by their senior year of high school, students with SBHCs were 20% more likely to report knowing about “all effective contraceptive methods” than their counterparts at urban schools without SBHCs. The study did not find a consistent relationship between health center usage and risk-reduction behaviors, such as contraceptive use.
The most recent study of reproductive health services at SBHCs, however, found a more positive impact on teen pregnancy. Rickets and Guernsey (2006) compared the fertility rates of black adolescent girls in Denver, Colorado schools with and without SBHCs between the early 1990s and 1997. The researchers found that the overall fertility rate for this target population decreased during this time period, but the rate of decline was more pronounced at schools with a SBHC (77%) than at schools without a SBHC (56%). The authors concluded that pregnancy prevention strategies in place at SBHCs helped to influence the decline in black adolescent fertility.

Unlike the previous studies, which focused on SBHCs with reproductive health services, Coyne-Beasley, Ford, Waller, Adimora, and Resnick (2003) focused their study on students at SBHCs without reproductive health services. The authors conducted a survey of 949 students to investigate how open sexually-active adolescents were to the idea of accessing reproductive health services at SBHCs. At the time of the study, a state law was in place that banned schools from providing sex education or dispensing contraception. The authors conducted a survey in two middle and five high schools in North Carolina of nearly 1,000 sexually experienced male and female youth, seventy-five percent of whom had previously used a SBHC. A majority of the respondents stated that they would use SBHCs to access reproductive health services if they were made available – including “information to protect against pregnancy and STIs” (58%), pregnancy testing (51%), and birth control (48%). The authors concluded that an opportunity to prevent against unintended pregnancy and STIs is lost when reproductive health services are not made available where students are likely to seek them.
An analysis of the literature on reproductive health services at SBHCs shows that a range of services is made available, but there are frequent barriers to providing contraception. Early research was inconclusive on the impact of SBHC services on adolescent contraceptive use and pregnancy rates, but demonstrated increased knowledge and access to reproductive health care services. More recent research brings hope that SBHCs do, in fact, have the potential to reduce teen pregnancy rates.

Parents’ Views of Reproductive Health Education and Services for Adolescents

Studies that have looked at the views of parents on either offering or restricting access to reproductive health services and education for adolescents find that parents have complex opinions on this issue, but are generally supportive of offering access. Eisenberg, Bernat, Bearinger, and Resnick (2008) conducted telephone surveys of 1,605 parents of school-age (5-18 years) children in Minnesota with a 63% participation rate. Results found that – regardless of gender, race, ethnicity, political orientation, and religious background – parents overwhelmingly supported comprehensive sexuality education in schools (89.3%), while less than 10 percent of parents supported abstinence-only education. The majority supported a range of sexuality education topics, including pregnancy prevention (91.3%) and even abortion (63.4%). Parents believed most subjects should be taught beginning in middle school.

Eisenberg et al. (2009) published another article using the same survey data that highlighted the finding that parents were largely supportive of education around condoms, as well as distribution of condoms. A majority of parents (62%) agreed that making condoms available in schools would decrease pregnancy rates, and 58 percent disagreed that making condoms available would encourage teens to have sex. A strong
majority of parents (86%) were supportive of providing teens with information about condoms, and 60% stated that condoms should be made available in high schools. Political orientation was positively associated with support for education and provision of condoms; 87% of “very liberal” parents supported making condoms available to high school students, versus 19% of “very conservative” parents. Support was also strongly and positively associated with public schools; only 12% of parents with children in public school believed that schools should be barred from providing condom education.

Only one study has been conducted of parents’ views of contraception specifically in the context of school-based health centers, but it, too, found that parents were supportive. Santelli et al. (1992) conducted telephone interviews with a sample of 262 parents of SBHC enrollees in Baltimore, Maryland to determine both their views on current reproductive health services at the SBHCs and how they felt about SBHCs dispensing contraception. A majority of parents were supportive of the existing services at the clinics, including family planning for sexually active students. A majority of parents (63%) supported the SBHC prescribing and dispensing contraception, and 27-30 percent were against it. These numbers became more dramatic if the teen was already having sex; 76 percent supported and only 14 percent opposed it in this context. Almost all (93%) of parents supported contraception in cases where parental consent was given, with no significant difference between parents of middle school students and high school students.

Parental support for reproductive health education and services is more nuanced when it comes to their views on parental notification and consent. Eisenberg et al (2005) conducted 15-minute telephone surveys of 1,069 parents of adolescents in Minnesota and
Wisconsin to study how parents feel about parental notification laws (PNLs). The researchers also looked at exceptions parents would support and what consequences they would predict. Results found that more than half (55.1%) of the parents supported the idea of PNLs – yet a majority (96.1%) expected at least one negative consequence, and almost half (47.6%) expected 5 or more negative consequences. In addition, a majority of parents supported at least 1 exception to PNLs. The most common exceptions included cases of abuse or incest (67.6%), cases where the teen was at risk of harm from the parent (56.7%) or had a poor relationship with the parent (51.3%). Only a very small percentage of parents believed that PNLs would cause teenagers to have less sex (15.4%) or stop having sex (3.6%).

Studies that have looked at the views of parents on either offering or restricting access to reproductive health services and education for adolescents find that parents have complex opinions on this issue, but are generally supportive. Parents think their children should have access to information about sexuality and reproductive health at school, and a majority is also supportive of actually prescribing contraception at school.

**Best Practices in Crisis Communications**

To protect an organization’s reputation and prevent fall-out, best practices in crisis communications theory, research, and operations suggest that there are critical steps that should be taken to plan pre-crisis, to manage communications as the crisis unfolds, and to rebuild post-crisis. Seeger (2006) culled a list of best practices for crisis communication based on theory, research, anecdotal observations, experience, and case study analysis. The author then organized a panel of crisis communications experts at the National Center for Food Safety and Defense to review and critique the list, which he
then refined. According to Seeger, the ten best practices of crisis communication are to include communications experts and strategies into the risk and crisis decision-making process; to conduct pre-event planning that includes risk analysis and assessment to identify potential problems and prevent a crisis; to view the public as a partner; to listen to the public’s concerns and respond appropriately; to respond to crises with honesty, candor, and openness; to develop strategic partnerships both before, during, and after, a crisis in order to coordinate and collaborate on response; to engage the media as a resource rather than a liability; to communicate with all audiences with an appropriate level of “compassion, concern, and empathy;” to accept that crisis situations lack clarity and certainty; and to include self-efficacy in crisis response messages to give audiences a sense of control over uncertain situations.

A list of best practices was also compiled by Covello (2003), and included many of the same or similar items as discussed by Seeger. Covello advised that best practices in risk and crisis communication are as follows: include all of those involved or having a stake in the crisis as legitimate partners at all stages of the process; listen to and empathize with your audience, and let them know that they have been heard and what actions will be taken; be “truthful, honest, frank, and open;” build relationships and alliances with partner organizations before any crisis, and then coordinate and collaborate with other credible sources during the crisis; satisfy the requirements of the media by being accessible and acting as a resource, while still being prepared with messages and avoiding saying ‘no comment;’ communicate plainly without jargon, but also with empathy and in language that acknowledges and responds to people’s emotions; and finally, plan in advance for crisis events by identifying stakeholders, recruiting
spokespeople, training staff in crisis communications skills, preparing and testing messages, and evaluating results and sharing best practices post-crisis.

Most recently, Sisco (2010) also collected best practices for crisis communications management from a group of communications professionals. The author conducted in-depth phone interviews lasting 60-90 minutes with seven non-profit public relations professionals. Each participant had at least five years of professional experience and a recent experience with an organizational crisis. Participants defined the critical elements of a crisis response plan as “research, planning, implementation, and evaluation.” Research and planning included acknowledging the possibility of crisis scenarios, identifying audiences, organizing a crisis response team, and having prepared media responses on hand. All of the participants stressed that “no comment” is no longer an appropriate crisis communications response.

Ulmer (2001) conducted a case study of real-life use of crisis communications best practices, which also found strong support for pre-crisis planning and relationship-building. Ulmer examined the case of an industrial accident that occurred at a textile manufacturing plant in 1995, and the subsequent handling of the crisis by Aaron Feuerstein, the chief executive officer and owner of Malden Mills. Ulmer conducted taped-recorded, semi-structured interviews of 60-90 minutes each with Feuerstein and other key stakeholders – including two employees, the union president, the head of communications, two reporters who covered the crisis, and the director of the Chamber of Commerce. The author used media coverage of the crisis as his second data set. Ulmer found that Feuerstein and his staff followed several best practices for crisis communication that prevented the incident from damaging the company. For example,
the author notes that Feuerstein evoked “trust, reciprocity, and loyalty” amongst stakeholders because of strong relationships and consistent communication prior to the crisis. One way Feuerstein did this was by refusing to move his operation to a location with cheaper labor. He also “worked to save local businesses, educate community members, and improve community life for citizens,” which – along with other actions – strengthened his position “as an important and reputable member of the community.” The Malden Mills response was also characterized by prompt responses to internal and external stakeholders during and after the crisis. The author used the example of how, after the crisis, Malden Mills “implemented a ‘blast fax system,’ enabling them to provide information quickly to customers."

The above research demonstrates that there are critical steps that organizations should take to plan pre-crisis, to manage communications as the crisis unfolds, and to rebuild post-crisis. These best practices can help protect an organization’s reputation and prevent long-term and serious repercussions. These best practices may be used by school-based health care stakeholders to plan for and manage crises.

**Conclusion**

Research shows that SBHCs provide access to an array of reproductive health services to varying degrees, with inconsistent impact on contraceptive use and teen pregnancy rates. Studies that have looked at the views of parents on either offering or restricting access to reproductive health services and education for adolescents find that parents have complex opinions on this issue, but are generally supportive of offering access. Despite support from many parents, the access that SBHCs provide to reproductive health education and services tends to increase the potential for
controversial media coverage – with potential implications for both policy and practice. To protect an organization’s reputation and prevent fall-out, best practices in crisis communications theory, research, and operations suggest that there are critical steps that should be taken to plan pre-crisis, to manage communications as the crisis unfolds, and to rebuild post-crisis. This study will expand on the current knowledge base by exploring two case studies of reproductive health communications crises that occurred at SBHCs to answer the following research questions as they relate to reproductive health crises at two school-based health centers:

**Research Questions**

RQ1: How did SBHC stakeholders manage the crisis as it unfolded?
   
   RQ1a: What was the strategy?
   
   RQ1b: Were messages created, and how?
   
   RQ1c: What spokespeople were chosen, and why?

RQ2: What were stakeholder perceptions of the media coverage?

RQ3: Did SBHC stakeholders use best practices from the crisis communications literature?
   
   RQ3a: Did SBHC stakeholders use best practices in conducting pre-crisis preparations?
   
   RQ3b: Did SBHC stakeholders use best practices while the crisis unfolded?
   
   RQ3c: Did SBHC stakeholders use best practices post-crisis?

RQ4: What did SBHC stakeholders learn from the crisis?
   
   RQ4a: What would they do differently?
   
   RQ4b: What would they do the same?
   
   RQ4c: What were the long-term effects of the crisis, if any?
Method

In this thesis I present two case studies of reproductive health communications crises at SBHCs. Case study research uses a variety of evidence to produce an in-depth and richly contextualized “how and why” of a social phenomenon – particularly contemporary events (Yin, 2009). The case studies feature in-depth interviews of key stakeholders involved in the crisis; as a research method, in-depth interviews help to better understand individuals’ thoughts and actions (Rubin & Rubin, 2005). The case studies also include textual analysis of internal communications documents, external communications documents, and news media coverage. Textual analysis helps to define how individuals and society make sense of the world (McKee, 2005) and allows researchers to better understand and explain humans’ use of and reactions to symbols (Foss, 2004). It contributes to our understanding of society by “making visible what might otherwise be too obvious to see” (McKee, 2005).

The first case study examines an incident that took place at a SBHC in fall, 2007, in a city in New England. The city’s school board voted to dispense birth control at a SBHC in a middle school in response to an increase in reported sexual activity and pregnancies at the school. Media coverage of this decision sparked heated debate that played out over several weeks in the news media at the local and national level, with serious and lasting national policy repercussions for school-based health care.

The second case study explores an incident that took place at a high school in a city in the Pacific Northwest in 2010. A parent alleged to the news media that her teenage daughter received an abortion without her knowledge and with the aid of the SBHC at her school. This incident ignited a news media debate about the role of parental rights versus
patient rights, as well as the role the SBHC played in the incident. The duration and the extent of the coverage were largely contained, the crisis was short-lived, and there were no long-term repercussions of the incident on policy or practice.

**Data Sources & Procedures**

For both of the case studies, my primary data source is in-depth interviews with school-based health center stakeholders who were involved in managing each crisis, and my secondary data sources are news media coverage and internal and external communications documents. This combination of data sources helped answer my research questions by providing a 360-degree view of the crisis and how it was managed.

**Interviews.**

For the 2007 case study I interviewed the following SBHC stakeholders (for a list of interview participants, please refer to Appendix C): school nurse coordinator for the city’s public schools and liaison between the schools and SBHCs; the manager of family health programs with the city health department and board member of the state SBHC association; the director of the state SBHC association; the vice president of the public relations firm that consulted with NASBHC during the incident; the executive director of NASBHC; the communications manager at NASBHC; the principal of the middle school; and the middle school’s nurse. For the 2010 case study, I interviewed the SBHC administrator and manager; the manager of the city’s investment in SBHCs at the department of health; the communications person with the school district; and the communications manager for the city’s department of public health.

I made an initial contact with these stakeholders via email to request a one-hour phone interview (see Appendix A). I emailed copies of the consent forms to the interview
participants in advance of our phone interview and asked them to review the form, email me or call me with any questions, and then return the signed consent form to me via mail or email. I asked my participants if they had any questions regarding consent or the research at the beginning of our phone conversation. I conducted all of the interviews myself, and used an interview guide (see Appendix B). The interview guide covered how participants were involved in the crisis, how they perceived the crisis to unfold over time, what they learned, and what they would do differently in the future. I recorded each interview with a digital voice recorder, as well as taking notes. I paid an assistant to transcribe the digital voice recordings for me.

**Internal and external communications documents.**

To obtain the external and internal communications documents I searched the internal files saved on the shared drive of the National Assembly on School-Based Health Care (NASBHC). I looked for internal documents such as talking points and message guidance, as well as external documents such as newsletter articles and press releases. I also asked my interview participants to share documents with me that they had in their possession – including personal email exchanges related to how the communications crisis was managed, internal talking points, and email exchanges with reporters. I removed all identifying details from these documents before saving them to my computer to protect the confidentiality of my participants.

**News media coverage.**

To obtain a sample of news media coverage for each case study I conducted a search using the database Lexis-Nexis for print and television news coverage from each case. I searched from the first date that the news broke through the following one month,
using search terms that include the name of the SBHC, keywords related to the incident (such as “birth control middle school”), and names of people involved in the incident. I included results only from the city where the case is based, as well as national coverage from major news media organizations, as defined by circulation.

**Data Analysis**

To analyze the interviews, I read through the interview transcripts multiple times, identifying key themes that responded to my research questions. Themes are defined as “patterns that repetitively occur” (Gullifer & Tyson, 2010). I also attempted to tell a narrative of how the crisis incidents evolved – as told through the voices of my interview participants, organized by research question, and supported by findings from the internal and external communications documents. Finally, I produced a written report of my findings organized by research question – extracting direct quotes from the interview transcripts and incorporating them into the narrative in response to the research questions.

To analyze the internal and external communications documents, I read through all of the documents several times before beginning to note whether they were useful for supporting the narrative of my interview subjects, contextualizing or enriching the timeline of events surrounding the incident, providing evidence of messaging used and spokesperson chosen, or all of the above. I then used these findings, as well as direct quotes from the documents, in my written report.

To analyze the news media coverage, I reviewed my research questions and closely examined the texts to determine how they related to the questions. I used these findings to bolster my response to different research questions in the final written report.
I sought to reduce any potential bias by sharing a draft of the results chapter with the interview participants to gather their feedback on whether or not I had accurately characterized the incidents. I received an overwhelmingly positive response from seven interview participants, with only a few minor comments and edits.
Results

This section reports the results of analysis of 12 in-depth interviews and 4 types of documents – news media coverage, external messages, internal talking points, and internal electronic communications – from two school-based health center crises. Background for each case is presented, followed by results for each case organized by the study research questions. The documents were used as secondary data points to provide context or to verify, expand upon, and, if necessary, clarify the perceptions expressed by the interview participants. All individuals’ names have been changed to pseudonyms and names of the cities, states, and schools have been redacted to protect the confidentiality of the interview participants.

Case One, New England, 2007

Background.

A school-based health center (SBHC) at a middle school in New England had provided a full range of health care services to students – many of whom relied on the SBHC as their primary medical home – since the 1990s. Although the SBHC could test for pregnancy and sexually transmitted infections, it could not prescribe hormonal contraception to those patients who reported being sexually active. In response to increased sexual activity and reported pregnancies, local SBHC stakeholders prepared a proposal for the school committee to request that the SBHC be allowed to prescribe contraception. The issue of making hormonal birth control pills available at the middle school SBHC was included as an item on the school committee agenda.

A reporter from the local newspaper saw the birth control item on the agenda prior to the meeting and started making calls. The resulting story, “Prescribe ‘the pill’ at
middle school?” (Bouchard, October 16, 2007) led with the fact that students would need their parents’ permission to receive services at the SBHC, noted that the SBHC had provided condoms for 7 years, and reported that “contraception would be prescribed after a physical examination by a physician or a nurse practitioner” (2007). Amy, the school nurse coordinator for the city’s public schools and liaison between the schools and SBHCs, was quoted saying, “This is a service that is totally needed. It’s about very few kids, but they are kids who don’t have the same opportunities and access as other students.” The article noted that, while the parents had to sign a consent form for the child to go to the SBHC, because of a state minor consent law students could receive certain services, such as reproductive health services, in full confidence. While students were encouraged to tell their parents when they access reproductive health services at the SBHC, “by law they cannot compel students to do so or inform parents without the student’s consent” (2007).

The article was objective and accurate, and the school committee voted 7-2 on October 17, 2007 to allow birth control to be prescribed at the middle school SBHC. However, the article was picked up by the Drudge Report, a conservative-leaning news aggregation website, and then by the Associated Press. From there it went viral – and the resulting national coverage was often far from balanced. Jennifer, the manager of family health programs with the city health department and board member of the state SBHC association, said: “I thought it was a joke when the day after the school committee [meeting] I got a call from Good Morning America. I knew it wasn’t a joke when Fox called.”

RQ1: How did SBHC stakeholders manage the crisis as it unfolded?
RQ1a: What was the strategy?

According to the interview participants, there was no initial strategy for how to manage the ensuing media deluge. The National Assembly on School-Based Health Care (NASBHC) contacted Paul, the director of the state SBHC association, to ask what they could do to be of assistance. Yet, Paul said, “It was so overwhelming and happened so fast, so intense we didn't have a chance to plan how to respond in the short term. Had we known how absurd this would be we would have done that.”

In terms of public response, Paul’s board of directors at the state SBHC association wanted to be supportive of the SBHC, but at the same time “there seemed to be a real strong bias towards avoiding any additional media exposure.” This same hesitancy was reflected at NASBHC, which was very conscious of the fact that a key piece of federal legislation around school-based health care, the School-Based Health Clinic Establishment Act, was in front of Congress. Kelly, the vice president of the public relations firm that consulted with NASBHC during the incident, stated:

One of the schools of thought was, “Let’s let everyone know that this story is out and respond from a policy perspective.” And the other point of view…was, “Let’s just not talk about it at all. Because if we do that, it’s just going to spread the fire.”

Ultimately, NASBHC and the state association decided that it was important to speak publicly about the decision to prescribe birth control at the SBHC. Diana, NASBHC’s communications manager, began working to create different sets of talking points and messaging templates for SBHCs to use across the country. NASBHC issued the directive that if states received press calls about the incident they should field requests back to Diana. They stopped short of proactively seeking media coverage because, according to Kelly, they felt it was too risky without strong messages in place.
**RQ1b: Were messages created, and how?**

At the state level, the interview participants did not have any messages created at first, but they eventually compared notes to make sure that they were all on the same page. Paul said: “I remember feeling it was very important that we talked about it and at least knew what each other was saying.” Simon, the principal of the middle school, agreed that early on the group of key local stakeholders “made a smart decision” to always use the same 3 or 4 messages with the media, and echoed Paul’s main talking point: “We’ve always been a school that has said we’re about all kids, so we emphasized that if you want to be that, you have to be about all kids 100% of the time.”

While the key stakeholders on the ground were confident in their messages, a few of the interview participants stated that they did not feel particularly supported by their national organizations, including NASBHC and the National Association for School Nurses. The national organizations initially stated that it was a community decision whether or not to provide birth control, rather than issuing a stronger statement that the SBHC at the middle school was making the right decision for their students. On October 26, 2007, NASBHC issued a press release responding to the incident that stated:

One of the greatest strengths of the SBHC model is that services provided in a SBHC are a direct response to the needs of the individual community and are determined as such. The community decides what services will be offered, based on health and safety needs of children and in accordance with community values. (“NASBHC Responds to School-Based Health Centers Providing Contraception,” October 26, 2007)

The statement also noted, “It is rare that SBHCs in middle schools dispense contraception,” and did not make any comment regarding the decision to prescribe birth control at the middle school. “I thought it was lame not to be more supportive,” Amy, the
school nurse coordinator for the city’s public schools and liaison between the schools and SBHCs, said. Jennifer agreed, “It felt a little lonely.”

NASBHC’s policy up until the incident had been, in Diana’s words, to “fly under the radar” when it came to reproductive health issues at SBHCs. Yet NASBHC staff, including Diana, were aware that the SBHC field was feeling unsupported, and personally felt dissatisfied with this tactic. Notes from a NASBHC phone meeting on November 6, 2007 with SBHC leaders from across the country stated:

NASBHC’s response has been support of local control. We don’t feel that is supportive of communities providing the care and not consistent with what we believe. We are re-opening our position on SBHC and reproductive health and confidentiality to be in line with other national provider organizations. Our position will be grounded in professional standards of care (“NASBHC Leadership Call,” November 6, 2007).

NASBHC soon made the conscious decision to shift their messaging to be more supportive of the SBHC field, and to better reflect their belief that SBHCs should meet national medical standards of adolescent care.

**RQ1c: What spokespeople were chosen, and why?**

As the president of the state SBHC association, Paul’s first response to hearing news of the crisis was to tell his board of directors that it was an important issue and that he’d like to see their support for the SBHC. “I asked if there was anyone who wanted to be the spokesperson for the [state association]. [There were] no takers – they saw it as my role.” For the most part, however, Paul deferred to Amy, the school nurse coordinator for the city’s public schools and school-SBHC liaison, as a key spokesperson. Overall, the local interview participants did not use one spokesperson, and all were quoted at various points in the media coverage – in addition to school committee board members, various
parents, and others at the local level.

At the national level, Diana, the communications manager at NASBHC, was the main spokesperson. Adam, the executive director of NASBHC, did TV interviews, and another staff member did a couple of interviews to provide a health care provider perspective, but it was largely viewed as Diana’s job as communications staff. She felt that this made sense:

This took up every hour of every single day of my life for a month. …I don’t think anyone else in the organization would have been appropriate or would have had the time to really respond to it.

Simon, the principal of the middle school, and Leslie, the middle school’s nurse, describe the one time that students were used as spokespeople as playing a pivotal role in shifting how the incident was covered in the local media. A reporter from the local newspaper interviewed several students about the insinuations made in the press coverage that the students at the school were sexually active and that it was a bad school.

According to Simon:

[The students] said, “Most of us have great parents, but there are some kids who live in dark places and they still matter.” And I think that interview with those kids really turned things around. Our parents got very indignant with the media and started writing letters of support. It cemented the idea that [the middle school] is about all kids. The kids did a fabulous job… They had a voice.

RQ2: What were stakeholder perceptions of the media coverage?

A recurring theme among the interview participants was that the media coverage – and particularly the national media coverage – was sensationalized. Adam stated: “It doesn’t take much to get the media interested in sex in schools. There were very few voices of reason in the debate. It seemed salacious.” Kelly believed that the media coverage was not as objective as it should have been: “Immediately, the media just go to,
‘Oh my god, middle schoolers and birth control, that’s just crazy.’ So it was a really negative environment.” It was difficult for some not to take the negative media coverage personally. Paul said: “So many people around me were so upset that people like Geraldo Rivera, for example, would say the things he said – that we were encouraging little kids to have sex.”

According to Amy, part of the problem was that much of the public – including press reporters – was unclear about parental involvement and consent at SBHCs. Conservative media personalities fueled the misperception that a student could easily procure birth control pills. Interview participants described the common themes in the media coverage as “stealing parents’ rights,” and “giving birth control pills to 11 year-olds, just handing them out like aspirin.” This perception was confirmed by an analysis of national TV news coverage that featured the incident at the time. A common depiction of events was that the school board had voted to “give middle school girls the pill without parental consent” (Vieira, 2007, October 18). Radio talk show host Mark Williams appeared on NBC to accuse the school nurse of “enabling more children to get involved with sex” by “air drop[ping] a bunch of pills on them” (Abrams, 2007, October 17).

Jennifer stated that the media “played on the fear of parents,” and told a story to illustrate how she “lost a lot of respect for what passes as news.” The television host Dr. Phil invited her to come on his show to discuss the issue of making birth control available at a middle school. When Jennifer declined, the show producers instead booked a health provider from a SBHC in Baltimore, MD, that had been prescribing birth control with community support for several years. According to Jennifer, Dr. Phil and a “preacher friend” talked about how parents need to take responsibility for their children’s sexual
activity, and gave a mother in the audience a hard time about considering taking her teenage daughter to Planned Parenthood.

[Dr. Phil and the preacher] both reamed her out and said, “Who’s the parent here?” It was a horror show. And they never called upon this poor person [from the SBHC in Baltimore]. It was just for the sake of entertainment at our expense.

In fact, national television news coverage did frequently raise the question of responsibility when it came to managing young people’s sexuality. Those who defended the middle school’s decision to make birth control available stated that the policy was for students who lacked responsible adults in their lives. Paul, the director of the state SBHC association, was a guest on The Big Story with John Gibson on Fox News in the early days of the incident, and stated on the air:

I think it’s important that the school offer the services that are needed to keep kids healthy…They’re really targeted to the very small number of students who may not have caring adults in their lives who can give them the guidance that they need to stay safe. (Gibson, 2007, October 18).

Conservatives also used the theme of responsibility, accusing the middle school of “appealing to the lowest common denominator” at the expense of “responsible families who have a handle on what their children are doing and the other parents who are trying to raise their children” (Mathews, 2007, October 18). Sean Hannity, a conservative talk show host on Fox, stated, “There are a lot of us that believe it is our job as the parents to talk to [children] about sex, not some teacher, not some health class, not some educator” (Hannity, 2007, November 4).

The participants did acknowledge that there was some positive coverage of the incident in the media. Adam cited Dr. Nancy Snyderman, NBC’s medical correspondent,
as taking a “fair and balanced” public health stance. In a national TV news segment that aired shortly after the school vote, Dr. Snyderman stated: “Now, the nurse in this story, as a public health advocate, knowing that kids are having sex, her job is to protect them from having unwanted pregnancies.” (Vieira, 2007, October 18). Jennifer described a balanced editorial in *The Boston Globe*, as well as a political cartoon that equated pregnancy at 13 with getting on the poverty train. The principal stated: “Eventually our messages got through,” citing *The Boston Globe, The New York Times*, and the local newspapers as having “supportive” coverage. Diana cited a public opinion survey with positive findings that helped turn the tide of the national coverage:

> Ultimately, the AP did this survey of the country that said, “Should school-based health centers be able to provide birth control?” Overwhelmingly, people said yes. So there was this public support for it, even though it was so sensationalized.

The Associated Press article that cited the survey was published November 01, 2007, and titled “Poll: Most OK Birth Control for Schools.” The article, while it quoted parents with different perspectives, stated that “sixty-seven percent support giving contraception to students” and that “62 percent said they believe providing birth control reduces the number of teen pregnancies” (Fram, 2007).

**RQ3: Did SBHC stakeholders use best practices from the crisis communications literature?**

**RQ3a: Did SBHC stakeholders use best practices in conducting pre-crisis preparations?**

As the manager of family health programs with the city health department and board member of the state SBHC association, Jennifer noted that, in retrospect: “The time to develop a strategy around crisis communication is not while you’re building the plane
and trying to fly it, too.” However, that is what the stakeholders – both at the local and the national level – did because of a lack of advance preparation. Stakeholders did not conduct pre-event planning to identify potential problems and prevent the crisis, and did not identify or recruit stakeholders, train staff in crisis communications skills, or prepare and test messages.

Fortunately, the stakeholders built relationships and alliances with partner organizations before the crisis, which served them well when they needed support. The SBHC stakeholders at the local level had relationships with the local Planned Parenthood affiliate, which ultimately provided behind-the-scenes support. At the national level, strong relationships and frequent communication with state SBHC associations allowed NASBHC to take leadership around handling press calls.

The principal and staff at the middle school were also viewed as trustworthy by local stakeholders, which helped the school and the SBHC maintain their strong reputation and rebuild quickly after the crisis had passed. Leslie said: “It really could have turned out a lot different. People had trust and faith in many years of services.” Paul said: “we challenged the news media to look at [the principal’s] record and everything that [the middle school] does and everything he had spoken on. And it’s just so consistently focused on what’s right for the kids.”

**RQ3b: Did SBHC stakeholders use best practices while the crisis unfolded?**

The local team was not experienced in communications, yet still managed to use some best practices in crisis communications. Jennifer said: “We didn’t know a whole lot about crisis communications management at that point. We learned quickly. We naturally pulled ourselves together and went into the bunkers together to both support and develop
strategy.” At the state level the SBHC team did not include communications experts in the crisis decision-making process. On the other hand, at the national level Diana, the communications manager at NASBHC, was closely involved in managing the crisis, and she also involved Kelly, the public relations consultant.

The interview participants felt that they did their best to satisfy the requirements of the media by making themselves accessible and acting as a resource, while at the same time protecting the students. Amy described how Simon, the principal of the middle school, allowed the media a window of access to his staff and students: “[Simon] said ‘you can come into my school for one day, we’ll set up whatever you want and then get out of my school.’ They camped across the street but didn’t try to grab the kids.” The stakeholders were eventually prepared with messages and avoided saying ‘no comment.’ Jennifer explained: “We decided what our messaging would be. We wanted to give our messages rather than be drawn into messaging that was out there.” The candor and honesty of their messaging also falls in line with best practice recommendations. Simon said: “I think we had a good story that was the right story. It was about serving kids 100% of the time.”

Another best practice is coordinating and collaborating with other credible sources during the crisis. At both the state and national level the interview participants worked behind the scenes with reproductive health organizations to get advice and assistance with messaging. At the national level, Diana mentioned two different people from the SBHC field that she identified as effective 3rd party experts that could be put in touch with the media. The interview participants made an attempt to have consistent communications with and prompt responses to internal and external stakeholders during
and after the crisis, with mixed success. Paul said: “I definitely kept [the board of
directors] apprised of opportunities, activities, key messages. We were very consistent
about getting messages out to folks on a regular basis.” However, Jennifer admitted: “We
were so in the trenches with our stuff that we were not as closely coordinating our efforts
with NASBHC as we could have been. We were reaching out and learning as we went.”

NASBHC seemed to have a more positive view of their level of collaboration with the
state stakeholders. A wrap-up article in the December 2007 newsletter stated:

The constant dialogue between national, state and local advocates was
critical – because most of us at every level were fielding inquiries of one
kind or another (Barron, December, 2007).

Interview participants at the local and national level didn’t think to communicate
with policymakers early on. Amy stated: “[The policymakers] were mad because they
didn’t know about it up front, and of course they were getting all kinds of questions about
it in Congress… and then our governor started getting some pressure to get into it.” At
the national level, Diana stated:

[The state congressional representatives] really felt like we should have
been more proactive in letting them know that this was happening so they
could have been prepared. …They were like, “We need to know these
things, if it’s going to come up and be such a big deal.”

**RQ3c: Did SBHC stakeholders use best practices post-crisis?**

A central best practice for communications post-crisis is to evaluate the results of
the crisis and to share best practices. The stakeholders did not hold an immediate debrief
of how the crisis was handled. However, NASBHC wrote an article about the experience
that they published in their December 2007 member newsletter that summarized the
events and included 5 lessons that they learned from the experience. Several months later
Diana, Jennifer, and Amy gave a presentation on their experience at the annual school-
based health care convention for an audience of SBHC providers, funders, and advocates.

In addition, Kelly led a crisis workshop for SBHC state associations in 2009 on how to manage a range of crises at SBHCs. Kelly stated that this work “absolutely came out of what happened in [2007].” The principal of the middle school, Simon, continues to teach a leadership course for school principals at the local university in which he talks about what he learned from the incident.

Another best practice is to respond promptly to internal and external stakeholders after the crisis. A few of the interview participants talked about how the Somali immigrant community at the school was, in Amy’s words, “pretty shook up and horrified” about the incident and the fact that they felt it forced them to discuss the taboo topic of sexuality with their children. Amy stated: “We made a point of trying to mend fences there.” A few of the interview participants met with the immigrant communities, and developed special programs for the parents. Leslie said: “It’s taken a lot of communication and trust to try to rebuild [the relationship].”

**RQ4: What did SBHC stakeholders learn from the crisis?**

**RQ4a: What would they do differently?**

Several interview participants stated that it would have been helpful to have a crisis management and communications plan in place prior to the incident. Amy said:

> We just got slammed. By the seat of our pants, we kept calling each other saying, “Are you getting this call from this one? What are you saying to that one?” …Going forward I would anticipate this kind of thing more …and have more of a communication plan.

Paul expressed that it would have been useful to have a media strategy that everyone agreed to early on. Diana and Kelly both agreed that it would have been useful to have messaging – particularly around reproductive health issues – already prepared. Kelly
said: “The timing would have been better had we looked and said, ‘Hey, our hot button is always going to be reproductive health. We should really sit down and figure this out.’ But it took a crisis.”

Another common thread among the interview participants was regret that they had not communicated earlier with their state policy makers. Diana also expressed that she would have liked more of a warning at the national level that there was a potential crisis situation so that she could have been better prepared to provide assistance to the states and manage national media calls. Amy stated that it would have been helpful if the national organization had sent a communications expert to help them handle the crisis. Also regarding handling the media, Paul stated: “I don’t know if we got our message out in a proactive way other than using it as a response.” Finally, Kelly stated that it would have been beneficial to debrief with everyone involved to examine what steps were taken, what the media coverage was, and then – after six months – the impact of the incident.

**RQ4b: What would they do the same?**

A consensus among the interview participants was that strong partnerships were critical to handling the crisis and preventing further negative outcomes. At the national level, Diana stated that the coordination and cooperation of the SBHC field was critical, and that it was positive that most states agreed that press inquiries should be run through NASBHC, as “we had to be really responsive.”

On a local level, Paul stated that bringing all the stakeholders together as early as possible was a good thing. Amy stated: “I think we had really good people in place… We knew each other. We supported each other. We trusted each other. That was important.” In terms of how they communicated, Paul felt that their messaging was “consistent and
communicated well.” Simon believed that having a “straightforward” key message was “the best thing we did.”

**RQ4c: What were the long-term effects of the crisis, if any?**

Interview participants discussed a range of long-term effects of the crisis. In terms of the SBHC at the middle school, Amy credited the school superintendent and school committee for not voting to weaken access to reproductive health services despite the criticism they faced from some quarters. In fact, “there was a recall petition for three of the members [of the school committee] because of their vote [to allow birth control dispensation at the middle school]…They could have folded, but they stayed strong.”

The incident didn’t appear to have any impact on the long-term sustainability of the SBHC at the middle school. On the contrary, a record number of families signed their children up for services the following year. Additionally, Paul stated that he experienced strengthened support and increased understanding among policy makers of the positive impact of SBHCs. The interview participants also noted that, at the local level, a positive long-term effect was that the incident motivated parents to speak to their children about sex for the first time. The principal stated “it shook people up, but in a good way.”

On a national level there were serious repercussions when it came to federal policy supporting SBHCs. An article about the incident in NASBHC’s December 2007 newsletter said “a total of seven anti-SBHC amendments were introduced in the Senate by conservative Senators De Mint (R-SC) and Brownback (R-KS). Luckily, with the help of partners at NARAL Pro-Choice America and Planned Parenthood, as well as supportive legislators, the amendments never materialized – but concerns from advocates and neutral members of Congress did” (Barron, December, 2007). Diana said:
At the same time [that the crisis broke], they were talking about our school-based health care authorization [in Congress]. There was a stand-alone bill that had been introduced that summer, and we were thinking that it would be attached to the Community Health Center reauthorization that was being negotiated that fall. Unfortunately…instead of attaching it as it was, they made it the [Government Accountability Office] study because it was just so controversial with all of this stuff that was happening around the press.

This was a major setback for the school-based health care movement, and – in fact – SBHCs would not become a federally authorized program for another three years.

From a policy and communications standpoint, Diana noted that the incident was a “driver of [NASBHC] abandoning our duck and cover strategy” when it came to talking publicly about reproductive health services. Adam stated:

It prompted us to question a fairly long-term position, which was that communities should have the responsibility to shape these programs and services based on what the community sees as its needs. We took a close look at that and thought, “This doesn’t really feel supportive of communities that put a stake in the ground on this and put themselves out there.”

NASBHC crafted a new board-approved position statement on reproductive health at SBHCs that made it clear that the organization considered reproductive health services a standard of care for adolescents. NASBHC also worked to draft strong reproductive health messaging to be used by the SBHC field. Kelly, noting that that the messages had to be reviewed and approved by more than two dozen people, acknowledged that “it wasn’t easy to get there,” but that it “created a real cohesion and confidence in being able to address the issue” for the school-based health care movement.

A long-term effect of the incident at both the local and national level was that it raised local and national awareness of school-based health care. Jennifer said: “We laughed afterwards about now we know that everyone in [city] knows about the school-
based health centers. Maybe not in the way we wanted it, but we didn’t have to do a whole lot of marketing.” At the national level, Diana stated: “It was really exciting, because school-based health care had not received any attention in the media very much at all until this happened. And while it was negative publicity, at least it was putting school health on the map.”

**Case Two, Pacific Northwest, 2010**

**Background.**

In March 2010, the mother of a 15 year-old girl went to the media to complain that her daughter received a referral for an off-site abortion from the school-based health center at her high school. The mother was primarily angry that she had no idea it had happened until months later; the SBHC had not notified her, and her daughter had chosen not to share the information with her. The SBHC was within its legal right not to inform the parent because of a state law that allows youth to access reproductive health care without a parent or guardian’s consent. Although the mother had signed a blanket consent form allowing her daughter to access services at the SBHC, she alleged that it was unclear that abortion was one of the services for which her daughter could receive a referral.

The SBHC stakeholders learned that the mother had gone to the media when they received a phone call from the television station that they were about to interview the mother. Stacy, the SBHC administrator and manager, also spoke to the mother, and found that she was misinformed regarding several key facts related to her daughter’s case. Stacy said: “We couldn’t correct these facts [because of patient confidentiality]. We could just speak to best practice and the law.” Stacy and her press officer immediately contacted
Tom, the manager of the city’s investment in SBHCs at the department of health: “He was instrumental in getting folks involved from the school district as well as public health and their communications folks.”

**RQ1: How did SBHC stakeholders manage the crisis as it unfolded?**

**RQ1a: What was the strategy?**

Tom had a conference call with Maria, the communications person with the school district, Jonathan, the communications manager for the city’s department of public health, and Stacy to strategize a response. Tom’s next step was to contact all of the agencies that run SBHCs, the local city government, and multiple stakeholders up the chain of public health and city government. Secondly, he contacted stakeholders at the state university, at public health centers, and at family planning centers to let them know what was going on and to share key messages in case they were approached for interviews. He also prepared a presentation for the school district and alerted NASBHC.

Regarding media response, Jonathan was the main point person on handling the media calls. He followed the public health department’s standard communications protocol by working with a subject matter expert, “someone in the program that can really speak to the issue,” and then doing initial media screening to determine “what level of response is needed” and “how we wanted to handle individual requests.” This arrangement freed up Tom’s time to focus on working and communicating with partners.

The initial decision was to be very available to the media. According to Tom,

Part of Jonathan’s guidance was, “These guys aren’t going to go away – let’s go for it.” …If we leave it to these media representatives to tell only their side of the story, we’re going to have an ignorant public. It’s our responsibility to tell the full picture.

**RQ1b: What spokespeople were chosen, and why?**
Within hours of recognizing that a potential crisis was unfolding, the stakeholders decided to route all of the press calls to the public health department, making Tom the primary media spokesperson. According to Tom, a driver of this decision was the fact that the public health department, as the entity that oversaw SBHCs in the city, had the most subject matter expertise of all the stakeholder groups:

This was about the health center, best practices in adolescent health, in program modeling, and district level oversight. We took [the medical sponsor] out of the mix because they only run one site and public health oversees the whole SBHC system. We can speak to a broader perspective. We decided this was the home for it.

Internally, Tom and Jonathan discussed which of them should be the main spokesperson for the health department. Tom described how they weighed whether he should be on point as the content expert, or whether Jonathan should be the spokesperson as the public relations expert:

Jonathan [was] in the position where if there’s something that he didn’t know, he could skillfully go, “We could get back to you.” Versus me being essentially the subject matter expert who could be candid and responsive and available, etc. And we chose the latter. …We felt like moving the conversation forward.

The decision to route media calls to the public health department was popular with all of the interview participants. Stacy felt that this strategic decision was instrumental in removing the spotlight from the SBHC she oversees: “We are the only sponsor with just one clinic and we could’ve been alone out here, but we had the support of other clinics. It wasn’t just about [the medical sponsor] or [the high school] – it was about school-based health care. They took a swing for all of us.” Maria, the media relations person with the school district, said: “It was truly a team effort to talk to them
about an idea of how to respond. [The public health department] agreed to receive the phone calls – I was thankful it allowed us to manage this well.”

**RQ1c: Were messages created, and how?**

Jonathan stated that they didn’t have any messages prepared but were “able to put together solid messaging pretty quickly.” Before Tom did his first television interview they had a brief window of time to craft his talking points. Jonathan recalled that they quickly came to the conclusion that they couldn’t say anything specifically about the case because of patient confidentiality.

So our conversation with the reporter needed to … address factual issues. “Do you provide abortions?” No. We always encourage parental support on important decisions, but ultimately it’s the student’s choice. And [the] student's choice is based in state law. It was a broader education about a state law that many people aren't familiar with.

Tom’s quote in the first coverage of the incident did focus solely on the law around minor consent: “At any age in the state… an individual can consent to a termination of pregnancy” (“Mother furious,” 2010). Jonathan and Tom created and shared the first draft of messages with other stakeholders for feedback. They then circulated the final messages with the medical sponsor of the SBHC, the local government, the school district, and the providers at all of the city’s SBHCs. They also shared the messages with the communications director at NASBHC.

The internal talking points document had 5 main message points (“Key messages,” March 24, 2010). The first addressed how adolescent health care providers, including SBHCs, focus on preventing unintended pregnancy and “addressing risky behaviors that can lead to these difficult situations.” The second point stressed that SBHCs provide a range of comprehensive health services, of which reproductive health is
The third point stressed that “when faced with challenging decisions, providers encourage parental or guardian involvement in that decision-making.” The fourth point noted that, while the SBHC encourages parental involvement, “ultimately, under state law, minors are allowed to make their own decisions about some types of care, including reproductive health services, and have their privacy protected.” The final point addressed the consent form signed by parents to allow their child to access services at the SBHC, and how much detail was included about reproductive health.

At the school district level, Maria found the messages very helpful – and involved the school principal and the superintendent in talking through the messages. Maria stressed the importance of having strong messages prepared in handling the crisis:

> [Messaging] helps us to stay focused when we’re talking to the media…They can ask you a question 10 different ways to try to get a different answer. If you don’t have some messages in front of you to remind you of what we’re really talking about, it can get very intimidating and confusing.

The messages were revised during the course of the incident to acknowledge that the SBHC consent form may have been unclear to some parents, and to state that it was being reexamined for possible changes.

**RQ2: What were stakeholder perceptions of the media coverage?**

Coverage of the incident was primarily contained within the state over the period of a couple of weeks. The consensus among the interview participants was that the media coverage was sensationalized – particularly the limited national coverage. According to Tom, the media coverage had a “clear arc from sensational to rational.” Jonathan agreed that the TV coverage, in particular, was “highly sensational” – and said that he was disappointed but not surprised given the emotionally sensitive and politically charged
topic. The early coverage was, indeed, highly emotional, and tended to focus on the theme of parental rights. One of the first articles focused on the emotions of the mother who was “furious” and “fuming” that her daughter received a referral for an abortion without her knowledge (“Mother furious,” 2010). The article concluded with a quote from the mother: “Makes me feel like my rights were completely stripped away” (2010).

Tom stated that the sensationalism slowly died down, with the last major piece of coverage an editorial in the city’s main newspaper: “It was the pinnacle of a practical, rational response.” The editorial did, in fact, squarely side with the SBHC and against those who they accuse of “political grandstanding.” The editorial stated that:

Privacy is critical for open and honest communication between medical practitioners and patients. Victims of incest or rape may be less likely to seek help if they knew their parents would be informed. (“Health Clinic,” 2010)

For the first time in any of the coverage, the editorial raised the issue of rape and incest – placing the parent as potential abuser. In the mind of the reader this may have helped to contextualize and justify the state law that protected minor consent. Jonathan described this editorial as a “pleasant surprise,” and also described a NPR interview as a “good, straightforward story.”

RQ3: Did SBHC stakeholders use best practices from the crisis communications literature?

RQ3a: Did SBHC stakeholders use best practices in conducting pre-crisis preparations?

The stakeholders did not conduct pre-event planning to identify potential problems and prevent a crisis, nor did they identify stakeholders, recruit spokespeople, or
prepare and test messages. However, they did build relationships and alliances with partner organizations with consistent communications before the crisis took place – a best practice in preventing crises. For example, the SBHCs, the public health department, the school district, and the medical sponsors were all in close communication and had positive relationships in place before the incident.

Tom and Jonathan were also seen by other stakeholders and community members as trustworthy and experienced, as well as holding a position of authority and respect. Tom stated: “We have our office that centrally manages the [city’s] school-based health program, and the level of ‘authority’ that goes with that, because people would listen to us… in terms of allowing us to manage the process and them having confidence in us.” Jonathan noted that there were “strong lines of communication and a good deal of trust” between the school district, the SBHC sites, the city government, and the public health department.

**RQ3b: Did SBHC stakeholders use best practices while the crisis unfolded?**

The stakeholders included communications experts in the risk and crisis decision-making process – Tom acknowledged that having “sophisticated communications expertise available” helped them. Jonathan was instrumental in developing the strategy, and had years of experience as a public information officer. Jonathan also worked closely with the communications experts on staff at the medical sponsor of the SBHC and the school district.

The stakeholders coordinated and collaborated with other credible sources during the crisis, particularly illustrated in the partnership between the school district, the public health department, and the medical sponsor. Tom also engaged with adolescent medicine
experts from the local university and both alerted and shared messages with the public health sector family service providers, public health centers, and NASBHC. In a personal email dated March 23, 2010 – the day the story broke – Tom let Jonathan know that he had spoken with the chief of the division of adolescent medicine at the state university: “If needed, she would speak with media about the laws and standards of care related to adolescent health in general and specific to Family Planning Services” (“Tom,” personal communication, March 23, 2010). On the same day, Tom emailed Maria and advised: “you may want to loop-in the principals at the 14 schools that have SBHCs” (“Tom,” personal communication, March 23, 2010).

The stakeholders were all prepared with the same set of messages and avoided saying ‘no comment.’ The stakeholders responded with honesty, candor, and openness, even to conservative bloggers who were unlikely to cover the incident with any degree of journalistic objectivity. Jonathan stated: “Even if that [coverage] is highly editorialized and sometimes incorrect, to a certain extent we have an obligation to respond.” They satisfied the requirements of the media by being accessible and acting as a resource – up to a point. By April 6, 2010, Tom shared an email with the communications manager at the medical sponsor of the SBHC that said: “The story was fully explored in a variety of media, people have made many comments on it, and I think the time has come to discontinue the conversation, unless there are new facts or issues that warrant additional discussion” (“Tom,” personal communication, April 06, 2010). Jonathan stated:

When we would get another request and it was just a variation on everything we’d heard already…we’d give a brief 2-sentence email response or we’d just send them the state law stuff and go, “Here, this should answer your question.”
Another best practice for communications during a crisis is to communicate plainly and without jargon, but also with empathy and in language that acknowledges and responds to the public’s concerns and emotions. Jonathan described their messaging as “trying to set a tone of support for the students in our facility, respect for the family, and emphasizing the value of the family in decision-making, but then also acknowledging the law in our approach in providing care.” He also acknowledged that their messaging could have better responded to public concerns about the state’s parental consent law: “in hindsight maybe we could have had some better messaging at least prepared to talk about why confidentiality itself is important.”

Jonathan described how their messaging shifted over the course of the crisis to reflect concerns that they were hearing from the community at large about a lack of clarity in the consent forms for the SBHCs. The mother of the SBHC patient who went to the media was angry that she didn’t understand the scope of reproductive services that her daughter could potentially receive at the clinic, particularly that it could include a referral to receive an abortion. In several media interviews Tom was asked about why they didn’t simply revise the consent form to make it clearer. According to Jonathan there was some evolution in their conversation about what they wanted to say about it: “Our message became, ‘that’s something we are going to take a look at with our form, the best way to make it clearer for parents about what we do.’” Two days after the incident first broke in the media, the local newspaper quoted Tom as saying: “Not every individual is aware of what is included in ‘reproductive health care.’ We’re going to work constructively with our partners and experts in adolescent health to strategize the best ways to communicate that (Ramirez, March 25, 2010).”
The interview participants were diligent in giving prompt responses to internal and external stakeholders during the crisis. For example, at the school-district level, Maria and her colleagues drafted a letter for the school principal to send to parents, and also posted a statement on their website. In addition, they communicated with the school board, the school staff, the parent-teacher association, and other school stakeholders to keep them abreast of the situation and also so that “in case they get questions, they know to refer phone calls to us.” Jonathan also stated that he felt that they did a good job updating elected officials, “and felt supported by them as well.”

**RQ3c: Did SBHC stakeholders use best practices post-crisis?**

The SBHC stakeholders included all those involved or having a stake in the crisis as legitimate partners at all stages of the process. However, when it came to evaluating results and sharing best practices post-crisis, they did not debrief as a group. Stacy said that she eventually debriefed with other SBHC managers at their regular bi-monthly meeting:

> We talked a lot about what else we would do in the future or what they would do if it happened to them. And I think we all felt like we did all the right things, that we would do it again that way.

**RQ4: What did SBHC stakeholders learn from the crisis?**

**RQ4a: What would they do differently?**

Jonathan would have liked to have messages pre-staged so that they didn’t have to start from scratch in creating talking points to use and to share with other stakeholders: “In hindsight that probably would have been useful.” Jonathan also noted that he would also consider tweaking the messaging that they produced to address head-on some of the public discomfort with the state’s minor consent law:
Underlying some of this controversy is why don’t parents get to know? I think strategically at the time it probably didn’t make sense to dive into the details of why this law is important, but it’s something that in hindsight perhaps we could have had some better messaging at least prepared to talk about why the confidentiality itself is important.

Jonathan felt that he underestimated how long the incident would remain in the public eye, and had he a better idea of its lasting power he would have “thought more about 3rd party supporters – what other ways we can get supporters to speak for us… Are there other advocates in the community that can convey a supportive message for us – why we’re doing this work?” He also would have considered proactively seeking opportunities to get their message out as opposed to solely responding to media requests.

Stacy expressed some concern that students were a stakeholder group that could have benefited from more attention and targeted communications efforts:

I remember that I felt a little bit like the students need to hear from us [about what’s going on]. I’m not [at the SBHC] every day, so [my staff] were the ones who had to deal with the kids coming in and saying, “What’s up? What can you tell us?” …The rumors were everywhere, as you can imagine.

**RQ4b: What would they do the same?**

Tom and Jonathan both felt that they benefited greatly from coordinating with strong partners. At the school district, Maria also felt that the best aspect of how the incident was handled was their partnership with the public health department, identifying in particular the close communication they shared:

It is really critical …to have partnerships like that with other organizations, whatever the issue might be, so that you’re not in it by yourself. Especially for a school district [that is involved with providing health services] in your system and you’re not considered to be health experts, it’s great to have somebody on hand who is willing to serve in that kind of role.
When asked what he would do the same, Tom stressed the value of having one spokesperson rather than multiple spokespeople: “From go, we said there’s one place that’s going to field all this. And we did a good job when we reached out to our partners and other stakeholders who were involved in this work and said, Don’t talk [to the media], send it all to us.” Jonathan also noted that having one spokesperson allowed them to better stay on message.

Tom found value in “being open and available at initial [media] requests” because that meant they were not only responsive, but that they were able to take advantage of the opportunity to disseminate a larger message about the value of SBHCs.

RQ4c: What were the long-term effects of the crisis, if any?

The incident led SBHC stakeholders in the city to review their policies and procedures, and resulted in minor changes to the consent form. Stacy said:

Everybody had a chance to update and review consent forms, notifications, and procedures about how and when we do send students out for referrals, whether for abortion or anything else.

Jonathan added that: “Subsequently…there have been modifications to the form to provide more clarity about what things [parents] are signing for, and that there are other types of services that [parents] are not signing for.”

The general consensus among the interview participants was that there were no long-term negative effects of the crisis. Tom noted that: “school-based health centers are well regarded. Our program is held in high regard.” Most significantly, the city tax levy that supports SBHCs passed in late 2010 with a significant majority. Jonathan said: “The mayor and people supportive of the levy are very clear that school-based health centers are part of the levy, and that reproductive care is part of the services that are offered.”
Discussion

Controversy surrounding reproductive health issues at school-based health centers (SBHCs) arises frequently at the community level and in the news media, with potential impact on the strength and sustainability of the national movement. In order to survive during times of crisis and rebuild post-crisis, SBHC stakeholders must learn from past incidents. For this reason, I conducted case studies of communications efforts used during reproductive health crises at two SBHCs. This final chapter summarizes the results of my research, and discusses their implications.

The first crisis I studied took place at a SBHC in 2007 in New England, and the second crisis took place in 2010 in the Pacific Northwest. In both cases no one was harmed, the law was on the side of the SBHC, and the SBHC eventually had the support of the community – including parents and students. In both cases the media incited much of the crisis, and the interviewees perceived the resulting coverage – particularly at the national level – as highly sensationalized.

The 2007 case had much more extensive, negative coverage than the 2010 case – particularly national coverage. To some extent, this may have been due to the political environment in the country; in 2007 a Republican president was still in office and the focus was on abstinence-only education, while in 2010 a Democrat was in office and the political climate was more amenable to reproductive health access. It is possible, though, that the manner in which SBHC stakeholders managed the crisis had some impact on the tenor and duration of the news coverage, as well as the resulting political backlash (or lack thereof).
While it is impossible to control for all of the differences, one can point to several factors that may have played a contributing role in the 2010 case having more contained and short-term media coverage, with fewer national repercussions. In the 2007 case, a few days went by before the key stakeholders were able to connect to develop a strategy and compare messages, while in 2010 the stakeholders had a phone meeting within hours of hearing about the impending crisis. The first case did not have any communications experts on the ground, whereas the second case had the benefit of several communications experts. The 2010 case selected one main spokesperson for all of the stakeholders at various levels, whereas in 2007 the stakeholders did not select a main spokesperson. In the first case, interview participants reported that they did not feel supported from their national organizations, whereas in the second case interviewees expressed that they felt strong support at all levels. In 2007, stakeholders did not alert policymakers in a timely manner, which also may have exacerbated some of the national policy implications of the 2007 crisis.

Even though the two cases were very different – in terms of the circumstances and the level of communications expertise on the ground – they were strikingly similar in the manner that they managed some aspects of the crisis. Both cases used many best practices from crisis communications research, although with less intentionality in the 2007 case. In both cases the stakeholders were initially very responsive to the media, and then reduced their availability when they felt they had dispersed their message to the extent possible. Both cases coordinated with third party stakeholders behind the scenes in preparing messaging and in speaking to the media. In both cases stakeholders revised their messages during the course of the crisis to reflect feedback they had received. In
both cases the stakeholders exemplified the best practice of having leaders and
spokespeople that were trusted in their community and amongst partners. A consensus
among interview participants was that strong partnerships were critical to managing the
crisis and preventing further negative outcomes. In both cases this was aided by having
consistent and straightforward messaging.

In terms of what the stakeholders wished had gone differently, in both cases the
interview participants regretted that they did not have a crisis management plan and
prepared messaging in place prior to the incident. Both expressed that it might have been
helpful to get their message out more proactively, rather than simply responding to the
crisis. Both mentioned that a more extensive debrief session with stakeholders would be
helpful. These findings point to the need for the school-based health care field – at the
national and local level – to do more work to prepare for and ideally prevent crises from
taking place. In addition, in the event that crises occur, the SBHC field should invest time
in debriefing, evaluating impacts, and revising crisis plans.

In my role as the current communications director at the National Assembly on
School-Based Health Care, my perception is that most in the SBHC movement live in
fear of reproductive health issues becoming a controversial issue in their community and
playing out in the media. A key finding of this study – and one that was surprising to me
– is the extent to which, in retrospect, the interview participants viewed the crises as
positive events. At the local level, the incidents did not appear to hurt the SBHCs – in
fact, positive outcomes were more frequently mentioned, both at the personal level and at
the practice level. Interview participants from both cases talked about how the crises put
“school-based health care on a national platform,” and “brought light to the work we do.”
Interviewees from the 2007 case described how they still experience people telling them that they’re grateful for the work they do for kids. On a professional level, interviewees mentioned that the experience helped them strengthen relationships with colleagues, partners, and others in the SBHC movement. On a personal level, interview participants expressed that they feel more confident to handle future situations. One interviewee stated: “my convictions were strengthened. I learned a lot about strategy, and if I were faced with a similar situation I feel better prepared.”

**Study Limitations and Implications for Future Research**

A limitation of this study is that, because I work in the school-based health care field I have some personal and professional bias as the primary researcher. I sought to mitigate the effects of this personal bias by sharing a draft of the results chapter with the interview participants to gather their feedback on whether or not I had accurately characterized the incidents. However, I did not interview any opponents of SBHCs that provide access to reproductive health care services.

My involvement with the school-based health care field may also be seen as a strength of this study; my personal and professional experience in school-based health care communications granted me unique insight to the issue, and I also had access to documents that would not have been available to a researcher outside of the movement.

Future research on this issue should include both parent and youth perspectives on how crises are handled in the school-based health care context, and how they would like to receive communications from the school and the SBHC. In addition, research should look at what value may be found in using parents and youth as spokespeople in crisis scenarios involving school-based health centers.
Appendices

Appendix A: Interview Request Email

Dear [Name],

My name is Adrienne Ammerman, and I’ve been the director of communications at the National Assembly on School-Based Health Care since November, 2009. I’m also currently completing my Master’s degree at Johns Hopkins. For my thesis I’m conducting a research study on reproductive health communications crises at school-based health centers (SBHCs), and I have chosen [City, State] in [year] as one of my examples. The research study will include in-depth interviews with stakeholders involved in the crisis, as well as news coverage and both internal and external communications pieces (talking points, press releases, etc.).

I know you were very involved in what happened at [name of SBHC] in your role as [job title]. I would be most appreciative if you would agree to be interviewed by me. I will conduct the interview over the phone, and it should take around an hour. Your identity, as well as the locations of the case studies, will be kept confidential. That said, I should note that there may be enough details of the story available in the final report that someone would be able to figure out where the story took place if they made an effort.

As you know from experience, controversy around reproductive health issues at SBHCs arises frequently at the community level and in the news media, with real and lasting repercussions for the strength and sustainability of the movement. Frequently, in my role as communications director at NASBHC, I am asked to provide advice and support to SBHCs that are trying to deal with situations very similar to the one you experienced in [year]. My hope is that this research will provide best practices as to how to manage communications around reproductive health issues before, during, and after a crisis. These insights will help the SBHC movement better manage its communications strategy in future reproductive health-related crises.

If you are able to participate, please respond with dates and times when you are available for a one-hour interview. In advance of the interview, please review the attached consent form, sign it, and return it to me via email (Adrienne.ammerman@gmail.com) or mail (1217 Holbrook St. NE, Washington, DC 20002).

Please let me know if you have any questions about my research. I hope that you’ll be willing to participate.

Best,
Adrienne Ammerman
Appendix B: Interview Guide

Thank you so much for agreeing to an interview. The interview should take about 1 hour, and I may follow up at a later date with further questions if you agree. Your identity will remain confidential.

1. I have received the signed consent form that I emailed to you – thank you.
   a. Do you have any questions about the consent form, or about the research study?
   b. Do I have your consent to audio record this interview?
2. Let’s start with your background. How did you get involved with school-based health care?
3. My case study is on what happened at [name of the school-based health center] in [date]. What was your role at that time?
4. Had you ever experienced a reproductive-health related crisis before? What happened?
5. In this case, how did you first hear about the incident?
6. Tell me about how you perceived the episode to unfold from start to finish.
7. Let’s talk about how the communications was handled around the crisis.
   a. Who managed the communications?
   b. Who were involved?
   c. How did you communicate with each other?
8. Did you have messages in place to use before incident?
   a. Were messages developed after the incident had taken place?
   b. Who created the messages, and how were they shared? With whom?
   c. Do you think the messages were helpful?
   d. Were they successful?
9. How did you perceive the media coverage of the incident?
   a. Did you speak with reporters? What was that experience like?
   b. Who would you say were the spokespeople chosen to represent what happened?
10. What would you say you learned from the experience?
    a. What would you do differently if a similar incident took place again?
    b. What would you do differently?
11. What were the long-term effects of the crisis, if any?
Appendix C: Interview Participants

Case One, New England, 2007
Adam: The executive director of NASBHC
Amy: The school nurse coordinator for the city’s public schools and liaison between the schools and SBHCs
Diana: NASBHC’s communications manager
Jennifer: The manager of family health programs with the city health department and board member of the state SBHC association
Kelly: The vice president of the public relations firm that consulted with NASBHC during the incident
Leslie: The middle school’s nurse
Paul: The director of the state SBHC association
Simon: The principal of the middle school

Case Two, Pacific Northwest, 2010
Jonathan: The communications manager for the city’s department of public health
Maria: The communications person with the school district
Stacy: The SBHC administrator and manager
Tom: The manager of the city’s investment in SBHCs at the department of health
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Vita

Adrienne Ammerman was Communications Director of the National Assembly on School-Based Health Care (NASBHC) from November, 2009 through March, 2012. Prior to joining NASBHC, Adrienne managed press communications for the National Women's Law Center and was responsible for marketing and communications at Bread for the City, a non-profit that provides direct services to low-income DC residents. Adrienne first became passionate about the potential to use communications to promote and enhance the health and well-being of young people while a fellow at a health non-profit in New Delhi, India, where she worked with Indian media to raise awareness about child marriage and teen pregnancy. Adrienne graduated with a BA in gender and sexuality from the New School in New York City, and began the MA in Communications program at The Johns Hopkins University in September, 2008. She currently lives in Asheville, North Carolina with her husband and daughter.