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ABSTRACT

The 1994 Nebraska Governor's round table subcommittee established the goal of lowering teenage pregnancies in the state by the year 2000. School nurses are in key positions to provide continuous support and surveillance of adolescent health through graduation. This publication presents guidelines and resources to encourage and assist school nurses across the state of Nebraska to fulfill the objectives of Nebraska Year 2000. These guidelines and resources are written with the intent of providing school nurses with additional information as they advocate for male and female adolescents in confronting issues of adolescent pregnancy. Materials presented here include: (1) Nebraska Year 2000 health goals related to sexual activity; (2) teen pregnancy statistics nationwide and in Nebraska; (3) discussion of the roles of parents, adolescents, health care providers and school system in making decisions about teen pregnancy; (4) discussion of cultural competency to address racial and ethnic minorities; (5) overviews of four prevention strategies identified as successful pregnancy intervention programs; (6) resources for strategies used in Nebraska; (7) the role of the school nurse; and (8) legal issues impacting adolescents. Bibliographical materials include an annotated resources list, current reading list, bibliography, and a resources list. Eleven appendices include statistical data, surveys, and other resources for school nurses. (JPB)

Roles For School Nurses in Adolescent Pregnancy Prevention Intervention and Support

ROLES FOR SCHOOL NURSES
IN
ADOLESCENT PREGNANCY

PREVENTION, INTERVENTION AND SUPPORT

DEVELOPED BY

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ADOLESCENT PREGNANCY PREVENTION AD HOC COMMITTEE
1994-1995

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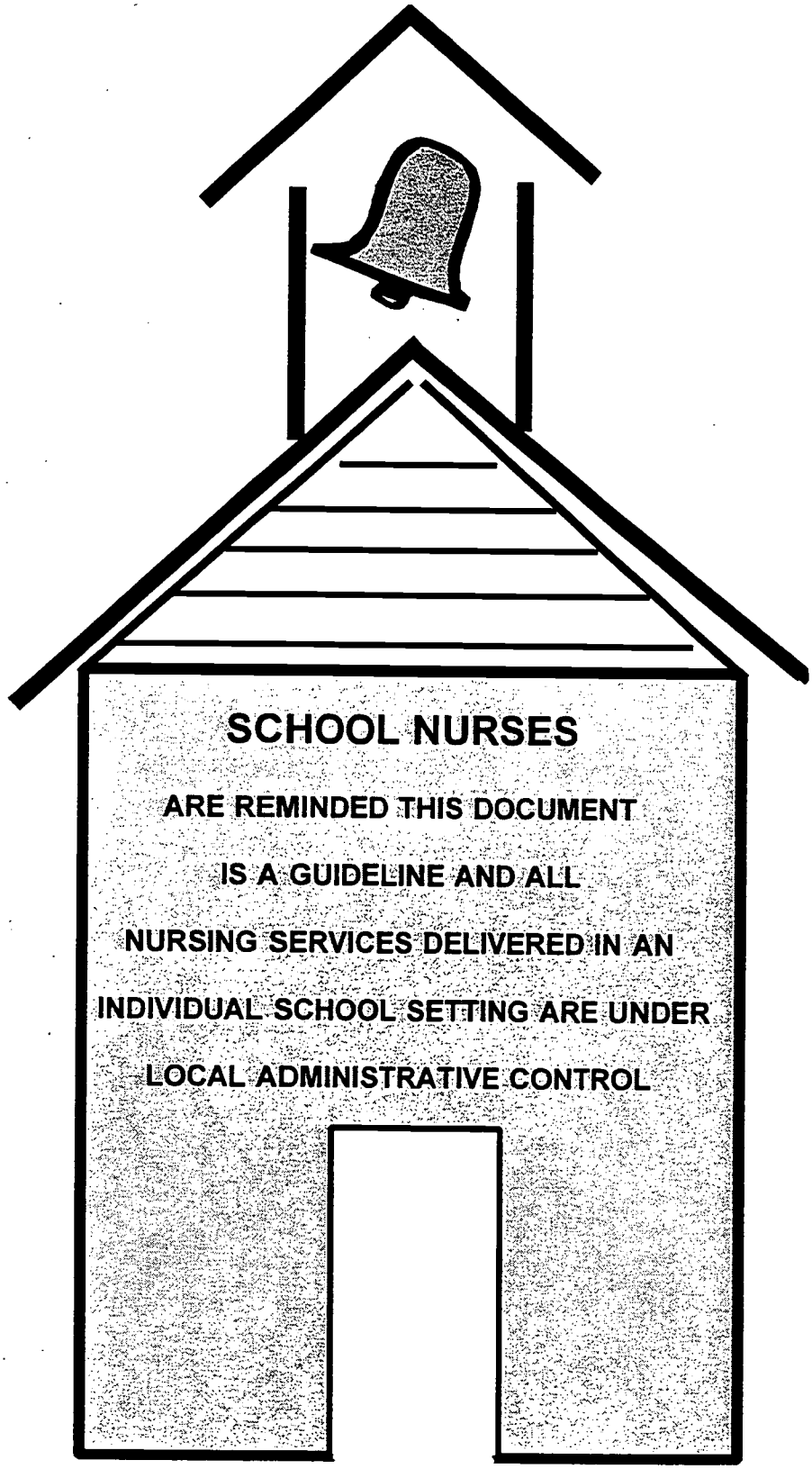

SCHOOL NURSES
ARE REMINDED THIS DOCUMENT
IS A GUIDELINE AND ALL
NURSING SERVICES DELIVERED IN AN
INDIVIDUAL SCHOOL SETTING ARE UNDER
LOCAL ADMINISTRATIVE CONTROL

GOALS

Consensus rests upon the fact that teenage pregnancy is a societal concern. Large amounts of data support this conclusion. However, little agreement regarding solutions has been reached. As a result of the 1994 Nebraska Governor's round table subcommittee report addressing teenage pregnancy, it was identified that two general categories of strategies to prevent teenage pregnancies exist. One method includes those programs which give teens the capacity to delay parenting through education and contraceptive services and the other improves options for teens so that they will desire to delay parenting.

Interventions to address pregnancy prevention in teenagers must speak to specific age groups in order to be successful. The Alan Guttmacher Institute refers to a "reproductive continuum" with young teens with no sexual experience at one end of it to older teen parents of more than one child at the opposite end. Diverse intervention services are needed at each end of the continuum. Nebraska's Round Table Subcommittee, in reviewing materials from other states, found that a large number of the states were using a variety of approaches.

The goal is to lower teenage pregnancies. The situation is complex. Solutions must be multidirectional and multifaceted. Nebraska is a community of diversity and the "one-size-fits-all" approach will not work. Achievement of the **"Year 2000"** goals will demand varied approaches to addressing teenage pregnancy.

Early intervention with adolescents, who are all at risk of teenage pregnancy, will allow more opportunities for pregnancy prevention.. The adolescent population that convenes five days per week, for nine months of the year in the schools is accessible to the school nurse. School nurses are in key opportunistic positions to provide continuous support and surveillance of adolescent health through graduation. These guidelines and resources are presented to encourage and assist school nurses across the state of Nebraska to fulfill the objectives of **Nebraska Year 2000.** These guidelines and resources are written with the intent of providing school nurses with additional information as they advocate for male and female adolescents in confronting issues of adolescent pregnancy

IDENTIFIED HEALTHY PEOPLE 2000 OBJECTIVES

- To reduce pregnancies among girls ages 17 and younger to no more than 50 per 1,000. For non-white adolescents ages 15-19, reduce pregnancies for Blacks to 120 per 1,000, and Hispanics to 105 per 1,000.
- To increase to at least 90 percent the proportion of all pregnant women who receive prenatal care in the first trimester of pregnancy.
- To reduce the infant mortality rate to no more than 7 per 1,000 live births.
- To reduce low birth weight to an incidence of no more than 5 percent of live births.

IDENTIFIED NEBRASKA YEAR 2000: HEALTH GOALS

- Make teen pregnancy prevention information readily available.
- Provide human growth education in all schools, including information on sexuality, pregnancy prevention, and sexually transmitted diseases.
- Promote programs directed at coalition building among community groups to address the teen pregnancy issues.
- Offer training in sex education for parents and teachers through employers, Parent-Teacher Associations, and church groups.
- Emphasize to legislators the need for funding and the positive results to be achieved through case management of pregnant and parenting teens.
- Obtain funding for accessible clinics offering physical examinations, family planning and treatment of sexually transmitted diseases. Explore the concept of school-linked clinics for delivery of these and other health services to teenagers.
- Develop and implement programs to work with preadolescents and adolescents to improve their self-esteem, with a view toward enabling them to make healthier choices regarding sexual activity.

FACTS . . . NATIONAL

1990 Center for Population Options has estimated that the current cost of teen childbearing including Aid to Families with Dependent Children (AFDC), medical assistance, and food stamps, amounts to $19.83 billion per year.

- The proportion of sexually active teens ages 15 to 19 years increased during the 1970's, leveled off during the early 1980's and then increased at the end of the decade.
- 1994 figures indicate that 56 percent of females and 73 percent of males have had intercourse before their 18th birthday.
- In 1994, in the U.S. there were an estimated 1 million pregnancies and 521,826 births among teenagers between the ages of 15 and 19.
- National figures from 1994 (The Alan Guttmacher Institute) state that 2 percent of teenage mothers have a second child within twenty-four months of their first.
- Among sexually experienced females ages 15 to 17, 55 percent have had two or more partners.
- Twenty-three percent of male high school students have had four or more partners.
- In 1993, only 50 percent of teen fathers graduated from high school, 40 percent married while under the age of 18.
- 1993 data indicates 65 percent of teen fathers who do not marry contribute toward the support of the child. Only 44 percent are expected to continue to support the child after two years.
- One sexually active youth in four becomes infected with a STD each year, accounting for 3 million cases in 1994.
- National pattems indicate that pregnant teens are less likely to receive health care during the first trimester of their pregnancy than older women and are more likely to continue to smoke and drink alcohol.
- The Institute of Medicine reports that every dollar spent on prenatal care for low income women saves approximately $3 in medical expenses for low birth weight infants during their first year of life.
- During 1988 through 1992, infant deaths were 13.7 per 1,000 for 10-17 year old mothers and 12.3 per 1,000 for 18-19 year old mothers.

FACTS . . . NEBRASKA

- Teen pregnancy rates in Nebraska in 1994 revealed more than 9 teens became pregnant each day.
- Teenage childbearing in Nebraska in 1994 accounted for 11.0 percent of all births in the State, which is the highest figure recorded since 1981. See Appendix Item A.
- According to Nebraska Teenage Parenthood 1994 Facts, 3,729 teens became pregnant. 1,178 teens had abortions, accounting for 22.1 percent of all abortions in the state.
- Of the total teen births in Nebraska in 1994, 19.8 percent were second or later births.
- Nebraska's pregnant teens don't begin to get prenatal care until the 2nd trimester in 31 percent of the cases. Another 8.3 percent don't begin prenatal care until the 3rd trimester.
- The percentage of low birth weight births was 9.0 percent for women 10 to 17 years of age and 7.9 percent for 18 to19 year old mothers in Nebraska between 1988 and 1994.
- Low birth weight babies accounted for 97 (54.8 percent) of Nebraska's 1994 infant deaths.
- In 1994, 67 of Nebraska's 93 counties were designated as medically under-served areas with 2/3 of these identified counties also being designated as areas of health professional shortage.
- In Nebraska there are less than 20 local health departments and none provide family planning services. However, Nebraska's ten family planning agencies served 6,854 adolescent women and 44 adolescent males in 1994.
- From 1990 to 1992, the infant mortality rate for the Nebraska population declined from 8.3 to 7.3 per 1,000 population, but increased to 9.1 per 1,000 in 1993, its highest point in four years.
- Infant mortality rates per 1,000 live births were highest for women in the 16 to 19 years of age category in Nebraska.

Teen Pregnancy and Out-of-Wedlock Births: Issues and Recommendations. Governor's Roundtable Section V Subcommittee Nebraska Department of Health

During the Nebraska legislative session of 1994, LB 1224 was passed stating that the Department of Health was to study and make recommendations regarding teen pregnancy prevention to the Governor. This report to Governor Benjamin Nelson, of Nebraska, summarizes state and national pregnancy rates and births involving adolescents. It evaluates predictors of pregnancy, costs of teen pregnancy to the state, and methods used by other states to reduce teen pregnancy. The report proposed activities that have the potential to reduce adolescent pregnancy in Nebraska. This is the most recent survey of teen pregnancy issues in Nebraska.

This resource provides available facts, rationale, discussion and a data update. A copy of this report may be obtained by writing to :

Carol J. Iverson, Program Manager
School & Adolescent Health Program
Nebraska Department of Health
Section of Family Health
301 Centennial Mall South
P.O. Box 95007
Lincoln, NE 68509-5007

KEY PARTICIPANTS: PARTNERS WORKING TOGETHER

Adolescents are themselves responsible to make choices that will play a key role in determining their future well-being, the strength of their body and mind, and their success in life. Adolescents are not immune to forces beyond their control and to the environment in which they live. Help is needed from adults representing all segments of society to engage in a collaborative effort to improve the health status of the adolescent.

Partners working together make better use of existing resources and avoid service duplication. Everyone has an important role to play. The key to success is a commitment on the part of every partner. A coalition* is a temporary joining of individuals and groups sharing at least one concern that organizes them to take joint action. *Adolescent pregnancy is an issue that stimulates the formation of a coalition.* Schools represent an optimal setting for providing pregnancy prevention and education programs because they reach 95% of the nation's youth. However, the responsibility cannot be assigned exclusively to the school.

Identifying Members

Potential coalition members may include representatives of the family unit, of social services, of health care, and of the educational system. Other priority members may include ministerial representatives, Parent Teacher Association designees, school board members, and consideration of adolescents as coalition members should be addressed.

Role of the Family

Families must work diligently to promote the sound physical, mental, emotional and social development of their children. Parents and guardians are to provide support, nurturance and guidance, and are to serve as role models of positive health behavior. Unfortunately, not all children and adolescents enjoy this positively described family environment. Many experience emotional deprivation, maltreatment and are exposed to the negative behaviors of adults addressing their environment in ineffective ways.

Actions Families Can Take to Improve Adolescent Health

1) Role model healthy behaviors.

2) Establish and maintain open, direct communication within the family.

3) Advocate effective schools, comprehensive school health education.

4) Take time for kids making them a priority.

5) Communicate values and set reasonable, consistent limits.

6) Encourage involvement in structured youth activities.

7) Minimize overexposure to television and other mass media forms.

8) Seek help to reduce family conflict, to be better parents, to better support children's growth and development.

* Cohen, L., Baer, N., & Satterwhite,P. (1991). Developing Effective Coalitions: An eight step guide. Injury Awareness and Prevention Centre News, 4(1).

Role of Public Health Services

The public health system strives to ensure optimum health and well-being for all adolescents by promoting healthy lifestyles and appropriate use of health services, preventing disease, disability and premature death, protecting them from unhealthy or unsafe environments, and providing or ensuring access to health services.

Actions Public Health Can Take to Improve Adolescent Health

1) Conduct adolescent needs assessments, monitor and analyze trends.

2) Develop policy to support school-community efforts to assure adolescent health needs for education and services are addressed.

3) Develop and enhance community-based systems of care which assure adolescents confidential reproductive health services.

4) Promote culturally and linguistically appropriate sexuality education designed for the developmental stages of adolescence.

5) Foster coalitions to identify and solve adolescent health problems.

Role of Social Service Agencies

A very significant role in providing services as well as community education is held by social service agencies. In many instances, these agencies serve those who fail to receive services anywhere else. Adequate funding is an ongoing concern for these agencies.

Actions Social Service Agencies Can Take to Improve Adolescent Health

1) Increase public awareness of teen pregnancy.

2) Provide education and or educational materials on teen pregnancy.

3) Develop and/or fund innovative programs addressing teen pregnancy issues.

4) Promote legislative and policy changes advancing adolescent health.

5) Give assistance to schools, the community and to youth.

6) Research more effective strategies to meet prescribed goals.

Role of Health Care

A dominant force in adolescent health is the primary health care provider. These individuals hold influential roles in personal and community health decisions. Teenagers do not routinely see the physician, physician's assistant or nurse practitioner as the ideal health promotion model advocates. The high-risk, low-income adolescent is seen even less by primary care providers.

The primary health care domain encompasses the physician, physician's assistant, nurse practitioner, and registered nurse. Each member has a significant role to play in addressing adolescent health.

Actions Primary Health Care Providers Can Take to Improve Adolescent Health

1) Update training in adolescent health, including adolescent gynecology, family counseling, violence, mental health and injury prevention.

2) Reduce teenager's perceived barriers to care.

3) Advocate for adolescent health through community, parent and school coalitions.

4) Teach parents to be effective sexuality educators for their children.

5) Actively identify teens at risk and provide anticipatory guidance.

Role of the Educational System

The school system is a logical means for reaching teenagers. Comprehensive health education, school nursing services, school-based or linked clinical models of health services, and programs supporting positive school climates are a means of advocating for adolescent health through the educational system.

Actions the Educational System Can Take to Improve Adolescent Health

1) Maintain health records on each student and develop Individual Health Plans as needed.

2) Offer health education curricula in grades K-12.

3) Establish on-site health services of a school nurse.

4) Establish school-based or linked clinical model of health services.

5) Support teenage pregnancy prevention and teen pregnant and parenting programs.

CULTURAL COMPETENCY

Culture is the set of values, attitudes, and practices held in common by a group of people usually identified by ancestry, language, and traditions. Cultural competence is defined as a set of congruent behaviors, attitudes, and policies which come together as a continuum thus enabling an individual or system to function effectively in trans-cultural interactions. It refers to the ability to honor and respect the beliefs, interpersonal styles, attitudes and behaviors of individuals from cultures different than one's own. It first requires self-awareness, then knowledge of other cultures, including awareness and acceptance of cultural differences. And finally, adaptation of one's skills to translate beliefs, attitudes and orientation into action and behavior within the context of daily interactions with clients and staff. Racial and ethnic minorities are expected to comprise 25% of the population of the United States by the year 2000. Children and adolescents are the major portion of this population.

Differences related to culture can pose challenges in meeting the already unique issues of adolescent pregnancy. A multicultural view enables problems to be seen from the individual's perspective. Integration of cultural beliefs, practices, and attitudes into care delivery plans demonstrates cultural competence. Failure to understand the cultural background of adolescents and their families can lead to problems such as, misdiagnosis, lack of cooperation, poor use of health services, and general alienation of the adolescent and family.

Acknowledgment of personal cultural background is an exercise of self-assessment. Self-assessment promotes understanding of the multiple cultural influences on behavior. A coalition of individuals and groups formed to address adolescent pregnancy will need to explore and identify cultural values and beliefs in order to effectively meet the needs of culturally diverse adolescents and their families.

Guidelines for Cross Cultural Counseling

Develop a professional stance that views the needs of student and family from their perspective, and integrate their world view, cultural beliefs and strengths into the Individualized Healthcare Plan (IHP).

- Take time to build trust.
- Convey respect for the student's and family's values.
- Be aware of cultural differences in body space, eye contact, touching, use of silence, emotional expressiveness and other non-verbal behaviors.
- Assure that the interaction between you and the student is confidential and that information is only shared with her consent, unless there is danger to herself or others.
- Demonstrate your own willingness to share information.
- Use language that is respectful and understandable to the student and family. Avoid slang, technical jargon and complex sentences.
- Check frequently to make sure your message was heard and understood.
- Accept responsibility for possible misunderstanding or miscommunication. Summarize or paraphrase main points, then check your understanding.

- Use open-ended questions or questions phrased in several ways to obtain information.
- Avoid asking very personal questions until you have established rapport and realize what is considered private by the culture.
- Maintain consistency between your actions, non-verbal behavior and your words. Follow through on promises.
- Involve the family and their concerns in the student's health care plan.
- Use a translator the culture considers appropriate.
- Determine student/family reading ability before using written materials.
- Determine the level of acculturation (adaptation to mainstream American ways) in order to gauge how closely the student/family is likely to adhere to traditional ethnic values and beliefs.
- Incorporate the cultural strengths and values into your education and Individualized Healthcare Plan (IHP).
- Anticipate that there will be multiple needs such as medical, legal, financial, nutritional, social and psychological.
- Expect and acknowledge differences between your own experience and views and those of your student/family.
- Above all be genuine, sincere, respectful and non-judgmental. Remember, we learn about ourselves by learning about others.

The LEARN Model developed by E. Berlin and W. Fowkes (1983) and modified by Tafoya and Wirth (1992) is helpful to this process:

L Listen with empathy (active listening). Listen for strengths in the student's support system.

E Elicit the student/family world-view and perception of the problem/ needs. Then explain your perceptions of the problem/needs.

A Acknowledge and discuss differences and similarities between student/family perceptions and your own.

R Recommend actions/interventions/treatment.

N Negotiate actions/interventions/treatment.

Appendix Item B provides a brief cultural awareness check list along with cultural strengths identified for four cultures: African American, Latino Hispanic, Native American, Asian American.

PREVENTION STRATEGIES

Thousands of teen pregnancy prevention programs are operating in this country today. It is uncertain as to whether multi-faceted approaches are superior to single-faceted ones. No single strategy can work with every adolescent group. Far too often, program and research on adolescent pregnancy prevention focus solely on young women. Such a limited focus can hamper the effectiveness of efforts. Understanding young men and their behaviors, experiences and attitudes regarding sexuality and parenthood is central to understanding the causes of teen pregnancy, and to providing all teenagers with the information they need to make responsible sexual decisions. Sexuality teaching comes from a variety of sources: friends, school, television, the movies, books and magazines. However, it is at home where children first begin to absorb and form the attitudes and values that shape their sexual behavior as they grow into adults. Parent-child communication about sexuality is an essential element in this development.

Approaches to preventing teen pregnancy appear to fall within four broad categories: Sex and contraceptive education, the encouragement of abstinence, increased access to contraception, and life options.

- Sex and contraceptive education programs generally include abstinence, contraception, pregnancy, sexually transmitted disease, and AIDS education.

- Encouragement of abstinence programs target the younger teenagers, age 12 to 15 and address how and why to delay sexual activity. They provide specific reinforcement activities to 'say no.'

- Access to contraception approach is where school systems, with school board approval, try providing on-campus contraceptive prescriptions and condom availability. Another means for this type of program is linkage with a family planning clinic.

- Life options intervention is a blending of sex education with drop-out prevention, individual counseling, job training and job placement as a means to discourage early parenting.

Four prevention strategies that have been identified as 'successful' pregnancy interventions programs are: Postponing Sexual Involvement, Peer Power and Adam, Reducing the Risk, and the Self Center Program. An overview of these four programs follows, with their respective individual contact information.

POSTPONING SEXUAL INVOLVEMENT

Targeted Grade Level: Seventh and Eighth grade

Overview: Focuses on enabling youth to resist social and peer pressure that lead them to become sexually involved.

Program Evaluation: Series was given to all eighth grade students in one of the four school systems served by Grady Hospital in Atlanta, Georgia. A subgroup of low-income, high risk students from all four school systems was studied to determine program effectiveness for that population. Evaluations examined data from 536 students with respect to opportunity, sexual involvement, pregnancies, births, sexually transmitted diseases, and birth control use.

Findings:

- Series participants were significantly more likely to abstain through the end of the ninth grade than were nonparticipants.
- Nonparticipants were as much as five times more likely to have begun having sex that program participants by the end of the eighth grade.
- Participants experienced fewer pregnancies that nonparticipants.

CONTACT

Marion Howard, PhD.
Clinical Director, Teen Services Program
Box 26158, Grady Memorial Hospital
Atlanta, Georgia 30335
(404) 616-3513

PEER POWER AND ADAM

Targeted Grade Level: Sixth through eighth grade

Overview: Encourages students to delay pregnancy and sexual activity, complete high school, and develop realistic career goals.

Program Evaluation: Considered short-term results in academic achievement and sexual behavior and attitudes. School data was used to compare math and reading levels for 137 program participants and 86 other non-participating peers. Behavior and attitudes was gauged by self-reporting.

Findings:
- Students participating in the program were more likely to remain at or above grade level for math and reading
- School attendance by participants improved, with average days missed per year reduced by four.
- Rates of sexual abstinence by participants nearly doubled since the initial start of the program.

CONTACT

Saundra Lightfoot
Ounce of Prevention Fund
188 West Randolph
Suite 2127 and 2200
Chicago, Illinois 60601
(312) 853-6080

REDUCING THE RISK

Targeted Grade Level: Tenth grade students

Overview: Focuses on reducing unprotected intercourse among high school students.

Program Evaluation: Forty-six classrooms were assigned to receive or not receive the program. Questionnaires were give to the intervention group and the control group before and immediately after the intervention, six months later and 18 months later.

Findings:
- Program had a greater impact on delaying sexual initiation than on increasing birth control practices.
- Knowledge increased among intervention students by 18% compared with and 11% increase among control students.
- After 18 months, only 29% of intervention students had intercourse, compared with 38% of control students.

CONTACT

Douglas Kirby
Director of Research
ETR Associates
P.O. Box 1830
Santa Cruz, California 95061
(408) 438-4060

SELF CENTER PROGRAM

Targeted Grade Level: Seventh through twelfth grade.

Overview: Program provides a sexuality education curriculum emphasizing delaying sexual intercourse and practicing effective contraception.

Program Evaluation: A three-year study assigned male and female students in one junior high and one senior high school to the program. The program group was surveyed before the program and again in the spring of each of the following three years.

Findings:

- After 16 months' exposure to the program, pregnancies rose only 13% in the program group compared to 50% in the non-program group. After 20 months rates fell 22.5% in the program group and rose 39.5% in the non-program group. After 30 months rates fell 30.1% in the program group and increased 57.6% in the non-program group.

- Males in the program groups showed a significant increase in knowledge about reproductive biology and pregnancy.

- After program exposure, less that 20% of program females participated in unprotected intercourse compared to 44-49% in the non-program group.

CONTACT
Lauarie Schwab Zabin
Associate Professor
Department of Population Dynamics
John Hopkins University
School of Public Health
Baltimore, Maryland 21287
(410) 955-5753

STRATEGIES USED IN NEBRASKA

Prevention

Carrera Project
United Methodist Community Centers
2001 North 35th Street
Omaha, NE 68111
(402) 451-2228

- A joint venture of United Methodist Community Centers Wesley House and Planned Parenthood of Omaha-Council Bluffs, *"The Carrera Program* makes lifestyle options available for youth that will enhance and enrich their lives by providing alternatives to teenage pregnancy."

Girls, Inc.
2811 N. 45th St.
Omaha, NE 68104
(402) 457-4676

- Provides abstinence based pregnancy prevention program for girls ages 9 to18 and their families. Teaches and promotes parents to be primary health and sexuality educators of their children

Nebraska Coalition on Adolescent Pregnancy Prevention
P.O. Box 231
David City, NE 68632

- The Nebraska Coalition on Adolescent Pregnancy Prevention is an organization of individuals and agencies who share an interest in limiting the incidence of adolescent pregnancy and reducing the negative effects of adolescent parenting.

Survival Skills Program
YWCA Lincoln, NE

- Comprehensive adolescent pregnancy prevention program serving Lincoln youth ages 12 through 17. This is a co-ed program in a collaborative effort between the Lincoln YWCA and Planned Parenthood of Lincoln.

Contact: Jody L. Busse
Survival Skills Coordinator
YWCA
1432 "N" Street
Lincoln, NE 68508

Teen Talk
Nebraska Department of Health
P.O. Box 95007
Lincoln, NE 68509-5007

- Two-page flyer/handout for Teens discussing abstinence and making healthy decisions.

There's No Place Like Home...for Sex Education.
Nebraska Reproductive Health Care Program
(Copyright, 1988 PPALC 134 E. 13th Ave., Eugene, Oregon 97401)

- Fifteen handouts written for ages 3, 4 and 5 and grades 1st through 12th. These handouts, for parental use, address developmentally appropriate sexuality information.

Contact: Nebraska Reproductive Health Care Program
(402) 471-3980

Intervention and Support

HYMS: Helping Young Moms Survive
Created by Adolescent Health Initiative
Office of Mental Retardation
West Virginia Bureau of Public Health
1411 Virginia Street East
Charleston, West Virginia 25301
(304) 558-3071 Fax: (304) 558-2866

- A voucher system, initiated by the school nurse, to help pregnant or parenting teens stay in school by authorizing the purchasing small items needed for daily living.

(Available from Nebraska Department of Health School & Adolescent Health Program at 800-801-1122)

Intervention and Support....continued

Nebraska Reproductive Health Care Program
Nebraska Department of Health

- Strategically located at 30 sites across the state. Provides reproductive health care to adolescents on a sliding scale. See Appendix Item C for a map of site locations.

Contact: Julie Reno
Nebraska Department of Health
301 Centennial Mall South
Lincoln, NE 68509

Program for Pregnant and Parenting Teens
Millard Public Schools

- Co-ed program for pregnant and parenting students. Meets every other week. Stresses good pre-natal care, nutrition, parenting skills. Invited speakers from community support agencies, e.g. WIC, provide information. After delivery, baby checks monthly.

Contact: Collie Fjell, RN
School Nurse
Millard South High School

Kathy Muehlich, RN
School Nurse
Millard North High School

Project Success
Scottsbluff and Gering Public Schools

- Program for teen-age mothers providing daily classes on parenting, prenatal care and child development, as well as college and career counseling. See Appendix Item D.

Contact: **Sally Sylvester**
Director
Project Success
Scottsbluff, NE

Intervention and Support....continued

Resource Program for Pregnant and Parenting Teens
Papillion LaVista High School

- Co-ed program for pregnant and parenting students. Seventeen lessons, one hour in length, addressing pregnancy, labor and delivery, newborn care, paternity, finances, day care and future planning.

Contact: Karen Van Briesen, R.N.,M.A.
School Nurse
Papillion LaVista High School

The Student-Parent Program
Lincoln Public Schools

- Reaches out to students who are parents to help them stay in school and graduate, to establish good health practices for themselves and their children,allows students to learn and use quality parenting skills, to balance the challenges of parenting, personal development and school and to develop career and life plans. See Appendix Item E.

Contact: Ann Irvine
Family and Consumer Sciences Consultant
Lincoln Public Schools
5901 "O" Street
Lincoln, NE 68501

The Parenting Program
Norfolk High School

- Program for pregnant adolescents. School nurse and counselor work with NE Department of Social Services, meet with student's teachers to modify educational program to assure graduation goal is met. Program support includes individual health counseling and tutoring, community mentors, parent training and volunteer transportation.

Contact: Mary Smalley, RN
School Nurse
Norfolk High School

Teen Pregnancy Helpline: 1-800-669-8086

ROLE OF THE SCHOOL NURSE IN ADOLESCENT PREGNANCY

Each pregnant or parenting adolescent requires multi-professional and multi-agency intervention in order to meet the dual goals of graduation and positive parenting skills. The individual possessing the medical and psychosocial knowledge necessary to coordinate the needed services is the school nurse. School policy should identify the school nurse as the case manager or team leader for pregnant and parenting students. Core elements of a Comprehensive Strategy are illustrated in Appendix Item F.

Pregnant and parenting students face many obstacles before they can attain their diploma. The school nurse must advocate for them so that these obstacles can be overcome. This may seem to be a contradictory task, given the nurse also advocates for pregnancy prevention. Influencing other professionals to view pregnant and parenting adolescents positively will lead to improved support, enhanced parenting skills, encouragement to meet educational goals, and ultimately improve social outcomes for any subsequent children.

Foremost in advocating for the pregnant and parenting adolescent, the school nurse must be non-judgmental and unbiased with the adolescent. Discouragement of judgmental and harmful conversations among school employees will role model the neutral stand needed by the student. Attitudes are one of the many barriers these students face when striving to meet educational goals.

Nurse/Student Prenatal Conference

1) Create rapport-the first interview provides the foundation for the continuing relationship.

2) Establish confidentiality-give clear evidence of respect for this need.

3) Review communication skills and interviewing techniques (See Appendix Item G)

4) Provide emotional support-active listening and a non-judgmental demeanor are vitally important.

NURSING ASSESSMENT

Subjective

- Chief Complaint: a brief statement of the reason the student is seeking the school nurse. This statement may reveal the student's underlying concern/issue. See Appendix Item H for Intervention Strategy.
- Age, Gynecological Age (Chronological age minus time since onset of menarche). Gravity and Parity. Last menstrual period, previous normal menstrual period. Last physical examination. Verification of pregnancy. Contraceptive usage.
- Present Problem: nausea, vomiting, weight gain, weight loss, pain, discharge, lightening, fatigue, edema.
- Personal and Social History: Feelings towards verified or unverified pregnancy. Social support system: family, significant other, friends, teachers, counselors. History of abuse in relationships. Coping mechanisms: crying, suicidal thoughts.
- Review of Systems: (Keep in mind that the effects of pregnancy are seen in all systems.)
- Risk Assessment: OTC medication usage, Prescription drug intake, Illicit drug use, Alcohol intake, Tobacco: cigarettes, marijuana, chew. See Appendix Item I for indicators of alcohol and other drug dependency.

Objective

- General statement of overall health status: age, race, general appearance, weight, height, Body Mass Index (BMI), vital signs, communication skills, behavior, awareness, orientation, cooperation.
- Presence of edema: hands, feet, facial.
- Presence of pain: abdominal pain, leg pain, headache.

Analysis

- Identified areas of concern, both nurse detected and student expressed. Include anything that will require further evaluation or attention.
- Differential diagnosis-do not jump to conclusions. More than one impression or nursing diagnosis is possible and likely.
- Nursing diagnosis: A summary statement of a condition, behavior, or situation amenable to nursing intervention. States the concern (present or potential health problem) incorporating the etiology of the problem which may be anatomical, physiological, psychological or environmental- (related to—). Include signs, symptoms (as evidenced by), indicate the Adolescent response, (resulting in ---).

Example: ***Possible unintended pregnancy (problem) related to recent unprotected intercourse (etiology) as evidenced by absence of menses (symptom/sign) resulting in adolescent's high anxiety level. (Response)***

Plan

- Individualized Health Care Plan created by the school nurse and student addresses each nursing diagnosis. Multi disciplinary contributions will be necessary to assure student success in their educational program.

Implementation

(Refer to Appendix Item J for matrix/health record examples)

- Verification of pregnancy if not already done.
- Notification of social support system (family, significant other) if not done.
- Verification of pregnancy for school records (identify school policy regarding pregnant student participation in P.E., sports, etc.).
- Establish health care provider appointment.
- Provide education for pregnancy knowledge deficit (including physiological changes of pregnancy, nutritional requirements (see Appendix Item K for recommended weight gain), fetal development, medical care needs, teratogen exposure, signs and symptoms of pregnancy complications, preparation for delivery classes, agency support.)
- Address future issues: Graduation, Adoption/Other, Work, Day care needs.
- Obtain medical release to return to school postpartum.

Evaluation

- Ongoing evaluation through student graduation.
- Document class attendance and academic progress.
- Document prenatal and postpartum health care provider visits.
- Identify agency and support system networking.
- Document status of parent-child relationship.

This S.O.A.P.I.E. documentation of the nursing assessment is only a portion of the information that may be identified in assessing the needs of pregnant and parenting adolescents. This is starting point.

Social Information

It is important to have social information to effectively work with and provide for the pregnant and parenting adolescent. What follows is a partial list of information that may be needed:

Emergency Demographics

- Student's current address and telephone number. (Student may not be living with their custodial parent as a result of the pregnancy.)
- Parent/guardian address and telephone number if different from the student's.
- At least two additional emergency contact telephone numbers.
- Delivering physician or clinic name and telephone numbers.
- Hospital where student plans to deliver.
- Determine the involvement of the baby's father, name, age, contact status.
- List agencies where the student is receiving assistance, caseworker/counselor names, telephone numbers.
- Obtain release of information permission for referrals and interagency contacts, as needed.

LEGAL ISSUES

Legal barriers greatly affect the manner in which adolescents facing pregnancy behave. This issue has largely been unexamined. The population addressed here can not vote, lobby, or speak for themselves. Legal issues to consider when advocating for adolescents include paternity, parental consent, parental notification, judicial bypass, the Hyde amendment and confidentiality.

Paternity

Paternity means fatherhood. If parents are married the husband is considered to be the father of children born during the marriage. If parents are not married, it is important that paternity be legally established.

Paternity Acknowledgment

Paternity acknowledgment is when a man signs a form stating or acknowledging that he is the father of a child. This is the first step in establishing a child's legal paternity. The law will assume the man who signed a paternity acknowledgment is the father or a genetic test can identify paternity. In Nebraska, the paternity of a child can be established at any time up to the child's 18th birthday.

Aid To Dependent Children

To receive Aid to Dependent Children benefits, the father of the child must be named in order to receive full benefits. If there is evidence that there is endangerment from the alleged father, it may be decided to not establish paternity.

Child Support

Child support can be collected for the child once paternity has been established. Once paternity has been established the father has the right to ask the courts to give him custody and for visitation rights. The child's father is responsible for child support even if he is in school. If child support is not paid, the child support office can take up to 65 percent of a paycheck, can get money from any property owned, or take an income tax refund. The child may also be eligible for benefits through the father's employer and the Social Security system.

Parental Consent

Parental consent laws require abortion clinics or a doctor to obtain the written consent of a minor's parent(s) before an abortion can be performed.

Parental Notification

Parental notification laws require abortion clinics or a doctor to inform a minor's parents in writing that she plans to have an abortion.

Judicial Bypass

Judicial bypass is the procedure where a minor who feels she cannot tell her parents about her decision to have an abortion may appear before a judge who determines if she is mature enough to make the decision herself or if the abortion is in her best interest.

Nebraska Statute

NE ST. § 71-6902, 6903, 6906

Nebraska statute states that no abortion shall be performed upon a pregnant minor until at least 48 hours after written notice to a parent of the pending abortion. If a pregnant woman elects not to notify her parents, a judge shall, upon the minor's petition or motion, authorize a physician to perform the abortion without parental consent if the court determines that the pregnant woman is mature and capable of informed consent or if the abortion without parental notification is in the best interest of the minor. Notification is not required if the continuation of the pregnancy provides an immediate threat and grave risk to the life or health of the pregnant woman and there is insufficient time to provide the required notification. If the pregnant minor declares she is a victim of abuse, neglect, or sexual abuse, she must be informed of the physician's duty to notify the proper authorities.

Hyde Amendment

Under the Hyde Amendment, federal Medicaid funds cannot be used to fund abortions, except when the life of a woman would be endangered by a full-term pregnancy.

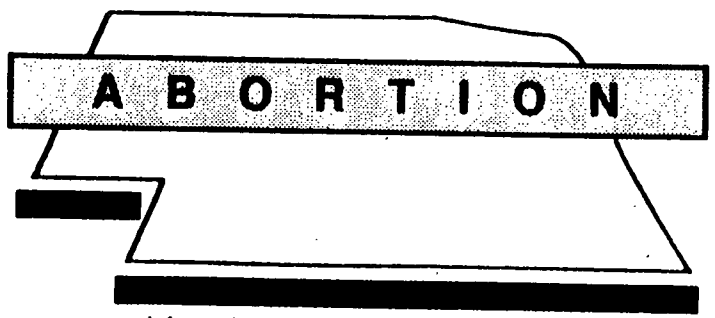
Confidentiality

The obligation to maintain confidentiality of health care information has many legal sources: professional codes of ethics, implied contractual duties of the physician/nurse-patient relationship, state and federal statutes, and constitutional provisions. The legal obligation of confidentiality is not absolute; disclosure without the patient's consent may be prohibited, required, or permitted under different circumstances.

ABORTION NOTIFICATION:

The law as of September 6, 1991

Parent accompanies minor	OR	Notify Parents	OR	Have clinic doctor notify parents	OR	Go to court to seek a judicial waiver of notification.
Parent or guardian goes to the doctor with minor.		Parent or person entitled to a notification must authorize the abortion in writing. Authorization is presented to the doctor.		Written notice must be presented by the doctor to the parent. Notice may be delivered in person or sent by certified mail to the home of the parent.		Petition for bypass of parental notification requirement must be filed with the court. The judge will appoint an attorney & guardian for the minor and schedule a confidential hearing.
Abortion can be performed immediately.		Abortion may be performed immediately.		Doctor must wait 48 hours from the time of notification to perform the abortion.		After the hearing, the court has 7 days to rule whether the minor is mature enough to make the decision on her own or if no notification is in the best interest of the minor.
						If judge denies request, minor may appeal to the State Supreme Court.
						If judge approves, abortion may be performed immediately.



Information provided by Women's Services, P.C.
201 South 46th Street (402) 554-0110
Omaha, NE 68132-3290 1-800-922-8331

ANNOTATED RESOURCES

Prevention

Advocates for Youth
Suite 200
1025 Vermont Ave., N.W.
Washington, D.C. 20005
(202) 347-5700 Fax (202) 347-2263
-Family Options for Population Control
-Works to increase the opportunities and abilities of youth to make healthy decisions about sexuality. Provides information, education, and advocacy to youth-serving agencies and professionals, policy makers and the media. Their publication is a must!

American School Health Association
7263 State Route 43,P.O. Box 708
Kent, OH 44240
(216)678-1601 Fax (216)678-4526
-HIV Infection and the School Setting: A Guide for School Nursing Practice
-Reducing Pregnancy and the Spread of HIV and Other STDs Among Adolescents
-Membership, publications, resources available
-Journal of School Health

Baby Think It Over, Inc.
3665 Ruffin Road, Suite 100
San Diego, CA 92123
Telephone: (800) 830-1416
Fax: (619) 268-7995

-provide the state-of-the-art in infant simulators. Anatomically correct male and female dolls. Ethnicities and drug-dependent dolls available.

Bureau for At-Risk Youth
645 New York Avenue
Huntington, NY 11743
(800)99-YOUTH
-Free buyers guide featuring pamphlets, posters, publications, videos on teen health and sexuality.

CDC National AIDS Clearinghouse
P.O. Box 6003
Rockville, MD 20849-6003
(800) 458-5231 Fax (301) 251-5343
-AIDS education and prevention materials
-CDC/NAC ON LINE: computerized information network-registration required.

Centers for Disease Control and Prevention
Division of Adolescent and School Health
4770 Buford Highway, NE
Atlanta, GA 30333
(404) 488-5323

-Vincent, M. Reducing Unwanted Adolescent Pregnancy Through School/ Community Intervention: A South Carolina Case Study.

Combined Health Information Database (CHID)
BRS Information Technologies
1200 Route 7
Latham, N.Y. 12110

-computerized bibliographic database of health information and resources
-request a password. Cost is $75.

Family Life Matters
Network for Family Life Education
Building 4086, Livingston Campus
Rutgers, The State University
New Brunswick, NJ 08903-5062
(908)445-7929 Fax (908)445-4154

-Newsletter for Health, Family Life and Sexuality Educators, $12 for 3 issues.

Friends First
821 17th
Suite 690
Denver, Colorado 80202
(303) 298-8520

-Friends First program is a curriculum guide of interaction targeted to middle and high school teens to teach a choice approach whether or not to become sexually active. The basic foundation of relationships is taught.

Great Transitions: Preparing Adolescents for a New Century
Carnegie Council on Adolescent Development
P. O. Box 753
Waldorf, MD 20604
(202) 429-7979
1995

-a concluding report of the Council on Adolescent Development findings on adolescence needs for education, reengagement with the family, the changing world, health and reducing the risks.

Healthy Communities, Healthy Youth
The Search Institute
RESPECTEEN
Lutheran Brotherhood
625 Fourth Avenue So.
Minneapolis, MN 55415
(800) 888-3820

-report of students in grades 9th-12th and their self-reported assessment of perspectives, values and behaviors.

KNOW HOW
Intermedia
1300 Dexter Avenue North
Seattle, WA 98109
(800)553-8336

-Curricula teaching adolescents to make statements of objection to their peers.

Morning Glory Press
6595 San Harold Way
Buena Park, CA 90620-3748
Telephone: (714) 828-1998
Fax: (714) 828-2049

-Catalog of books, videos and pamphlets for teens and those providing programs for teenagers.

National Association for Abstinence Education
6201 Leesburg Pike, Suite 404
Falls Church, VA 22044
(703)532-9459 Fax (703)532-0654
-Abstinence Based Sexuality Education report

National Maternal and Child Clearing House
8201 Greensboro Drive, Suite 600
McLean, VA 22102
(703) 821-8955 Fax (703) 821-2098
-Culturally Competent HIV Counseling and Education
1st Edition, August, 1994
Elizabeth Randall-David, Ph.D.

National Organization of Adolescent Pregnancy, Parenting and Prevention, Inc. (NOAPPP)
4421-A East-West Highway
Bethesda, MD 20814
(301) 913-0380 Fax (301) 913-0380
-Mission to provide leadership on adolescent pregnancy and parenting issues.
-NOAPPP Network: newsletter published quarterly for members.

Office of Disease Prevention and Health Promotion
Public Health Service
U.S. Department of Health and Human Services
Switzer Bldg., Room 2132
330 C St., S.W.,
Washington, D.C. 20201
-Locating Funds for Healthy People 2000 Health Promotion Projects

Office of Family Planning
California Department of Health Services
714 P Street, Room 440
P.O. Box 942732
Sacramento, CA 94234-7320
-Education Now and Babies Later (ENABL)
-Postponing Sexual Involvement Through Education

School-Based Programs to Reduce Sexual Risk Behaviors: A Review of Effectiveness
Public Health Reports Vol. 109, No. 3
Douglas Kirby, Ph.D.
ETR Associated
PO Box 1830
Santa Cruz, CA 95061-1830

-Identifies 23 studies of school-based programs that were published in professional journals and measures program impact on behavior.

SIECUS/Sexuality Information and Education Council of the United States
Publication Department
130 West 42nd Street, Suite 2500
New York, NY 10036

-SIECUS Report
-SIECUS fact sheets addressing comprehensive sexuality education
-Guidelines for Comprehensive Sexuality Education: Kindergarten-12th grade

The Troubled Journey: A Profile of American Youth
The Search Institute
RESPECTEEN
Lutheran Brotherhood
625 Fourth Avenue So.
Minneapolis, MN 55415
(800) 888-3820

-report of 152-question, youth-needs assessment survey of students in grades 6-12.The findings address grade trends, gender differences and the connection of assets to behavioral choices.

Truth, Lies & Pregnancy: Teen Stories (Video)
The Teen Pregnancy Consortium, Inc.
P.O. Box 31184
Omaha, NE 68132

- "Truth, Lies & Pregnancy: Teen Stories," is a collection of teens' thoughts on pregnancy and its prevention. Teens tell their own experiences in their own words. A study guide is included with each video which can be used by a group leader for suggested learning activities, challenges and topics of discussion.

Intervention

For Women, Adult and Adolescent, Who Are Pregnant.
Nebraska Department of Health
Bureau of Family Health Services
301 Centennial Mall South
P.O. Box 95007
Lincoln, NE 68509-5007
(800) 548 2593

-Booklet made available by Nebraska state law regarding abortion and carrying a pregnancy to term.

Support

Morning Glory Press
6595 San Harold Way
Buena Park, CA 90620-3748
Telephone: (714) 828-1998
Fax: (714) 828-2049

-Catalog of books, videos and pamphlets for teens and those providing programs for teenagers.

National Organization of Adolescent Pregnancy, Parenting and Prevention, Inc. (NOAPPP)
4421-A East-West Highway
Bethesda, MD 20814
(301) 913-0380 Fax (301) 913-0380

-Mission to provide leadership on adolescent pregnancy and parenting issues.
-NOAPPP Network: newsletter published quarterly for members.

Sundial Promotions
200 Overlook Drive
Franklin, TN 37069
(615) 794-6700 Fax: (615) 790-0820

-Baby's First Year & Pregnancy Calendars. Educational keepsakes for recording memorable events. Pregnancy calendar serves as an educational tool and updated journal, providing vital information for every mother-to-be.

What It Takes: A Survival Guide For Young and Teen Dads-To-Be
Code: WIT ISBNI-888231-02-5
For Teen Moms Only
P.O. Box 962
Frankfort, Illinois 60423

-Written for dads-to-be between the ages 13-25. Addresses paternity, career and education, pregnancy and birth, father importance, and caring for a baby.

RESOURCES

Prevention

Adolescent Pregnancy Prevention Guidebook for Communities
Health Promotion Resource Center
Standford University
100 Welch Road
Palo Alto, CA 94304-1885.

Comprehensive School Health Education and Coalition Resource Guide
National School Health Education Coalition (NaSHEC)
100 G Street, NW
Suite 400 East
Washington D.C. 20001

Getting Local Agencies to Cooperate
University Park Press
P.O. Box 434
Grand Central Station
New York, NY 10163

Health Care Reform:
Opportunities for Improving Adolescent Health
National Maternal and Child Health Clearinghouse
8201 Greensboro Ddrive, Suite 600
McLean, Virginia 22102

Healthy Youth 2000
National Health Promotion and Disease Prevention Objectives for Adolescents
Betsy J. Davis
American Medical Association
Department of Adolescent Health
515 N. State Street
Chicago, Illinois 60610

March of Dimes Birth Defects Foundation
1275 Manaroncek Avenue
White Plains, NY 10605
(914) 428-7100

Nebraska WIC Program
Department of Health, Family Health Section
301 Centennial Mall South
Lincoln, NE 68509 (402) 471-2781

Promoting School Health Through Coalition Building
Eta Sigma Gamma
Professional Health Science Honorary National Office
2000 University Circle
Muncie IN 47306

Society for Adolescent Medicine (SAM)
10727 White Oak Avenue, Suite 101
Granada Hills, CA 91344
(213) 368-5996
Publication: Journal of Adolescent Health Care

Teen Pregnancy Prevention Clearinghouse
Laura Davis
Advocates for Youth
1025 Vermont Avenue, N.W., Suite 200
Washington, D.C. 20005
(202) 347-5700 Fax (202) 347-2263

Intervention

Nebraska Department of Health
1994 Vital Statistics Report
Data Collection Section
301 Centennial Mall South
P.O. Box 95007
Lincoln, NE 68509
(402)471-2241

Open Adoption
3603 North 7th Avenue
Phoenix, Arizona 85013
Telephone: (602) 266-TALK

Policy Compendium on Reproductive Health Issues Affecting Adolescents
American Medical Association
PO Box 109050
Chicago, IL 60610

Report to Congress on Out-of-Wedlock Childbearing
U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
National Center for Health Statistics
Hyattsville, Maryland
DHHS Pub. No. (PHS)95-1257-1

Society for Adolescent Medicine (SAM)
10727 White Oak Avenue, Suite 101
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New York, NY 10163

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Department of Health, Family Health Section
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Lincoln, NE 68509 (402) 471-2781

Society for Adolescent Medicine (SAM)
10727 White Oak Avenue, Suite 101
Granada Hills, CA 91344
(213) 368-5996
Publication: Journal of Adolescent Health Care

CURRENT READING LIST

These articles are available from the State School Nurse Coordinator by calling 1-800-801-1122

Prevention

Biro, F. M.& Rosenthal, S.L. (1995). Adolescents and sexually transmitted diseases: Diagnosis, developmental issues, and prevention. Journal of Pediatric Health Care, 9, 256-262.

Sexually transmitted diseases (STDs) continue to be a public health priority; adolescents are the highest risk group for nearly all STDs. This article reviews diagnostic approaches, developmental aspects of adolescents, and theoretic/pragmatic issues regarding prevention efforts.

Blair, J. (1993). Condom availability in schools. Journal of Adolescent Health, 14, 565-568.

This article discusses Ms. Blair's experiences with New York Public Schools when Chancellor Joe Fernandez initiated their controversial comprehensive HIV/AIDS education program as the number one health education priority of all responsible school systems.

Christopher, F.S. & Roosa, M. W. (1990). An evaluation of an adolescent pregnancy prevention program: Is "Just say no" enough? Family Relations, 39, 68-72.

This article reports on an evaluation of the impact of an abstinence promotion program that targeted low-income, primarily minority middle school students. SUCCESS EXPRESS provided 6 program sessions with focus on self-esteem, communication skills, peer pressure, and teaching the value of sex confined to marriage.

English, A. (1993). Condom distribution in the schools. Journal of Adolescent Health, 14, 562-564.

This article speaks to the legal and ethical considerations related to condom availability programs in the schools. The author address four points: the ethical implications of requiring parental consent, the related legal considerations, the necessity of remembering that legal issues are often a smokescreen for something else, and the importance of viewing legal issues in the broad context of adolescent health, teen pregnancy and HIV.

Frost, J. & Forrest, J. (1995). Understanding the impact of effective teenage pregnancy prevention programs. Family Planning Perspectives, 27: 188-195.

This article reviews five rigorously evaluated adolescent pregnancy prevention programs which incorporate an emphasis on abstinence or delay of sexual initiation, training in decision-making and negotiations skills, and education on sexuality and contraception. Four programs reduced the proportion of adolescents who initiated sexual activity by as much as 15 percentage points, and were most successful when they targeted younger adolescents. Two programs significantly decreased the proportion of adolescents who became pregnant.

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

This article reports on Grady Memorial Hospital's family planning-based outreach program for 8th graders in a local Atlanta school system which serves low income, at risk youth. Students who had NOT participated in the peer-led Post-poning Sexual Involvement Curriculum were as much as 5 times more likely to have begun having sex.

Jorgensen, S.R., Potts, V., Camp, B. (1993). Project taking charge. Six-month follow-up of a pregnancy prevention program for early adolescents. Family Relations, 42, 401-406.

This article reports on Project Taking Charge, an abstinence-based adolescent pregnancy prevention currculum that provides evidence that cognitive gains achieved at post-test are retained at 6 months.

Koenigs, L.M., & Miller, N.H. (1995). The contraceptive use of depo-provera in U.S. adolescents. Journal of Adolescent Health, 16, 347-349.

This article reports on the experience of physicians and their adolescent patients who used DMPA as a contraceptive. The author reports a high continuation rate of use for this contraceptive.

Leigh, B.L., Morrison, D.M., Trocki, K., Temple, M.T. (1994). Sexual behavior of American adolescents: Results from a U.S. national survey. Journal of Adolescent Health, 15, 117-125.

This article reports data from a national household survey (multi-stage area probability sample) of the sexual behavior of male and female adolescents aged 12-17. The results of this study underscore the need for in-depth, population-based research on adolescent sexual behavior, especially given the concerns about AIDS and unwanted pregnancy.

Males, M. (1993). School-age pregnancy: Why hasn't prevention worked? Journal of School Health, 63, 429-432.

This article reveals that the consistency of STD and birth statistics provide evidence that most sexual outcomes -- either pregnancy or disease -- among teenagers result from contacts with adults, not peers. The author notes 3 aspects of current school curricula and programming that appear beneficial, but counsels educators must be informed by research and statistics in order to make needed contributions to policy reform.

Smith, K., Wheeler, B., Pilecki, P., Parker, T. (1995). The role of the pediatric nurse practitioner in educating teens with mental retardation about sex. Journal of Pediatric Health Care, 9, 59-66.

The sexual needs of adolescents with mental retardation are often overlooked, underestimated, or considered problematic by parents, teachers or caregivers. This article describes ways in which the nurse practitioner can help these special teens develop responsible social and sexual relationships through assessment, education, coordination of services, appropriate referrals, and regular follow-up.

Intervention

Berenson, A.B.,SanMiguel, J.D.,Wilkinson, G.S. (1992). Prevalence of physical and sexual assault in pregnant adolescents. Journal of Adolescent Health, 13, 466-469.

This article addresses the prevalence of violence among pregnant adolescents. Pregnant teens under age 17 reported significant history of assault: 9% physical, 8% sexual, and 8% both physical and sexual assault. The most common perpetrator of physical assault was a member of their family of origin as compared to a mate (46% versus 33%). The authors conclude that a significant proportion of pregnant teens have experienced violence, and should be screened routinely for a history of abuse.

Biro, F. M.& Rosenthal, S.L. (1995). Adolescents and sexually transmitted diseases: Diagnosis, developmental issues, and prevention. Journal of Pediatric Health Care, 9, 256-262.

Sexually transmitted diseases (STDs) continue to be a public health priority; adolescents are the highest risk group for nearly all STDs. This article reviews diagnostic approaches, developmental aspects of adolescents, and theoretic/pragmatic issues regarding prevention efforts.

Boyer, D. & Fine, D. (1992). Sexual abuse as a factor in adolescent pregnancy and child maltreatment. Family Planning Perpectives, 24, 4-11.

This article, based on extensive research done in Washington state, examines the role of sexual victimization in the etiology of adolescent sexual behavior and pregnancy.

Cheng, T.L., Savageau, J.A., Sattler, A. L., DeWitt, T.G. (1993). Confidentiality in health care. A survey of knowledge, perception, and attitudes among high school students. Journal of American Medical Association, 269, 1404-1407.

This article reports survey research on 9-12th grade students from central Massachusetts. A majority have health concerns they wish to keep private from parents and friends. A striking percentage report they would not seek health services from their regular doctor (43%) or school based clinic (32%) because of their concern about confidentiality. Effective adolescent health care requires this issue be addressed.

English, A. (1993). Condom distribution in the schools. Journal of Adolescent Health, 14, 562-564.

This article speaks to the legal and ethical considerations related to condom availability programs in the schools. The author address four points: the ethical implications of requiring parental consent, the related legal considerations, the necessity of remembering that legal issues are often a smokescreen for something else, and the importance of viewing legal issues in the broad context of adolescent health, teen pregnancy and HIV.

Newacheck, P.W., McManus, M.A., Brindis, C. (1990). Financing health care for adolescents: Problems, prospects, and proposals. Journal of Adolescent Health Care, 11, 398-403.

This article revels 1 of 7 adolescents, aged 10-18, is uninsured and more likely than insured counterparts to be members of poor and minority families. These uninsured adolescents use fewer health services than their peers even after controlling for health status differences. Efforts to increase public and private insurance and the prospects for future improvements in coverage are discussed.

Toledo-Dreves, V., Zabin, L., Emerson, M.R. (1995). Durations of adolescent sexual relationships before and after conception. Journal of Adolescent Health, 17, 163-172.

This article reveals, contrary to common belief, that the median duration of a girl's prior relationships with a partner with whom she conceives is two years. Thus, there may be sufficient time and commitment to include many male partners in intervention programs before, and in parenting programs after, a first conception.

Support

Warrick, L., Christianson, J.B., Walruff, J., Cook, P.C. (1993). Educational outcomes in teenage pregnancy and parenting programs: Results from a demonstration. Family Planning Perspectives, 25, 148-155.

This article attests to the efficacy of a comprehensive, school-based, community-linked program in keeping pregnant and parenting teens in school. Strong outreach efforts and case management are believed to have an especially favorable impact on continuation in school.

BIBLIOGRAPHY

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Boyer, D.,& Fine, D. (1992). Sexual abuse as a factor in adolescent pregnancy and child maltreatment. Family Planning Perspectives,24(1),4-11.

Center for Population Options (Feb., 1994). School-based and School-linked Health Center, Advocates for Youth.

Davis, M.A., Betsy J., Voegtle, Ph.D., Katherine H., Culturally Competent Health Care for Adolescents, Department of Adolescent Health, American Medical Association, 515 N. State Street, Chicago, Illinois 60610

Dryfoos, J. Adolescents at Risk: Prevalence and Prevention. New York, N.Y.:Oxford University Press; 1990.

Eldelman, M.W. (1987). Families in Peril: An Agenda for Social Change. Cambridge, MA.: Harvard University Press.

Epner, J. (Ed.). (1996). Reproductive health issues affecting adolescents. American Medical Association. Chicago, IL.

Healthy People 2000: National Health Promotion and Disease Prevention Objectives. Washington, D.C.: U.S. Department of Health and Human Services publication (PHS) 91-50212;1991.

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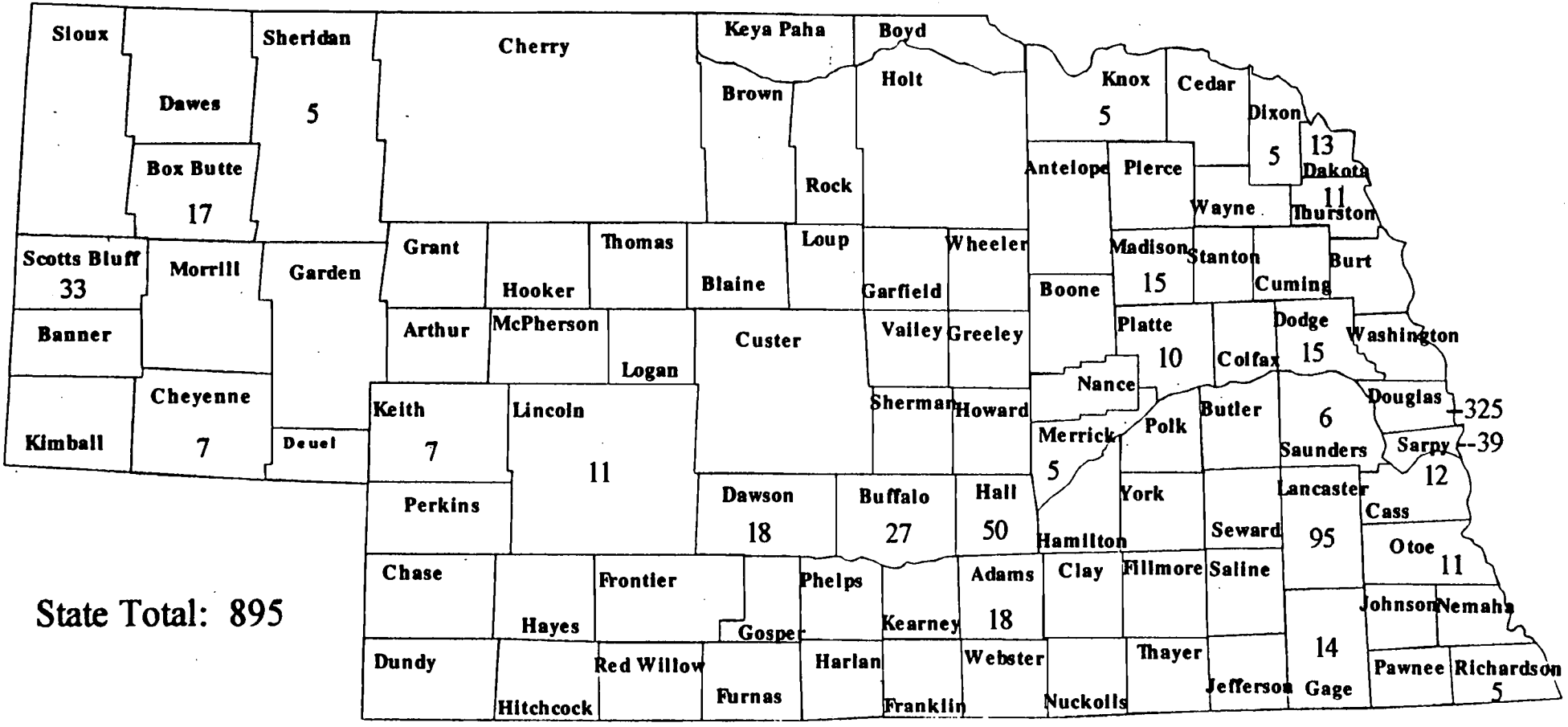
APPENDIX

APPENDIX ITEM A

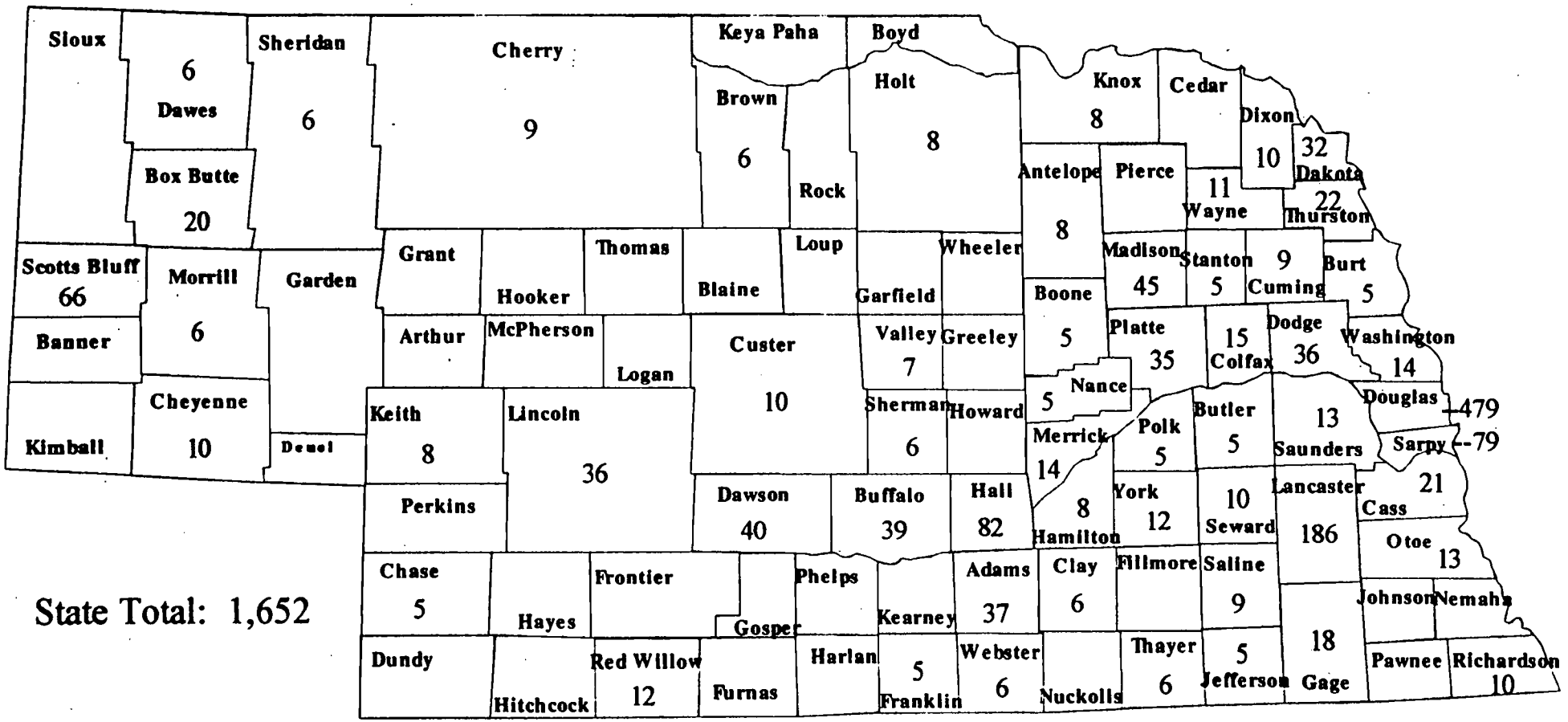
Nebraska Resident Births, 1994
By Mother's Age (17 and Under)



State Total: 895

Please Note: Teen Births are not provided if there were less than five for any given county for reasons of confidentiality.

Nebraska Resident Births, 1994
By Mother's Age (18 - 19)



State Total: 1,652

Please Note: Teen Births are not provided if there were less than five for any given county for reasons of confidentiality.

APPENDIX ITEM B

African American Cultural Strengths

- **Strong kinship bonds and sense of family and community**

  - Involve the extended family in education and counseling sessions and in development of the I.H.P.
  - Emphasize that the client will be protecting future generations by modeling responsible sexual behavior and drug use.
  - Emphasize that by staying healthy the client can build future generations and ensure the continued existence of a strong African American Community.
  - Emphasize in African American Churches and other institutions the importance of the community caring for its own members who are pregnant.
  - Involve key respected members of the community as peer educators.

- **Strong religious belief system**

  - Emphasize that it is the individual's responsibility to help God with His plan for them (i.e., work with God rather than giving all the responsibility for their future to God.)
  - Ask clients not to judge their fellow man/woman but to leave God to judge the actions of other individuals.
  - Involve African American ministers in adolescent pregnancy prevention and care efforts.
  - Suggest ways that church members can help adolescents who are pregnant or parenting (E.g. making home visits, providing child care, transportation, food, respite care, etc.)

- **Strong history of self help**

  - Emphasize the importance of the African American community "owning" the problems in their communities and taking leadership roles in finding solutions or effective strategies for dealing with these problems.
  - Rename support groups to be "self help" groups for families coping with adolescent pregnancy.
  - Utilize the many wonderful "cultural heroes" and role models from the African American community as credible messengers for pregnancy prevention messages.

- **Present time frame focus**

  - Focus on client's priorities first, and then move to provider's agenda.
  - Emphasize short term effects of behavior change rather than long term effects.

- **Action valued over words**

  - Utilize direct, tangible, action-oriented approaches to counseling as opposed to introspective talk and listen methods.
  - Emphasize practical approaches to behavior changes that are concrete.

Adapted from Chapter Five, Providing Culturally Competent HIV Counseling, Education and Health Care, Randall-David, Ph.D., E., 1019 W. Marnham Ave, Durham, NC 27701. (919) 687-2765

- **Importance of children**

  - Understand that children fulfill many roles and thus the decision to postpone or not have children is a complex one. Discuss the significance of children for each client.
  - Discuss quality of life issues for children brought into a single parent family when both parents are not available.
  - Evaluate the ability of others in the community, especially the grandparents, to care for children whose parents are young adolescents (i.e., traditionally the grandparents or other relatives may care for children over an extended period of time).

Adapted from Chapter Five, Providing Culturally Competent HIV Counseling, Education and Health Care, Randall-David, Ph.D., E., 1019 W. Marnham Ave, Durham, NC 27701. (919) 687-2765

Latino/Hispanic Cultural Strengths

- **Emphasis on family as primary social unit and source of support. (Familisimo)**
  - Involve family members in education, counseling and treatment and in the emotional and physical support of the adolescent.
  - Use the family as a support group rather than referring client to a support group of strangers since Latinos may avoid discussing their problems/concerns outside the extended family.
  - Emphasize adoption of safe behavior for good of the unborn child.
  - Emphasize that client should develop behaviors which can serve as a positive model for the younger generation.
  - Accept individuals because of who they are not because of what they have or have not done, so accept family members who may have experienced adolescent pregnancy. This corresponds to carino - a deep sense of unqualified caring and protection.

- **Importance of personal contact. (Personalisimo)**
  - Take time to establish rapport since Latino clients will be more likely to trust health care workers with whom they have established a personal relationship.
  - See clients in person because Latinos value face to face interactions over less personal modes such as telephone or computer communications.
  - Expect that the client may not be punctual for appointments and don't hurry through the encounter, because being on time and being efficient are seen as far less important than interpersonal relationships.

- **Respect in social relationships which dictates the appropriate deferential behavior from others on basis of age, socioeconomic position, gender and authority status. (Respeto)**
  - Treat each client with the utmost respect to maintain the person's sense of integrity.
  - Encourage Latinos to ask questions and make sure they understand the information and advice, because Latinos respect authority figures and often accept their suggestions without question.

- **Importance of smooth social relations. (Simpatico)**
  - Emphasize politeness and respect rather than assertiveness and direct criticism, so be sure to check for understanding of your message, because the client might appear to understand information and agree to suggestions when in fact she is merely avoiding conflict.

- **Traditionally prescribed sex roles**
  - Use concept of machismo or man's role to assume responsibility for and protection of the family to encourage men to adopt healthy behaviors to protect the whole family.
  - Use the value of women as child rearers and child educators to encourage them to protect themselves in order to protect their children.
  - Give women options they can control.

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- **Importance of children**

  - Emphasize that parents should take care of their own health so they will be around for their children.
  - Emphasize importance of modeling of responsible behaviors.

- **Strong religious belief system**

  - Emphasize that it is the individual's responsibility to help God with His plan for them (i.e. work with God rather than giving all the responsibility for their future to God.)
  - Ask them not to judge their fellow man/woman but to leave it to God to judge the actions of other individuals.
  - Utilize religious leaders in the care of adolescents who are pregnant. Include santeras and espiritistas, spiritual leaders who are believed to possess psychic powers and knowledge of spells, charms and incantations.
  - Suggest ways that church members can help adolescents who are pregnant or parenting (e.g., making home visits, providing child care, transportation, food, respite care, etc.)

- **Present orientation and action oriented**

  - Focus on client's priorities first and then move to provider's agenda.
  - Emphasize short term effects of behavior change rather than long term effects.

- **Action valued over words**

  - Utilize direct, tangible, action-oriented approaches to counseling as opposed to introspective talk and listen methods.
  - Emphasize practical approaches to behavior changes that are concrete.

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Native American Cultural Strengths

- **Importance of community cohesion - "the honor of one is the honor of all"**
  - Involve the extended family in education, counseling, and treatment planning, since kinship bonds extend beyond blood relatives to non-related friends and members of the tribe or clan.
  - Ensure tribal sanction for all activities.
  - Utilize the cooperative spirit of the community to promote peer educators.
  - Involve the elderly, who are deeply respected, in education.
  - Involve the whole community in caring for adolescents who are pregnant.

- **Strong belief in the interplay of the spiritual, physical, and psychological spheres**
  - Utilize sweat lodges, vision quests, talking circles to help the adolescent get in touch with their feeling, fears, and strengths.
  - Ensure that the client is being taken care of in her usual surroundings by family, friends and neighbors.
  - Call upon the Winds of the Four Directions to show the way in counseling and care (east =knowledge, south=warmth and affection, west=courage and strength and north=wisdom and healing).

- **Present time frame focus**
  - Focus on client's priorities first, and then move to provider's agenda.
  - Emphasize short term effect of behavior change rather than long term effects.

- **Action valued over words**
  - Avoid negotiation and communication with partners as goals.
  - Utilize direct, tangible, action-oriented approaches to counseling as opposed to introspective talk and listen methods.
  - Emphasize practical approaches to behavior changes that are concrete.

- **Importance of children**
  - Understand that children fulfill many roles and thus, the decision to postpone or not have children is a complex one. Discuss the significance of children for each client.
  - Discuss quality of life issues for children brought into a single parent family when both parents are not available.
  - Evaluate the ability of others in the community, especially the grandparents, to care for children whose parents are young adolescents (i.e. traditionally the grandparents or other relatives may care for children over an extended period of time.
  - Emphasize the importance of modeling responsible sexual and drug use behavior for future generations.

Adapted from Chapter Five, Providing Culturally Competent HIV Counseling, Education and Health Care, Randall-David, Ph.D., E., 1019 W. Marnham Ave, Durham, NC 27701. (919) 687-2765

- **History of self reliance and self help**

  - Emphasize the client's inner strengths and ability to make important decisions about his/her lifestyle and behaviors.
  - Understand the principle of non-interference, which allows people to make their own mistakes and decisions. Since support and assistance for a member of the extended family is not seen as interference, involve these significant people in education, counseling and treatment efforts.
  - Stability is valued over change, so emphasize the continuity of the tribe or community by the adoption of healthful and safe behaviors.

Adapted from Chapter Five, Providing Culturally Competent HIV Counseling, Education and Health Care, Randall-David, Ph.D., E., 1019 W. Marnham Ave, Durham, NC 27701. (919) 687-2765

Asian American Cultural Strengths

- **Importance of the extended family group**
  - Since the family is valued over the individual and bringing honor to the family is a strong value, emphasize that the adoption of responsible behaviors will reflect well on the family unit. Conversely, irresponsible behaviors will bring shame to the family.
  - Involve the family in education, counseling and care planning.
  - Since the elderly are well respected involve them as educators and care givers.
  - Personal problems are not discussed outside the family so consider the extended family as the support group rather than referring client to a support group of strangers.

- **Strong emphasis on education**
  - Frame counseling in educational terms rather than counseling ones.
  - Emphasize practical approaches to behavior change that are concrete and goal directed.
  - Focus on the present and immediate future rather than long term effects of behavior change.
  - Encourage peer education.

- **Interplay of the spiritual, physical and mental spheres**
  - Understand that emotional problems are sometimes manifested somatically.
  - Involve healers such as Buddhist monks or folk healers in both counseling and care efforts, since medical intervention is often believed to interfere with one's spirit.
  - Help clients get in touch with their inner strengths and help them develop the skills and resources needed to help themselves, because self-healing is valued.

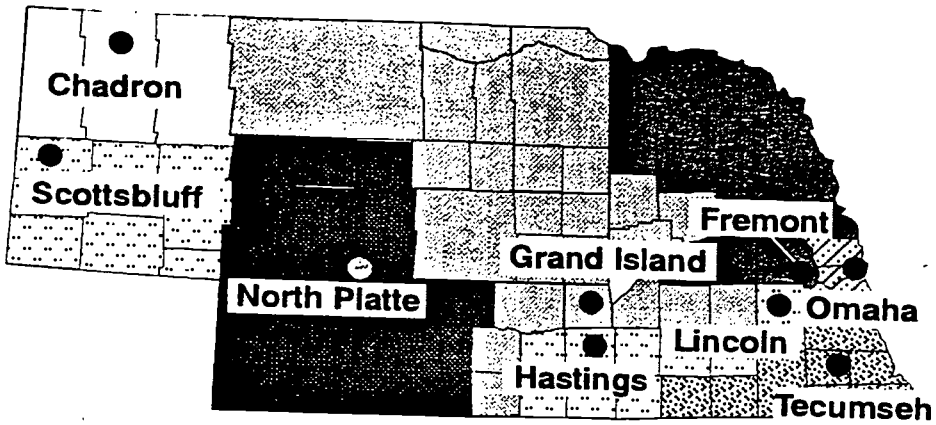
- **Importance of children**
  - Emphasize the importance of providing good role models for the next generation by the use of responsible sexual behaviors and refraining from drug abuse.

- **Modesty and chastity among women**
  - Respect this value when counseling women about behaviors and approach the topic of responsible sex obliquely rather than directly.
  - Don't ask a lot of personal questions until rapport has been established. Rapport building may take several sessions.

Adapted from Chapter Five, Providing Culturally Competent HIV Counseling, Education and Health Care, Randall-David, Ph.D., E., 1019 W. Marnham Ave, Durham, NC 27701. (919) 687-2765

APPENDIX ITEM C

NEBRASKA REPRODUCTIVE HEALTH CARE PROGRAM
NEBRASKA DEPARTMENT OF HEALTH



Chadron
Chadron Community Hospital
Family Reproductive Health Svcs
739 Morehead
Chadron, NE 69337
308/432-8979

*Alliance*Crawford*Gordon

Fremont
Fremont Family Planning/WIC
630 North "D" Street
Fremmont, NE 68025
402/727-5336

*Columbus*Norfolk

Grand Island
Women's Health Services of Central Nebraska
2337 North Webb
P.O. Box 5346
Grand Island, NE 68802
308/384-7625

*Ainsworth*Kearney
*Broken Bow*Lexington

Hastings
Hastings Family Planning
422 North Hastings Street, Suite 204
P.O. Box 288
Hastings, NE 68901
402/463-5687

Lincoln
Planned Parenthood of Lincoln
2246 "O" Street
Lincoln, NE 68510
402/441-3300

North Platte
People's Family Health Services
102 South Elm
North Platte, NE 69101
308/534-3075
*McCook*Ogallala

Omaha
Planned Parenthood of Omaha-Council Bluffs
4610 Dodge Street
Omaha, NE 68132
402/554-1040
*Ames Center*Northwest Center
*Southwest Center

UNMC -Family Planning
5211 South 31st Street
Omaha, NE 68107
402/595-2296
*UNMC Hospital*Harvey Oaks

Scottsbluff
Panhandle Community Services
975 Crescent Drive
Gering, NE 69341-1700
308/635-7354

Tecumseh
Family Health Services
186 South 4th Street
PO Box 68
Tecumseh, NE 68450
402/335-3988
*Beatrice*Falls City*Peru-Peru State College

APPENDIX ITEM D

Scottsbluff Public Schools/Gering Public Schools
Panhandle Communnity Services
"PROJECT SUCCESS"

Program Description

The Gering and Scottsbluff Public Schools and Panhandle Community Services collaborate to provide a program for pregnant and parenting teens which includes a full-day child development program for prekindergarten age children and a comprehensive parent education program. The program provides parenting classes and encourages teen parents to obtain a high school diploma.

Program Activities

- Child/Parent labs.
- Record of child's monthly growth.
- Thirteen guest speakers.
- Tutoring.
- Work study.
- Educational plans/visions
- Summer planning.
- Mother mentor program.
- Social Services.

Efforts at Collaboration

- Student attendance.
- Scheduling adjustments to meet individual needs.
- Transportation scheduling.
- Tutoring assignments.
- Homework for home-bound students due to pregnancy complications.
- Academic and personal counseling.
- Participation in student Individual Education Plan (IEP) planning and evaluation.
- Coordination of Child Development/Parenting class into school curriculum and grading system.
- Coordination of Project Success classes with special school scheduling.
- Conferences with staff about special needs and concerns of Project Success students.
- Support of counselors to refer students to Project Success.
- Coordinate work study opportunities.

Collaboration with Other Programs and Agencies

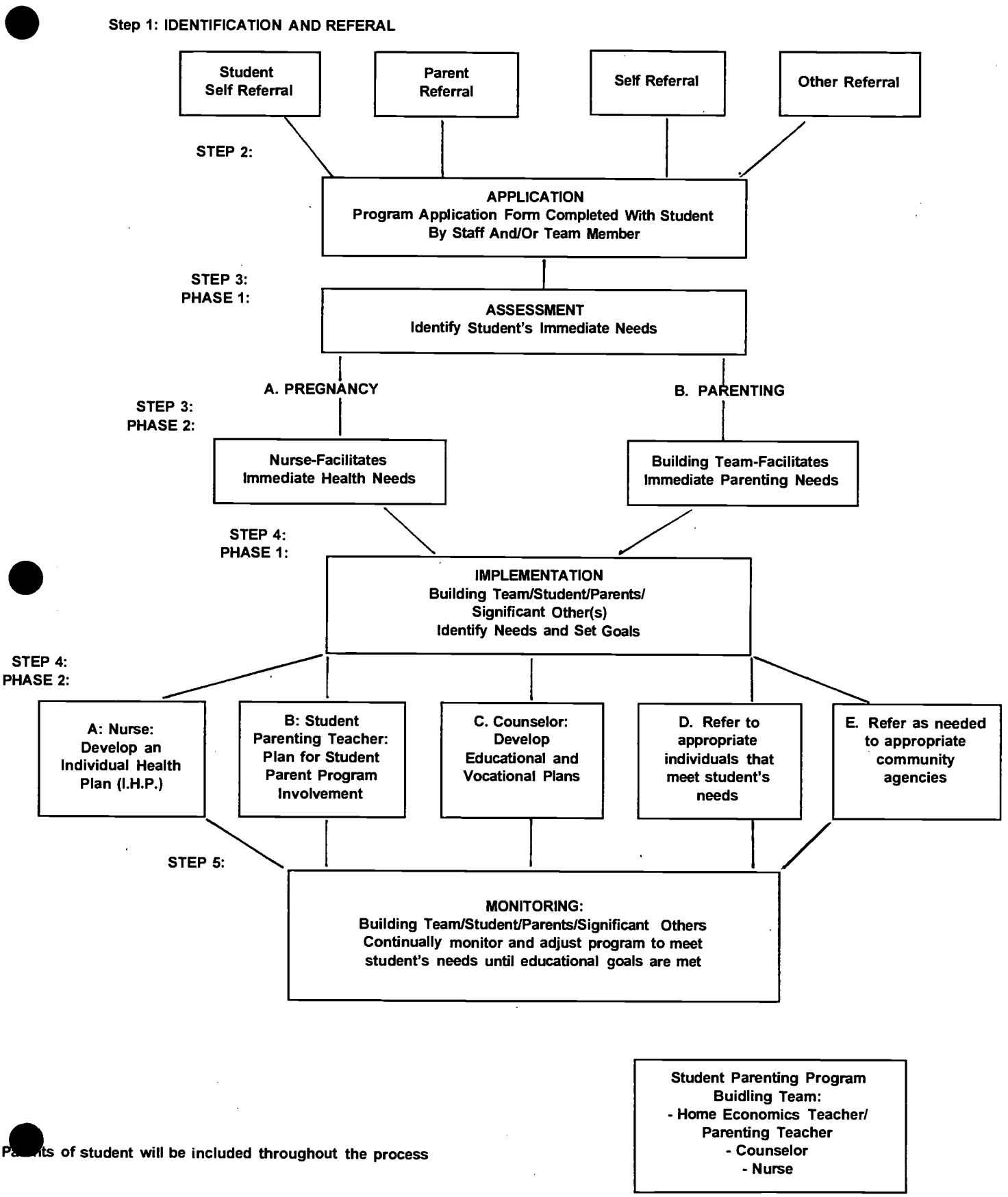
- Women, Infants, Children (WIC)
- Maternal Child Health (MCH)
- Head Start
- Western Nebraska Community College (WNCC)
- Panhandle Youth Shelter
- Weatherization Division of Panhandle Community Services
- Nebraska Department of Health and Safety
- Scottsbluff Library
- State Vocational Rehabilitation Office
- Single Parent/Displaced Homemaker
- Kiwanis Club
- University of Nebraska Nursing Program
- Foster Grandparent Program
- Panhandle Substance Abuse Center

Issues/Improvement Goals

- Keep encouraging significant others to participate in as many activities as possible.
- Communicate program goals to the mothers.
- Continue to reinforce to the mothers that the program is a partnership and a support group.
- Expand the Advisory Board's membership to include teen parents.
- Continue to offer as many educational options as feasible for the mothers supportive of career planning and the goal of graduation.
- Continue collaboration efforts.

APPENDIX ITEM E

STUDENT PARENT PROGRAM
INTAKE AND MONITORING PROCESS



STUDENT PARENT PROGRAM*
Intake and Monitoring Process Description

The Student Parent Program Intake and Monitoring Process is the procedure that would assure any student needing the program would be identified and would have the benefit of the program to meet their needs. The process can be adapted to match the needs of each individual school. In making adjustments, individual schools need to provide for the following:

1. identification of student's who are pregnant, will be parents or are parenting;
2. assessment of student's needs;
3. implementation of program to meet student's needs; and
4. monitoring throughout the program until educational goals are met for that student.

The process is described here to identify the purpose and action of each step.

STEP 1: IDENTIFICATION AND REFERRAL

The first step in the Intake and Monitoring Process is to identify and refer those students who are eligible to participate in the Student Parent Program. Any student who is pregnant or parenting is eligible. This includes both male and female students. Students may be referred to the program through self, parent, staff or other referrals. All staff members will receive information about the program and will be an important link between students and the Student Parent Program.

STEP 2: APPLICATION

In the second step the Program Application form is completed. This should be completed by a staff member with whom the student feels comfortable. This may be the nurse, counselor, student-parenting teacher, or any other staff member. It could be the staff person making the initial referral.

STEP 3: PHASE 1: ASSESSMENT

The purpose of this step is to quickly assess and determine the immediate needs of the student and refer them to the appropriate person or persons. If the student is pregnant, health needs would be the first concern and that student should always be referred to the nurse. Other immediate needs and concerns will be facilitated through the student parent building team. For example, if child care is an immediate concern, the student parent team leader would refer the student to the director of the district child care facility or if district child care is not available, the student and appropriate student parent team member would contact other child care sources. Other immediate needs might be housing, protection from abuse, school attendance, etc.

Note: Step 2 and 3 may be completed at the first conference and should be completed quickly after the initial referral.

STEP 3: PHASE 2: PATH A

For the student who is pregnant, step 3, phase 2 is to conference with the nurse. First step of the conference is to determine if the student has had a pregnancy test. If the student has not had a test, the student is referred for a pregnancy test to their personal physician or community agencies such as:

LMEF, Lincoln Medical Education Foundation, Family Practice Program, 4600 Valley Road
Planned Parenthood, 2246 "O" Street
City-County Health Department

*Included with permission from Lincoln Public Schools, 5901 "O" Street, Lincoln, NE 68510

Student returns to nurse with the information they received from the community agency or their personal physician.

If pregnancy test is negative, the nurse conferences with the student about sexual decisions, abstinence, and/or other birth control methods.

A determination of the male's involvement and commitment is established and attempts are made to conference with him. This is usually done by the counselor or designated person. A packet of information will be available for the male at the conference. This will include information on paternity, legal and ethical responsibilities, sexual decision-making and responsibilities.

If pregnancy test is positive, the first issue discussed is the parents' awareness of the pregnancy. "Have you told your parents?" A videotape of other student parents discussing this issue may be available for viewing. Included in this videotape will be effective and ineffective ways of communicating the pregnancy and possible outcomes and reactions.

The student will receive a resource packet to help facilitate decisions related to choices for this pregnancy and include information on nutrition, prenatal care, and community and school resources. This would be the student's first introduction to the student parent program. This packet will also be helpful to parents and may be a good way of facilitating education and communication.

A summary of the first conference will include these things to think about:

A time frame for the student to inform their parents of the pregnancy.
Possible reactions of parents.
Doctor preference.
Choice of options.
Complete Pregnancy Assessment.
Establish date of second conference.

Second Conference

Determination is made whether parents were informed of the pregnancy and of their reactions. The stages of crisis may be discussed here. If the student has been unable or unwilling to talk to their parents, obstacles are determined, and discussed. Counseling is provided and an intervention is discussed. It is critical that prenatal care be facilitated at the earliest possible date.

Parents are informed. Teachers and counselors are notified. It is important to know where the student is in the decision making process and which options and resources would be helpful.

Also, at this second conference, the student is acquainted with the other aspects of the student parent program, such as student-parenting classes, student-parenting support group, and support available from counselors, the nurse and other appropriate individuals and community agencies.

STEP 3: PHASE 2: PATH B

If the student is already a parent, the student will contact or be contacted by the member of the student parent team that can best assist them with their immediate need(s). This may be the nurse if the needs are health-related, the counselor if the needs are school-related, or the student-parenting teacher if the concern is parenting in nature. Students will receive a packet of information on the student parent program, community resources, and where to gain information related to pregnancy and parenting.

STEP 4: IMPLEMENTATION -- FIRST PHASE

This stage has two phases. In the first phase student's needs are determined, goals are set. This will involve any or all members of the building team, parents, and/or significant others. The Program Plan is used to facilitate needs assessment and goal setting.

*Included with permission from Lincoln Public Schools, 5901 "O" Street, Lincoln, NE 68510

STEP 4: SECOND PHASE

In the second phase of Implementation, the student makes the following contact.

a. The nurse will identify health needs of both parent and child. The Parent-Child Health Assessment form will be completed at this time. The student and nurse, along with others, such as parents and significant others will design a plan to meet the health needs of the student parents and the child.

b. The student-parenting teacher will plan how the student parent will be involved in the student parent program. This involvement could involve support group, parenting classes, child care, etc.

c. The counselor will develop the educational and vocational plan for the student parent.

d. Other individuals within the school or community that would help meet specific needs of the student

e. Community agencies that meet a specific need of the student.

The Program Plan is used to facilitate this planning stage.

STEP 5: MONITORING

The monitoring step is a continual process of checking the students goals, needs, concerns, and adjusting the plan to better meet these goals, needs, and concerns. This step will be designed to best serve the student. It may include frequent checks and adjustments or may be only an occasional check and adjustment.

The student will remain in the program until their educational goals are met or the program can no longer serve the student.

BUILDING TEAM

The Student Parent Program Building Team will consist of those staff members identified to serve the needs of the student parents in that school. It is suggested that the team include the nurse, a counselor, and the home economics teacher who teaches the student-parenting classes. Additional staff members could be a part of this team.

One member of the building team will be the team leader. The team leader's role is to facilitate the Intake and Monitoring Process. This person needs to know who has been referred, if follow-up contact have been made, if the individual's goals and needs are being met, and evaluate the progress of the student parents and the effectiveness of the program. The team leaders will be the central communication contact for the student, parents, staff, and community agencies and individuals.

*Included with permission from Lincoln Public Schools, 5901 "O" Street, Lincoln, NE 68510

FORMS

The following forms are suggested to facilitate the process and assist in monitoring individual students. Individual programs will select from and/or adapt these forms to meet their particular needs.

Referral

The "Referral" form will be used for identifying students who are pregnant and/or parenting. These students will need additional resources and support and could benefit from the program. This form will be completed when a person gains knowledge of a student who is pregnant and/or parenting. Any staff person will complete this form and return to Building Team leader.

Application

The purpose of "Program Application" form is to collect basic student information that will assist in the initial assessment and planning for the student's immediate needs. Information will also assist in any future contacts. The student should complete the application with a staff member with whom they feel comfortable. This staff member does not need to be a member of the Student Parent Building Team. This will be an important opportunity to establish positive rapport with the student and begin building the confidence needed for open communication.

Pregnancy Assessment

The "Pregnancy Assessment" form was developed for the school nurse to use in working with the pregnant student. It contains basic health information, as well as information regarding the student's plans and use of community resources. The form may be completed at the initial visit with the nurse, but probably it will be generated as needed and used throughout the student's pregnancy with additions added regularly.

Parent and Child Health Assessment

The "Parent and Child Health Assessment" form is to be used for any student parenting. It contains basic health information regarding the parent and child that is needed for the nurse to work effectively with the student parent. This information would be obtained by the nurse as an initial assessment or as an additional assessment after the birth of the baby.

Intake Information

The "Intake Information" form will be completed at the implementation step to collect information that would assist in program planning foe the individual student. This could be used as an in class educational experience.

Program Plan

The "Program Plan" is utilized at the Implementation and Monitoring steps to facilitate the needs assessment, goals setting, program planning, and evaluation. This form should be on N.C.R. paper. Four copies would be needed, one each for student file, the student, student's parents, and the student's program manager.

Recommended Color and Paper for Forms

Referral - Blue, ½ sheet Application - Blue Pregnancy Assessment - Yellow
Parent-Child Health Assessment - ½ sheet, pink card stock
Intake Information - Green Program Plan - N.C.R. paper

APPENDIX ITEM F

Table 1.2
CORE ELEMENTS OF A COMPREHENSIVE SERVICE STRATEGY

Services for Adolescent Parents

- Flexible quality schooling, either in alternative settings or within comprehensive high schools, that complies with Title IX and incorporates accountability on the part of education providers
- Subsidized, accessible, reliable, quality child care while in school and during transitions between school and continued education, job training, or employment
- Pre-natal care and family planning services
- Case management services, including referrals to other services as needed (e.g., housing), help with transitions back to home schools, and visitation as necessary (i.e. case management)
- Family support and development services, including personal and relationship counseling
- Parenting and child development education
- Critical support services, including transportation assistance, that will allow the adolescent to stay in school
- Services that facilitate transition to post-secondary education, training or employment

Services for Children

- Quality child development programming (either in center(s), on or off-site, or in family child care homes nested around schools or with relatives and linked to schools in such a way that children receive the same services as those in school-based care)
- Preventive health care, developmental screens and follow-up services for children

APPENDIX ITEM G

COMMUNICATION SKILLS

- **Listen**. Do not interrupt the adolescent. "Check out" what the teenager is saying by restating it in your own words. Listening is an active process. If you are thinking about how you are going to respond when the other person stops talking, you are not listening.

- **Look.** Use eye contact frequently during the interview and note the adolescent's body language. Also, be aware of your own body language. Sitting back with hands folded indicates a much more closed attitude than leaning forward with your hands in your lap as the student talks. A desk between you and the adolescent can act as a barrier, whereas if the two of you are facing each other on the same side of the desk, a more open situation is created.

- **Level-be honest.** Speak only for yourself by using words such as "I", "my", "mine".

- **Be accepting.** Always keep in mind positive things about the adolescent. It is difficult to work with someone we do not accept and like. If we constantly remind ourselves about the positive aspects of the individual, we will be able to counsel her more effectively.

- **Reinforce.** Always reinforce the adolescent's strengths and positive attributes. Coping with the dramatic changes of adolescence is difficult-- no adult can truthfully deny that this was not true in their time; therefore, adolescents need all the positive strokes they can get along their way to adulthood.

- **Be objective.** Decide not to take personally what is said to you. Listen not to how issues affect you and your beliefs, but to how they will affect the adolescent.

- **Check for understanding.** Ask the teen to repeat what was decided, including her plans or possible outcomes.

Indiana State Board of Health, Local Support Services; Adolescent Pregnancy, School Nurses Can Make a Difference!

ROAD BLOCKS TO COMMUNICATION

The following are examples of road blocks to communication with an adolescent.

- Ignoring the problem. Not responding to an identified problem is a response which can be interpreted by the student population that either you do not care or you approve of the situation.
- Name calling or labeling. For example, "Don't be silly, you shouldn't feel that way."
- Why questions. "Why?" is a very threatening question. Often we do not know why something happened. It helps to change your questions into "what" questions, or simply state your observation of the situation.
- Advising. For example, "If I were you..." or, "You ought to have known better than that.
- Saying "you" when you mean "I". For example, saying "You shouldn't do that" when you mean-- "I would like you to stop that" or stating "you shouldn't eat so many sweets" when actually it would help to say "I would like to see you cut down on sweets and eat some fruit instead." Saying "You shouldn't" conveys a more judgmental attitude; "I would like to see you..." conveys a caring attitude that may better encourage compliance with suggestions.
- Speaking for someone else. For example, "That is not what you really think." You do not actually know what they really think. Let them speak for themselves.

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APPENDIX ITEM H

INTERVENTION STRATEGY:
CUMMUNICATING PREGNANCY STATUS TO PARENTS

INITIAL SCHOOL NURSE/STUDENT INTERVIEW

1. Assess probability of pregnancy
   - a) date of last menstrual period (LMP)
   - b) are menses regular
   - c) was last menses typical

2. Establish supportive role. Explain parameters of professional confidentiality
   - a) must reveal to appropriate others if danger to self or others

3. Determine to whom student has confided concerns regarding pregnancy
   - a) has she obtained medical confirmation of pregnancy
   - b) has she done home pregnancy test

4. Explore current relationship with sexual partner(s)

5. Explore patterns of sexual activity and/or useage of birth control

6. Explore relationships with each parent
   - a) determine if risk of abuse/neglect exists

7. Facilitate positive medical determination of pregnancy at appropriate provider resource
   - a) private provider
   - b) public health/community clinic
   - c) reproductive health clinic

8. Facilitate parent/guardian awarenss of pregnancy
   - a. Method of notification selected by student
     - Student __
     - Student and partner __
     - Other family member & friend __
     - Other school personnnel ___
     - Requests school nurse support ____
   - b, Place of notification determined
     - Home visit ___
     - School conference room ___
   - c. Time of notification
     - Allow one week timeframe. If notification not completed, must assist student

9. Explore present health care options
   - Insurance status
   - Medicaid eligibility
   - Other resources

10. Maintain professional supportive relationship
    - Student
    - Male partner
    - Grand-parents
    - Family support system

11. Monitor health and educational status
    - Pregnancy and post-partum period
    - Advocate graduation and vocational/college programs

APPENDIX ITEM I

INDICATORS SUGGESTING ALCOHOL OR OTHER DRUG DEPENDENCE IN A PREGNANT WOMAN

Behavioral

Vague history regarding personal or medical problems.

Conflicts with significant others or domestic violence

History of child abuse or neglect

Decreased job performance or chronic unemployment

Suicidal gestures, thoughts, or attempts

Car accidents

Cited for driving while intoxicated

Depression

Irritability or agitation

Difficulty concentrating

Mood swings or outburst of anger

Inappropriate behavior

Smell of alcohol on breath

Unreliability or unpredictable behavior

Missed appointments

Intense daily drama, family chaos

Slurred speech

Staggering gait

Medical

Liver disease, Hepatomegaly

Pancreatitis, Hypertension

Gastritis, esophagitis

Neurologic disorders

Poor nutritional status

Hematologic disorders

Seropositivity for HIV*

Bacteremia

Alcoholic myopathy

Sensory impairment

Problems of sepsis, cellulitis

Hepatitis

Abscesses

Mitral valve disease

Septicemia

Swelling and erythema of hands

Overdose, Withdrawal effects

Pulmonary infections

Hair loss

Erratic menses

Loss or appetite

Poor dental hygiene

Anemia, Tuberculosis

Sexually transmitted disease

Obstetric complications, including spontaneous abortion, abruption placentae, breech presentations, previous cesarean section, eclampsia, intrauterine growth retardation, premature labor and delivery and premature rupture of membranes, intrauterine fetal death, postpartum hemorrhage

Historical

Alcohol or drug-abusing partner

Many emergency department contacts

Many physician contacts

Child with neonatal narcotic abstinence syndrome

Child with alcohol-related birth defects

Placement of other children outside the home

Complex perinatal histories and outcomes

Psychiatric treatment or hospital admissions

Affective disorders

Infants with low birth weights

Frequent physician prescriptions for mind-altering drugs

Family history of alcoholism or other drug dependence

Sudden infant death syndrome

Family dissolution

*HIV=human immunodeficiency virus

Jessup, 1990

APPENDIX ITEM J

SUPPORT STRATEGY
MONITORING PRE-NATAL/POST-NATAL PERIODS

Name_____ DOB_____ Date_____
(Initial Student//Nurse Conference)

* See explanation, examples of each task on reverse side of this matrix.

Month →

Task ✓*	1	2	3	4	5	6	7	8	9	10	11	12
1. Verify Pregnancy & PE Eligibility												
2. Assess paternal & family support, determine method of notification												
3. Assess School & community resources & support systems												
4. Enter into prenatal care												
5. Monitor compliance with medical orders and appointment schedule												
6. Monitor for emerging health problems												
7. Adjust class schedule												
8. Offer adolescent pregnancy program												
9. Monitor infant & early childhood development												
10. Educational challenges/ opportunities												

* ✔ Task explanation/examples

Task # 1) Written communication from medical provider verfying pregnancy, expected date of delivery, and physical education limitations, if any.

Task # 2) Determine method of notification, monitor relationship status and emancipation status.

Task # 3) Determine resources needed: NE Dept. of Social Services (social worker/Medicaid), prenatal classes, WIC, transportation, psychosocial support, and parenting classes.

Task # 4) Obtain baseline data; BP, Pulse, Pre-pregnancy and current weight, and monitor weight monthly.

Task # 5) Check adherence to healthy nutrition, prenatal vitamin therapy, and weight gain parameters.

Task # 6) Responses to RX, gestational diabetes, STDs, cystitis, premature labor, BP, weight gain, edema, PE eligibility/modification.

Task # 7) Appropriate notification of staff.

Task # 8) Weekly individual support, bi-weekly group support, include teen dads.

Suggested Topics: •Option: adoption, open adoption •Parenting, community resources •Normal stages of pregnancy •Nutrition; refer to WIC, food stamps, medical care, program eligibility •Private physician, SSI, Medicaid, selecting hospital for delivery •Legal issues; establish paternity, adoption laws, child support, visitation rights •Comfort issues; shoes, supportive clothing, posture, rest •Normal labor and delivery; Lamaze class, breast feeding(prepare) and post-partum care •Emergent care issues; high BP, sudden weight gain, spotting, vaginal bleeding, persistent pains •Post-Partum health; birth control, appropriate exercise, STD prevention, continued nutritional needs, rest, further educational opportunity, career.

Task # 9) Breast feeding or formula preparation, pediatric supervision, safety issues (car seats, toys, furniture), child care options (day care, baby sitters, parent involvement).

Task #10) Transportation issues, complete graduation requirements, tutoring support, employment, college preparation, vocational counseling.

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Prenatal/Postnatal Record

Name_____ DOB____/____/____ Student No. _____

Address_____ Phone_____ SS#_____

Parent/Guardian_____ Address_____

Phone: Home_____ Work _____

Emergency Contact	Relationship	Phone
(1)_____		
(2)_____		

Clinic/Physician_____ Phone_____ Hospital_____

Confirmation Note (Date)____/____/____ EDC____ Para____ Gravida____

Restrictions (including PE)_____

Parenting_____ Not Parenting_____ Father of Baby (opt)_____

Resources (including date of referral)

NDSS - Social Worker_____ Phone_____

Services_____ Date____/____/____

Prenatal/Birthing Class (location)_____ Date____/____/____

WIC (location)_____ Date____/____/____

CSI____/____/____ First Step____/____/____ Girls Inc.____/____/____ OPS Parenting/Prenatal Class____/____/____

Other Resources_____

Baseline Data - Date____/____/____
BP_____ P_____ Pre-Pregnancy Wt_____ Current Wt_____
Assess/Education: BP, Weight, Edema, Fetal movement, N&V, Drug Use, Headaches, Bleeding, Ucs, Discharge, Other Warning Signs
Psycho-Social: Acceptance of Pregnancy, Support, Developmental Status etc.

Nursing Notes
(S = Subjective, O = Objective, A = Analysis, P = Plan, E = Evaluation)

Date	Nursing DX/ Focus	Documentation

Postnatal

Release to Return to School - Date ____/____/____ Physician _____

Delivery Date ____/____/____ Sex _____ Length _____ Weight _____ Complications _____

Daycare Arrangements _____ 6-week PE ____/____/____

EducationalPlans _____

APPENDIX ITEM K

RECOMMENDED MATERNAL WEIGHT GAIN FOR PREGNANT ADOLESCENTS

For pregnant adolescents, body weight is assessed at time of conception. The recommended ranges for maternal weight gain provide flexibility in meeting the pregnant adolescent's caloric needs based on individual body weight and proximity of onset of menarche to time of conception.

In category 1, for example, an adolescent who is underweight at the time of conception and conceives only one year after onset of first menses should be counseled to achieve the upper end of the range. Conversely, an obese adolescent who also conceives one year after onset of first menses should be counseled to achieve the lower end of the range.

BODY WEIGHT AT TIME OF CONCEPTION	RECOMMENDED RANGE OF TOTAL MATERNAL WEIGHT GAIN
Entering pregnancy underweight (BMI<15th percentile **or** time of conception occurred less than two years after first menstrual period.	28 - 40 lbs
Entering pregnancy at an acceptable weight (BMI≥ 15th < 85th) **and** time of conception occurred more than two years after first menstrual period.	23 - 35 lbs
Entering pregnancy overweight (BMI ≥ 85th percentile) **and** time of conception occurred more than two years after first menstrual period.	15 - 25 lbs

"Basic Concepts in Identifying the Health Needs of Adolescents" Center for Continuing Education in Adolescent Health, Division of Adolescent Medicine, Children's Hospital Medical Center, Elland and Bethesda Ave., Cincinnati, OH 45229

U.S. Department of Health & Human Services
Public Health Service

HRSA

Health Resources & Services Administration
Maternal & Child Health Bureau
Office of Adolescent Health

NEBRASKA DEPARTMENT OF HEALTH
301 Centennial Mall South
Lincoln, NE 68509

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