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ABSTRACT

In the quest to establish public programs for reducing pregnancy, childbearing, and sexually transmitted diseases among adolescents, much attention has been given to family life education as a piece of the prevention paradigm. Research has shown that family life education that includes accurate and age-appropriate information will increase young people's knowledge about human sexuality. Its effects on attitudes and behaviors, however, depends largely on how, by whom, and for how long the curriculum is taught. For states and communities interested in implementing a family life education program that will help adolescents synthesize that knowledge into appropriate skills and behaviors, the literature provides a number of elements essential to any school-based effort: (1) build on an abstinence base; (2) include information on pregnancy prevention; (3) build skills to say no to sexual activity or unprotected intercourse; (4) help understand why to say no; (5) start at an early age; (6) include as part of a sequential health framework; (7) use peer educators; (8) promote parents as sex educators; (9) include the entire community in the intervention; (10) provide direct linkages to health services; and (11) use well-trained educators in the classroom. States can facilitate the development of programs by providing a clear policy; providing technical assistance; monitoring local districts to ensure implementation; and providing funding and human resources for teacher training and materials development. (ABL)

Southern Governors Association

ISSUE BRIEF

Southern Legislative Conference

REALIZING *the* PROMISE *of* FAMILY LIFE EDUCATION

Southern Center on Adolescent Pregnancy Prevention

Southern Regional Project on Infant Mortality

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Executive Summary

In the quest to establish public programs for reducing pregnancy, childbearing, and sexually transmitted diseases among adolescents, much attention has been given to family life education as a piece of the prevention paradigm. In the last decade, a variety of family life education approaches have been studied to determine the impact of school-based programs on sexuality knowledge, attitudes, opinions, and behaviors among adolescents. The essence of this research is clear: family life education that includes accurate and age-appropriate information will increase young peoples' knowledge about human sexuality. Its effect on attitudes and behaviors, however, depends largely on how, by whom, and for how long the curriculum is taught. For states and communities interested in implementing a family life education program that will help adolescents synthesize that knowledge into appropriate skills and behaviors, the literature provides a number of elements essential to any school-based effort:

- Build on an abstinence base;
- Include information on pregnancy prevention;
- Build skills to say no to sexual activity or unprotected intercourse;
- Help understand why to say no;
- Start at an early age;
- Include as part of a sequential health framework;
- [illegible] educators;
- Promote parents as sex educators;
- Include the entire community in the intervention;
- Provide direct linkages to health services;
- Use well-trained educators in the classroom.

States can facilitate the development of family life education programs at the local level by:

- Providing a clear policy on family life education;
- Providing local communities with technical assistance to build broad-based support;
- Monitoring local districts to ensure implementation; and
- Providing funding and human resources for teacher training, and materials development.

Realizing the Promise of Family Life Education

family life education—*a curriculum, program or framework for helping young people make responsible choices and decisions by providing accurate and age-appropriate information about human sexuality and by exploring the attitudes, behaviors, and value systems that shape the development of healthy sexuality.*

Family life education. Human growth and development. Healthy living. Sex education. The titles alone reflect the unique and diverse approaches taken by our public schools to instruct young people about their sexuality. As the incidence of adolescent pregnancy and childbearing continues to persist and the threat of AIDS looms as much in our school hallways as on our urban streets, policymakers across the country are struggling with identifying and implementing a curriculum which best reflects the values of its community while meeting the needs of its youth.

With its disproportionately high incidence of adolescent pregnancy and childbearing, policymakers across the South are acutely sensitive to the need for addressing this problem. Regional leadership summits, convened in 1989 and 1990 with the task of crafting infant mortality and adolescent pregnancy prevention strategies for the South, identified family life education as a vital component for reducing unwanted pregnancies to adolescents. The acknowledgement from state lawmakers, governors' staff, and public health officials echoes the endorsement of family life education for all children and young people received by a growing list of national, state, and community organizations.

Family life education does indeed merit consideration from state and community policymakers. The ability of family life education to impart accurate and age-appropriate information about human sexuality is nearly undisputable. The promise of preventing early sexual activity and its consequences is, however, less clear. Not until the complexities of adolescent sexual behavior—and the impact of education programs on that behavior—are fully understood, can this promise be realized. This report examines the changing focus and intent of family life education, particularly in the direction of adolescent pregnancy prevention, and highlights important evaluative research on promising school-based approaches ●

The Changing Face of Family Life Education

Perhaps no other public education curriculum has endured as much controversy and metamorphosis as family life education. The focus and intent of human sexuality education has been, and remains today, subject to society's changing attitudes and norms regarding sexual behavior. At the turn of the century, educators expounded on anti-sexual themes, associating masturbation and premarital intercourse with a loss of self-control. Classroom time in the `40s and `50s was devoted to preparation for marriage and family life, including parenting skills, reproduction, hygiene, and venereal disease prevention (Strouse & Fabes, 1985). The "youth revolution" of the `60s, coupled with growing attention during the `70s to adolescent childbearing and its link to missed opportunities and poverty, gave rise to a human sexuality education movement. Educators sought to incorporate the emotional, social, psychological and spiritual aspects of sexuality into the reproductive and biological "facts only" approach of sex education past (Scales, 1989).

Family life education has evolved rapidly over the last decade to meet the demands of our ever-changing, pluralistic society. Faced with the inordinate challenge of preventing unintended pregnancy and early parenthood, exposure to AIDS and other sexually transmitted diseases, and sexual exploitation and abuse among its youth, communities across the country gave schools overwhelming support for addressing these pressing social issues in the classroom. No longer just human anatomy and reproductive functioning, school-based programs became forums for promoting positive health practices, critical thinking, and values clarification. Classrooms became laboratories for building skills in communication, responsible decision-making, and assertiveness.

The demands and expectations of family life education today far exceed those of sex education in decades past. The increase in sexual activity among adolescents, and the resulting increases of sexually transmitted diseases, pregnancies, abortions, and childbearing to this same population, have placed enormous pressure on education programs to produce measurable changes in young people's behaviors. But is this expectation realistic? Is family life education an effective vehicle for changing sexual attitudes and behaviors? ●

The Impact of Family Life Education: Understanding its Limitations

The last decade of research and evaluations has enabled educators and policymakers to better understand the value, as well as the limitations, of family life education programs.

From conventional textbook approaches to the more comprehensive, skills-focused programs, researchers have examined a wide range of programs to determine the variables most likely to produce desired changes in adolescent sexual attitudes and behaviors. Because the research-based models vary in course objectives, topic areas, instruction methodology, time commitment, targeted age groups and socioeconomic levels, it is difficult to make broad generalizations about family life education as a whole. However, three important themes seem to emerge consistently across the literature:

- Family life education programs increase knowledge about important health and sexual matters;
- Family life education programs do not appear to have any significant effects on values that guide sexual behavior; and
- Adolescents' attitudes or opinions regarding sexuality are not always consistent or congruent with their behaviors.

The research implies that family life education—in any form—is crucial to providing facts and accurate information about human sexuality. The intrinsic value of its cognitive impact cannot be understated: knowledge-based family life education programs dispel myths and misconceptions regarding sexuality, and give young people information that is essential to their full human development (Kirby, 1989; Scales, 1989).

Research also suggests that most young people come into family life education with appropriate and responsible attitudes toward sexuality (Zabin et al., 1984). Why then have family life education programs been unable to demonstrate significant contributions in changing sexual behaviors? The complexities of adolescent sexuality, and the numerous, competing forces in shaping it create an enormous challenge for school programs. Parental and cultural values, peer pressure, sexual desire, aspirations for the future, and availability of contraception are among the many influences on sexual behavior (Kirby, 1989). Coupled with the powerful influence of the media, especially television (Strouse & Fabes, 1985), education experts question the impact of knowledge-based classroom programs alone on countering negative, and reinforcing positive factors that influence an individual's sexual attitudes and behaviors. Their contention is supported by the growing number of public initiatives showing positive results through unconventional classroom approaches ●

. . . Capitalizing on its strengths

Classrooms have the potential to be more than "facts of life" purveyors. Contributions from the research community reveal a number of strategies and methodologies useful in directing and assessing school-based family life education programs in the South. States and communities interested in

Correction: Postponing Sexual Involvement (PSI) is an abstinence-based program that evolved out of, and continues to incorporate, family planning education. The author incorrectly reported that this component was added subsequent to PSI's implementation.

establishing, as well as achieving, realistic family life education goals must be challenged by the limitations of traditional programs and capitalize on the promise of others. If one of our objectives is to change risk-taking sexual behaviors, we must continue to expand what we know about adolescent sexuality and alter our approaches to reaching young people based on that knowledge ●

Promising family life education should:

Build on an Abstinence Base

Postponing sexual intercourse until a person is psychologically and emotionally ready is a universally held value that should be the foundation of any family life education program. The message needs to be delivered early and in tandem with communication and assertiveness skills building. Just saying "no" to adolescent sexuality is an "imprecise and insufficient" (Blonna, 1990) communication vehicle because it denies any form of sexual expression. Saying no should be a starting point only. Emphasis should be placed on why the message is being promoted, which forms of sexual expression are to be rejected, and how to communicate that rejection.

Postponing Sexual Involvement (PSI), out of Grady Memorial Hospital in Atlanta, is one model that has successfully incorporated these concepts into its sexuality education program for eighth graders. Postponing Sexual Involvement is designed to help junior high students understand the reasons for postponing sexual activity, the motivations behind why young people become sexually active, and the communication skills necessary for resisting sexual activity. Matched with older students, young people get opportunities to role play situations where they may find themselves at risk and to rehearse refusal skills. Evaluations indicate significant delays in sexual involvement among young women and men who participate (Howard & [illegible]be, 1990).

With the establishment of the federal adolescent pregnancy prevention demonstration grant program (the Adolescent Family Life Act), significant attention has been given to the effectiveness of "abstinence only" education programs (see Mecklenburg & Thompson, 1983). Conclusions from several projects indicate that these programs can positively influence attitudes regarding abstinence. They have not yet demonstrated, however, any impact on sexual behaviors, with the exception of one program which actually resulted in increased sexual activity among young boys (Roosa and Christopher, 1990; Christopher and Roosa, 1990). Because we know that responsible adolescent attitudes toward sexuality are not necessarily consistent with responsible behaviors (Zabin et al, 1984), the education and research fields must direct more attention to the long-term behavioral impact of "abstinence only" programs ●

Include Information on Pregnancy Prevention

The inability of conventional family life education to reduce adolescent pregnancy and childbearing can be attributed, in part, to the lack of information on pregnancy prevention: family planning and birth control instruction are rarely part of school-based programs (Barth et al, 1989). Family life education programs that do not provide information on pregnancy prevention and family planning fail to address the needs of adolescents who decide to become sexually active, or who are already active at program start. National data indicate that over half of the young people in this country are sexually active in their teens (National Center for Health Statistics).

Information on the variety of family planning methods and their limitations helps young people recognize the value of contraception as a means for protection from pregnancy and disease (Dawson, 1986; Kirby, 1989; Marsiglio & Mott, 1986; Stout & Rivara, 1989), and increases the likelihood that they will use contraceptives at first intercourse (Howard & McCabe, 1990; Eisen, M., Zellman, G., & McAlister, A., 1991). Without appropriate information, adolescents are less likely to protect themselves from pregnancy and sexually transmitted diseases when sexual activity is initiated.

Does providing information about contraceptives conflict with or diminish the message that abstinence is a valued and important expression of one's sexuality? The Postponing Sexual Involvement program says "no". When program developers recognized that PSI had no effect on adolescents sexually active prior to program start, and that many young people exposed to the program still became sexually active in high school, a contraception unit was incorporated. Researchers discovered that participants were capable of integrating both messages: they were more likely than their peers to abstain from sex and were more likely to use contraceptives at first intercourse (Howard & McCabe, 1990) ●

Build Skills to Say No

Deciding when, and knowing how, to say "no" to sexual activity or unprotected intercourse requires skills in responsible decision-making, interpersonal communication, and assertiveness. Family life education interventions which utilized these classroom approaches found a combination cognitive/skills training approach effective in improving attitudes and behaviors regarding contraception among high schoolers (see Reducing the Risk: Building Skills to Prevent Pregnancy, Barth, et al, 1989; Life Skills Counseling Program, Schinke, et al 1981). Educators employed problem-solving techniques to help students identify the range of options in making decisions about sexual activity, to understand the value of those options, and to select the choice that makes the most sense to them. Role playing and rehearsing facilitated the use of social skills—dealing

with peer pressure and saying no to unwanted or unprotected intercourse—and gave students a sense of success in managing their sexuality ●

Help Understand Why to Say No

Young people are inundated with ubiquitous sexual images and messages, yet have limited opportunities to explore their implications. Consequently, this sexual stimulus, combined with the "just say no" message, creates great confusion. Examining one's family, religious and cultural values, as a component of family life education, helps young people sort through the barrage of confusing, mixed messages they receive daily about human sexuality. Why does our society stimulate young people sexually and then chastise them for sexually acting out? Why do some social institutions value sex solely as an expression of marital love? Why do adults want adolescents to abstain from early, unprotected, sexual intercourse? What are the consequences of sexual intercourse for you and your partner? Students should be invited to discuss these values and examine their contribution to the students' own value systems. This study of values will not change young people's attitudes toward sex, but it can facilitate insights into the motivation behind others' behaviors, make them more understanding of people with values different from theirs, and change inaccurate perceptions of peer groups regarding sex (Scales, 1987; Trussell, 1988; Kirby, 1989) ●

Start Early

Perhaps the strongest message from family life education research is that most programs aren't starting early enough.

Consider:

- the influence of the popular media on children's attitudes or;
- puberty and the surmounting peer pressure to explore sexual feelings associated with it are facts of life for middle school-aged children or;
- the age of sexual initiation appears to be decreasing, as evidenced by the growing number of pregnancies to girls under the age of 15 or;
- abstinence-based programs showed no impact on the behaviors and attitudes of students already sexually active at the start of programs.

It should be no surprise that children are naturally curious about their sexuality even in the elementary school years. It seems only logical that an appreciation and respect for postponing sexual involvement should begin before sexual decision-making becomes a reality. Most family life programs do not introduce frank discussions about sexual decision making, if at all, until high school. Developmentally-appropriate objectives for middle level students can include: understanding the value of postponing sexual involvement; understanding human reproduction and the importance of preventing unwanted pregnancies; practicing refusal skills; recognizing appropriate and inappropriate dating and interpersonal behaviors; and recognizing personal, family and career goals (Delaware State Board of Education, 1990) ●

Be Part of a Sequential Health Framework

The school setting has enormous potential for influencing responsible, healthy behaviors and attitudes through school-based health education. Comprehensive health education, the most appropriate and logical setting for family life, provides a meaningful context to human growth, sexuality, and other health-related issues consistently and sequentially across every grade level. Beginning with basic wellness concepts in the early years (hygiene, safety, feelings, and family, for example), and building sequentially each additional year, vital health information and wellness messages are positively and continually reinforced to help young people take ownership for their own health.

The health education framework is also a logical choice for integrating the increasing demands placed on schools to provide topical education on AIDS/HIV, alcohol and other drug use, child abuse, and adolescent pregnancy prevention ●

Use Peer Educators

The concept of using peers as health educators has become a popular mechanism for reaching out to younger children with information and support on difficult issues like AIDS, substance abuse, suicide prevention, and pregnancy prevention. Program administrators feel that young people can relate to each other better, and that health information from peers might be better synthesized. Aside from information-sharing, peer educators also serve as models of positive health behaviors and attitudes.

The success of Postponing Sexual Involvement (PSI) in producing attitudinal and behavioral changes is attributed largely to the use of peer educators. Older students discuss peer pressure, explore the motivations behind it, and assist with developing techniques for resisting it. The peers model communication and assertiveness skills that are rehearsed by the younger students. The older students also provide positive role models who affirm abstinence as an accepted choice. Program evaluations indicate that students involved in PSI are more likely to postpone sex than their counterparts ●

Promote Parents as Sex Educators

Including parents in the family life education process is an absolute win-win situation. It can facilitate important parent-child dialogue, assuage parental fears regarding sexuality education, and strengthen the role of parent as primary sexuality educator. Parental influence in the development of children's sexual attitudes and behaviors can be powerful: research suggests that discussions

	FLE State Policy	Required for which grades?	Focus on pregnancy prevention	Teacher training
Alabama	Mandate	K-8/one health unit 9-12	Comprehensive	State Department of Public Health
Arkansas	Mandate	K-8/one health unit 9-12	Abstinence-based	
Delaware	Mandate	K-8/ 1/2 health unit 9-12	Comprehensive	Voluntary in-service teacher seminar
District of Columbia	Mandate	K-10	Comprehensive	In-service training/ graduate credit for recertification
Florida	Mandate	6-8	Comprehensive	State Department of Education
Georgia	Mandate	K-8/one health unit 9-12	Comprehensive	
Kentucky	Local Option		Abstinence-based	State Department of Education
Louisiana	Local Option		Abstinence-based Grades 7-12 only	
Maryland	Mandate	K-8	Local Control	
Mississippi	Local Option		Abstinence-based	
Missouri	Local Option		Local Control	By request through universities' extension services
North Carolina	Mandate	K-9	Local Control	
Oklahoma	Local Option		Local Control	By request through Planned Parenthood
Puerto Rico*	No Information available			
South Carolina	Mandate	6-8/one health unit 9-12	Local Control	State Department of Education Graduate coursework- state conference
Tennessee		K-8/one health unit 9-12	Abstinence-based	By request through State Department of Education
Texas	Local Option		Local Control	
Virginia	Mandate	K-8/one health unit 9-12	Comprehensive	State/Local Education Departments
Virgin Islands	Mandate	K-12	Abstinence-based	
West Virginia	Mandate	6-12	Local Control	Voluntary training through state

Mandated for school districts with adolescent pregnancy rate of 19.5 or higher for 15-17 age group. Data not yet available at press

of sexual matters can influence the delay of sexual activities (Darling & Hicks, 1982), or increase the use of contraceptives (Casper, 1990). Despite the fact that adolescents regard their parents as the most important source of information on issues pertaining to sexuality (Wattleton, 1987), only a third of the adolescents polled actually reported any such instruction.

Schools can be catalysts for improved parent-child communication by including parents in the family life education process. Aside from notifying parents that their child's participation in the family life program requires approval, few programs encourage parental involvement. Examples of such involvement include parent teaching seminars to give parents accurate information and strategies for reinforcing the postponement of sexual involvement, and classroom assignments which require parent/child discussions. Select studies of programs that included take-home assignments to facilitate parent-child communication indicate that parents appreciate the opportunity to talk about sexuality issues initiated by the family life education program, and report improved communication with their child ●

Include the Entire Community

School districts successful in implementing comprehensive family life education are quick to note the extreme importance of the community's participation in its development from the ground up. Active communities develop a sense of ownership and responsibility for their youth's development, while sending principals and teachers a clear message of support for their work in the classroom.

Health and education leaders in Denmark, South Carolina (Vincent & Dod, 1989), rallied every sector of their community to help promote the postponement of sexual activity and effective contraceptive use among its young people. "Children having children detracts from good health and is not conducive to a happy and successful future" was the prevailing theme of the community's broad-based, multi-leveled education and health services strategy. Parents, teachers, and civic, religious and community leaders underwent intensive family life and sex education to

augment instruction in the home, churches and schools. Extensive media events and trained peer educators helped reinforce the program's theme. Health education, which emphasized the value of postponing sex, was tied closely to community preventive health services so that adolescents who chose otherwise could access family planning services. This intensive community intervention reduced local pregnancy rates over a four year period by nearly half, while comparison counties recorded increases in the same period ●

Provide Linkages to Health Services

Linking family life education to reproductive health and family planning services can have a positive impact on the use of contraceptives by young people, according to several studies that found improved changes in contraceptive use among program participants (Dryfoos, 1990). The unique link between medical clinic staff— whether school nurse or public health provider—and the classroom brings valuable resources to young people who might not have access to health professionals: health care workers provide instruction on family life issues, counsel on individual health needs, and provide accessible, confidential health care services. Results from several clinic programs around the country indicate increased clinic use for primary preventive health and family planning services (if available), a delay in initiating first intercourse among young women, improved contraceptive use among sexually active teens, and decreases in pregnancy and childbearing rates among participants ●

Include Well-trained Educators

The success or failure of any education program lies largely with the commitment and expertise of the instructor. This seems especially true of family life education. Given the sensitive nature of family life content, teachers should be well-trained and supervised to cover the gamut of human sexuality issues comfortably and completely. A study of health education relating teacher preparedness to program success found that instructors receiving what researchers called "full training" were more committed to program content and covered a greater percentage of the curricula than those receiving partial or no training (Fors & Doster, 1985). Seemingly logical, and documented as fact, an investment in teacher training is an investment in effective education ●

Policy Directions for Southern States

Family life education in southern states and across the country has been plagued by a variety of barriers that have prevented its widespread implementation. Fear among a minority of community members regarding family life and its potential for undermining parental religious values, misperceptions about content matter, local school autonomy, poor teacher training, and inadequate resources have contributed to preventing the development of effective family life education programs (Southern Regional Project on Infant Mortality, 1990).

Despite increased attention from states—nearly 70% of the states in the southern region have mandated family life education—many communities have been reluctant to address the establishment of a comprehensive family life education program. Although state mandates give hesitant communities sanction to establish a family life education program, directives do not always result in effective programming at the classroom level.

States should play a more significant role in supporting family life education by:

Providing a clear policy on family life education, including a framework of goals and objectives with prescribed coverage of subject matter, minimum time commitment for each grade level, and detailed guidelines for curricula. Vital issues in health and family life education should be afforded similar standards as traditional coursework to ensure consistent implementation across communities.

Providing local communities with technical assistance to build broad-based support for realizing family life education goals. Organizing communities in support of school-based programs requires specific knowledge of coalition-building, media relations, and curriculum development, skills which many communities lack.

Monitoring local districts to ensure implementation. Despite directives for state-wide programming, some communities simply are not complying, reveal adolescent pregnancy prevention advocates from across the region. The state can play a greater role in overseeing or enforcing mandates. Incentives—financial or technical assistance - can be developed to facilitate implementation.

Providing funding and human resources for teacher training, and materials development. Perhaps the greatest challenge for local school districts is meeting state mandates for curriculum development without resources or training opportunities for teachers. Teacher training is the most critical element of ensuring a successful school-based program. A report on sex education in America found that 80% of sex education instructors needed more assistance with teaching strategies, classroom materials, and professional development (The Alan Guttmacher Institute, 1989).

The promise of family life education as a component of the adolescent pregnancy prevention paradigm is not out of reach for any school or community. The elements identified in this report are not arbitrary recommendations for achieving program success, but rather a guide for maximizing the effectiveness of school-based approaches through studied, research-based models. The implications are clear: effective family life education requires more than textbooks and lectures. Innovative teaching approaches that 1) target children and youth at every grade level with comprehensive, age-appropriate learning experiences, and 2) link them to

their families and communities will yield the greatest rewards. We must also be realistic in our expectations of family life education. The knowledge, skills and attitudes gained through education should guide them so the choices children and adolescents make regarding their own sexuality are healthy, informed and thoughtful ●

Family Life Education Resources

To obtain information about family life education curricula, professional resources, and teacher training resources, contact:

The Center for Early Adolescence
University of North Carolina at Chapel Hill
Suite 211 Carr Mill Mall
Carrboro, North Carolina 27510
(919) 966-1148

Education Development Center
55 Chapel Street
Newton, Massachusetts 02160
(617) 969-7100

ETR Associates/Network Publications
Post Office Box 1830
Santa Cruz, California 95061-1830
1 (800) 321-4407

New Jersey Network for Family Life Education
Rutgers University
Building 4087
Kilmer Campus
New Brunswick, New Jersey 08903
(201) 932-7929

Rocky Mountain Center for
Health Promotion and Education
7500 West Mississippi Avenue
Suite 230
Lakewood, Colorado 80226
(303) 934-1814

Sex Information and
Education Council of the U.S.
130 West 42nd Street
Suite 2500
New York, New York 10036
(212) 819-9770

Bibliography

The Alan Guttmacher Institute (1989). Risk and Responsibility: Teaching Sex Education in America's Schools Today, New York.

Barth, R., Middleton, K., & Wagman, E. (1989). A skill building approach to preventing teenage pregnancy. *Theory Into Practice, 28* (3), 183-190.

Blonna, R. (1990). Just say no: imprecise and insufficient. *Family Life Matters, 10*, 1.

Casper, L. (1990). Does family interaction prevent adolescent pregnancy? *Family Planning Perspectives, 22* (3), 109-114.

Christopher, F. & Roosa, M. (1990). An evaluation of an adolescent pregnancy prevention program: is "Just Say No" enough? *Family Relations, 39*, 38-72.

Darling, C. & Hicks, M. (1982). Parental influence on adolescent sexuality: implications for parents as educators. *Journal of Sex Research, 11* (8), 256-270.

Dawson, D. (1986). The effects of sex education on adolescent behavior. *Family Planning Perspectives, 18* (4), 162-170.

Delaware State Board of Education (1990). Recommended Plan for a Comprehensive Family Life Education Program K - 12: A report to the House Committee on Human Resources.

Dryfoos, J. (1990). *Adolescents at Risk: Prevalence and Prevention*. Oxford University Press: New York.

Eisen, M., Zellman, G., and McAlister, A. (1990). Evaluating the impact of a theory-based sexuality and contraceptive education program. *Family Planning Perspectives, 22* (6), 261-271.

Fors, S. & Doster, M. (1985). Implications of results, factors for success. *Journal of School Health*. 55 (8), 332-334.

Howard, M. & McCabe, J.B. (1990). Helping teenagers postpone sexual involvement. *Family Planning Perspectives, 22* (1), 21-26.

Kirby, D. (1989). Sex education programs and their effects. *The World and I*, September, 591-604.

Marsiglio, W. & Mott, F. (1986). The impact of sex education on sexual activity, contraceptive use and premarital pregnancy among American teenagers. *Family Planning Perspectives. 18* (4), 151-162.

Mecklenburg, M., & Thompson, P. (1983). The Adolescent Family Life Program as a prevention measure. *Public Health Reports, 98* (1), 21-29.

National Center for Health Statistics, National Survey of Family Growth, 1982-1988.

Roosa, M. & Christopher, F. (1990). Evaluation of an abstinence-only adolescent pregnancy prevention program: a replication. *Family Relations, 39*, 363-367.

Scales, P. (1981). Sex education in the '70s and '80s: accomplishments, obstacles, and emerging issues. *Family Relations, 30*, 557-566.

Scales, P. (1989). Overcoming future barriers to sexuality education. *Theory Into Practice, 28* (3), 172-176.

Scales, P. (1987). Sex education policies and strategies: lessons for legislators. *Youth Policy*, November, 3-6.

Schinke, S., Blythe, B., & Gilchrist, L. (1981). Cognitive behavioral prevention of adolescent pregnancy. *Journal of Counseling Psychology, 28*, 451-454.

Southern Regional Project on Infant Mortality (1990). "Adolescent Pregnancy in the South: A Mandate for Leadership". Washington, D.C.

Stout, J. & Rivara, F. (1989). Schools and sex education: does it work? *Pediatrics, 83*, 375-379.

Strouse, J. & Fabes, R. (1985). Formal verses informal sources of sex education: competing forces in the sexual socialization of adolescents. *Adolescence, 20* (78), 251263.

Trussell, J. (1988). Teenage pregnancy in the United States. *Family Planing Perspectives, 20* (6), 262-272.

Vincent, M. & Dod, P. (1989). Community and school based interventions in teen pregnancy prevention. *Theory Into Practice. 28* (3), 191-197.

Wattleton, F. (1987). American teens: sexually active and sexually illiterate. *Journal of School Health, 57* (9) 379-380.

Zabin, L., Hirsch, M., Smith, E., & Hardy, J. (1984). Adolescent sexual attitudes and behavior: are they consistent? *Family Planning Perspectives, 16* (4), 181-85.

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Maternal and Child Care Section
North Carolina Division of Health Services

Cassandra Jackson, Sc.D.
Community Service Council (Oklahoma)

No Appointee
South Carolina

Richard Light, M.D.
Chief Medical Officer
Tennessee Department of
Health and Environment

Walter Peter, M.D., Bureau Chief
Maternal and Child Health
Texas Department of Health

Jean C. Bruce
Executive Director
The Planning Council (Virginia)

Joyce LeBron
Coordinator of Adolescent Pregnancy
Prevention Programs
Virgin Islands Department of Health

Nancy Tolliver, R.N., M.S.I.R.
Director
West Virginia Office of Community Health
Services

Legislative Appointments

The Honorable **Nick Jeralds**
Member
North Carolina House of Representatives

The Honorable **Lois DeBerry**
Speaker Pro Tem
Tennessee House of Representatives

The Honorable **Nancy McDonald**
Member
Texas House of Representatives

The Honorable **Joan Munford**
Member
Virginia House of Delegates

Community Leaders

Vanella Crawford
SPIRIT Project Director
Congress of National Black Churches

Barbara Huberman, M.Ed.
Executive Director
North Carolina Coalition on
Adolescent Pregnancy

Ray O'Brien
Children's Defense Fund

Truman Thomas, CSW
Lemmon Avenue Bridge
(Texas)

Southern Regional Project on Infant Mortality

Tamara Lucas Copeland,
Director

Shelly Gehshan,
Deputy Director

Cathy McGovern,
Administrative Assistant

Southern Center on Adolescent Pregnancy Prevention

John J. Schlitt,
Coordinator

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