

**San Francisco Citywide School  
Health Planning Committee**

San Francisco Department of Public Health  
San Francisco Unified School District

November 1999

Prepared by:

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&  
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## **PLANNING COMMITTEE**

The Citywide School Health Planning Committee was convened in 1998 under the auspices of the Superintendent of Public Schools and the Director of Health. The Committee serves in an advisory capacity to the Superintendent of Public Schools, the Director of Health and private educational and healthcare institutions that choose to participate.

The Committee's charge involves:

- identification of common health risks and problems experienced by pre-school and school-aged children
- development of a resource inventory within SF Unified School District (SFUSD), SF Department of Public Health (SFDPH), and city-wide to address those problems
- review of mandates governing the provision of school health services and the child development health programs
- development of program proposals to effectively address health risks and problems in school-based and school-linked settings
- identification of financing strategies to support those program proposals
- coordination of efforts to foster collaboration and to avoid duplicative efforts

## **MEMBERSHIP**

The Planning Committee is comprised of persons approved by the Superintendent of Public Schools and the Director of Health to form a broadly representative body. This body creates a forum in which experts in youth and adolescent development, education, health and parenting come together to develop effective strategies and programs to improve the health and well-being of children and youth in San Francisco.

## **SUBCOMMITTEES**

### ◆ **Steering**

- Co-Chair: Trish Bascom - Supervisor, SFUSD School Health Programs
- Co-Chair: Jimmy Loyce - Deputy Director of Health, SFDPH

### ◆ **Assessment**

- Co-Chair: Juan Diego Montemayor - Special Assistant, SFUSD School Health Programs
- Co-Chair: Janet Shalwitz, MD - Medical Director, SFDPH Children, Youth and Families Section

### ◆ **Fiscal Strategies**

- Co-Chair: Y. Mei Lam - Program Administrator, SFUSD Student Attendance & Medi-Cal Unit
- Co-Chair: Anne Okubo - Budget Manager, SFDPH Office of Finance

### ◆ **Program**

- Co-Chair: Meyla Ruwin - Program Administrator, SFUSD School Health Programs
- Co-Chair: Mildred Crear - Director, SFDPH Children, Youth and Families Section

### ◆ **Education, Outreach, and Advocacy**

- Co-Chair: Gwen Henry - Social Service Manager, SFUSD Child Development Program
- Co-Chair: Ginger Smyly - Deputy Director, SFDPH Community Health Prevention and Promotion

## **A**cknowledgments

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The formation of the Citywide School Health Committee is the result of the vision and perseverance of Bob Prentice, former Director, SFDPH Population Health and Prevention Division and Trish Bascom, Supervisor of the SFUSD School Health Programs Office. They believed firmly in strengthening interdepartmental dialogue, collaboration, and joint planning and overcame numerous barriers to establish the Committee. The Committee has relied on the talents and skills of Joanne Kimata of SFDPH Policy and Planning who brings clarity, determination, organization, and common sense to everything she does. Many thanks to Bob, Trish and Joanne for making this endeavor possible.

This report reflects the dedication and participation of the members of the Assessment Sub-Committee of the Citywide School Health Committee:

Lu Blajez (SFUSD Facilities)  
Eric Boutwell (SFUSD Information Technologies)  
Charlene Clemons (Family Service Agency)  
Harry Duh (SFDPH Children, Youth and Families Section)  
Roberta Gee (SF Parent Teachers' Association)  
Ritu Khanna (SFUSD Office of Program Evaluation)  
Joanne Kimata (SFDPH Office of Policy and Planning)  
Maureen McCarthy (SFDPH Balboa High School Health Center)  
John McGee (SFDPH Management Information Systems)  
Juan Montemayor (SFUSD School Health Programs)  
Anson Moon (SFDPH Community Health Network, Planning and Marketing)  
Randy Reiter (SFDPH Community Health Epidemiology)  
Mary Ann Shafer (UCSF Adolescent Medicine)  
Janet Shalwitz (SFDPH Children, Youth and Families Section)  
Lark Thomas (Family Service Agency/Teenage Pregnancy and Parenting Program)

We appreciate the time and effort of the following people who reviewed data and report drafts and provided valuable comments and information:

Trish Bascom (SFDPH School Health Programs)  
Twila Brown (SFDPH California Medical Services)  
Deborah Bryant (SFUSD School Health Programs)  
Nani Coloretti (Dept. of Children, Youth and Families)  
Jim Delara (SFUSD Information Services and Technology)  
Karyn Dresser (SFDPH Children, Youth and Families Community Mental Health Services)  
Juno Duenas (Support for Families of Children with Disabilities)  
Diedra Epps-Miller (Bayview Hunter's Point Healthy Start Collaborative)  
Ben Gale (SFDPH Environmental Health)  
Neil Gendel (Healthy Children Organizing Project)  
Lisa Gordon (San Francisco Teenage Pregnancy and Parenting Program)  
Robert Harrington (SFUSD Associate Superintendent)  
Gwen Henry (SFUSD Child Development Program)  
Mary Isham  
Jeff Klausner (SFDPH STD Prevention and Control)  
Lisa Kline (SFUSD Office of Research, Planning, and Evaluation)  
Y. Mei Lam (SFUSD School Attendance and Medi-Cal Revenue Unit)  
Wendy Leong (SFUSD Office of Research, Planning and Evaluation)  
Hoover Liddell (SFUSD Office of the Superintendent)  
Frank Morales (SFUSD Special Education)  
Ron Reid (California Department of Education)  
Yelena Slinin (UCSF School of Medicine)  
Ginger Smyly (SFDPH Community Health Promotion and Education)  
Joe Walseth (SFDPH Children's Environmental Health Program)  
Wendy Wolf (SFDPH STD Prevention and Control)  
Cliff Young (SFDPH – California Children's Services Medical Therapy Unit)

### STUDENT HEALTH AND EDUCATION – WHAT’S THE CONNECTION?

*“Teachers know that learning comes easier to a healthy child. Any health problems—hunger, poor vision or hearing, increased blood lead levels, dental caries, and child abuse—can interfere with learning. Physical and mental health problems cause children to miss school, lack energy, be distracted, or have other problems, which impair their ability to learn.” --National Health/Education Consortium (1990)<sup>1</sup>*

Health and education are interdependent entities. Children who suffer from violence, hunger, substance abuse, early pregnancy, depression, or hopelessness are not healthy. Healthy children are in an indisputably better position to learn than those who are not. As contributing representatives to the National Action Plan for Comprehensive School Health Education have cautioned, “no curriculum is brilliant enough to compensate for a hungry stomach or a distracted mind.”<sup>2</sup>

Numerous studies posit the inextricable link between the health status of students and their academic achievement. Literature in the fields of education, public health, and medicine have confirmed a strong relationship between specific health risk behaviors and negative outcomes on the following measures of school performance: *education outcomes* (e.g. graduation rates, class grades, and standardized test performance); *education behaviors* (e.g. attendance, dropout rates, school behavioral problems, and degree of involvement in school activities such as homework and extracurricular pursuits); and *student attitudes* (e.g. aspirations for post-secondary education, feelings about safety on school property, and personal attitudes such as self-esteem and locus of control). For instance, exposure to violence, tobacco and substance use, high risk sexual behavior, teen pregnancy, emotional distress, and poor nutrition have all been found to negatively affect school performance.<sup>3</sup>

Moreover, the relationship between students and their schools is not merely affected by health factors, but exerts a strong effect in turn upon student health. By promoting healthy practices through education, schools possess the unique capacity to affect the well-being of students, staff, parents, and entire communities. In addition, recent studies increasingly and convincingly link school connectedness and academic achievement of students to protection from negative health outcomes such as emotional distress, suicide, violence, tobacco and substance use, high-risk sexual activity, teen pregnancy, and delinquency.<sup>4-5</sup>

As stated by the National Commission on the Role of the School and the Community in Improving Adolescent Health, “efforts to improve school performance that ignore health are ill-conceived, as are health improvement efforts that ignore education.” Therefore, improving the academic achievement of SFUSD students will “require attending to health in the broadest sense.”<sup>6</sup>

# SAN FRANCISCO'S NEEDS ASSESSMENT

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*The Health & Well-Being of SFUSD Students K-12* was prepared under the auspices of the San Francisco Citywide School Health Planning Committee as part of a needs assessment process in the planning for public school-linked/school-based health services. This report compiles available health status indicators that include not only health-related information, but also economic and psychosocial measures that significantly influence the health status and outcomes of individuals and populations.

The data that was collected for this report was gathered from a number of sources within the SFUSD and the SFDPH, as well as various local and state information sources. Currently, there exists only limited connections among the separate SFUSD departmental data bases, and even less among SFDPH, other city, and state databases. Reflecting the lack of both inter- and intra-systemic linkages, important gaps exist within the information presented, which hinder a fully comprehensive picture of SFUSD student health and well-being. While every attempt has been made to present health status data that is directly pertinent to SFUSD students, information that pertains to the children and youth population of San Francisco as a whole has sometimes been used where SFUSD-specific data is unavailable.

It is important to note some of the important missing areas of data regarding SF students:

- ◆ Accurate health insurance coverage information for all students
- ◆ Risk behavior information specific to elementary age students
- ◆ Medical conditions of students
- ◆ Important psychosocial indicators such as abuse, loneliness, isolation, fear, family discord, adult support and supervision
- ◆ "Quality of life" indicators such as parent or family involvement in their children's schooling and/or participation in a full range of academic, social, athletic and civic activities
- ◆ Measurement of students' strengths and positive behaviors
- ◆ Any health data regarding students enrolled in private schools

Regardless of the limitations of the available data, it is apparent that some improvements have been made in student health and achievement. However, the overall picture of student health and well-being is far from optimal, and this report can serve as a baseline from which to establish goals and actions to ensure the best possible health status for San Francisco's child and youth.

Finally, we recognize that the SFUSD is not an island unto itself. While schools play a substantial role in shaping the environment of children, the health of students cannot be considered without acknowledging the integral roles of families, homes, neighborhoods, and the entire community. Ultimately, few lasting improvements in the health, well-being, and education of SFUSD students can be made unless all facets of the community including schools, parents, private and public sectors, health care providers, policy-makers, and community leaders accept personal responsibility for our children.

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# HIGHLIGHTS

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There are a number of recurrent themes and pressing issues which stand out in this report. Some of these key findings are:

## **POVERTY AND SFUSD STUDENTS**

While San Francisco is generally regarded as an affluent city, this affluence is often not reflected within the SFUSD student population:

- In 1998-99, nearly 50% of SFUSD students were eligible for free or reduced-price lunches (yearly family income of under 180% of Federal Poverty Level).
- In 1998, 10% of SFUSD students lived in public housing.

## **IMMEDIATE THREATS TO THE HEALTH, SAFETY AND EDUCATION OF STUDENTS**

### *Elementary school students (K-5)*

- In 1997-98, nearly 45% of elementary school student spoke limited or no English.
- In 1998, a study of 6 Bayview/Hunter's Point elementary schools found that 39% of diagnosed asthmatic students missed 5 or more school days in the previous year due to asthma-related illness.
- In 1996-97, 66% of elementary school students had dental caries, of which over half were untreated.

### *Middle School Students (6-8):*

- 9% of middle school students have attempted suicide.
- 45% of sexually active middle school students have had 3 or more sexual partners.
- 52% of middle school students have been in a physical fight in the past year.

### *High School Students (9-12):*

- 8% of high school students have attempted suicide in the past year.
- 40% of sexually active high school students did not use a condom at last intercourse.
- 8% of high school students carried a gun, knife, or club on school property in the last 30 days.

## **HEALTH AND EDUCATIONAL DISPARITIES OF AFRICAN AMERICAN STUDENTS:**

African American students experience a disproportionate share of the problems identified in the report compared to students of all other race/ethnicities:

- Highest percentage of students eligible for free/reduced lunches.
- Lowest attendance rates in middle and high school.
- Highest dropout rates.
- Highest percentage of Special Education and Severely Emotionally Disturbed students.
- Lowest immunization completion rates.
- Highest percentage of asthma-related hospitalizations.

## **POSITIVE NOTES**

While there are many areas of concern regarding the health and well-being of SFUSD students, there are also a number of more positive areas to highlight:

- Immunization completion rates appear to be rising for SFUSD kindergarten students.
- Nearly two-thirds of middle school students have never tried cigarette-smoking.
- The SF teen pregnancy rate is notably lower than the statewide rate.

# DEMOGRAPHICS

In 1998-99, approximately 70% of San Francisco's (SF) school-aged children were enrolled in the San Francisco Unified School District (SFUSD), the city's public school system; and 30% (26,059) were enrolled in private schools.<sup>7</sup>

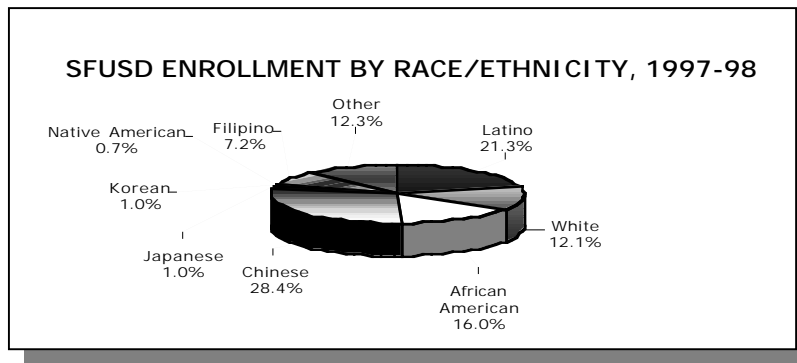
## SFUSD STUDENTS K-12

ENROLLMENT K-12, 1998-99: 61,054 students<sup>8</sup>

<u>GENDER</u>	<u>%STUDENTS</u>
Male	51.3%
Female	48.7%

<u>GRADE LEVEL</u>	<u>#STUDENTS</u>	<u>%STUDENTS</u>
Elementary School (grades K-5)	29,250	47.9%
Middle School (grades 6-8)	12,984	21.3%
High School (grades 9-12)	18,816	30.8%
Ungraded	4	

<u>RACE/ETHNICITY</u>	<u>#STUDENTS</u>	<u>%STUDENTS</u>
Chinese	17,367	28.4%
Latino	12,977	21.3%
African American	9,765	16.0%
White	7,381	12.1%
Filipino	4,380	7.2%
Korean	634	1.0%
Japanese	607	1.0%
Native American	414	0.7%
Other Non-White <sup>9</sup>	7,529	12.3%



## STUDENTS WITH LIMITED/NON-ENGLISH PROFICIENCY, 1998-99

<u>GRADE LEVEL</u>	<u>#STUDENTS</u>	<u>%GRADE LEVEL</u>
K-5	11,999	41.0%
6-8	3,301	25.4%
9-12	4,232	22.5%
Unknown	6	N/A
ALL	19,538	32.0%



**TOP 8 HOME LANGUAGES OF STUDENTS BY GRADE LEVEL, 1997-98<sup>10</sup>**

<u>LANGUAGE</u>	<u>K TO 5</u>	<u>6 TO 8</u>	<u>9 TO 12</u>
English	42.5%	41.9%	37.8%
Cantonese	22.1%	22.4%	24.5%
Spanish	19.9%	16.1%	15.7%
Tagalog	2.5%	3.5%	4.3%
Vietnamese	1.9%	2.8%	3.5%
Mandarin	1.3%	1.6%	1.8%
Korean	0.8%	0.7%	1.0%
Other <sup>11</sup>	9.0%	11.0%	11.4%
ALL	28,182	12,349	17,369

**TOP 10 SFUSD HOME ZIP CODES, 1997-98<sup>12</sup>**

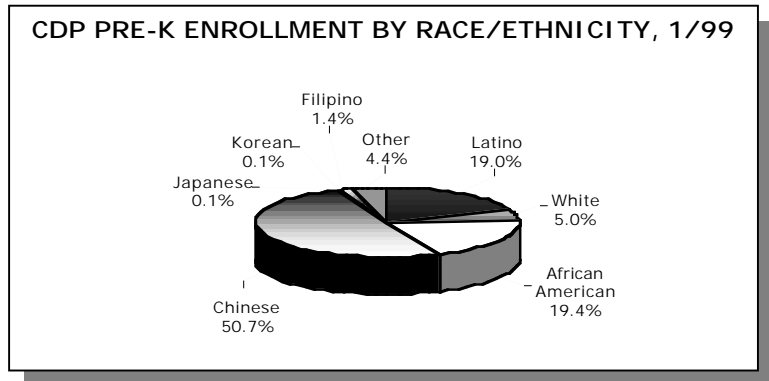
<u>ZIP CODE</u>	<u>AREA</u>	<u>#STUDENTS</u>	<u>%STUDENTS</u>
94112	Ingleside-Excelsior	8,170	13.3%
94110	Inner Mission	7,876	12.5%
94124	Bayview/Hunter's Point	6,287	10.2%
94134	Visitation Valley-Portola	5,181	8.4%
94122	Sunset	4,677	7.6%
94121	Outer Richmond	4,554	7.4%
94116	Parkside	4,003	6.5%
94118	Inner Richmond	2,505	4.1%
94109	Pork Gulch/Russian Hill	2,168	3.8%
94133	North Beach/Chinatown	2,093	3.4%
Other	Other	13,989	22.8%

**SFUSD CHILD DEVELOPMENT PROGRAM, PRE-KINDERGARTEN PROGRAM, 1998-99**

The SFUSD Child Development Program (CDP), the largest provider of early childhood education programs for SF's young children, helps young children beginning at infancy to improve their school readiness.

**PRE-K ENROLLMENT, JAN 1999:** 1,523 students<sup>13</sup>

<u>GENDER</u>	<u>% STUDENTS</u>
Male	49.0%
Female	51.0%



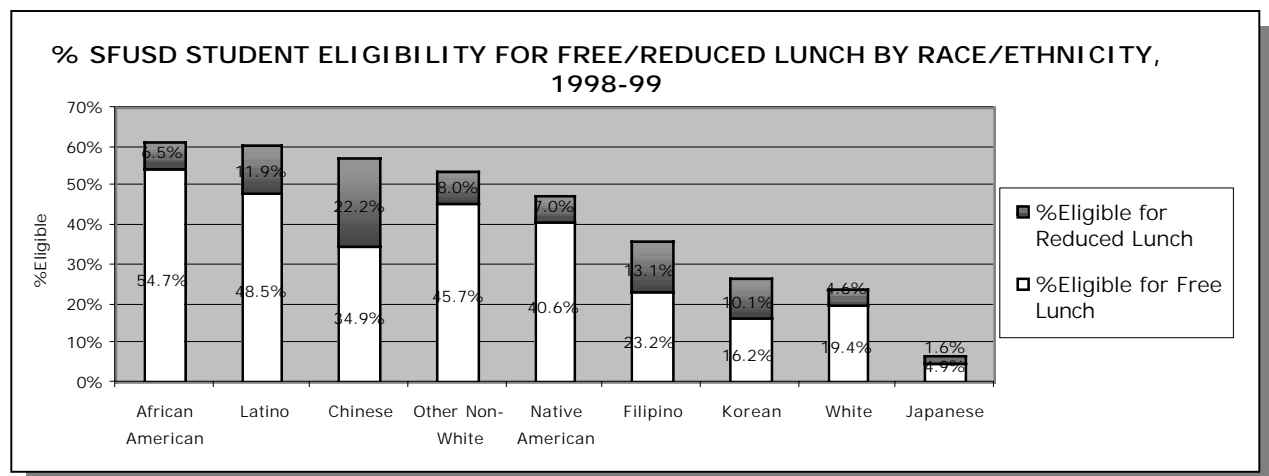
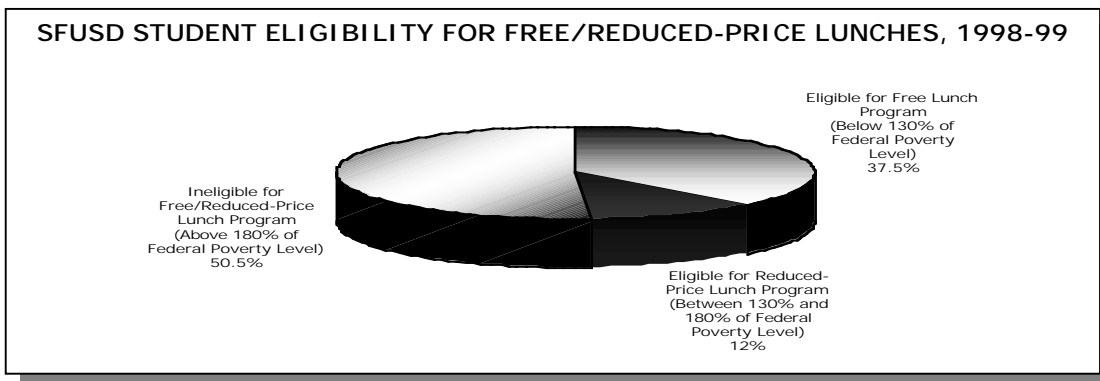
# P OVERTY

Poverty is perhaps the single most important factor linked to the health status of children. Low socioeconomic status contributes to poor nutrition, limits access to quality health care, and exposes children and youth to social and physical environments that endanger health and well-being. Poverty is associated with health and psychosocial problems in children and adolescents, including higher rates of violence, emotional problems, sexually transmitted infections, and unintended teen pregnancy.<sup>14-15</sup> Impoverished children have twice the rate of hospitalizations as children with more financial resources. In addition, poverty is strongly associated with school performance-related problems such as learning disabilities, grade repetition, expulsion/suspension from school, and dropping out of school.<sup>16</sup>

- 20% (17,448 out of 88,402) of SF children ages 5 to 17 live in poverty.<sup>17</sup>
- In 1997, 40,000 children and youth under age 21 were eligible for Medi-Cal, accounting for about one-third (35%) of all individuals eligible for Medi-Cal (113,826) in SF.<sup>18</sup>

## SFUSD FREE/REDUCED LUNCH PROGRAM, 1998-99

- In 1998-99, 37.5% (22,843) of SFUSD students received free lunches (family incomes below 130% of Federal Poverty Level) and 12% (7,308) received reduced-price lunches (family incomes between 130% and 180% of Federal Poverty Level).<sup>19</sup>



## SFUSD FREE BREAKFAST PROGRAM, MAY 1999<sup>20</sup>

- Students who are eligible for free or reduced school lunches are also eligible for the free breakfast program (yearly family income of less than 180% of Federal Poverty Level).

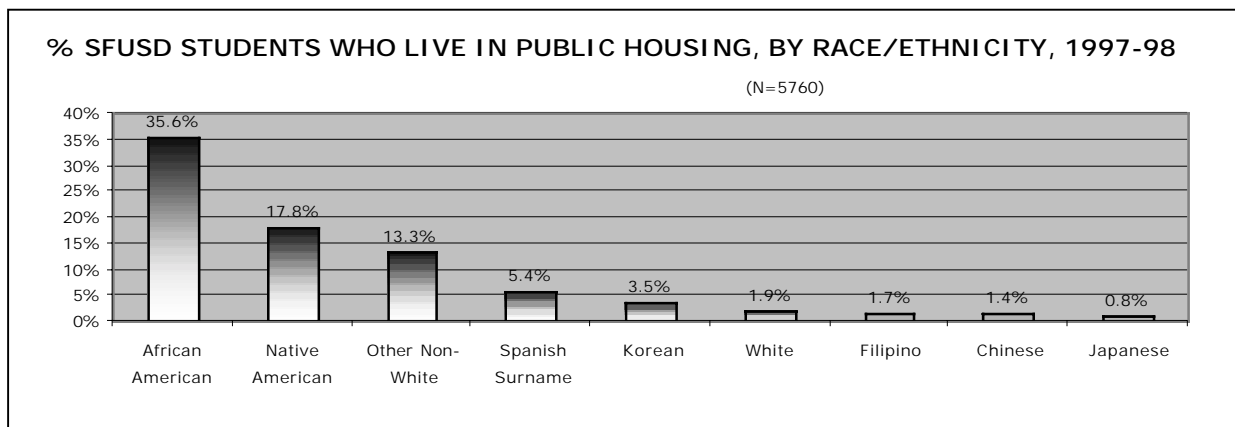
<u>GRADE LEVEL</u>	<u>AVERAGE DAILY PARTICIPATION</u>
K-5	6800
6-8	1371
9-12	1119
Total	9290

## SFUSD STUDENTS IN PUBLIC HOUSING, 1997-98

There are approximately 11,000 public housing units subsidized by local, state, and government funds serving eligible lower-income SF residents. Of the over 25,000 public housing residents, nearly half are children under 18 years old. The average household income for family units living in SF public housing is under \$10,000 per year.<sup>21</sup>

- In 1998, approximately 5760 (10%) SFUSD students lived in public housing (PH).<sup>22</sup>

<u>RACE/ETHNICITY</u>	<u>#STUDENTS IN PH</u>	<u>% STUDENTS IN PH</u>
African American	3,513	61.0%
Spanish Surname	705	12.2%
Other Non-White	711	12.3%
Samoan	245	4.3%
Chinese	233	4.0%
White	147	2.6%
Filipino	77	1.3%
Native American	74	1.3%
Indochinese	27	0.5%
Korean	23	0.4%
Japanese	5	0.1%
ALL	5,760	100.0%



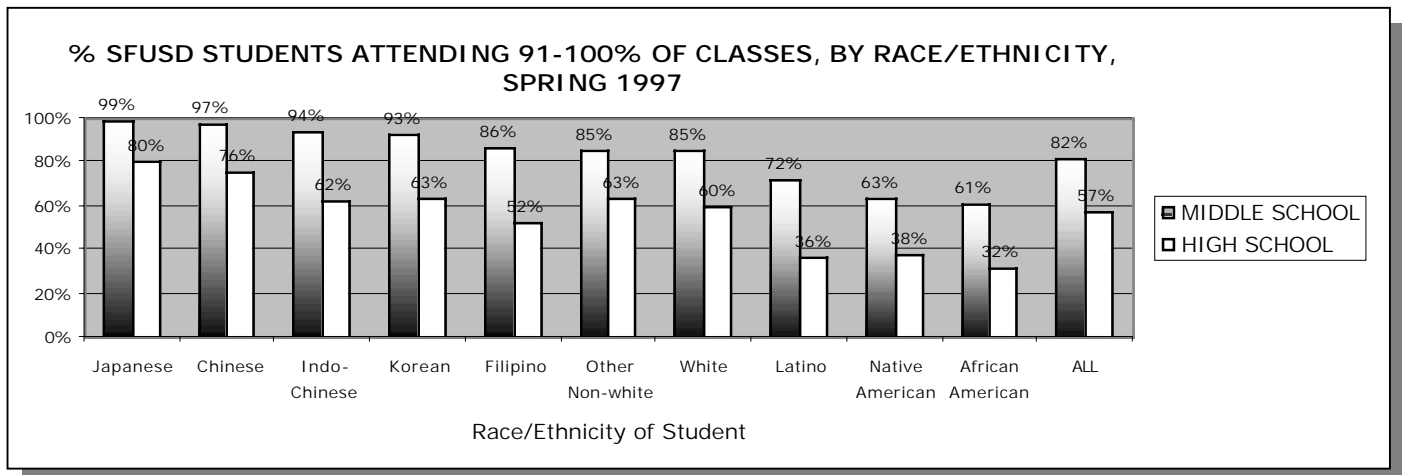
# SCHOOL ATTENDANCE

Student risk factors that have been shown to be associated with a lower attendance rate include chronic illnesses (e.g. asthma), physical abuse or exposure to abuse, substance use, poor nutrition, lack of physical activity, high-risk sexual behaviors, and teen pregnancy.<sup>23</sup> In addition studies have also found institutional characteristics of schools, such as higher degree of academic emphasis, better safety conditions, and reduced racial problems to be positively correlated with higher student attendance.<sup>24</sup>

Students with lower school attendance are more likely to have a lower grade point average and a higher school drop-out rate.<sup>25</sup> Excessive school absence rates have also been found to be associated with a host of subsequent high-risk health behaviors such as early sexual activity, sexually transmitted infections, HIV infection, cigarette-smoking, illicit drug use, violations of the law.<sup>26</sup>

## SFUSD DAILY ATTENDANCE/ABSENCES 1997-98

<u>GRADE</u>	<u>%ATTENDING DAILY</u> <sup>27</sup>	<u>DAILY ABSENCES</u>	<u>%EXCUSED ABSENCES</u> <sup>28</sup>
K-5	99.0%	269	81%
6-8	97.9%	257	56%
9-12	95.9%	777	42%
Total	97.1%	1,769	46%



# DROPOUTS/SUSPENSIONS

A number of risk factors have been shown to predict students who will drop out of school. Poor school performance, excessive absences, grade retention, truancy, suspensions, expulsions, and delinquency have all been associated with dropping out. Low family income and low level of parental support also increase the likelihood of leaving high school. In addition, male youth, youth of color, and youth who engage in early sexual intercourse are more likely to drop out of high school.<sup>29</sup>

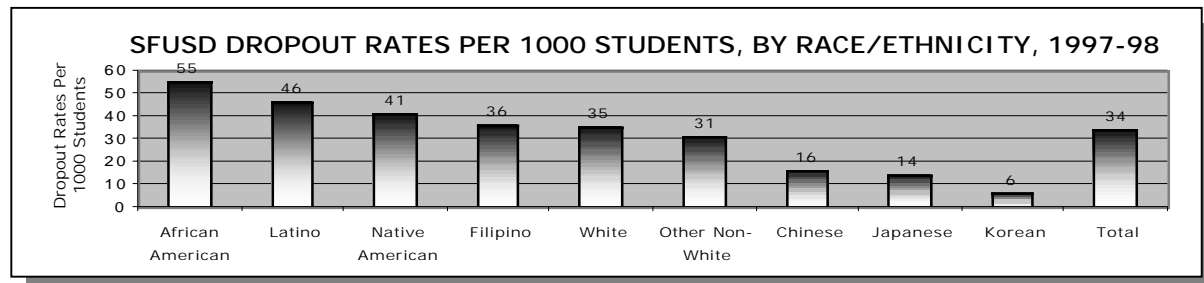
Dropping out of high school is associated with economic and social disadvantage. Dropouts have lower earnings, more unemployment, and increased reliance on welfare than students who complete high school or college. Female high school dropouts are more likely to become pregnant, have a birth at younger ages, and become single parents.<sup>30</sup> In addition, dropping out of school is associated with delinquency, substance abuse, and injury.<sup>31</sup>

## SFUSD STUDENT DROPOUT BY GRADE LEVEL, 1997-98<sup>32</sup>

<u>GRADE LEVEL</u>	<u>STUDENTS</u>	<u>%GRADE LEVEL</u>
K-5	513	1.6%
6-8	107	0.8%
9-12	1,479	6.4%
ALL	2,099	3.0%

## SFUSD STUDENT DROPOUT BY RACE/ETHNICITY, 1997-98

<u>RACE/ETHNICITY</u>	<u>#DROPOUTS</u>	<u>% ALL DROPOUTS</u>	<u>RATE PER 1000<sup>33</sup></u>
African American	543	25.9%	55
Latino	592	28.2%	46
Native American	17	0.8%	41
Filipino	164	7.8%	37
White	262	12.5%	35
Other Non-White	230	11.0%	31
Chinese	279	13.3%	16
Japanese	8	0.4%	14
Korean	4	0.2%	6
ALL	2,099	100.0%	34



## SFUSD SUSPENSIONS, 1997-98

- A total of 1599 (2.7%) SFUSD students were suspended during the 1997-98 school year, of which 51% were African American students.

# SPECIAL EDUCATION

Special education students in the SFUSD, "individuals with exceptional needs," have learning and/or emotional problems which require special help in order for the child or youth to succeed in the classroom.

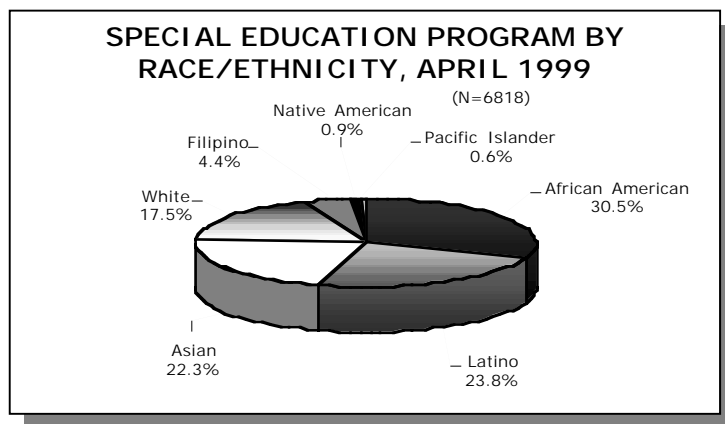
Because students receiving special education services are seldom identified in, and sometimes excluded from, surveys of child and adolescent health behaviors, little is known about health risks and outcomes in this population. However, a recent survey of high school students in Minnesota indicated that students who had received special education services were more likely to report a history of family violence (physical abuse or sexual abuse), family alcohol or drug abuse problems, and emotional distress than those student who had never been in classes for learning problems. In addition, students who had received special education services were more likely to live in single-parent and nontraditional households.<sup>34</sup>

## SFUSD SPECIAL EDUCATION PROGRAM, 1999

- In April 1999, 6422 (10.5%) SFUSD students (K-12) were enrolled in the Special Education/Severely Emotionally Disturbed (SED) programs.<sup>35</sup>

<u>GRADE LEVEL</u>	<u>#STUDENTS</u>	<u>%GRADE LEVEL</u>
Pre-K	396	N/A
K-5	2958	10.1%
6-8	1720	13.2%
9-12	1744	9.3%
ALL	6818	100.0%

<u>GENDER</u>	<u>#STUDENTS</u>	<u>%SPECIAL ED</u>
Male	4524	66.3%
Female	2294	33.7%
ALL	6818	100.0%



<u>DISABILITY CATEGORY</u>	<u>#STUDENTS</u>	<u>%SPECIAL ED</u>
Specific Learning Disability	4259	62.5%
Speech and Language Impaired	1317	19.3%
Mentally Retarded	478	7.0%
Seriously Emotionally Disturbed	354	5.2%
Autism	109	1.6%
Other Health Impaired	82	1.2%
Hard of Hearing	68	1.0%
Orthopedically Impaired	66	1.0%
Non-Categorical	28	0.4%
Visually Impaired	27	0.4%
Multihandicapped	23	0.3%
Deaf	3	<0.1%
Traumatic Brain Injury	3	<0.1%
Deaf-Blind	1	<0.1%
ALL	6818	100.0%

**SFUSD SED (SEVERELY EMOTIONALLY DISTURBED) SCHOOL MENTAL HEALTH PARTNERSHIPS PROGRAMS, 1996-97<sup>36</sup>**

<u>GRADE LEVEL</u>	<u>#STUDENTS</u>	<u>%SED STUDENTS</u>
K-5	127	52.2%
6-8	91	28.8%
9-12	98	31.0%
ALL	352	100.0%

<u>GENDER</u>	<u>#STUDENTS</u>	<u>%SED STUDENTS</u>
Male	264	75.0%
Female	88	25.0%
ALL	352	100.0%

<u>RACE/ETHNICITY</u>	<u>#STUDENTS</u>	<u>%SED STUDENTS</u>
African American	193	54.8%
Latino	50	14.2%
Asian/PI	30	8.5%
White	14	4.0%
Native American	6	1.7%
Other	59	16.8%
ALL	352	100.0%

<u>PRIMARY HANDICAPPING CONDITION</u>	<u>%SED STUDENTS</u>
Learning Disabilities	50.0%
Serious Emotional Disturbance	43.6%
Mild Cognitive Delay	3.8%
Speech and Language Impairment	1.0%
Moderate Cognitive Delay	0.3%
Hearing Impairment	0.3%
ALL	100.0%

# HEALTH INSURANCE

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The health of children depends partially upon their access to appropriate health services. Insurance coverage has an important impact on a child's access to health care services. Among children, the uninsured are more than seven times less likely to have a usual source of health care, and more than 3 times more likely to have gone without needed medical, dental, or other health care than insured children.<sup>37</sup> Uninsured children are also less likely to receive preventive screenings from health care providers, less likely to use prescription drugs, and more likely to delay seeking health care because of cost issues when compared to insured children.<sup>38</sup>

While it is imperative that all children should, at a minimum, have health insurance, it is important to note that simply being insured does not guarantee access to necessary or appropriate health care services. While the number of uninsured school-aged children remains alarmingly high, many more children have health plans with inadequate benefits, thereby limiting their access to developmentally-appropriate primary care, medical subspecialties, mental health, substance abuse, health promotion, supportive counseling, and case management services.

- In 1997, an estimated 10,517 SF residents under 18 years had no health insurance, representing 8.5% of the 0-17 population<sup>39</sup> and 7% of the uninsured population.<sup>40</sup>
- In 1998, over 4000 students from 11 SFUSD high schools<sup>41</sup> were surveyed about their health insurance coverage and intention to use school-based health services. 17% of respondents indicated they had no health insurance, and 67% stated that they would use services at a health clinic based at their school.<sup>42</sup>

## MEDI-CAL (MEDICAID)

Medicaid is the nation's major publicly-financed program, jointly financed by the federal and state governments, for providing health insurance to low-income people. In California, the Medicaid Program is known as Medi-Cal, and is administered by the California Department of Health Services. Medi-Cal covers a core of basic services required by federal law, including hospital inpatient and outpatient care, physician visits, laboratory tests and x-rays, family planning, periodic preventive health care visits for children under age 21, in addition to optional services such as prescription drugs, adult dental, durable medical equipment, chiropractic and podiatry services and medical supplies.

## SFUSD STUDENTS RECEIVING MEDI-CAL: 1998-99<sup>43</sup>

<u>GRADE LEVEL</u>	<u>MEDI-CAL RECIPIENTS</u>	<u>%GRADE LEVEL</u>
K-5	9,672	33%
6-8	4,123	32%
9-12	4,679	26%
Unknown	2,592	38%
ALL	21,066	35%



# DISABLED CHILDREN

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Children and adolescents with chronic health conditions and disabilities have long been considered at substantial risk for excess psychosocial morbidity. Many chronic health impairments may be associated with recurrent episodes of pain or acutely altered physiologic function, which may promote anxiety, depression, and poor self-esteem. The presence of physical or mental disability may also limit social interactions and distinguish children from their peers, thus increasing the risk of psychosocial maladjustment.<sup>44</sup> In addition, disabled children must cope with their own emotional reactions to their illness and care as well as to the reactions of family members, friends, peers, teachers, and others.<sup>45</sup> A recent report from the National Health Survey and Child Health Supplement found that children with chronic health problems were more likely to have behavioral problems (such as anxious/depressed mood, social withdrawal, immature dependency, anti-social behavior), higher rates of school grade repetition, and placement into special education classes than their healthy counterparts.<sup>46</sup>

While there is currently no systematic tracking of students with disabilities within the SFUSD, data from the California Children Services Medical Therapy Units and the SFUSD School Therapy Programs may serve as indicators for disabled students.

## CALIFORNIA CHILDREN SERVICES: MEDICAL THERAPY UNITS (MTU)<sup>47</sup>

California Children Services (CCS), a publicly-supported physical rehabilitation program for children up to age 21 with certain handicapping and medical conditions, helps children achieve maximum physical and social function. 20% of SF children receiving CCS services participate in its Medical Therapy Program, which serves eligible children diagnosed with neuromuscular, musculoskeletal, or muscular diseases. The MTUs conduct evaluations and provide physical and occupational therapy.

### ACTIVE MTU CLIENTS IN SAN FRANCISCO, APRIL 1999

<u>GRADE LEVEL</u>	<u>TOTAL NUMBER</u>	<u>#SFUSD STUDENTS</u> <sup>48</sup>	<u>% IN SFUSD</u>
Pre-K	120	N/A	N/A
K-5	157	109	69%
6-8	64	54	84%
9-12	160	112	70%
ALL K-12	381	275	72%

The most frequent diagnoses in 381 school-aged children (5 to 21 years) receiving PT/OT services in MTU units were cerebral palsy, spastic diplegia, spastic quadriplegia, juvenile rheumatoid arthritis, and spina bifida.<sup>49</sup>

## SCHOOL THERAPY PROGRAMS<sup>50</sup>

The School Therapy Program provides school-based physical and occupational therapy services to disabled or handicapped children, including those with learning disabilities and developmental delay due to chromosomal defects.

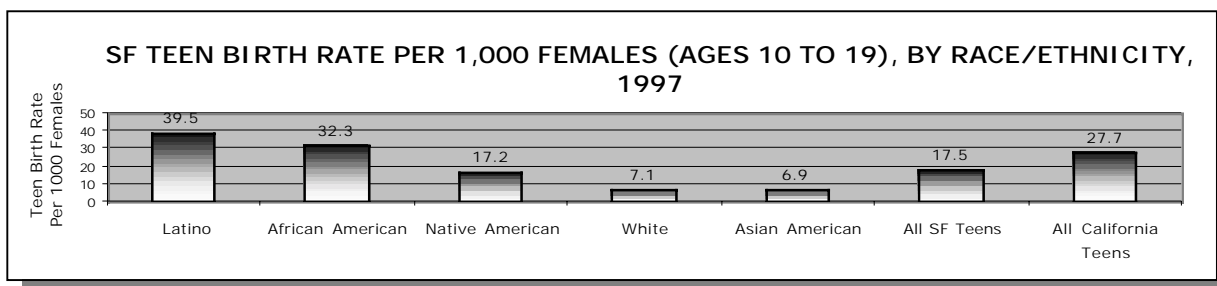
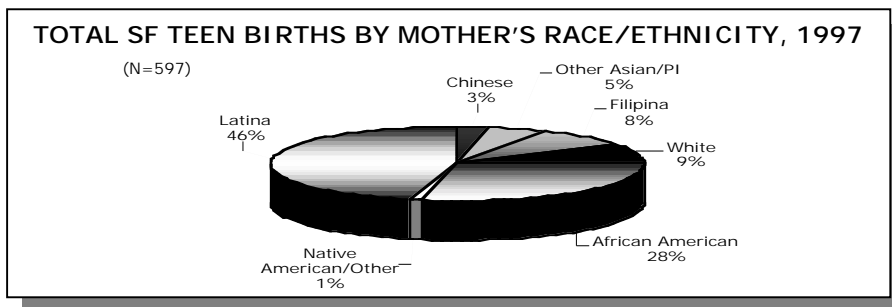
<u>GRADE LEVEL</u>	<u>PRE-K</u>	<u>K-5</u>	<u>6-8</u>	<u>9-12</u>	<u>TOTAL</u>
<u>#STUDENTS SERVED</u>	9	293	78	42	422

# T EEN PREGNANCY

Many of the negative health and social factors (e.g. poverty, school dropout) may lead to and/or result from teen pregnancy. Adolescent females who are at higher risk for unintended pregnancy often include those with low educational goals, substance abusers, early initiators of sexual activity, and those who live in communities with high rates of poverty, welfare use, and single-mother households.<sup>51</sup> School connectedness and school achievement have both been shown to be protective factors against teen pregnancy.<sup>52-53</sup> Negative consequences of teenage pregnancy include lower rates of school attendance and high school completion, higher future poverty rates, increased welfare dependence, lower employment stability, poorer psychological functioning, and slightly greater rates of health problems for both mother and child.<sup>54</sup>

## LIVE BIRTHS TO ADOLESCENT MOTHERS (AGES 12 TO 19) IN SF, 1997<sup>55</sup>

- There were 597 births to adolescents mothers (ages 12 to 19) in 1997, representing 7.2% of total SF births for the year. This percentage was notably lower than the 1995 statewide figure of 12%. 40% (237) of the teen births were to mothers under age 18.
- In 1997, more than 90% of teen births in SF were to females of color vs. 68% of total SF births. Highest birth rates were among Latina and African American teens.<sup>56-57</sup>

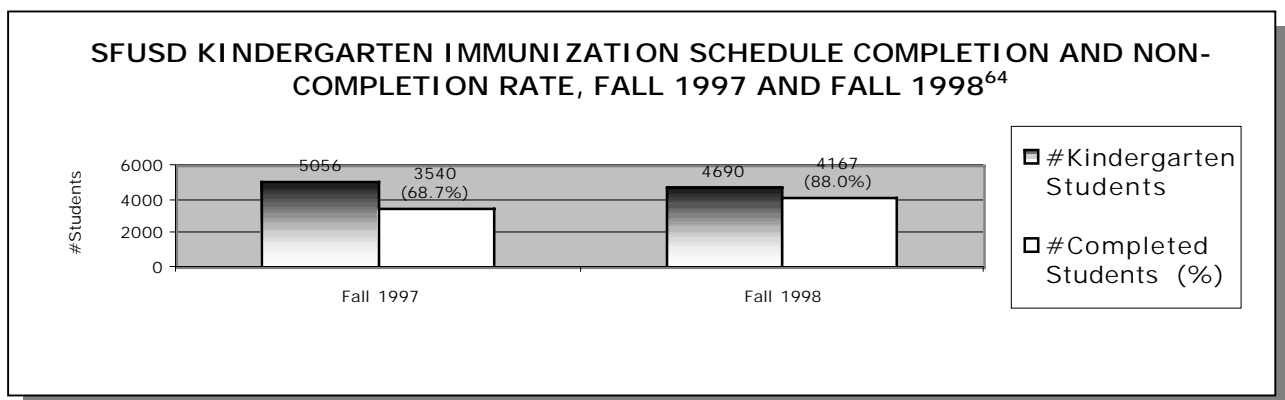
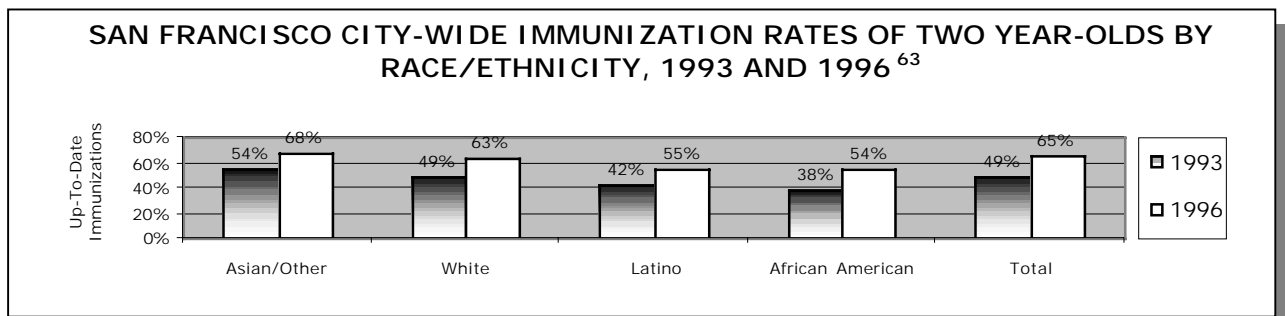


- In 1997, 6% of all SFUSD high school students (16% of sexually active students) reported having been pregnant or having gotten someone pregnant.<sup>58</sup>
- In May 1999, there were 514 active pregnant and parenting clients enrolled in the SF Teenage Pregnancy and Parenting Project.<sup>59</sup> 50% (257) were enrolled in a SFUSD school; 8% (43) were SFUSD school graduates; and 4% (18) completed GED's.<sup>60</sup> Of the 196 (38%) who were not in school, barriers to school attendance included transportation, childcare, educational, psycho-social, medical, refusal to attend, and expulsion.<sup>61</sup>

## IMMUNIZATIONS

Immunization is the most effective and inexpensive tool for prevention of communicable diseases. National studies have shown that, despite dramatic improvements in child vaccination rates in the past decade, immunization levels appear to differ significantly by poverty status as well as race and ethnicity.<sup>62</sup> While the immunization rates of children in SF also appear to be improving, the completion rates for immunization schedules are notably lower among African American and Latino children, and the rates for all racial/ethnic groups fall short of the Healthy People 2000 objective of 90% immunization completion at 2 years of age. However, with the recent advent of stricter California immunization laws, rates of vaccination completion are expected to continue rising in San Francisco.

The recommended basic immunization schedule (1999) specifies that children by the age of 24 months should have received four doses of the diphtheria-tetanus-pertussis (DTP), three doses of polio, four doses of Hib (Haemophilus influenza type b), and a single dose of the measles-mumps-rubella (MMR) vaccine. As of August 1997, California children entering kindergarten are required to have additional immunization requirements, including three doses of HBV (hepatitis B) vaccine. Most recently, as of July 1999, California children entering the 7<sup>th</sup> grade are now required to have three doses of HBV vaccine (in order to immunize adolescents who were not immunized as infants) and 2 doses of MMR.



- In 1997, 51% of SFUSD high school students reported having been vaccinated against the hepatitis B virus. Of those who had been vaccinated, 69% received their vaccination in a health clinic or by their doctor, and 28% received it at school.<sup>65</sup>

## DENTAL HEALTH

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Improvement in oral health in the U.S. is one of the major public health success stories of this century. Public health measures such as fluoridation and dental services have resulted in dramatic improvements in oral health status for many children. However, many children in SF have not benefited from preventive dental care. Access to dental services continues to be a problem in SF and throughout the state since dental services are costly and are typically not subsidized. Although there is no available data specifically regarding access to dental care in SF, data from the National Center for Health Statistics on Children's Access to Health Care indicate that more U.S. children between the age of 0 and 17 are unable to get dental care than any other single health service.<sup>66</sup> A study published by the California Health Department in 1997 noted that 26 percent of pre-school, 28 percent of elementary school, and 44 percent of high school student in California lack dental insurance.<sup>67</sup> Not surprisingly, poverty is strongly correlated with lack of access to dental care and dental problems, including extensive tooth decay, pain, and infection.<sup>68</sup>

### **SFUSD STUDENTS AND DENTAL CAVITIES/DECAY<sup>69</sup>**

- SFUSD PRE-SCHOOLERS: In 1996/97, 33% of children had treated (filled) and untreated (unfilled) dental caries, of which over half had untreated caries.<sup>70</sup>
- SFUSD ELEMENTARY SCHOOL STUDENTS: 66% had treated or untreated dental caries, of which over half had untreated caries.<sup>71</sup>
- In May, 1999, 60 Balboa High School students had dental screenings: 40% (24) had at least 1 cavity; 15% (9) had 4 or more cavities.<sup>72</sup>

Asthma is one of the most prevalent chronic illnesses found in children of industrialized countries, and the prevalence seems to be increasing. It is estimated that 6.7% to 12% of US children have asthma, with significantly higher rates among African Americans and Latinos than whites. Studies have demonstrated higher rates of severe asthma and asthma-related hospitalizations in children of lower socioeconomic status.<sup>73-74</sup>

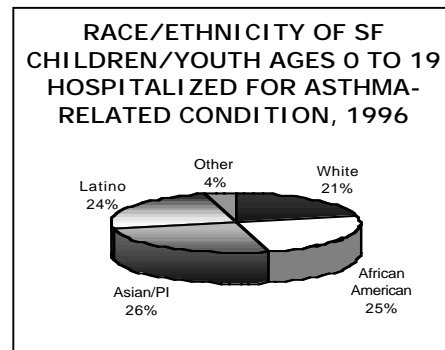
Like many children with chronic illness, children with asthma may suffer from both the physical discomforts of their condition as well as psychosocial impairments that may result. Children with asthma are more likely than healthy children to have lower school attendance and worse school performance, with a higher correlation among poorer children.<sup>75</sup>

**SAN FRANCISCO HOSPITALIZATIONS FOR ASTHMA-RELATED REASONS: CHILDREN AND YOUTH AGES 0 TO 19, 1996<sup>76</sup>**

- In 1996, asthma was the most common principle diagnosis of children ages 0 to 19 who were hospitalized in San Francisco, representing 9% (398) of the hospitalizations and 15% (330) of hospitalizations for children under 10 years old.
- Of the asthma-related hospitalizations for SF children in 1996, highest rates of hospitalization were among African Americans and lowest were among Asian/Pacific-Islanders.

**SF ASTHMA-RELATED HOSPITALIZATION RATES (AGES 0 TO 19) BY RACE/ETHNICITY, 1996**

<u>RACE/ETHNICITY</u>	<u>RATE PER 1,000</u>
African American	4.5
Other	3.5
Latino	2.9
White	2.0
Asian/Pacific-Islander	1.7
ALL	2.5



**BAYVIEW HUNTERS POINT: 94124 ASTHMA STUDY<sup>77</sup>**

In 1998, 2,188 surveys were mailed to homes of students attending the six BV/HP schools (Charles R. Drew, George Washington Carver, Bret Harte, Malcolm X Academy, Gloria R. Davis Academic, and 21<sup>st</sup> Century Academy). Results from the 665 (30%) returned surveys revealed the following (*Note: given the relatively low return rate of the surveys, there may have been a response bias toward students with asthma symptoms, leading to an overestimate in some of the prevalence data*):

- 45% indicated the presence of asthma and/or asthma-like symptoms in their households, and 18.8% indicated a diagnosis of asthma.
- 39% of diagnosed asthmatic students missed more than 5 days of school in the previous 12 months due to asthma-related illness; with 5% reporting 10 or more days missed.
- 66.2% of diagnosed asthmatic students used bronchodilators (short-acting medications), and 7.4% used corticosteroids (long term anti-inflammatories).

The primary threats to the health of adolescents are preventable “social morbidities” that are partially related to a host of risky behavioral factors. The three primary causes of mortality during adolescence are injuries, homicide and suicide; together these are responsible for 75% of all adolescent deaths.<sup>78</sup> Major sources of adolescent morbidity include injury and disability associated with the use of motor/recreational vehicles, pregnancy complications, sexually transmitted diseases, consequences of substance abuse, and unhealthy dietary/exercise practices.<sup>79</sup> Student health risk factors/behaviors such as emotional distress, tobacco and substance use, risky sexual behaviors, exposure to violence, and poor nutritional/physical activity practices have been shown in numerous studies to correlate with negative school performance outcomes.<sup>80</sup> In addition, school connectedness and school achievement have been demonstrated in turn to exert some influence over student risk behaviors.<sup>81-82</sup>

The **Youth Risk Behavior Survey (YRBS)** is a national survey conducted every two years, developed by the Division of Adolescent and School Health, National Centers for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention in collaboration with representatives from 71 state and local departments of education and 19 other federal agencies. Its main purpose is to monitor priority health risk behaviors that contribute to the leading causes of morbidity, mortality, and social problems among youth and adults in the United States. In San Francisco, the 1997 YRBS was administered to 1,783 middle school (grades 6 to 8) and 1,914 high school students in the SFUSD.<sup>83</sup>

### **MENTAL HEALTH<sup>84</sup>**

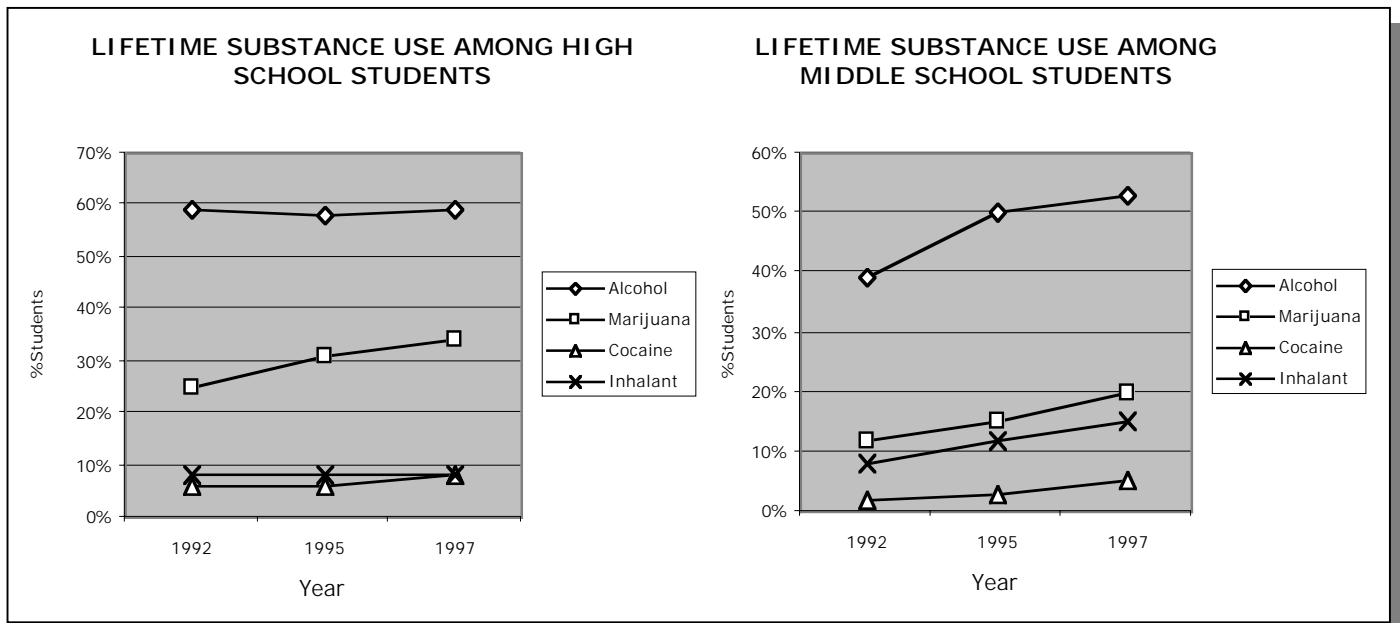
- 77% of middle school students felt sad and depressed at least one day over the past 30 days, 61% from 1-9 days, and 4% for all 30 days. Female middle school students (83%) were more likely to have felt that way than male students (71%).
- 24% of middle school students have ever seriously thought about killing themselves, and 21% of high school students have in the previous month.
- 13% of middle school students have ever made a suicide plan, and 15% of high school students have made a suicide plan within the past 12 months.
- Female students were more likely than male students to have made a suicide plan in both the middle (16% vs. 9%) and high school levels (18% vs. 12%). 21% of 10<sup>th</sup> grade females have made a suicide plan.
- 9% of middle school students have ever attempted suicide, and 8% of high school students have attempted suicide in the past year. 4% of high school students have attempted suicide at least twice, and 0.7% have attempted suicide 6 or more times. Females are more likely than males to have tried to kill themselves, in both middle (12% vs. 7%) and high school (11% vs. 4%) levels.
- In 1996, mental health disorders were the second leading cause of hospitalization (following pregnancy) of youth ages 10 to 19 in San Francisco, representing 14% (316 out of 2193) of youth hospitalizations.<sup>85</sup>

## TOBACCO USE<sup>86</sup>

- 37% of middle and 59% of high school students have tried smoking at least once.
- 13% of middle school students smoked cigarettes in the past 30 days; 57% of these have smoked 5 days or less. 19% of high school students have smoked cigarettes in the past 30 days, including 5% daily and 9% who smoked on school property.
- 8.5% of middle school students used chewing tobacco or snuff at least once. 2% of high school students used smokeless tobacco during the past 30 days.

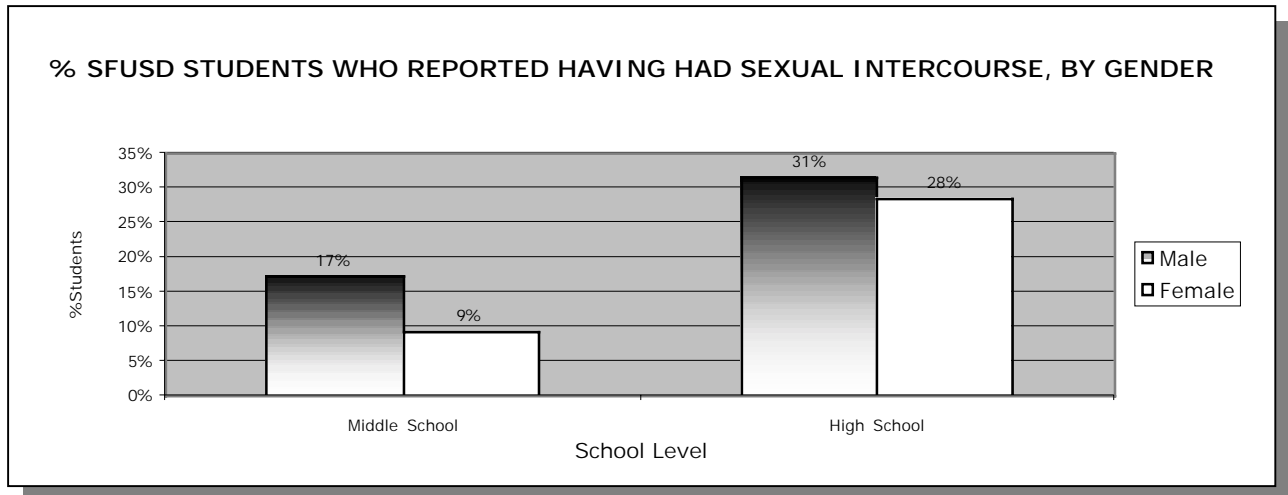
## DRUG AND ALCOHOL USE<sup>87</sup>

- Alcohol is the most common substance used among SFUSD middle and high school students. 53% of middle and 59% of high school students have ever tried alcohol. 21% of middle and 30% of high school students used alcohol in the past 30 days.
- Marijuana is the second most common substance used among SFUSD students. 20% of middle and 34% of high school students have ever used marijuana. 18% of high school students used marijuana in the past 30 days (up from 14% in 1992).
- Lifetime cocaine use increased from 2 to 5% among SFUSD middle school students and 6 to 8% among high school students between 1992 and 1997. 3% of high school students used cocaine in the past 30 days.
- Lifetime inhalant (glue, spray paint, chemo, and other chemicals) use increased from 8 to 15% between 1992 and 1997 for middle school students, while use for high school students remained stable at 8% during the same period.



## SEXUAL BEHAVIOR<sup>88</sup>

- 14% of middle and 31% of high school students have had sexual intercourse at least once; males were more likely than females to be sexually. 45% of sexually-active middle and 39% of sexually-active high school students have had 3 or more sexual partners.



- Among sexually-active students, 61% of middle and 60% of high school students used a condom at last intercourse.
- Of high school students using condoms, 26% obtained them from a store, 24% from a program at school, and 22% from a friend or relative.
- 31% of middle school students and 15% of high school students used alcohol or drugs before the last time they had sexual intercourse.
- 28% of sexually-active middle and 22% of sexually-active high school students have been told by a doctor or nurse that they had a sexually transmitted disease.
- In April 1999, asymptomatic SFUSD students from 4 high school were screened for sexually transmitted infections with the following results:<sup>89</sup>

<u>SCHOOL</u>	<u>STUDENTS SCREENED</u>		<u>#CHLAMYDIA CASES</u>		<u>% OF SCREENED</u>	
	Females	Males	Females	Males	Females	Males
Washington	48	103	3	0	6.3%	0.0%
Wallenberg	57	62	1	1	1.8%	1.6%
Balboa	119	162	4	2	3.4%	1.2%
Downtown	54	12	11	0	5.6%	0.0%
Total	278	339	11	3	4.0%	0.9%



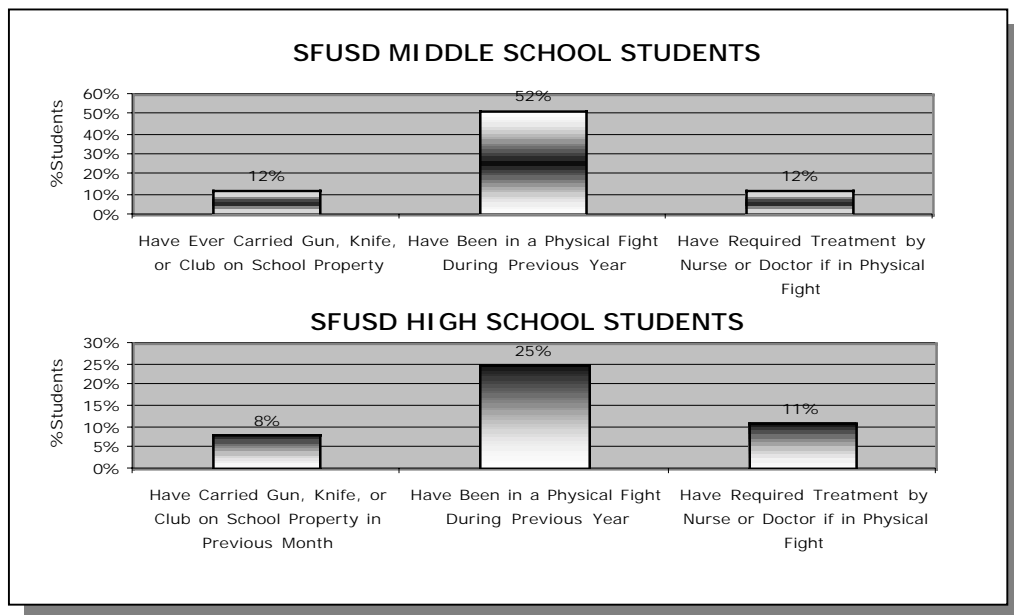
## VIOLENCE/INJURIES<sup>90</sup>

### UNINTENTIONAL INJURIES

- 70% of middle and 78% of high school students wear seat belts most or all of the time when riding in a car driven by someone else.
- 51% of middle school students who ride a bicycle and 65% of those who rollerblade or ride a skateboard never or rarely wear a helmet.
- 26% of middle school students have ridden in a car driven by someone who had been drinking alcohol.
- 5% of high school students drove after drinking alcohol during the past 30 days.

### FIGHTING AND WEAPON-CARRYING

- 23% of middle school students have ever carried a knife as a weapon, 10% a club, and 12% a gun. 14% of high school students carried a weapon within the past 30 days, including 11% who carried a knife, 6% a club, and 3% a gun. 12% have ever carried a knife or club, and 3% a gun on school property. 8% of high school students carried a gun, knife, or club on school property in the past 30 days.
- 52% of middle and 25% of high school students have been in a physical fight in the past year. 12% of middle and 11% of high school students who had been in a fight were treated by a doctor or nurse for injuries.



- 16% of middle school students did not go to school at least once because they felt unsafe at school. 7% of high school students did not go to school within the past 30 days due to safety concerns at school, or on the way to and from school. 9% of high school students have been threatened or injured on school property by someone with a weapon, such as a gun, knife, or club within the past 30 days.

## DIETARY AND EXERCISE PATTERNS<sup>91</sup>

### SELF-PERCEPTIONS OF WEIGHT

- 52% of middle and 49% of high school students consider their weight to be “about right.” 27% of middle and 30% of high school students said they are slightly or very overweight; 21% of middle and 20% said they are slightly or very underweight. Females were more likely than males to consider themselves overweight.
- 74% of middle and 75% of high school students have tried to change their weight. More females than males try losing weight in middle (47% vs. 29%) and high school (56% vs. 27%).
- 54% of middle and 47% of high school students use exercise as to lose or maintain weight. 29% of middle and 27% of high school students diet.
- 5% of middle and 4% of high school students have used vomiting or laxatives as a means to lose weight; 4% of both middle and high school students have taken diet pills to control weight.

### DIETARY PATTERNS

- 77% of middle and 71% of high school students ate fruit on the previous day. 60% of middle and 66% of high school students ate cooked vegetables at least once on the previous day.
- Both middle and high school students had consumed foods typically high in fat content on the previous day. 42% of middle and 34% of high school students had eaten hamburgers, hot dogs, or sausage; 57% and 46% had eaten french fries or potato chips; 54% and 58% had eaten cookies, doughnuts, pie, or cake.

### EXERCISE PATTERNS

- 74% of middle and 52% of high school students had engaged in aerobic exercise three or more days in the past week. 50% of middle and 46% of high school students did strengthening exercises three or more days in the past week.
- 96% of middle school students attend physical education class at least one day a week, and 87% usually go for five days a week. 38% of high school students attend physical education class five days a week, and 48% do not attend at all.

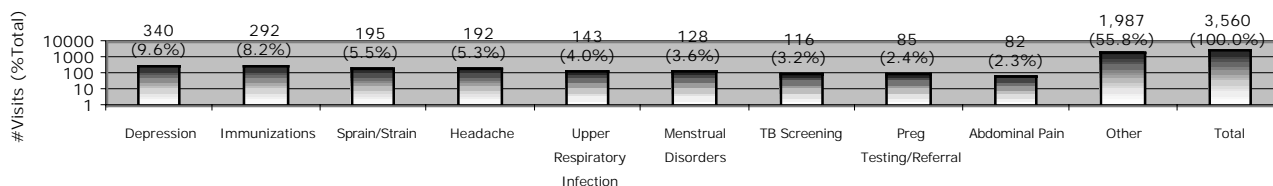
# SCHOOL-BASED HEALTH SERVICES

The following section details health service data limited to specific high schools within the SFUSD. While the studies apply most directly to the students in these high schools, the results may reflect to a limited extent health issues and concerns of the entire SFUSD high school population.

## MISSION HIGH SCHOOL HEALTH CENTER: VISIT DATA, 6/1/96 TO 5/31/97<sup>92</sup>

<u>PATIENTS</u>	<u>VISITS</u>	<u>% VISITS</u>		<u>VISIT TYPE</u>	<u>% TOTAL</u>
Total	4,868			Illness	74.2%
Female	2,815			Psych Counseling	23.9%
Male	2,053			Other	1.9%
<u>ETHNICITY</u>	<u>% TOTAL</u>			<u>VISIT TYPE</u>	<u>% TOTAL</u>
Latino	44.7%			Illness	74.2%
African American	19.5%			Psych Counseling	23.9%
Chinese	12.1%			Other	1.9%
Filipino	7.2%				
Other	16.4%				

## MISSION HIGH SCHOOL HEALTH CENTER: MOST COMMON DIAGNOSTIC CODES BY VISITS, 9/96 TO 6/97



<u>RISK FACTOR(6/96 to 5/97)<sup>93</sup></u>	<u>NUMBER</u>	<u>% TOTAL</u>
School Performance	1,384	15.8%
Family Relations	1,006	11.5%
Depression	864	9.9%
Self Esteem	706	8.1%
Abuse	677	7.6%
Stress	424	4.9%
Self Harm	396	4.5%
Peer Violence/Gangs	385	4.4%
Pregnancy	341	3.9%
Anxiety	297	3.4%
Other	2,252	25.8%
Total	8,732	100.0%

## BALBOA TEEN HEALTH CLINIC: SCHOOL HEALTH CLINIC SURVEY<sup>94</sup>

- In 1998, 123 survey Balboa High School students said the top 4 reasons for using the Balboa Teen Health Clinic were: no cost (81), confidential services (75), convenience (66), and likeable staff (59). Students listed the top 5 health issues for SF teens as 1) pregnancy, 2) sexually transmitted infections, 3) sex, 4) drugs, and 5) HIV/AIDS.

- <sup>1</sup> *Crossing the Boundaries Between Health and Education*. National Health/Education Consortium, convened by the National Commission to Prevent Infant Mortality and the Institute for Educational Leadership, 1990.
- <sup>2</sup> *National Action Plan for Comprehensive School Health Education*. Atlanta, GA: American Cancer Society, 1992.
- <sup>3</sup> Symons C.W. et al. *Bridging Student Health Risks and Academic Achievement Through Comprehensive School Health Programs*. *Journal of School Health*, August 1997, 67(6):220-227.
- <sup>4</sup> Blum R.W. et al. *Reducing the Risk: Connections That Make a Difference in the Lives of Youth*. *Division of Pediatrics and Adolescent Health*. University of Minnesota, 1997.
- <sup>5</sup> Neumark-Sztainer D. et al. *Psychosocial Correlates of Health Compromising Behaviors Among Adolescents*. *Health Education Research*, March 1997, 12(1):37-52.
- <sup>6</sup> *Code Blue: Uniting for Healthier Youth*. National Commission on the Role of the School and the Community in Improving Adolescent Health, convened by National Association of State Boards of Education and American Medical Association, 1990.
- <sup>7</sup> *Private School Affidavits*. District and School Support Program Unit, California Department of Education.
- <sup>8</sup> San Francisco Unified School District, 1998-99 Data.
- <sup>9</sup> Other Non-white category includes Indo-Chinese, Samoan, and Arabic groups.
- <sup>10</sup> The data for language groups by grade level was collected by aggregating the Home Language field in the Student Master File database for all active students for the total district and operational level Summaries. The Home Language field very often does not have a language code entered.
- <sup>11</sup> Includes Japanese, Laotian, Arabic, Other Chinese, Other Filipino, French, German, Greek, India Indian, Other Indo-Chinese, Italian, Portuguese, Russian, Samoan, Other Asian, and Other language groups.
- <sup>12</sup> San Francisco Unified School District, 1997-98 data.
- <sup>13</sup> Child Development Program Student Ethnicity Count, January 1999. Obtained from Gwendolyn Henry, SFUSD Child Development Program.
- <sup>14</sup> Brooks-Gunn J. and Duncan G.J.. *The Effects of Poverty on Children*. *The Future of Children*, 7(2):55-71, 1997.
- <sup>15</sup> Grant L.M., Demetriou E. *Adolescent Sexuality*. *Pediatric Clinics of North America*, 35:1271-1287, 1988.
- <sup>16</sup> Brooks-Gunn J et al., 1997.
- <sup>17</sup> County Estimates for Related Children Age 5 to 17 in Families in Poverty for California: 1995. U.S. Census Bureau.
- <sup>18</sup> Medi-Cal Program, County Population, Medi-Cal Eligibles, and Medi-Cal Eligibles as a Percent of Population, Calendar Year 1996. California Dept of Health Services.
- <sup>19</sup> Student Nutrition Services, San Francisco Unified School District, 1999.
- <sup>20</sup> Data provided by Student Nutrition Services, San Francisco Unified School District, 7/99.
- <sup>21</sup> San Francisco Housing Authority, data from March 1997.
- <sup>22</sup> Data prepared by Hoover Liddell, San Francisco Unified School District, 1997.
- <sup>23</sup> Symons C.W. et al., 1997.
- <sup>24</sup> Klerman L.V.. *School Absence—a Health Perspective*. *Pediatric Clinics of North America*, 35:1253-1269, 1988.
- <sup>25</sup> San Francisco Unified School District. Office of Planning, Research, and Evaluation.
- <sup>26</sup> Weitzman, M. and Siegel D.M.. *What We Have Not Learned from What We Know about Excessive School Absence and School Dropout*. *Developmental and Behavioral Pediatrics*, 13(1):55-58, 1992.
- <sup>27</sup> Average Daily Attendance = (#Days Present and #Days With Excused Absences)/(Total # Instructional Days).
- <sup>28</sup> Excused absences according to the State Education Code include 1) medical or dental appointment, 2) illness, or 3) funeral. % Excused Absences = #Excused Absences/Student Enrollment.
- <sup>29</sup> Barton W.H. et al.. *Youth and Communities: Toward Comprehensive Strategies for Youth Development*. *Social Work*, 42(5):483-493, 1997.
- <sup>30</sup> *Trends in the Well-Being of America's Children and Youth: 1996*. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Education.
- <sup>31</sup> *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*. US Department of Health and Human Services.
- <sup>32</sup> The drop-out rate was determined by searching the Student Master File database for students with activity codes of "W" (withdrawn) and with one of the six leave codes that indicate drop-out. Leave codes used: LM (Drop-out, moved, tried to locate); LX (Drop-out, no show in September); LP (Drop-out, pregnant); LU (Drop-out, confirmed drop-out); LR (Drop-out, runaway); LT (Drop-out, transitional status, under investigation). The drop-out rate for each school was calculated by dividing the number of drop-outs by the total number of active and withdrawn students at the school.
- <sup>33</sup> Rate per 1000 SFUSD students of the specific race/ethnicity category.
- <sup>34</sup> Borowsky I.W. and Resnick M.D.. *Environmental Stressors and Emotional Status of Adolescents Who Have Been in Special Education Classes*. *Archives of Pediatric and Adolescent Medicine*, 152:377-382, 1997.
- <sup>35</sup> Special Education Student Data Report. Prepared by Frank Morales, SFUSD, Department of Special Education, April 1999.
- <sup>36</sup> Data Report: School Mental Health Partnerships Teacher Reports on SED Children and Youth, 1996-97 School Year. San Francisco Department of Public Health, Community Mental Health Services Bureau.
- <sup>37</sup> Newacheck P.W. et al. *Health Insurance and Access to Primary Care for Children*. *New England Journal of Medicine*, 333(8):513-519, 1998.
- <sup>38</sup> *The Uninsured in California: Causes, Consequences, and Solutions*. Brown ER, Wyn R, and Levan R., UCLA Center for Health Policy Research, September 1997.
- <sup>39</sup> Based on Claritas 1995 Projection of 0-17 population of 122298 about 8.5% are uninsured or 7% of the uninsured SF population.
- <sup>40</sup> Bindman, Andrew, San Francisco County Estimates of Health Insurance, 12/19/97.
- <sup>41</sup> Total voters from each high school: Galileo HS 85 out of 1910; ISA 27 out of 512; Mission HS 58 out of 905; Balboa HS 186 out of 1385; Lincoln HS 479 out of 2314; Thurgood Marshall HS 713 out of 982; Washington HS 1171 out of 2455; Burton 524 out of 1607; McAteer HS 92 out of 1307; Wallenburg 258 out of 632; Lowell 462 out of 2534.
- <sup>42</sup> San Francisco Youth Vote: 1998 Election. Prepared by Coleman Advocates for Children and Youth, Youth Making a Change (YMAC), San Francisco Youth Commission, and San Francisco Peer Resources, 1998.
- <sup>43</sup> San Francisco Unified School District Medi-Cal Percentage for 98-99. Prepared by Mei Lam, LEA Medi-Cal Reimbursement Program. These percentages reflect eligibility over a period of 16 months (January 1998-April 1999). Therefore, the actual percentage for a particular day is lower. The SFUSD average/day is approximately 25% of students who are insured by Medi-Cal.

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- <sup>44</sup> Gortmaker S.L. et al. *Chronic Conditions, Socioeconomic Risks, and Behavioral Problems in Children and Adolescents*. Pediatrics, 85(3):267-276, 1990.
- <sup>45</sup> Perrin E.C., Ramsey B.K., and Sandler H.M.. *Competent Kids: Children and Adolescents with a Chronic Illness*. Child Care Health Development, 13:13-32, 1987.
- <sup>46</sup> Gortmaker S.L. et al, 1990.
- <sup>47</sup> San Francisco Medical Therapy Unit Database. California Children Services, 1999.
- <sup>48</sup> Other records either do not have any school data, or recipients have moved out of California, or are provided with home education.
- <sup>49</sup> 6% of clients acquired their condition due to trauma or injury. Other diagnoses include neoplasms, muscular dystrophies, and sickle cell anemia.
- <sup>50</sup> School Therapy Services Database. Designated Instructional Services, San Francisco Unified School District, 1999.
- <sup>51</sup> Coley R.L. and Chase-Lansdale P.L.. *Adolescent pregnancy and parenthood. Recent evidence and future directions*. American Psychologist, 53(2):152-66, 1998.
- <sup>52</sup> Neumark-Sztainer et al., 1997.
- <sup>53</sup> Blum R.W. et al., 1997.
- <sup>54</sup> Coley R.L. et al., 1998.
- <sup>55</sup> San Francisco County AVSS Birth Records. Vital Statistics Section of Population Health and Prevention Division, Dept of Public Health, 9/98.
- <sup>56</sup> *Teenage Live Births and Birth Rates by Race/Ethnicity and Age Range Within County, California 1997*. California Department of Health Services, Maternal and Child Health, Epidemiology Section, 4/99.
- <sup>57</sup> Denominator for birth rates taken from California Department of Finance population estimates for 1997.
- <sup>58</sup> San Francisco Unified School District Youth Risk Behavior Survey, 1997.
- <sup>59</sup> SF Teenage Pregnancy & Parenting Project. Data prepared by Lisa Gordon, May 1999.
- <sup>60</sup> Based on milestone reporting forms, completed for clients at intake, at pregnancy outcome, and every 6 months thereafter.
- <sup>61</sup> Transportation barrier refers to lack of transportation to either school or child care; child care barrier refers to unavailability of affordable child care; educational barrier refers to lack of appropriate school program (i.e. ESL, Special Ed), limited enrollment positions, etc.; psycho-social barrier refers to personal safety concerns, homelessness, domestic violence, family/cultural issues, etc.; medical barrier refers to physical or mental health problems of the client or any of her children.
- <sup>62</sup> Teitelbaum M. A. et al.. *Immunization and Vaccine-Preventable Illness, United States, 1992-1997*. Statistical Bulletin/Metropolitan Insurance Companies, 80(2):13-20, 1999.
- <sup>63</sup> Kindergarten Retrospective Surveys. San Francisco Dept of Public Health and California Dept of Health Services, 1996.
- <sup>64</sup> Immunization Screenings, Compliance and Non-Compliance Fall 97, Fall 98. San Francisco Unified School District, School Health Programs Department.
- <sup>65</sup> San Francisco Unified School District Youth Risk Behavior Survey, 1997.
- <sup>66</sup> Waldman H.B.. *More Children Are Unable to Get Dental Care Than Any Other Single Health Service*. Journal of Dentistry for Children, 65(3):204-208, 1998.
- <sup>67</sup> *The Oral Health of California Children*. California Department of Health Services, California Wellness Foundation, 1997.
- <sup>68</sup> *Child Health USA 1998*. U.S. Department of Health and Human Services, Health Resources and Services Administration, and Maternal and Child Health Bureau, 1998.
- <sup>69</sup> Screenings were performed with tongue blades and flashlights, and no x-rays. This form of screening generally underestimates the level of untreated decay.
- <sup>70</sup> 1996/97 Dental Screening Program Results. SF Dept of Public Health, Dental Programs, 1996/97.
- <sup>71</sup> 1996/97 Dental Screening Program Results, 1996/97.
- <sup>72</sup> Balboa Teen Health Clinic. Report prepared by Maureen McCarthy, May 1999.
- <sup>73</sup> Mielck A et al. *Severity of Childhood Asthma by Socioeconomic Status*. International Journal of Epidemiology, 25(2):388-393, 1996.
- <sup>74</sup> Lin S. et al. *Asthma Hospitalization Rates and Socioeconomic Status in New York State (1987-1993)*. Journal of Asthma, 36(3):239-251, 1999.
- <sup>75</sup> Celano M.P. and Geller R.J.. *Learning, School Performance, and Children with Asthma: How Much at Risk?* Journal of Learning Disabilities, 26(1):23-32, 1993.
- <sup>76</sup> Family Health Outcomes Project. Epi HOSP Data Set, 1996.
- <sup>77</sup> Condition Critical: The Bayview/Hunters Point 94124 School and Community Asthma Survey Report. The Bayview/Hunters Point Health Start Program, The Asthma Task Force, San Francisco State/City College, San Francisco Unified School District. May 1999.
- <sup>78</sup> Millstein S.G. et al.. *Promoting the Health of Adolescents: New Directions for Twenty-First Century*. Oxford University Press, New York, 1993.
- <sup>79</sup> Neumark-Sztainer D. et al., 1997.
- <sup>80</sup> Symons C.W. et al., 1997.
- <sup>81</sup> Neumark-Sztainer et al., 1997.
- <sup>82</sup> Blum R.W. et al., 1997.
- <sup>83</sup> *1997 Youth Risk Behavior Survey Middle and High School Level Summary Report*. San Francisco Unified School District, School Health Programs Department.
- <sup>84</sup> San Francisco Unified School District Youth Risk Behavior Survey, 1997.
- <sup>85</sup> Family Health Outcomes Project, Epi HOSP Data Set, 1996.
- <sup>86</sup> San Francisco Unified School District Youth Risk Behavior Survey, 1997.
- <sup>87</sup> San Francisco Unified School District Youth Risk Behavior Survey, 1997.
- <sup>88</sup> San Francisco Unified School District Youth Risk Behavior Survey, 1997.
- <sup>89</sup> Unpublished data from STD Prevention & Control, SF Dept. of Public Health. Prepared by Jeffrey Klausner, M.D., MPH, STD Prevention & Control.
- <sup>90</sup> San Francisco Unified School District Youth Risk Behavior Survey, 1997.
- <sup>91</sup> San Francisco Unified School District Youth Risk Behavior Survey, 1997.
- <sup>92</sup> Mission High School Health Center Data Report, 1996-1997.
- <sup>93</sup> Risk factors identified by clinic providers during client visits.
- <sup>94</sup> Balboa Teen Health Clinic, School Health Clinic Survey. Prepared By Maureen McCarthy, 1998.