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ABSTRACT

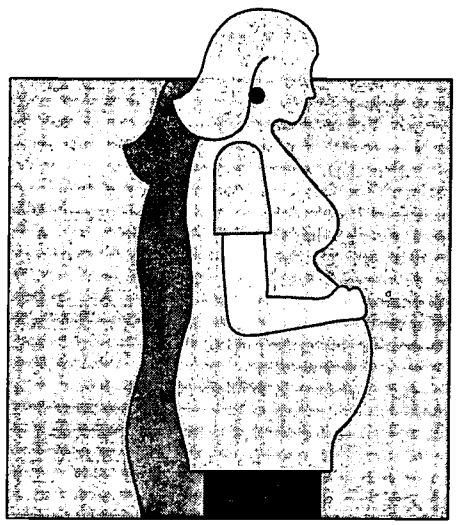
This introductory packet is designed to help those with an interest in preventing teen pregnancy. It opens with "A Brief Introduction to Teen Pregnancy Prevention and Support," an essay by the Center for Mental Health in Schools of the University of California, Los Angeles, that outlines the dimensions of the problem. "A Quick Overview of Some Basic Resources" follows, with lists of 29 selected references, 12 agencies and organizations (including Internet sites), and names from the Center's cadre of experts. A section titled "A Few Resource Aids" contains some fact sheets on "High Risk Factors and Adolescent Sexual Health," "Pregnancy, Poverty, School and Employment," and "How Many Adolescents Are Getting Pregnant?" Ten model programs are described, and contact persons are listed for further information. The resource packet also contains excerpts from some relevant articles, including: (1) a chapter from "Adolescent Pregnancy and Parenting in California: A Strategic Plan for Action" by Claire D. Brindis and Rita J. Jeremy for the Center for Population and Reproductive Health Policy; (2) a report from the National Adolescent Health Information Center, "Overview of Trends in Adolescent Pregnancy"; (3) excerpts from "Reframing the Issue: New Approaches to Teen Pregnancy" from Adolescent Pregnancy ChildWatch; (4) an article from the Minnesota Organization on Adolescent Pregnancy, Prevention, and Parenting (MOAPPP) "Monitor,", "Sexuality in the Multicultural Classroom" by Miriam Hecksel; and (5) an article from the MOAPP "Monitor" by Tisha Bolger, "Support Services for Pregnant Teens." (SLD)

Mental Health in Schools Center
Training and Technical Assistance

*From the Center's Clearinghouse...**

An introductory packet on

Teen Pregnancy Prevention and Support



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This Center is co-directed by Howard Adelman and Linda Taylor and operates under the auspices of the School Mental Health Project, Dept. of Psychology, UCLA, Los Angeles, CA 90095-1563 -- Phone: (310) 825-3634; Fax: (310) 206-8716 ; E-mail: smhp@ucla.edu; http://smhp.psych.ucla.edu

Support comes in part from the Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Maternal and Child Health Bureau, Office of Adolescent Health.

U.S. Department of Health & Human Services
Public Health Service
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Updated - 10/98

UCLA CENTER FOR MENTAL HEALTH IN SCHOOLS*

Under the auspices of the School Mental Health Project in the Department of Psychology at UCLA, our center approaches mental health and psychosocial concerns from the broad perspective of addressing barriers to learning and promoting healthy development. Specific attention is given policies and strategies that can counter fragmentation and enhance collaboration between school and community programs.

MISSION: ***To improve outcomes for young people by enhancing policies, programs, and practices relevant to mental health in schools.***

Through collaboration, the center will

- **enhance practitioner roles, functions and competence**
- **interface with systemic reform movements to strengthen mental health in schools**
- **assist localities in building and maintaining their own infrastructure for training, support, and continuing education that fosters integration of mental health in schools**

Consultation Cadre ***Clearinghouse***

Newsletter ***National & Regional Meetings***

Electronic Networking

Guidebooks ***Policy Analyses***

Co-directors: Howard Adelman and Linda Taylor
Address: UCLA, Dept. of Psychology, 405 Hilgard Ave., Los Angeles, CA 90095-1563.
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Website: http://smhp.psych.ucla.edu/

*In 1996, two national training and technical assistance centers focused on mental health in schools were established with partial support from the U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Maternal and Child Health Bureau, Office of Adolescent Health. As indicated, one center is located at UCLA; the other is at the University of Maryland at Baltimore and can be contacted toll free at 1-(888) 706-0980.

U.S. Department of Health & Human Services
Public Health Service
HRSA
Health Resources & Services Administration
Maternal & Child Health Bureau
Office of Adolescent Health

What is the Center's Clearinghouse?

The scope of the Center's Clearinghouse reflects the School Mental Health Project's mission -- to enhance the ability of schools and their surrounding communities to address mental health and psychosocial barriers to student learning and promote healthy development. Those of you working so hard to address these concerns need ready access to resource materials. The Center's Clearinghouse is your link to specialized resources, materials, and information. The staff supplements, compiles, and disseminates resources on topics fundamental to our mission. As we identify what is available across the country, we are building systems to connect you with a wide variety of resources. Whether your focus is on an individual, a family, a classroom, a school, or a school system, we intend to be of service to you. Our evolving catalogue is available on request; eventually it will be accessible electronically over the Internet.

What kinds of resources, materials, and information are available?

We can provide or direct you to a variety of resources, materials, and information that we have categorized under three areas of concern:

- Specific psychosocial problems
- Programs and processes
- System and policy concerns

Among the various ways we package resources are our *Introductory Packets, Resource Aid Packets, special reports, guidebooks*, and *continuing education units.* These encompass overview discussions of major topics, descriptions of model programs, references to publications, access information to other relevant centers, organizations, advocacy groups, and Internet links, and specific tools that can guide and assist with training activity and student/family interventions (such as outlines, checklists, instruments, and other resources that can be copied and used as information handouts and aids for practice).

Accessing the Clearinghouse

- E-mail us at **smhp@ucla.edu**
- FAX us at (310) 206-8716
- Phone (310) 825-3634
- Write School Mental Health Project/Center for Mental Health in Schools, Dept. of Psychology, Los Angeles, CA 90095-1563

Check out recent additions to the Clearinghouse on our Web site
http://smhp.psych.ucla.edu

All materials from the Center's Clearinghouse are available for a minimal fee to cover the cost of copying, handling, and postage. Eventually, we plan to have some of this material and other Clearinghouse documents available, at no-cost, on-line for those with Internet access.

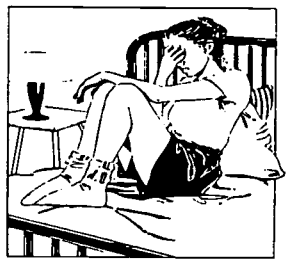
If you know of something we should have in the clearinghouse, let us know.

U.S. Department of Health & Human Services
Public Health Service
HRSA
Health Resources & Services Administration
Maternal & Child Health Bureau
Office of Adolescent Health

"Schools can play a significant role as the locus for interventions which improve the life options for pregnant and parenting teens and their children. A school-based program is defined as 'a program which serves youth who remain in or return to school with most core services provided on-site although not necessarily administered by the school.' "

C. Sipe
Center for Assessment and Policy Development
1995

Teen Pregnancy Prevention and Support



Adolescent pregnancy, always a feature of American life, has traditionally been a private family matter. What makes it a pressing public issue today is the changing social environment in which it is occurring and the growing awareness of its wider social consequences.
Brindis & Jeremy, 1988

This introductory packet contains: ***Page***

A Brief Introduction to Teen Pregnancy Prevention and Support

The following is adapted from several sources:

Overwhelmed! Confused! Helpless! As we try to address the complexities of preventing teen pregnancies and supporting teen parents, we often feel these emotions. It's not surprising; there is much to overwhelm us as we work with communities, parents and teens to create effective programs and policies...

Although sociocultural factors are important correlates of adolescent pregnancy, psychological factors are also implicated. One such factor is a sense of low self-worth and limited life options. Having a child may bring a sense of power and identity to the teen's life: "At least I can say I am a parent and I created this child"...

Solving the teen pregnancy problem is, in large part, an adult responsibility. We must do all we can on a personal and community level to increase contraceptive availability, and most important, to make sure our young people, from infancy through adolescence, feel valued. [Teen pregnancy rate headed in right direction. D. Fishman & N. Nelson (1997). *Minnesota Organization on Adolescent Pregnancy, Prevention, and Parenting (MOAPP) Monitor*, Summer].

Statistics indicate that we are making progress. Final data for 1995 and preliminary data for 1996 from the National Center for Health Statistics show that the teen birth rate has declined slowly but steadily for five years. However, it's not quite time to celebrate. Despite this decline, the rate of adolescent births in the U.S. remains higher than in virtually all other industrialized countries. [Unpublished data from the National Center for Health Statistics, Department of Health and Human Services taken from: Facts at a glance. *Child Trends, Inc.* (1997)].

The reasons for these alarming figures are not obvious. Although the U.S. is more racially heterogenous than most other countries, and the rate of teen pregnancy in minority groups (19%) is higher than among white adolescents (9%), racial heterogeneity alone does not account for the high rate. Indeed, when American minorities were excluded from the sample, the adolescent birth rate in the U.S. was still higher than in every other developed country...

In looking for answers, an important area to focus on is poverty. One difference between the U.S. and the comparison countries was the amount of poverty. The statistics indicate that 60% of teens who become parents are living in poverty before they become pregnant. This endemic poverty is essentially unknown in Canada and in Western Europe. Therefore, the relatively high rate of poverty may be associated with perpetuating adolescent pregnancy...

The U.S. and comparison countries also differ in societal attitudes toward adolescent sexuality and contraception. The general American attitude is that sex among teenagers in not acceptable. In contrast, the European attitude is less condemning. For example, contraceptives were more available in foreign countries. Furthermore, in all countries studied except the U.S., teenagers reported having easy access to family planning clinics. It is noteworthy that countries in which contraceptives were easily available did not have a higher rate of adolescent sexual activity than the United States...

A second factor is the lack of accurate contraceptive information. Adolescents are not likely to question the extent of their knowledge, and are more likely to act on their subjective (often inaccurate) beliefs about the probability of becoming pregnant. Research from other developed countries shows that even young sexually active teenagers can successfully avoid pregnancy if they are given appropriate information and not left to seek it out on their own...

Although some factors such as American poverty are not easily modified, each of these factors have implications for the prevention of adolescent pregnancy. However, two direct and readily implemented changes are recommended: more extensive education about sexuality and contraception, and an increase in the ease with which adolescents can obtain contraception. In addition, programs designed to enhance adolescents' life options and self-worth may give young women the incentive to delay pregnancy. [Summary of adolescent pregnancy research: Implications for prevention. R. MacFarlane (1995). *The Prevention Researcher*].

Included in this introductory packet are descriptions of model programs, the names of agencies, organizations, and individuals in our consultation cadre, as well as a list of selected references--all of which are designed to help you become well-informed and prepared to take action in preventing teen pregnancy.

A Quick Overview of Some Basic Resources

A. Selected References

B. Agencies, Organizations, and Internet Sites

C. Some Names from Our Consultation Cadre

A Quick Overview of Some Basic Resources

A. Selected References

I. A Broad Perspective

Adolescent sex, contraception, and childbearing: A review of recent research.
K.A. Moore, B.C. Miller, D. Glei, D.R. Morrison.Washington, D.C.: Child Trends, Inc., 1995.

A statistical portrait of adolescent sex, contraception, and childbearing.
K.A. Moore, A.K. Driscoll, L.D. Lindberg. Washington, D.C.: Child Trends, Inc., 1998.

Kids having kids: A Robin Hood Foundation special report on the costs of adolescent childbearing.
R.A. Maynard (ed.). New York: Robin Hood Foundation., 1996.

Sources of support for teenage parents.
Washington, DC: U.S. Government Printing Office, 1990.

America's youth in crisis: Challenges and options for programs and policies.
R.M. Lerner. Thousand Oaks, CA: Sage Publications, Inc., 1995.

Perceptions of pregnant/parenting teens: Reframing issues for an integrated approach to pregnancy problems.
C. Rodriguez, Jr., & N.B. Moore (1995). *Adolescence, 30*, 685-706.

Common components of successful interventions with high-risk youth.
J.G. Dryfoos. (1993). In: *Adolescent Risk Taking.* N.J. Bell, R.W. Bell, (Eds.). Newbury Park, CA: Sage Publications, Inc. 131-147.

Female adolescents and sexuality: A look at teen sexual behavior, its consequences, and pregnancy prevention programs.
J.R. Lappin. (1994). In: *Women in Context: Toward a Feminist Reconstruction of Psychotherapy.* M.P. Mirkin, (Ed.). NY: Guilford Press, 462-481.

II. *Pregnancy Prevention Approaches*

Prevention of sexual intercourse for teen women aged 12 to 14.
L.T. Postrado, F.L. Weiss, H.J. Nicholson. (1997). *The Prevention Researcher.* 4(1)

Programmatic prevention of adolescent problem behaviors: The role of autonomy, relatedness, and volunteer service in the Teen Outreach Program.
J.P. Allen, G. Kuperminc, S. Philliber, & K. Herre. (1994). *American Journal of Community Psychology,* 22, 617-638.

Teen pregnancy prevention: A rural model using school and community collaboration.
N.D. Barnes, & S.E. Harrod. (1993). *School Counselor*, 41, 137-140.

Preventing adolescent pregnancy: Model programs and evaluations.
B.C. Miller, J.C. Card, R.L. Paikoff, J.L. Peterson, (Eds.). Newbury Park, CA: Sage Publications, Inc., 1992.

Adolescents with negative pregnancy results: An at-risk group.
L.S. Zabin, M.R. Emerson, P.A. Ringers, & V. Sedivy. (1996). *JAMA, The Journal of the American Medical Association, 275, (3),* 113-117.

Evaluating teenage pregnancy prevention and other social programs: Ten stages of program assessment.
J. L. Peterson, Josefina J. Card, M.B. Eisen, B. Sherman-Williams. (1994). *Family Planning Perspectives, 26, 3.* 116-111.

Targeting the at-risk male: A strategy for adolescent pregnancy prevention.
F.I. Watson & M.J. Kelly (1990). *Journal of the National Medical Association, 81,* 453-456.

Preventing adolescent pregnancy: Counseling teens and their parents.
J.B. Hardy. (1987). *Medical Aspects of Human Sexuality,* July, 32-38.

III. Associated Factors

Sexual abuse, adolescent pregnancy and child abuse. A developmental approach to an intergenerational cycle.
C.Stevens-Simon & S. Reichert (1994). *Archives of Pediatrics and Adolescent Medicine, 148,* 23-27.

Adolescent pregnancy and sexual risk-taking among sexually abused girls.
J.L. Stock, M.A. Bell, D.K. Boyer, F.A. Connell (1997). *Family Planning Perspectives, 29,* 200-203, 227.

Relationship of alcohol use and risky sexual behavior: A review and analysis of findings.
B.L. Halpern-Felsher, S.G. Millstein, J.M. Ellen (1996). *Journal of Adolescent Health, 19,* 331- 336.

Poverty, rape, adult/teen sex: Why 'pregnancy prevention' programs don't work.
M. Males (1994). *Phi Delta Kappan (75) 5* 407-410.

Cognitive, psychosocial, and reported sexual behavior differences between pregnant and nonpregnant adolescents.
G.W. Holden, P. B. Nelson, J. Velasquez, K.L. Ritchie (1993). *Adolescence, 28,* 557-571.

III. Cross-Cultural Considerations

Substance use and sexual risk-taking among black adolescents and white adolescents.
M.L. Cooper, R.S. Peirce, R.F. Huselid (1994). *Health Psychology, 13,* 251-262.

Onset of fertility-related events during adolescence: A prospective comparison of Mexican American and non-Hispanic white females.
C.S. Aneshensel, R.M. Becerra, E.P. Fielder, R.H. Schuler (1990). *American Journal of Public Health, 80,* 959-963.

Race differences in the timing of adolescent intercourse.
F.F. Furtstenberg, S.P. Morgan, K.A. Moore, J.L. Peterson (1987). *American Sociological Review, 52, 511-518.*

Adolescent pregnancy prevention for Hispanic youth.
C. Brindis (1997). *The Prevention Researcher.* 4(1)

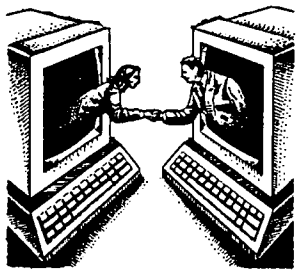
Attitudinal predictors of sexual activity in Hispanic adolescent females.
J.W. Gibson & J. Kempf (1990). *Journal of Adolescent Research,* 5, 414-430.

The correlates of the initiation of sexual intercourse among young urban black females.
A. Handler (1990). *Journal of Youth and Adolescence,* 19, 159-170.

A critique of adolescent pregnancy prevention research: The invisible white male.
V.F. Meyer (1991). *Adolescence, 26,* 217-222.

Sexually transmitted diseases, human immunodeficiency virus, and pregnancy prevention. Combined contraceptive practices among urban African-American early adolescents.
B.F. Stanton, X. Li, J. Galbraith, S. Feigleman, L. Kaljee (1996). *Archives of Pediatric and Adolescent Medicine, 150,* 17-24.

B. Agencies, Organizations, and Internet Sites



There are many agencies and organizations that help with teen pregnancy prevention and support. The following is a list of agencies, organizations and sites on the World Wide Web that offer information and resources related to teen pregnancy. This list is not a comprehensive list, but is meant to highlight some premier resources and serve as a beginning for your search. Also, at the end of this section is a guide to using the ERIC Clearinghouses on the Internet.

The Internet is a valuable tool when trying to find information on teen pregnancy prevention and support. For a start, try using a search engine such as Yahoo and typing in the words "teen pregnancy" or "teen sexuality". This will help you find relevant websites. Many of the websites you find will have "links" to other websites which cover similar topics. We have listed some below.

Advocates for Youth
1025 Vermont Avenue, NW, suite 200
Washington, D.C. 20005
(202) 347-5700
E-mail: info@advocatesforyouth.org

Advocates for Youth's mission is to meet the increasing demand for information on promising approaches to pregnancy prevention. It features the National Pregnancy Prevention Clearinghouse. The Clearinghouse researches, documents, and shares information on successful pregnancy prevention strategies, programs, and initiatives.

http://www.advocatesforyouth.org/
This website contains an order form for the Advocate Kit and the National Teen Pregnancy Prevention Month Planning Guidebook, resources designed to help local advocates organize at the state and local levels to promote comprehensive teen pregnancy prevention initiatives. The website also contains descriptions of model programs, statistics, and culturally specific information related to pregnancy prevention.

The Alan Guttmacher Institute
120 Wall Street
New York, N.Y. 10005
(212) 248-1111
E-mail: info@agi-usa.org

http://www.agi-usa.org
The Alan Guttmacher Institute provides extensive information about research and statistics in the area of pregnancy, contraception, sexual behavior, STDs, abortion youth and law/public policy. This website allows direct access to their publications "Facts in Brief" and "Issues in Brief," as well as other publication. The site also allows you to search by topic and access articles related to the areas listed above.

Bureau for At-Risk Youth

135 Dupont Street
P.O. Box 760
Plainview, New York 11803-0760
(800) 999-6884
E-mail: info@at-risk.com

http://www.at-risk.com
The Bureau for At-Risk Youth has developed resources for youth, parents, and educators on a variety of issues including adolescent sexuality and pregnancy. This site includes a resource directory, calendar of events, a buyer's guide to curriculum and a "community of the month" page honoring an outstanding youth program.

Child Trends, Inc.

4301 Connecticut Ave., N.W.
Washington, D.C. 20008
(202)362-5580
E-mail: webmaster@childtrends.com

http://www.childtrends.org/index/htm
Child Trends, Inc. Is a nonprofit, nonpartisan research organization that studies children, youth, and families through research, data collection, and data analysis. Their website lists available publications and reports, many of which deal with teen pregnancy issues. The site also provides national and state statistics on teen pregnancy.

Minnesota Organization on Adolescent Pregnancy, Prevention and Parenting (MOAPP)

P.O. Box 40392
St. Paul, MN 55104
(612) 644-1447
E-mail: moappp@juno.com

MOAPP's mission is to strengthen policies and programs related to adolescent pregnancy, prevention, and parenting in Minnesota.

http://www.cyfc.umn.edu/moappp/
This website contains the InfoExchange, a teen pregnancy and parenting clearinghouse with research, statistics, and information on effective program strategies and models. It also features the MOAPPP Monitor, a quarterly newsletter that focuses on topics related to the issues of adolescent pregnancy, prevention, and parenting. Also available are fact sheets for parents, educators, and teens, and an order form for the Community Empowerment Manual, which describes how to develop a community coalition.

National Campaign to Prevent Teen Pregnancy
2100 M Street NW, Suite 300
Washington, D.C. 20037
(202) 261-5655
E-mail: campaign@teenpregnancy.org

http://www.teenpregnancy.org/
The mission of the National Campaign is to prevent teen pregnancy by supporting values and stimulating actions that are consistent with a pregnancy-free adolescence. This web-site provides listings of their available publications and statistics on teen pregnancy.

National Organization on Adolescent Pregnancy, Parenting, and Prevention (NOAPPP)
1319 F Street, NW, Suite 400
Washington, D.C. 20004
(202) 783-5770
E-mail: NOAPPP@noappp.org

NOAPPP is the only national membership organization focused exclusively on these three issues. NOAPPP's mission is to provide leadership, education, training, information and advocacy resources, and support to practitioners in the field.

http://www.noappp.org
This website contains information on the annual NOAPPP conference, excerpts and subscription information for Network News, a leading quarterly informational newsletter, and Fact and Stats sheets related to teen pregnancy. It also has information relevant to state and local coalitions and advocacy.

Planned Parenthood Federation of America
810 Seventh Avenue
New York, NY 10019
(212) 261-4647
E-mail: communications@ppfa.org

Planned Parenthood's mission is to provide comprehensive reproductive and complementary health care services in settings which protect individual privacy; advocate public policies which ensure access to such services; provide educational programs which enhance understanding of human sexuality; and to promote research in reproductive health care.

http://www.plannedparenthood.org
This website provides information on women's sexual and reproductive health, birth control, abortion, sexually transmitted infections as well as fact sheets and external links relevant to these topics. It also contains guides for parents and teens which focus how to talk about sexuality, chose birth control, and deal with unplanned pregnancy. Local planned parenthood information is accessible by entering a zip code into the website's search engine.

Planned Parenthood Federation of America - Katherine Dexter McCormick Library
E-mail: communications@ppfa.org

http://www.plannedparenthood.org/library/PPFA-LIBRARY/defaultlibrary.html
The McCormick library has a collection of 5,000 volumes, over 50,000 articles and clippings, and 125 scholarly journals. This highly specialized collection provides the fields of family planning, population, sexual health, and sexuality education with an in-depth collection of materials on such topics as teenage sexuality, pregnancy and births. Over 80 branches nationwide.

Planned Parenthood Federation of America - Katherine Dexter McCormick Library-Southeastern Pennsylvania Branch
1211 Chestnut Street
Philadelphia, PA 19107
(215) 496-9696
E-mail: ppsp_lib@ppfa.org

http://www.libertynet.org/ppsepa/resctr.html
The McCormick library Southeastern Pennsylvania branch website contains a search engine of over 2,500 books and teaching curricula, 40 professional and trade journals, and thousands of news clippings, article reprints, and pamphlets. Type in all or part of a subject, title, or author's last name, or choose from a list of categories including teen pregnancy. A diverse selection of materials are also available to order on-line.

Planned Parenthood Federation of America - LINK
E-mail: communications@ppfa.org

http://www.plannedparenthood.org/library/PPFA-LIBRARY/link.html
LINK is a computerized database of over 15,000 books, brochures, programs, curricula, and audiovisual materials on all aspects of sexuality education. Database records locate: bibliographies of books and research articles in the Katharine Dexter McCormick Library; relevant information on pamphlets, flyers, posters, handbooks, and curricula for educational programs and events; and program records and abstracts from the national Education Resources Clearinghouse. Database searches are $10 for the service, and 10 cents per printout page. Database topics include teen pregnancy, parenting, and sexuality.

The Prevention Researcher
66 Club Road, Suite 370
Eugene, Oregon 97401-2464
(541) 683-9278 or (800) 929-2955
E-mail: ckinteg@cerf.net

http://www.integres.org/prevres
The Prevention Researcher is a non-profit corporation engaged in research, development and analysis in the behavioral and social sciences. Their website has overviews of each of its newsletters, one of which focuses on Teen Pregnancy Prevention.

C. Teen Pregnancy Prevention and Support Consultation Cadre:

Professionals across the country volunteer to network with others to share what they know. Some cadre members run programs, many work directly with youngsters in a variety of settings and focus on a wide range of psychosocial problems. Others are ready to share their expertise on policy, funding, and major system concerns. The group encompasses professionals working in schools, agencies, community organizations, resource centers, clinics and health centers, teaching hospitals, universities, and so forth.

People ask how we screen cadre members. We don't! It's not our role to endorse anyone. We think it's wonderful that so many professionals want to help their colleagues, and our role is to facilitate the networking. If you are willing to offer informal consultation at no charge to colleagues trying to improve systems, programs, and services for addressing barriers to learning, let us know. Our list is growing each day; the following are those currently on file related to this topic. Note: the list is alphabetized by Region and State as an aid in finding a nearby resource.

Central States

Iowa

Pam Bleam
Elementary Counselor
Manson Northwest Webster School
Manson, IA 50563
Phone: 712/469/2682

Kaye Grossnickle
Program Director
School Based Youth Services Program
Fort Dodge Senior High School
819 N. 25th St.
Fort Dodge, IA 50501
Phone: 515/574-5444
Fax: 515/574-5446
Email: kgrossnickle@aea5.k12.ia.us

Arlene Prather-O'Kane
Program Assistant
Black Hawk County health Department - Success Street
1515 1/2 Logan Ave.
Waterloo, IA 50703
Phone: 319/291-2674
Fax: 319/291-2676

Iowa (cont.)

Pamela Tekippe
Clinical Social Worker
Mental Health Clinic of Tama Co.
1309 S. Broadway
Toledo, IA 52342
Phone: 515/484-5234
Fax: 515/484-5632

Indiana

Susan Johnson
Clinic Social Worker
Tech. Teen Clinic of Health Net Inc.
1500 E. Michigan Street Room 120
Indianapolis, IN 46201
Phone: 317/226-3929

Michigan

Nancy Adadow Gray
Director, Fam. Coun.; Comm. MH Services
Arab Community Center for Economic and Social Services (ACCESS)
2601 Saulino Court
Dearborn, MI 48120
Phone: 313/843-2844
Fax: 313/842-5150

Michigan (cont.)

Karen Williams
Supervisor- School-Based Health Centers
Mott Children's Health Center
806 Tuuri Place
Flint, MI 48503
Phone: 810/767-5750
Fax: 810/768-7511

Minnesota

Jose Gonzalez
Interpreter / Supervisor
Minneapolis Dept. of Health & Family Support
250 4th St. So., Rm 401
Minneapolis, MN 55415
Phone: 612/673-3815
Fax: 612/673-2891

East

Connecticut

Thomas Guilotta, CEO
Child & Family Agency
255 Hempstead Street
New London, CT 06320
Phone: 860/443-2896
Fax: 860/442-5909
Email: tpgullotta@aol.com

Marsha Kline Pruett
Research Scientist
The Consultation Center
Yale University, School of Medicine
389 Whitney Avenue
New Haven, CT 06511
Phone: 203/789-7645
Fax: 203/562-6355
Email: tcc@yale.edu

District of Columbia

LuAnn Dickie
Program Associate
First Things First
Planned Parenthood Federation of America
1120 Connecticut Ave, NW, Suite 461
Washington, DC 20036
Phone: 202/973-6399
Fax: 202/296-0956
Email: luann_Dickie@PPFA.org

District of Columbia (cont.)

Ronda Talley
425 Eighth Street, NW, #645
Washington, DC 20004
Phone: 202/393-0658
Fax: 202/393-5864
Email: TalleyRC@aol.com

Delaware

Gregory Durrette
Project Cood.
Christiana Care Health Services,
The Wellness Center
DelCastle Technical High School
1417 Newport Road
Willington, DE 19804
Phone: 302/892-4460
Fax: 302/892-4463

R. Blaine Morris
Counselor
Middletown Adolescent Health Project
Middletown High School
122 Silver Lake Road
Middletown, DE 19709
Phone: 302/378-5776
Fax: 302/378-5760

Delaware (cont.)

Jacquelyn Wade
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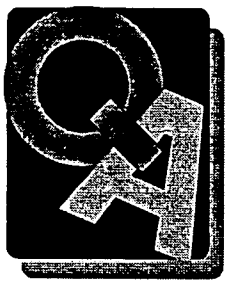
A Few Resource Aids



A. High-Risk Factors and Adolescent Sexual Health

B. Pregnancy, Poverty, School and Employment

C. How Many Adolescents are Getting Pregnant?

The following resource is adapted from 'The Facts: High-Risk Factors and Adolescent Health,' located on the Minnesota Organization on Adolescent Pregnancy, Prevention and Parenting (MOAPP) website. Please see website for complete document and references: http://www.cyfc.umn.edu/moapp/highrisk.htm

High-Risk Factors and Adolescent Sexual Health

Some studies suggest that teen pregnancy is not an isolated phenomenon, but one of several consequences that may result from a combination of factors. Such factors may contribute to teens' high-risk behaviors, including: substance abuse, early and unprotected sex, and involvement in crime and violence. Connections like these are often overlooked in efforts to prevent teen pregnancy. A deeper examination of the external influences on adolescents who become involved in a pregnancy is required in order to fully comprehend and effectively respond to the complexity of teen pregnancy.

Substance Use and Abuse

- ✘ Teens who become involved with tobacco and alcohol at a young age are more likely to associate with friends who have sexually permissive attitudes and behaviors (Moore 1995).

- ✘ Compared to both males and females with no drug history, the risk for early sex is high for those reporting prior use of alcohol and cigarettes, and other illicit drugs (Moore 1995).

- ✘ Nationally, 28% of students said that they used alcohol or drugs at last sexual intercourse. Male students (33%) are significantly more likely than female students (17%) to report that they used alcohol or drugs at last sexual intercourse (CDC 1995).

- ✘ Among sexually active adolescents, substance use has been associated with increased sexual risk taking at the time of first intercourse ever and at first intercourse with a new partner (Cooper 1994).

- ✘ Nearly one-third of students who have used drugs have had sexual intercourse with four or more partners and did not use a condom (Lowry 1994).

- ✘ Young men involved in a pregnancy reported more cigarette, alcohol, cocaine use, and were more likely to drink while driving than young men who had not been involved with a pregnancy (Spingarn 1996).

- ✘ In spite of the dangers to both the mother and the baby, many pregnant adolescents continue to use tobacco, alcohol, and other substances (Gilchrist 1996).

Sexual Violence

- Pregnant adolescents who report a history of sexual abuse are more likely to engage in subsequent risk behaviors than those who have not been abused. Such consequences of sexual abuse include: a younger age of first voluntary sexual intercourse; lower level of contraception use at first sexual intercourse; higher frequency of sexual activity; lower subsequent use of contraception; greater number of sexual partners; higher use of drugs or alcohol; and the presence of mental health problems (Boyer & Fine; Moore 1995; Stock 1997).

- According to a national survey, girls who had been physically or sexually abused report that the abuse occurred typically at home, it took place more than once, and the abuser was a family member or family friend. In addition, one in four high school girls said they had been either sexually abused, physically abused, and/or abused by a date or boyfriend (Commonwealth Fund 1997).

- Seventy-four percent of women who had intercourse before age 14 and 60% of those who had sex before age 15 report having sex involuntarily (Alan Guttmacher Institute 1994). In a national survey, 22% of the women who reported having first sexual intercourse at ages under 15 years described their first intercourse as "rape" or "not voluntary" (NCHS 1995).

- Among women, an estimated 32,101 pregnancies result from rape each year. Among 34 cases of rape-related pregnancy, the majority occurred among adolescents and resulted from assault by a known, often related perpetrator (Holmes 1996).

Crime and Violence

- In a national survey, 12% of girls and 8% of boys said that they did not always or often feel safe at home. Fifty-eight percent of abused girls said they wanted to leave home at some point because of violence, compared with 18% of nonabused girls (Commonwealth Fund 1997).

- Nationally, three-quarters of teenage males with past criminal involvement, including ever being picked up by the police, arrested, or jailed, are also sexually experienced (Moore 1998).

- Adolescents are more likely to be subjected to violence during pregnancy than older women; one in five teens experience abuse during pregnancy (Parker, 1994).

- Pregnant adolescents who have been exposed to violence are at increased risk for substance abuse, inadequate prenatal care, and poor birth outcomes (Covington 1997).

- Children of teen parents are twice as likely to be victims of child abuse and neglect as children of older parents (Maynard 1996).

The following resource is adapted from 'The Facts: High-Risk Factors and Adolescent Health,' located on the Minnesotta Organization on Adolescent Pregnancy, Prevention and Parenting (MOAPP) website. Please see website for complete document and references: http://www.cyfc.umn.edu/moapp/poverty.htm

Pregnancy, Poverty, School and Employment

Teenage childbearing is associated with adverse consequences for young mothers and their children, many of which can be attributed to the economically and socially disadvantaged situations in which most adolescent mothers live before becoming pregnant. Often the disadvantaged backgrounds of young women contribute to poor school performance, weak social skills and low earnings potential, and also increase the likelihood that a young woman will become pregnant as a teen.

Connections like these too often are overlooked in efforts to prevent teen pregnancy. A deeper examination of the external influences on adolescents who become involved in a pregnancy is required in order to fully comprehend and effectively respond to the complexity of teen pregnancy.

Poverty

- ❒ Poverty is the factor most strongly related to teen pregnancy. State comparisons show that states with higher poverty rates also have higher proportions of non-marital births to adolescents (Moore 1995). In addition, some researchers have suggested that high poverty rates in the United States account for the fact that U.S. teen birth rates are the highest of any industrialized nation (MacFarlane 1997; Males 1994).

- ❒ High rates of youth poverty precede high rates of teenage childbearing. Teens residing in communities with high rates of poverty, welfare use, and single-mother households are at higher risk for early pregnancy. Teen parents are therefore disproportionately concentrated in poor communities characterized by inferior housing, high crime, poor schools and limited health services (Maynard 1996; Wilson 1996).

- ❒ Sixty percent of teenagers who become pregnant are living in poverty at the time of the birth (Alan Guttmacher Institute 1994). More than 40 percent of teenage mothers report living in poverty by age 27 (Moore 1995).

- ❒ Young women with below average academic skills coming from families with below poverty incomes are about five times more likely to become teenage mothers than those with solid skills and above average family incomes (Brindis 1997) .

- ❒ Among all unwed teenage mothers, less than one third receive any financial support from the nonresident fathers of their children (Congressional Budget Office 1990).

- ❒ Poverty status is one of the strongest predictors of low birth weight, especially among teenage mothers (Alan Guttmacher Institute 1994).

Welfare

- ○ The Personal Responsibility and Work Opportunity Act of 1996 replaces Aid to Families with Dependent Children (AFDC) with Temporary Assistance for Needy Families (TANF), a single cash

welfare block grant. Because of the well-documented association between teen pregnancy and welfare, much of the recent welfare reform debate and many aspects of the new law focus on teen pregnancy. The Act contains a number of provisions, which require states to come up with goals, plans and actions to reduce out of wedlock births, and teen pregnancy (Tullman 1996).

- Overall, studies have found that larger AFDC payments in states are weakly associated with higher rates of out-of-wedlock teen childbearing among whites, but this association does not hold for African American or Latino teens. No correlation has been found between the level of welfare benefits and additional births to teen mothers (Moore 1995).

- In 1995, women under the age of 20 made up only seven percent of AFDC cases; however, over time, the role of teen parents is significant. Forty-two to 55% of AFDC households are headed by women who started families as a teenager (HHS/ACF/OFA 1996, GAO/HEHS 1994).

- More than 70% of unmarried adolescent mothers will receive cash assistance within five years of giving birth and 40% will remain dependent on the welfare system for 5 years or longer (Maynard 1996).

Success in School

- Research examining the relationship between educational attainment and teenage pregnancy has addressed background factors like individual, family, and neighborhood characteristics to better explain the relationship. These studies have confirmed that teenage pregnancy adversely affects level of educational attainment. However, it has been found that young women and men often drop out of high school before they become parents, and that school attendance and achievement before conception are the best predictors of school attendance and achievement after delivery of the child (Stevens-Simon 1995). In terms of educational achievement, dropping out, rather than having a baby, appears to be the key factor that sets adolescent mothers behind their peers. Adolescent mothers who stay in school are almost as likely to graduate (73%) as women who do not become mothers while in high school (77%) (The Alan Guttmacher Institute 1994).

- Thirty-two percent of adolescent mothers complete high school by the time they reach their late 20s, compared with nearly 73% of women who delay childbearing until after age 20 or 21 (Maynard 1996).

- About 40% of all adolescent mothers who drop out of high school attain a GED certificate by age 30 (Maynard 1996).

- Among whites, African Americans, and Latinos, childbearing before age 20 significantly reduces schooling attained by almost three years (Klepinger 1995).

- Young women who begin childbearing after age 20 are much more likely than teenage mothers to attend college (Klepinger 1995).

- The more years of education a mother completes, the older her daughter is likely to be at first sexual intercourse (Postrado 1997).

- Teens with high educational expectations are less likely than their peers with lower expectations to initiate sexual intercourse (Postrado 1997).

- Adolescent fathers are less likely to graduate from high school than older fathers (Maynard 1996).

- Children of teen parents perform worse in school than children of older parents. They are 50% more likely to repeat a grade, perform significantly worse on developmental tests, and are more likely to drop out of school (Maynard 1996).

Employment

- Failure to complete high school prevents young mothers from going on to post-secondary education and from participating in many vocational training programs (Stevens-Simon 1995). Limited educational achievement combined with low basic skills and limited job experience means fewer employment opportunities and lower wages for teenage mothers (Maynard 1996; Zill and Nord 1994).

- In addition, teenage mothers have more children on average and are less likely to be married than women who delay childbearing. As a result, they must stretch their limited incomes to support more children (The National Campaign to Prevent Teen Pregnancy 1997).

- Over the last two decades, the US economy has lost most of its low-skill, high-paying manufacturing jobs, restricting career opportunities for low-income youths, the population most likely to be involved in early pregnancies (Wilson 1996; Males 1994). As the qualifications for good jobs rise, teenage mothers who fail to finish school have more difficulty finding gainful employment (The Alan Guttmacher Institute 1994) .

- Higher levels of income and employment for women are related to lower rates of non-marital childbearing (Moore 1995).

- From 1960 to 1990, the percentage of teen births outside of marriage increased from 15% to 68%. This 68% of young mothers assume primary responsibility for their families' financial support (Maynard 1996).

- Fifteen to twenty percent of never married teens have child support awards. Of those, only about three-fourths receive any payments and the payments they do receive are only about one-third of the payments due (Congressional Budget Office 1990).

- Although the incomes of teen mothers are lower during their first 13 years of parenthood compared to those who delay childbearing (until age 20 or 21), they make up for this through increased employment and earnings by the time they reach their mid to late 20s (Hotz 1997).

- Among whites, one-fourth of teenage mothers had family incomes below the poverty level, compared with less than 1 in 10 of those who delayed childbearing (Brown and Eisenberg 1995).

- Adolescent fathers earn, on average, $4,732 less annually than those who delay fathering until age 20 or 21 and are therefore not as prepared to contribute financially to the well-being of their families (Maynard 1996).

- Nearly 30% of children born to adolescent mothers are neither working nor looking for work nor attending school by the time they are 24 years old, in contrast to 17% of children born to mothers who have delayed childbearing (Maynard 1996) .

The following resource was downloaded from Youthinfo, a website developed by the U.S. Department of Health and Human Services (HHS) to provide the latest information about America's adolescents: http://youth.os.dhhs.gov/youthinfo.htm#profile

How Many Adolescents Are Getting Pregnant?

From 1973 to 1990 the percent of females between the ages of 15 and 19 who became pregnant increased from 10% to 11.5% and declined to 11.2% by 1992, which is the last year for which data on this age group is available. Among females ages 15-19, pregnancy rates declined significantly between 1991 and 1992 in 30 of 41 states reporting and the District of Columbia.

Pregnancy is more prevalent among older teens and among African-American and Hispanic teens, and in the majority of cases is unintended. In 1992, 7.2% of teens ages 15-17 became pregnant, while 16.8% of teens ages 18-19 became pregnant. Among teens ages 15-17, Hispanics are more than two times as likely and African-Americans three times as likely to become pregnant as white teens. Among teens ages 18- 19, African-American and Hispanic teens are at least twice as likely to become pregnant as white teens. National survey data indicates that 86% of pregnancies to teens under age 20 were unintended.

Between 1960 and 1985 the birth rate for teens ages 15-19 fell from 89.1 to 51 births per 1000. Between 1985 and 1991 the teen birth rate increased to 62.1 per 1000, and between 1991 and 1995, the rate fell to 56.9 per 1000. As with teen pregnancy, there are differences in birth rates among different racial and ethnic groups. In 1995, the birth rate for white teens was 50.3% per 1,000, for African-American teens it was 95.5 per 1,000, and for Hispanic teens it was 106.2% per 1,000. Between 1991 and 1995, the birth rate for African-American teens dropped by 17%.

Data from 1988, the most recent data available, indicate that the majority of fathers of children born to teen mothers are not themselves teenagers. Among 17-year-old mothers, 55% of the fathers were 20 years old or older.

A Selection of Model Programs

Girls Incorporated of Delaware: Preventing Adolescent Pregnancy (PAP)

PAP is a comprehensive pregnancy prevention program that has been implemented across the country since 1985. This age appropriate program provides girls with information, support, and motivation to help avoid pregnancy. The program actively involves adolescent participation, focuses on skill building and refusal skills, is relevant to all sexual orientations, and is culturally specific and sensitive.

For more information, contact: Charlette Dickerson, Program Manager, 3301 Green St., Willmington, DE 19703; phone: (302) 798-8554.

Teen Outreach Program (TOP)

TOP is an effective primary pregnancy prevention and school success approach which aims to promote healthy development and achievement through building on youth strengths and engagement in community activities. Topic areas include: value clarification, communication skills, human growth and development, family relationships, and community resources. Baseline and outcome comparisons of intervention and control groups show a 33% lower pregnancy rate.

For more information, contact: Lynda Bell, Cornerstone Consulting Group, Inc., P.O. Box 710082, Houston, Texas 77271-0082; phone: (215) 572-9463.

Community Based Intervention

This intensive school and community-based educational approach included media campaigns, workshops for parents, community leaders, and clergy. Graduate-level sexuality education courses were provided for school teachers and students who were trained as peer counselors. A school nurse counseled at-risk youth to avoid initiating sexual activity, as well as contraceptive counseling for those declining to use abstinence. Outcome assessment showed a decrease in estimated pregnancy rates.

For more information, contact: Charles Johnson, Health and Human Services Finance Commission, South Carolina; phone: (803) 253-6154.

GRADS Program

GRADS has a curriculum working with teen parents, and Sharon Enright is recognized nationally for her work on parenting teens and preventing secondary pregnancy.

For more information, contact: Sharon Enright, Ohio Department of Education; phone: (614) 466-3406

A Brighter Tomorrow

This comprehensive teen pregnancy prevention program focuses on teen mothers and their families. An interesting component is that the program's point of entry is through the parenting teen's sister.

For more information, contact: Patty Martin, Miami Valley Hospital, Perinatal Health Center, Dayton, Ohio 45409

COPE

COPE is an adolescent pregnancy and parenting program in 3 public schools on the Navajo Reservation in Northern Arizona. In addition to reducing the high rates of school drop-out among pregnant Native American Teens, it also aims to reduce repeat pregnancies among the program participants.

For more information, contact: Gwen Williams, Kayenta Unified School District, P.O. Box 337, Kayenta, AZ 86033; phone: (520) 697-2178.

Adolescent Pregnancy Prevention and Services

APPS is a support service for pregnant and parenting adolescents which provides information, referrals and counseling. Support group meetings focus on a variety of issues including contraception.

For more information, contact: Joanie Kravitz, Northern Adirondack Planned Parenthood, 66 Brinkerhoff Street, Plattsburgh, NY 12901; phone: (518) 561-4522.

New Lives

New Lives serves pregnant and parenting adolescents, with a focus on preventing repeat pregnancies after delivery through close monitoring and counseling of the adolescent to encourage use of a reliable method of birth control by 6 weeks post-partum. The adolescent's health and birth control is then monitored throughout her involvement with the program.

For more information, contact: Karen DeGenova, Kent County Mental Health Center, 355 Centerville Road, Warwick, RI 02886; phone: (401) 732-5656.

Teen Pregnancy Prevention Program

This program aims to lower first and subsequent pregnancies among adolescents by emphasizing sexuality education and remaining in school. It reaches teens in grades 7-12, and has education and support groups for parenting teens.

For more information, contact: Leslie Jacox, Coordinator, Bryan County Health Department, Durant, OK 74701; phone: (405) 924-6562.

Teens Parenting Program

The goal of this program is to encourage adolescent parents to stay in school, and to prevent second pregnancy. Three adults-- a school nurse, social worker, and an adolescent pregnancy worker-- coordinate an in-school program for teen parents in rural Maine.

For more information, contact: Gail Drasby, School MSAD #68 & Foxcraft Academy, 147 West Main Street, Dover-Foxcroft, ME 04426; phone: (207) 564-2218.

Lake Cumberland District Health Department

Lake Cumberland has an intensive, home-based counseling, care and case management program for pregnant and parenting teens which encourages secondary pregnancy prevention.

For more information, contact: Sharon Mandt, Senior Health Educator, 500 Bourne Avenue, Somerset, KY 42501; phone: (606) 679-4416.

Teen OB Follow-up Program

This program is designed to reduce the incidence of secondary pregnancy to teens within 18 months of the first birth, promote the continuation of educational-vocational pursuits, improve health outcomes of infants born to adolescent mothers, and enhance teen's parenting skills.

For more information, contact: Patricia East, Ph.D. Department of Pediatrics, University of California, San Diego, Box H-814F, 225 Dickinson Street, San Diego, CA 92103-1990.

Family Talks

Family Talks is a foundation program and provides human sexuality education for parents of children from birth to age 10. The program promotes listening and communicating, and identifies the parent as the primary educator. Pre and post subjective questionnaires show that participants know more, talk more, and increase communication.

For more information, contact: Paula Sampson, Lincoln County Human Services, 351 SW Seventh, Newport, Oregon 97365; phone: (541)265-4112.

Grays Harbor Free Clinics

Grays Harbor County Health Department provides a full service family planning clinic. Services to teens, 19 and under, include: pregnancy tests, access to birth control, female exams, STD checks, HIV testing and counseling, and advocacy. The importance of involving adolescents in the assessment and planning process is emphasized.

For more information, contact: Jody Wayman, RN, BSN, Grays Harbor County Health Department, Teen Advocacy and Family Planning, 2109 Sumner Avenue, Aberdeen, WA 98520; phone: (360) 532-8631.

Mason-Lewis Counties Teen Advocacy Project

This unique model was designed to provide a supportive person in the lives of teen women who are at high risk for pregnancy. The advocate program, housed in an off-site location, targets those who may not be reached by the Planned Parenthood Clinic. The Teen Advocate assists the client in designing creative and individualized methods of support, helping the youth in numerous areas of their lives.

For more information, contact: Carol Miller, Project Coordinator, Planned Parenthood of Seattle-King County, Olympia Clinic, 312 4th Avenue East, Olympia, WA 98501; phone: (360) 754-1556.

De Madres a Madres

De Madres a Madres is an organization of volunteers that promote mother to mother support for at-risk pregnant women through caring, sharing information, and developing a safety network for a healthier community. Over 60 neighborhood volunteer mothers, and five staff members reach out to pregnant women in the community. Components include: home visitation, prenatal classes, child development education, counseling, junior volunteers, information and referral, arts and crafts, a clothes closet, and collaboration.
Outcome measures indicate a decrease in the infant mortality rate from 16.5% to 6.6%.

For more information, contact: Lamar Miramontes, Case Manager, De Madres a Madres, 1108 Paschal, Houston, TX 77009; phone: (713) 223-2432.

Growing Healthy

Growing Healthy of the National Center for Health Education (NCHE) is a school-based comprehensive health education curriculum designed to meet the needs of students in kindergarten through sixth grade. The curriculum helps children confront important health issues such as substance use, HIV/AIDS, teen pregnancy, violence, injury and abuse. Proactive attitudes and behaviors are taught which address peer negotiation, decision making, effective refusal skills, goal setting, critical media viewing and communication skills.

For more information, contact: Urvi Dalal, MPH, Director of Education, National Center for Health Education, 72 Spring Street, Suite 208, New York, NY 10012-4109; phone: (212) 334-9470, ext. 25; website: http://www.nche.org; E-mail: nche@nche.org

Mothers of Mount Sinai (MOMS)

MOMS provides educational programs which teach about the importance of pregnancy and prenatal care, assists teens in development of parenting skills and encourages teens to delay a second pregnancy.

For more information, contact: Andrea Rothenberg, Director, Mount Sinai Medical Center, Health Education Department, One Gustave L. Levy Place, Box 1502, New York, NY 10029-6574; phone: (212) 241-3604.

Pyramid Academy (Memphis School System)

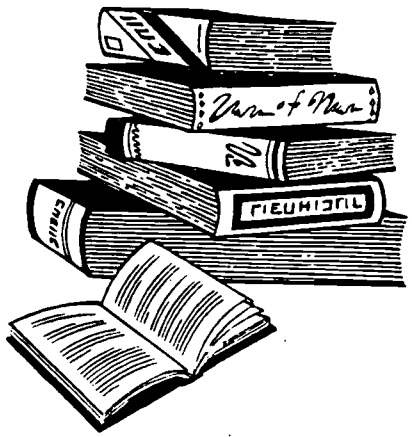
This is an entire school for parenting teens in Memphis. Their pregnancy prevention program is an Afrocentric program called Rites of Passage which has a full curriculum available.

For more information, contact: Ms. Hopson, 1266 Poplar, Memphis, TN 38104; phone: (901) 722-4412.

Norwich Young Parents Program

This program works in partnership with local high schools to provide education on a variety of issues including pregnancy prevention, health, and life skills. Services include: case management, tutoring, family counseling, home visits, incentives, sports and recreation, mental health counseling, parent education/training and support groups.

For more information, contact: Linda Blaise, Program Director, 23 Union Street, Norwich, CT 06360; phone: (203) 887-6464.



Excerpts from a Few Relevant Articles

A. A chapter from the Center for Population and Reproductive Health Policy: *Adolescent Pregnancy and Parenting in California: A Strategic Plan for Action*

B. A report from the National Adolescent Health Information Center: *Overview of Trends in Adolescent Pregnancy.*

C. Excerpts from the Adolescent Pregnancy Childwatch's Executive Summary *on: Reframing the Issue: New Approaches to Teen Pregnancy Prevention*

D. Articles from the Minnesota Organization on Adolescent Pregnancy, Parenting, and Prevention (MOAPPP) Monitor:

- *Sexuality Education in the Multicultural Classroom*
- *Support Services for Parenting Teens*

ADOLESCENT PREGNANCY AND PARENTING IN CALIFORNIA

A Strategic Plan for Action

Claire D. Brindis, Dr.P.H.
and
Rita J. Jeremy, Ph.D.
(1988)

Available from:

Center for Population and Reproductive Health Policy
Institute for Health Policy Studies
University of California, San Francisco
1388 Sutter Street, 11th Floor
San Francisco, CA 94109

Research Assistant: Rachel Roth

CHAPTER ONE

THE CONTINUUM OF ADOLESCENT LIFE

Adolescent pregnancy, always a feature of American life, has traditionally been a private family matter. What makes it a pressing public issue today is the changing social environment in which it is occurring and the growing awareness of its wider social and economic consequences. Adolescent sexual activity, pregnancy, and out-of-wedlock childbirth, especially among younger adolescents, have escalated dramatically during the past two decades. The negative effects of early parenthood have been amply documented: health, education, and future employment are adversely affected; poverty is a frequent outcome. Consequently, both individuals and society pay a high price.

Two significant trends have widened the time gap between biological ability to bear children and readiness to raise them. American youths are maturing biologically at earlier ages, which has extended significantly the number of years during adolescence when a pregnancy can occur. But the length of time it takes to prepare adolescents for full participation in our complex society has greatly increased.

Youths today are, on the one hand, biologically ready to reproduce but, on the other hand, emotionally unprepared and officially discouraged from doing so. American teenagers face a daily barrage of mixed messages regarding sexual activity. Television shows, movies, the print media, and advertisements in all media exploit sexuality.

These factors have contributed to an expanding number of teenagers bearing babies at younger ages, with a growing proportion of these births to unmarried mothers who lack financial support. In addition, the increased likelihood that these young mothers are school dropouts and have little chance of ever obtaining a high-paying job have long-term implications for the mothers, their babies, and the society that will have to provide financial assistance for years to come. The shifting of this economic burden from the family to the public and the high cost of public assistance for these children and their mothers have focused attention on adolescent childbearing as a major national concern. The costs are not only monetary; there are increased risks of poorer health and

developmental outcome for the children of adolescent parents. The private activity of sex leads to public consequences that have adverse and enduring effects on the teenage parents, their babies, their families, their communities, and society at large.

California, the most populous state in the nation, with the second highest adolescent pregnancy rate, lags far behind other states in its efforts to deal with this problem. Many people in the state—parents, teachers, religious and community leaders, health and social service professionals—are concerned with this issue. Despite their concern, California until recently had no strategic plan for action. The state is thus at a point where it must either begin to tackle the causes or be overwhelmed by the consequences.

Although existing laws provide for various health, education, and social service programs to assist teenagers who are pregnant or who have children, they reach only a limited number of those in need of assistance. There are tremendous gaps and occasional overlaps. To address such a complex issue, a statewide framework for a coordinated, comprehensive effort is needed.

There is a growing realization of the diversity that exists among adolescents and thus the need for strategies at the local community, city, county, state, and national levels that are simultaneously comprehensive and diversified. By bringing together an array of agencies, organizations, and programs that provide a variety of resources, we can target more appropriate interventions at teenagers' specific and changing needs at multiple points in their lives.

Key Factors in Successful Programs

Although much is yet to be learned and documented about adolescent pregnancy and treatment programs, the following have been identified as key factors in successful programs:

□ *Early intervention*. Whether the goal is abstinence, effective use of contraception, appropriate prenatal care, or improved maternal and child health, the earlier the medical, psychosocial, nutritional, or educational interventions are introduced, the higher the likelihood of successful outcomes.

□ *Accessibility and acceptability*. Programs and services need to be physically accessible (on major bus lines, close to a targeted neighborhood, near or on a school campus), affordable (inexpensive, sliding scale fee, or free), culturally sensitive (with multilingual and multiethnic male or female staff, as appropriate), and psychologically acceptable to the user.

□ *Continuity*. Programs with long-term follow-up and continued tracking are the most successful. The needs of adolescents, especially in the high-risk, low-income groups, are so extensive that without sustained social and financial support, maintaining progress is difficult.

□ *Targeting*. Teenagers' needs differ by age group, gender, and socioeconomic and cultural background. Appropriate services sensitive to the needs of the particular target group increase effectiveness.

□ *Institutionalization*. Without a commitment from school districts, medical care providers, parents, community groups, government, and private agencies to integrate prevention and treatment strategies into ongoing efforts, programs are often financially fragile and of limited long-range impact.

The key participants in these successful programs have been the following:

□ *Families, nuclear and extended*. Studies have demonstrated repeatedly the importance of family values and support. Family communication, especially between mother and daughter, can lower the rate of adolescent sexual activity. If a teenager gives birth and decides to raise the baby, family support—emotional, financial, and/or childcare—can reduce the likelihood of negative consequences.

□ *Schools.* Teachers, guidance counselors, nurses, and support staff in schools play an important role in pregnancy postponement by helping teenagers continue their educations, develop their decision-making skills, and expand their employment opportunities and life options. Schools also provide a setting in which family life education can be integrated into activities and other subject matter.

□ *Community-based organizations.* This category includes ethnic, cultural, and religious organizations, privately and publicly funded not-for-profit agencies, and public social service agencies. Through their wide range of services, they can reach teenagers who have dropped out of school or graduated, as well as those still in school.

Multiple and simultaneous approaches targeting a specific goal are needed to respond to the diverse needs of individuals. For example, family life education programs directed at high school students may be more effective if programs are also directed at parents and at students at the elementary school level. Strategies should be integrated with other aspects of the adolescent's life because the motivation to prevent an unintended or early birth is directly linked to a young person's perception of other life alternatives.

Policymakers generally have felt much more comfortable supporting programs that help pregnant teenagers and their infants than supporting programs aimed at postponing a first pregnancy. Their concerns have been whether the mother and infant are healthy, whether the first birth is followed by another within too short a period of time, and whether the teenage parent is able to graduate from high school. Attention to these areas does significantly mitigate the negative impact of early parenthood, but a much broader approach is needed today.

Comprehensive prevention approaches exist in a variety of settings, including schools, churches, clinics, and other community sites. Still, there is a tendency to seek a single approach widely promoted as "the answer" to teenage sexuality, when in fact no one approach is appropriate for all segments of the adolescent population. An underlying theme of this book is that planners and policymakers must work closely with their communities to assess need, establish priorities, set objectives, designate funding, and design programs that respond to community needs. The underlying guiding principle is to understand adolescent pregnancy and parenting in terms of life options available to adolescents and then to work toward empowering adolescents to make conscious choices—choices about their sexuality and reproduction in particular, but also about their personal relationships, health, education, and economic future. The partnership for this empowering endeavor is seen as among family, religious organizations, community organizations, public agencies, and private business.

There is no single solution to the complex problem of adolescent pregnancy.

A Framework for Devising a Solution

This book builds on the premise that a child born to a child is not an inevitable biological outcome. It is only one possible point in the continuum of adolescent life, and a late one at that. There are five stages related to reproduction in the continuum of adolescent and young adult life:

□ Sexual maturation
□ Initiation of sexual intercourse
□ Pregnancy
□ Birth
□ Parenting

Looking at teenage pregnancy and parenting within the framework of adolescent development provides a foundation for better understanding the issues that affect all teenagers. Progress from one stage to the next can be seen as a series of transitions, each of which involves active or passive choices (Flick 1986). At each transition point, a variety of interventions can be introduced, per-

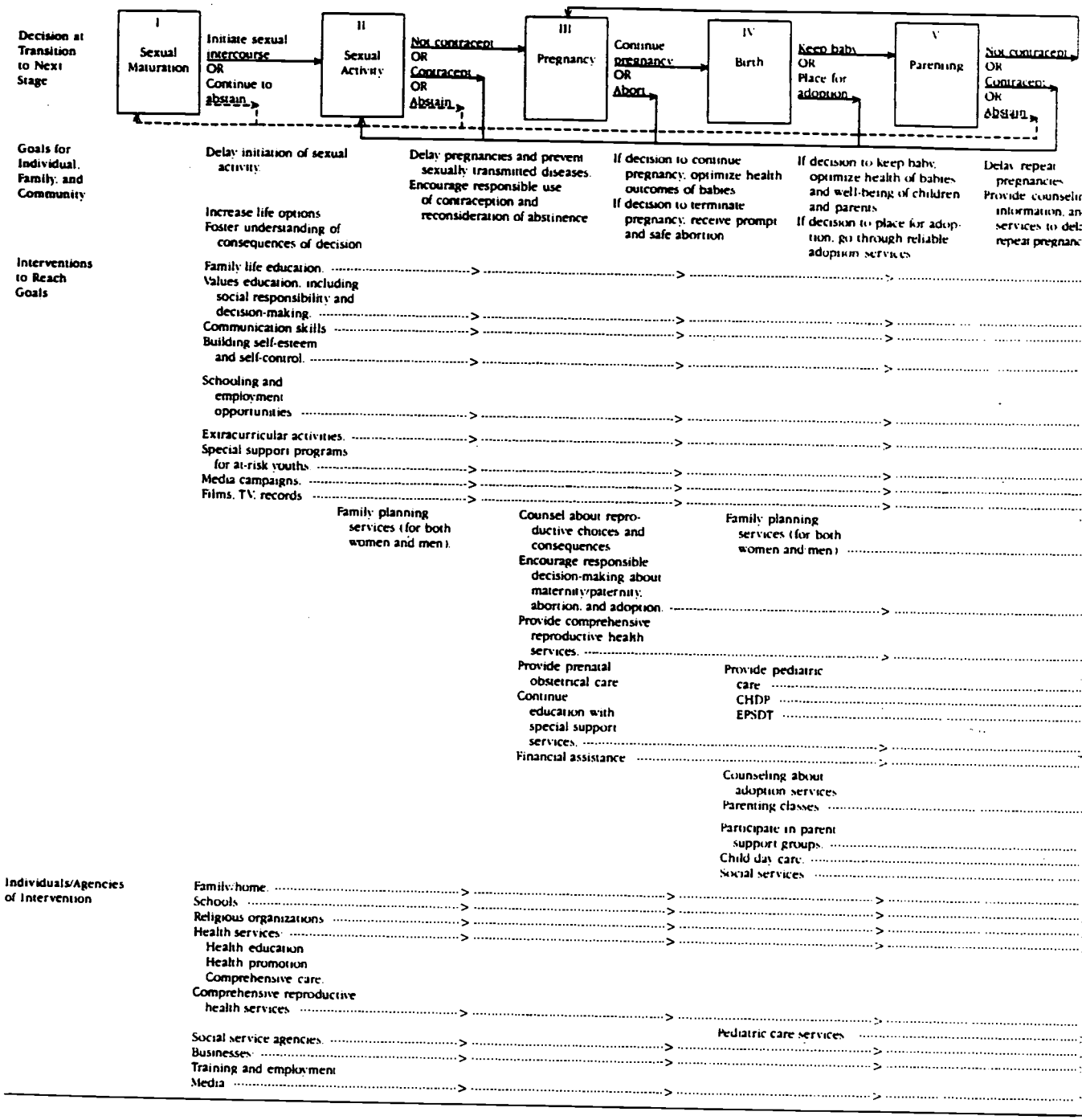


Figure 1.1. A Stage Model of Adolescent Sexual and Reproductive Decision Making

haps breaking a link in the chain of adolescent childbearing. These transition points offer repeated and separate chances for interventions that are appropriate for special ages and circumstances. Figure 1.1 shows these stages and a number of interventions at each of the transition points.

Although biology drives the passage from one stage to the next, the individual, family, and society can determine and set the pace. Because most adolescents are not ready to make major decisions on their own, adults need to know the critical issues involved at each transition point in order to identify the individuals and organizations best suited to help adolescents understand their choices and participate in making them. Active choice is stressed because adolescent sexual decisions are so often passive reactions to biological, social, economic, and peer pressures. At each transition point, the issues need to be analyzed from the perspectives of the teenagers themselves, their families, and their communities.

The idea of preventing unintended adolescent pregnancy is the basic force behind most intervention efforts. As public awareness of the problem and its personal and social costs increases, so does the debate about methods of addressing it. Many believe that delaying the initiation of sexual activity is the only acceptable method, and thus strategies should include only programs emphasizing abstinence. Others argue that methods should be expanded to reach young people who are sexually active and thus should include services that help them delay pregnancy, primarily through contraception, with parenting, adoption, or abortion available as choices in the event of contraceptive failure. In this era of widespread adolescent sexual activity, young people and their parents must be presented with a variety of strategies that reflect diverse value systems, cultural differences, and economic and educational disparity.

Adolescent pregnancy is an indicator of a nation's well-being. A high rate of teenage pregnancy and childbearing is a symptom of major social and economic ills. The symptom itself can be treated in isolation with limited success, but no cure can be expected unless underlying causes such as poverty, isolation, low self-esteem, and lack of hope for the future are identified and treated. The United States has among the highest rates of both adolescent pregnancy and childbearing of all developed countries. Attacking this problem will take major coordinated efforts at many levels of intervention aimed not only at the teenagers themselves, but also at the political, economic, medical, educational, and religious institutions whose policies affect teenage pregnancy and childbearing indirectly, but nevertheless strongly.

The basic challenge to those who want to help teenagers avoid the consequences of premature parenthood is to develop a coordinated network of public and private services. State officials play a central role in facilitating the necessary coordination. Policies established by the state in education, health, job training, and social services directly influence the availability and effectiveness of services to teenagers at risk. The following chapters present a statewide profile of the problem, causes and consequences of adolescent sexuality, existing programs and gaps, model programs, and a statewide strategic plan.

Adolescents must be made aware of their options.

Adolescent Pregnancy Prevention: Effective Strategies

National Adolescent Health Information Center
University of California, San Francisco

MAY 1995

Overview of Trends in Adolescent Pregnancy

Although the causes of teenage pregnancy are deeply rooted in the social fabric of our society, innovative adolescent pregnancy prevention programs have been successful and provide examples that can be replicated and adapted throughout the nation. Inherent to the success of these strategies is the underlying need for the teenager to be motivated to prevent pregnancy. We now know that emphasizing abstinence or contraception alone is not sufficient for adolescents at risk of unintended pregnancy[1]. Multi-pronged approaches that combine pregnancy prevention education, access to contraceptive services, programs to improve life options, and programs to prevent repeat pregnancies have been successful in: 1) delaying the onset of sexual activity among participants, 2) increasing contraceptive use among those who are sexually active and 3) reducing pregnancy rates. Such interventions should be tailored to meet the particular needs of adolescents at several critical junctures in their social, physical and emotional development.

More than half of American teenagers remain abstinent until they are at least 17[2]. However, there has been a dramatic rise in the proportion of adolescents who have had sexual intercourse over the past two decades. Currently 56% of unmarried women and 73% of unmarried men age 15-19 have had sexual intercourse[3]; about 20% of females and 33% of males have had sexual intercourse before age 15[4]. Over one million adolescents become pregnant every year; the majority of pregnancies (78%) among 15-17 year olds are unwanted[5].

Although half of all teenage births are to white, non-Hispanic adolescents, African-American and Latina teenagers have almost twice the pregnancy rate of whites; 40% of teenagers of color and 21% of white teenagers will become pregnant at least once by age 19[6]. Over half (56%) of the 15-19 year olds who gave birth in 1988 were poor, with annual family incomes under $12,000, while only 17% had family incomes of over $25,000. Nearly three-quarters of higher income teenagers who unintendedly become pregnant have abortions, compared with fewer than half of those from poor or low-income families[7]. A recent study suggests that regardless of sociodemographic status, teenagers may be at higher risk of adverse pregnancy outcomes because of physiological characteristics of young women[8]. The intrinsic risk factors associated with young maternal age and lower sociodemographic status may increase the likelihood of adverse birth outcomes of teen pregnancies.

Adolescent births are not the only consequence of unprotected teenage sexual activity. Each year three million adolescents are infected with sexually transmitted diseases; the rate of human immunodeficiency virus (HIV) infection is increasing rapidly among young adults in their 20s, who likely became infected during their teens[9].

Nonetheless, today's sexually active teenagers are *more likely to use contraception to avoid pregnancy and STDs*. Teenage women's contraceptive use at first intercourse rose from 48% in 1982 to 65% in 1988[10]. In a 1990 national study, over 77% of sexually active female students used contraception during their most recent act of sexual intercourse. Among those students who had sexual intercourse during the 3 months preceding the survey, 45% reported that they or their partners had used a condom the last time they had intercourse[11].

The *overall teenage pregnancy rate has risen, but the pregnancy rate among sexually experienced teenagers has actually declined* by nearly 20% over the past two decades, from 254 pregnancies per 1,000 sexually active women aged 15-19 in 1972 to 207 per 1,000 in 1990[12]. Moreover, recent data indicates that the teenage birth rate has slightly declined among both African-Americans and whites[13]. This may indicate the start of a *promising trend in decreased teenage childbirth rates.*

Several approaches have been particularly successful in encouraging abstinence and promoting contraceptive use among those teens who are already sexually active. These interventions range from education, to the direct provision of contraceptive supplies, to school-based health services, to life options programs. Promising strategies have also emerged to reduce the number of repeat pregnancies among adolescents.

Pregnancy Prevention Education

Many family planning clinics and almost all school systems now offer some sex education aimed at increasing young people's knowledge about reproduction[14]. However, almost half (48%) of 15-19 year olds think the average young person today still does not have enough accurate information about sex and reproduction. Contrary to the view that sex education hastens the onset of intercourse, research findings across a number of different types and groups of students has shown that it does not result in increases in the number of teens initiating sex. Evaluations have demonstrated that some sex education programs can reduce unprotected intercourse, either by delaying the initiation of intercourse or by increasing the use of condoms and other contraceptives[16].

For example, "Reducing the Risk" is a high school sex education curriculum which emphasizes avoiding unprotected sex through abstinence or using contraception. Students engage in role-playing activities to build skills and self-efficacy. The evaluation showed that the program significantly increased participants' knowledge about abstinence and contraception. Over time, the percent of students who had initiated intercourse rose from 14% to 38% among the control group and from 12% to only 29% among the treatment group[17]. The "Postponing Sexual Involvement" program is a 10-session curriculum on human sexuality that emphasizes concrete refusal skills such as resisting peer pressure, avoiding compromising situations, and becoming more assertive. By the end of eighth grade, students who had not participated in the program were as much as five times more likely to have begun having sex than were those who had participated in the program. The reduced sexual activity resulted in fewer pregnancies among program participants, although the pregnancy rates must be interpreted with caution because of the small sample size[18].

The most comprehensive sex education programs provide important reproductive information and positive motivation for young adolescents to resist pressures to become sexually active. Sex education programs directed at younger adolescents, before they are sexually active, have been shown to be generally more effective than programs directed at older adolescents[19]. For adolescents already sexually active, skills-based education can assist them in adopting contraception.

Access to Contraceptive Services

While education and information programs are important components of adolescent pregnancy prevention, these interventions cannot be viewed as substitutes for the actual provision of contraceptive services and supplies[20,21]. Teenagers are more likely to use contraception if the services are tailored to their needs and offered in an accessible and sensitive manner. For example, a program in Pennsylvania provided in-depth counseling and education geared to an adolescent's level of development. After one year, patients who received the specialized services were more likely to continue using a birth control method despite problems with the method (71%) than the control group (40%) who received traditional services. Moreover, the experimental patients were significantly less likely to have become pregnant (4%) as compared with the control group (8%)[22]. A more recent study in Philadelphia, however, showed that increases in funding for teenage family planning services had little impact on pregnancy or childbearing rates. The results suggest that community family planning clinics may be more effective when used in conjunction with school-linked health services and strategies to change the norms of sexual behavior [23].

Family planning clinics are the source of contraceptive care for two-thirds of all teens[24] and approximately one fourth of all family planning clients are sexually active teenagers[25]. An estimated 1.2 million to 2.1 million unintended pregnancies are averted each year with the availability of publicly funded reproductive health programs[26]. A recent analysis showed that preventing unintended pregnancies through contraceptives provides substantial economic savings[27]. An earlier study found that for every dollar of federal funds spent to provide contraceptives to women of all ages, $4.40 is saved that would otherwise be needed for medical care, welfare and nutrition programs just in the two years following a birth[28]. Federal spending for contraceptives however has decreased by over one-third between 1980 and 1990, after adjusting for inflation[29]. We are investing less in adolescent pregnancy prevention despite the potential for economic savings and social improvements.

School-based and school-linked health clinics provide an additional site for the delivery of health care at more than 600 clinics operating in high schools and middle schools throughout the country[30], although less than 15% of these clinics provide reproductive services on-site. An evaluation of six school-based clinics which provided reproductive health care indicated that the clinics neither hastened the onset of sexual activity nor increased its frequency[31]. A model pregnancy prevention program in Baltimore, MD for middle school and high school students provided classroom presentations along with small group and/or individual consultation; contraceptive services and informal educational sessions were offered in a nearby clinic. Pregnancy rates among enrolled students declined 30% in a three-year period, while rates among girls not enrolled increased by 58%[32]. Finally, programs to increase the availability of condoms have received increased public support in recent years[33]. Evaluations of their effectiveness are currently underway[34].

Life Options

Contraceptive services and educational interventions are necessary, but not sufficient to reduce teenage childbearing for many youth who lack a clear sense of hope for the future. Life options programs work more indirectly to reduce levels of unintended teenage pregnancy and sexually transmitted infections by promoting meaningful alternatives to childbearing. Community and service organizations have implemented interventions aimed at increasing the educational and employment options of disadvantaged young people. For example, the "Teen Outreach Program" is a school-based program used in 30 states throughout the nation. Teenagers participate in small group discussions and participate in volunteer community service to build self-esteem. The program reduced teenage pregnancy and school failure and dropout rates by approximately 30 to 50% relative to matched comparison groups of students[35]. Other examples of life options programs include mentoring, youth employment, and life-planning programs. Although these programs have not yet been fully evaluated, they are promising strategies to provide meaningful alternatives to pregnancy and parenting.

Programs to Reduce Repeat Pregnancies

The consequences of multiple births during adolescence can inhibit women's ability to attend school and obtain and maintain employment. In 1992, one-quarter of all teen births were to women who had previously given birth; a 12.5% increase in repeat teen childbearing compared to 1985[36]. Few programs have been able to effectively assist adolescent mothers to delay a subsequent pregnancy. Those that have been successful provide intensive individual counseling and services. For example, a single-site home visitation program in rural New York state found that during the four years after delivery of their first child, nurse-visited women had fewer subsequent pregnancies and postponed the birth of the second child an average of 12 months longer than women who received more limited services[37]. Other programs provide peer group counselors, parent support groups, and case management services to prevent repeat pregnancies.

Implications

National sentiment and public policy on adolescent pregnancy prevention is heavily debated and has evolved over time. Women who bear children as teenagers are more likely than women who postpone childbearing to have decreased educational attainment, to live in poverty and to rely on government assistance. There is increasing recognition, however, that the problem will not be readily resolved with simple solutions. The underlying causes of adolescent pregnancy, including poverty, unemployment and a lack of hope for the future, need to be considered in developing a variety of effective strategies. Recent successes in delaying the onset of sexual activity, increasing contraceptive use and reducing teenage pregnancy show that prevention efforts can decrease the incidence of teenage childbearing. Given life options, education and access to comprehensive reproductive health services, teenagers may choose to postpone sexual activity and when sexually active, to responsibly use contraception.

For additional information on adolescent pregnancy prevention, contact: **National Adolescent Health Information Center, University of California, San Francisco, 1388 Sutter Street, 6th Floor, San Francisco, CA 94109 (415) 476-5254.**

This fact sheet was compiled by Sara Petersoo, M.P.H. and Claire Brindis, Dr.P.H. through support in part from the Maternal & Child Health Bureau Grant #MJCJ063A80, Public Health Service, Health Resources and Services Administration, Department of Health and Human Services.

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Reframing the Issue: New Approaches to Teen Pregnancy Prevention

[Excerpts taken from *Adolescent Pregnancy Childwatch*(1996), Santa Monica, CA: Adolescent Pregnancy Childwatch (APCW). For copies of the complete report, please contact APCW, 1316 3rd Street Promenade, Suite B-5, Santa Monica, CA: 90401 at (310)395-0098.]

Too many babies are being born to adolescents. Every one seems to agree, but no one seems to agree on what should be done about it. Do we need more sexuality education in the schools? Or less? Should contraceptives be easily available to adolescents? Perhaps the media is the culprit. Is abstinence the solution? Or do we need a completely new approach?

The findings reported in this Executive Summary address these questions. They are based on a year-long project - *Prevention Strategies for Teen Pregnancy: A Regional Approach in Los Angeles County* - that brought together almost 800 people, from many walks of life, to talk about adolescent pregnancy in their communities.

A new approach is clearly required. In June, 1996, participants from the regional meetings came together in a county-wide forum, *Strategies That Work: A Forum in Teen Pregnancy Prevention.* Invited speakers addressed the necessity of "reframing" teenage pregnancy. Adolescent sexuality as a reflection of adult sexuality, sexual abuse, the psychological development of males, the importance of evaluation, and implications for public policy were among the topics discussed. The following three approaches challenge us to think about teen pregnancy in fresh ways.

I. THE HEALTHY SEXUALITY APPROACH: FROM DISEASE PREVENTION TO HEALTH PROMOTION

. . . . .Our present approach focuses on teenagers' "activity" or "behavior"- what they "do" rather than on natural, evolving adolescent sexuality. Present strategies are based on fear, rather than understanding one's sexual development. Based on the medical model, the focus is on pathology or disease, rather than health. . . . .

. . . . . a positive, developmental approach recognizes that becoming a sexually healthy adult is a key task of adolescence. It maintains that, "society has a responsibility to help adolescents understand and accept their evolving sexuality and to help them make responsible sexual choices, now and in their future adult roles."

II. A COMPREHENSIVE APPROACH: FROM "BELOW THE WAIST" TO THE WHOLE PERSON

Researchers like Claire Brindis and Joy Dryfoos have been pointing out for some time the importance of a comprehensive approach to adolescent pregnancy prevention. One of the most effective examples of this approach is that pioneered by Michael Carrera, founder and director of the Children's Aid Society Teen Pregnancy Prevention Program in New York City. Dr. Carrera's program, which will have been successfully replicated in 16 sites in New York City and 23 locations outside the city by next year, was highlighted at the forum.

Early on, Carrera understood that teen pregnancy is not simply a "genital problem" and not a "female sexuality problem". Rather, teen pregnancy is to a great extent a response to greater social and economic ills. Thus, he built his comprehensive teen pregnancy prevention program around the belief that "unintended pregnancies among poor, urban teens can be more effectively curtailed if we reduce the impact of the institutional racism that is systemic in our society; if we provide quality education for everyone; and if we create more employment opportunities for young people and adults."

> *...the most powerful contraceptive is activated when a young person believes he or she is a valuable individual who can and should make plans for a bright future.. We must help (young people) locate and grasp a positive, hopeful outlook on their lives and their future.*
>
> Michael Carrera, Founder and Director of the Children's Aid Society Teen Pregnancy Prevention Program

In Carrera's words, every teenager is "absolutely pure potential", "future successes waiting to happen", "human beings waiting for someone to believe in them." This approach is rooted in the basic belief that young people are capable of "doing good" for themselves, their family, and their community if given the chance. We must create a climate where this can happen.

The comprehensive approach, as implemented by Carrera, includes the following eight components: 1) a family life and sexuality education program, 2) medical and health services, 3) mental health services, 4) self-esteem enhancement through the performing arts, 5) lifetime individual sports, 6) academic assessment and homework help, 7) a job club and career awareness program, and 8) a college admission program.

III. A SOCIETAL APPROACH: FROM TEEN TO ADULT SEXUALITY AND COMMUNITY RESPONSIBILITY

To any thoughtful people working on issues of teenage sexuality and pregnancy, it has become clear that we cannot separate adolescent sexuality from adult sexuality. Whether we are talking about the models of sexual behavior that children learn from their parents, the unconscious messages they receive from teachers and social workers or other professionals who work with young people, or the media images that surround them, it is clear that adult attitudes and values about sexuality affect them.

Mike Males, social ecologist and speaker at the APCW forum, persuasively pointed out the correlation between adolescent and adult behavior. To talk about "teen" pregnancy as though only adolescents were involved is misleading, and results in distortion of facts and the scapegoating of our youth. . . . .

It is no longer realistic to view the adolescent as responsible for the increase in single parent families. These data urge us to focus on the societal issues as they relate to unemployment and job opportunities, changing attitudes about gender roles, welfare reform policy, and the changing structure of the family. . . . .

PREVENTION STRATEGIES THAT WORK

The APCW project steering committee identified six strategies that must be put in place if teen pregnancy is to be reduced. . . .

1. REDUCE ADULT DISCOMFORT WITH THEIR OWN AND ADOLESCENT SEXUALITY

. . . . . sexual behavior is learned. Teenage sexual behavior reflects that of adult behavior. Children do what they see adults do.

1. STRATEGIES THAT WORK

- Provide on-going training of trainers that increases knowledge, expands wisdom, and develops cultural understanding.
- Recognize that adolescent patterns of sexuality and birth rates mirror those of adults.
- Help parents become more comfortable with their own sexuality and better able to communicate with their children about difficult issues.
- Utilize a parent/ school-linked approach to provide family life/ sexuality education at the elementary level.
- Create a place for parent education and involvement in all school and community based sexuality curricula.
- Raise community awareness that research is clear that there is no correlation between sexuality education and increased rates of intercourse.
- Develop sexuality education and communication training for all adults who work with children and youth.

2. DEVELOP A FAMILY APPROACH TO TEENAGE PREGNANCY PREVENTION. PROMOTE HEALTHY SEXUALITY.

A family approach recognizes that sexuality education begins at birth. If the home is one in which children learn about sexuality as a natural aspect of their development and have a comfortable environment in which to ask questions and share feelings, they are well on the way to becoming sexually healthy people capable of making responsible sexual and reproductive decisions.

On the other hand, when a child grows up with restricted and stereotypical views about what it means to be a boy or girl, or when messages about sexuality at home are secretive or negative, we should not be surprised that the results are too often played out in troubled psyches and too-early pregnancies. Worse yet, when the child learns about sex from an abusive adult.

A family approach does not mean that the religious communities, the neighborhood, and the community at large has no responsibility. In fact, quite the revers. All families, whether they have problems or not, need support.

2. *STRATEGIES THAT WORK*

- Provide sexuality education at all levels, including sessions for parents, peer group activities and programs for young children.
- Offer prevention programs that are age-appropriate and include knowledge of contraception as well as abstinence, self-esteem, gender identity and roles, tools for setting and achieving goals, and hope for the future.
- Develop parenting/child development programs for new parents, including hospital and home visit programs.
- Recognize the association between child abuse/ child sexual abuse and teen pregnancy and work to develop prevention and intervention programs.
- Re-frame teen pregnancy prevention as a female and male issue.
- Support policies and programs which enhance responsible fathering and male involvement.
- Improve strategies for linking community members with community resources and services.

3. PROMOTE CARING, CONSISTENT ADULT INVOLVEMENT FOR EVERY CHILD

Why do many daughters of teen mothers not become teen mothers themselves? Why do most teenagers use a method of contraception the first time they have intercourse? Why do a significant number of girls who have been sexually abused at a young age not become pregnant? Why do so many young people who are at "high risk" of becoming teen moms or fathers not become teenage parents?

The answer to these and similar questions are part of an increasing focus on "resiliency factors." Many "high risk" children - children whose lives are filled with chronic poverty, parental abuse, poor schooling, and who themselves were children of teen moms and had no father present- avoid the pitfall of early parenting. How do we explain this? Why is it that some children just seem to be "resilient" to the negative influences around them?

One of the most powerful predictors of a child's ability to overcome overwhelming obstacles is whether or not that child has a close bond with at least one person who provides care and affection.

3. *STRATEGIES THAT WORK*

- Parents must be educated about the importance of their consistent involvement in their children's lives.
- Encourage adults in the community to become mentors and make them aware of the importance of an adult in children's lives.
- Encourage inter-generational activities and involvement. Develop more creative ways for seniors to become involved with children and young adults.
- Provide extra-curricular activities at school and other community sites, involving adults from the community as volunteer coaches, counselors, and mentors.

4. BUILD HEALTHY COMMUNITIES THROUGH SOUND ECONOMIC AND SOCIAL DEVELOPMENT

"Poverty, violence, and changing family structures have brought instability into the lives of many adolescents. Such teenagers, faced with insurmountable odds and few opportunities, are at high-risk for becoming pregnant or a teenage parent." These words, from a recent report prepared by Alan Guttmacher Institute, draw the direct connection between the economic and social context of our communities and adolescent pregnancy and parenthood.

In her analysis, "Fostering Resiliency in Kids: Protective Factors in the Family, School, and Community," Bonnie Benard reminds us that the greatest protection we can give children is ensuring them and their families access to the basic necessities: health care, child care, housing, education, job training, employment, and recreation. "That over one-fourth of the children in communities across our nation live in poverty, in the absence of basic necessities, clearly testifies to the lack of a national political will to provide the opportunities for all children to succeed."

4. STRATEGIES THAT WORK

- Expand job creation, skill building, career options awareness.
- Utilize tax incentives and public/private partnerships to invest in human capital.
- Minimum wage or Earned Income Credit for all full time working which corresponds to a living wage.
- Dramatically expand accessible, affordable, flexible, quality child care. Put them in all high and middle schools for use by the whole community as child development training labs.
- Provide all children and young adults involvement with work-related skill building and exposure to employment opportunities.
- Make urban renewal and restoration of neighborhoods a priority. Families and children should be proud of where they live and feel safe. Schools should be clean and safe.

5. PROMOTE MEDIA RESPONSIBILITY AND COUNTERACT NEGATIVE MEDIA IMAGES

Media does more than simply reflect society's norms and behavior. It is a powerful tool that can affect change in behavior-- in positive or negative ways.

Teenagers witness approximately 20,000 scenes of various forms of sexual behavior on prime-time television each year. Movies, music videos, and other media add to the mix, while advertising uses sex to sell products, each suggesting that sexuality is the key to popularity and personal happiness.

Most often what is portrayed is a glamorous, violent and often unrealistic side of sexuality. The consequences of risky behavior are seldom mentioned. Healthy sexuality in the context of loving or committed relationship or as an expression of mutual affection is not the norm.

5. STRATEGIES THAT WORK

- Encourage broadcast and print media to take responsibility for establishing ethical standards regarding both advertising and editorial portrayals of sexual images of boys and girls, women and men, and sexuality and violence.
- Make your concerns heard- respond to the media with letters to the editor, broadcasting company, television program or advertiser. Boycott advertisers who use sexually provocative ads and support those that use positive images.
- Create positive images in any media or editorial campaigns you do.
- Promote media literacy. Talk to children about the images they are seeing and hearing from the media.
- Create billboard project to lobby against negative, violent, gender division images.
- Provide training for advertising and entertainment industry about negative consequences of irresponsible and sexual images and messages.

6. REAFFIRM THE IMPORTANCE OF VALUES AND THE INVOLVEMENT OF RELIGIOUS AND OTHER ORGANIZATIONS

.....The United States is a pluralistic society. It may be in our efforts to protect our valued diversity we have neglected our responsibility to preserve certain basic values upon which our society depends: human dignity, cultivation of personal character, responsible citizenship, and community service. Teen pregnancy prevention finally means changing community norms and values.

6. STRATEGIES THAT WORK

- "Walk the Walk" of valuing our children. Make children our first priority in terms of time, funding, creative programs.
- Moral relativism is not working for raising caring, responsible, inner-directed children. A need for renewed connection with a spiritual center is widely recognized.
- Mobilize religious congregations and members to make a recommitment to their own and other people's children.
- Involve churches, temples and other faith organizations in planning activities and implementing parenting and teen pregnancy prevention programs.
- More frank and positive discussion regarding responsibilities as an individual and a member of society- incorporate character education programs like "Character Counts".
- Encourage the development of an interfaith coalition around sexuality issues.

Sexuality in the Multicultural Classroom

MOAPPP Monitor (Winter 1997)

By Miriam Hecksel

It shouldn't just be about sex, you should talk about everything. Because if you're going to teach a course like that, that's something that's going to encompass your whole life. - Student

In the spring of 1996, MOAPPP conducted focus groups with 60 high school students and 16 health educators in order to determine "what works" for sexuality education in the multicultural classroom. Participants were students in pregnant/parenting teen programs, peer education programs, and alternative high schools. We found that critical components for effective education on sexuality include: the social and physical comfort of the classroom; the educator's knowledge, skill and comfort level with the topic; relevant content; and strategies that motivate changes in behavior and increases in student knowledge and skills. Participants placed very little emphasis on cultural issues per se.

The *social environment* includes the quality of the relationships among everyone in the room, the rules of the classroom and the overall setting. Students expressed the importance of feeling comfortable in the classroom before talking about sexuality. In general, students preferred an informal setting. Students reported that the *physical environment* was also important in determining their comfort level in sharing about a topic that is very personal. Suggestions included having smaller class sizes, sitting in circles for discussion, and using more comfortable chairs and couches.

Students, educators, and research indicate that some characteristics, behaviors, and attitudes of the teacher can improve the effectiveness of sexuality education in the multicultural classroom. Effective educators refrain from judging or stereotyping students; demonstrate genuine care and respect for their students; listen to the students; and learn about students' cultural beliefs and attitudes related to sexuality. The ethnicity of the teacher was not important to most students.

> You can be a white teacher and teach just as well as a black teacher can. I really don't look at the color... If you make me feel comfortable around you, that's what I see.

When students were asked if the sexuality messages they received from school matched up with messages from their culture, most students cited messages from their immediate families rather than from their ethnic group. Many felt that their culture was too diverse to identify a unified message, and felt it came down to individual families' openness and beliefs about sexuality. Some students, particularly Hmong and Cambodian, attributed their parents' messages to cultural norms where their parents grew up (e.g. strict gender-behavior expectations).

Teachers who were interviewed addressed the multicultural composition of their classes in several ways, including using differences among students to learn about sexuality in different countries and cultures; initiating an exercise on stereotypes; and asking students directly for information about their cultures. They also used classroom materials which related to students' cultures, including posters, books, and pamphlets from many sources, and information brought in by the students themselves regarding their culturally-related health practices.

Teachers also shared strategies for involving parents in sexuality education. They suggested sending home a course syllabus and speaker list for parents to read and sign, offering extra credit for particular homework assignments done with parents, and inviting parents to a "parent involvement day" which targets different cultures.

[Teachers] have to be comfortable with their own sexuality. If they're not comfortable with their own sexuality, they really can't tell you how to be comfortable with your sexuality.

Miriam Hecksel is a recent graduate of the University of Minnesota 's Department of Children, Families, and Learning. She conducted this project to fulfill herMaster's degree requirements. This research was done under contract with the Minnesota Department of Children, Families, and Learning.

This Minnesota Organization on Adolescent Pregnancy, Prevention and Parenting (MOAPP) Monitor article is available on the web: http://www.cyfc.umn.edu/MOAPPP/multicult.htm For a full report of the findings, contact MOAPPP at (612) 644-1447 or toll-free in Minnesota (800) 657-3697, or e-mail moappp(a)jumbo.com.

Support Services for Parenting Teens

MOAPPP Monitor (Spring 1997)

By Tisha Bolger, M.Ed

A young woman who is seventeen has just had her second baby. She can no longer live with her mother because there is absolutely no room for another baby. She has not been able to attend school because her two year old has been sick this winter. She did not have reliable child care anyway and getting up in the morning was hard, especially in the final months of her pregnancy. We are familiar with this story. The names of the young women change but we know the story's ending. Our stories illustrate the problems, but offer no solutions.

Welfare reform is focusing on the issues of adolescent childbearing. We are concerned because the costs have been calculated and we do not want to pay the bill. Several sections of the new welfare reform law focus specifically on adolescent mothers, who represent nearly half the families receiving welfare. The severity of the problem is outlined in the major research project by the Robin Hood Foundation, *Kids Having Kids: A Robin Hood Foundation Special Report on the Cost of Adolescent Childbearing.* The report examines the consequences of adolescent parenthood by looking at the personal costs to families, their children, society and the taxpayer. The report states, *"The cost to taxpayers of adolescent childbearing together with the other disadvantages faced by adolescent mothers is between $13 billion and nearly 1.9 billion per year."* This price tag is staggering. Of course not each adolescent birth has such a high cost associated with it. Some young parents need minimal support and raise their children in a healthy home environment with strong support from their families. Unfortunately, this is the exception rather than the rule. Our challenge is to create community support for those young mothers in need, to empower them to successfully raise their children independently without extended financial aid.

I was recently discussing the impending implications of the new welfare reform provisions for adolescent mothers and their children with a group of colleagues. We were deliberating over the need for supportive and transitional living arrangements. I was surprised when one said, "Well you can't make teen parents stay where they don't want to be," and someone else responded by echoing, "Teen moms would rather be living in the street that living in a place where people tell them what to do." These comments reflected frustration with our approaches to working with teenage mothers. Our focus illuminates the deficiencies of programs and the young women themselves. Now more than ever we must look at what we know about the strengths of teenage mothers and what program components are necessary to build on those strengths. When we utilize a strength-based perspective to our service delivery, we are able to structure programs that engage adolescent mothers and enhance their capacity for growth.

There have been a number of recent publications and research projects that have examined the complexity of service delivery for adolescent parents. These reports have concluded that in order to support teen mothers and their children, it is necessary to offer a continuum of comprehensive services which are developmentally appropriate and adhere to what we know as "best practice." Programs should offer the following components in a gender specific and culturally competent manner: educational and/or vocational training, parenting education, social and life skills training, case management services, counseling, family planning, emergency assistance, and referral services. These program components should be integrated into health care settings, supportive living environments, and educational settings. Additionally, programs should include an evaluation component. A list of components is easy to generate; what makes the difference is our intent and rapport with the young women with whom we come in contact.

My colleagues were correct in some of their assertions about teen mothers. Developmentally, adolescent mothers are seeking their independence; they are not necessarily motivated to seek support from adults. Adolescent parents have the dual tasks of preparing for self-sufficiency and parenting their children. Often we connect with these young women when they are in crisis or have an immediate need with which they think an adult can help. This can be an entry point. Programs that are geographically accessible, offer emergency services, crisis intervention, emergency shelter, and other aid such as legal or health related assistance are in a position to reach out and establish a rapport with the young mother.

Our first interactions are crucial and will predict if we will ultimately be able to enhance the capacities and life options of adolescent mothers and improve the social, emotional and cognitive development of their children. In order to initially engage the adolescent mother, programs for these young women must focus on their relationships with other people and offer ways for the adolescents to master their lives while keeping their relationships intact. Often programs are not successful for young women because they are not based on principals which lead to strong, healthy female development. Programs must allow more opportunity for building trusting relationships and offer learning experiences and skill building after these relationships have been established. When programs adapt to adolescent mothers' developmental needs, they give them the chance to grow and improve their lives.

The population of teenage mothers is diverse. Because age, maturity, socioeconomic status, race, etc., can vary significantly in a program, the program should have the capacity to individualize the modes of interventions they use. A thirteen year old will have different needs and motivations that a seventeen year old; a rural teenager will have different experiences and expectations than one from the inner city. Being able to be flexible and augment programming through interagency collaborations is often necessary to ensure that individual needs are met.

Delivering services and support in a culturally competent manner is obligatory for programs. A culturally competent program possesses the skills and abilities to work effectively with diverse populations. Examining key components of a culturally competent program will help ensure that service delivery is relevant and respectful of the unique features and cultural beliefs within diverse populations. The five key components are: organizational commitment, culturally competent staff, culturally appropriate services, and community network.

Although emergency services may be an entry point for many adolescent mothers, comprehensive care programs often have the most positive outcomes (Polit-O'Hara et al., 1984). This, however, is dependent on essential resources existing in the community that are available and accessible. In addition to the points already discussed, expanding conditions are necessary for program success. They include: well-developed local health, education, and social services, local civic cultures supportive of services, flexible local funding sources, traditions of interagency collaboration, mechanisms for local coordination, and supportive state policies.

It is documented both anecdotally and through research that adolescent mothers are an inherently difficult group to serve. They will defy authority because it is in an adolescent's developmental nature to be that way. They will test relationships and sometimes appear unmotivated and unaffected. It is, however, incumbent upon us as adults to provide the support, structure, and experiences for adolescent mothers that promote growth in the developmental, psychological, emotional and spiritual dimensions of their lives. In doing so, our own lives may be enhanced. We too, should continue to urge those in power to address the fundamental conditions of poverty and unemployment that lead to adolescent childbearing and undermine the success of parenting teens and their families. Funding we allocate now to support adolescent parents and their children will cut that billion dollar price tag considerably in the future. (Please support Senate File 532/House File 1492 -- MN Parenting and Prevention support Pilot Program).

This Minnesota Organization on Adolescent Pregnancy, Prevention and Parenting (MOAPPP) Monitor article is available on the web: http://www.cyfc.umn.edu/MOAPPP/support.htm

Special Newsletter Resources

Two useful newsletters available from the Network for Family Life Education, at Rutgers.

Family Life Matters: The target audience for this newsletter is health, family life and sexuality educators and community agency staff. The topics addressed include best practices, current research and available resources related to educating young people about sexuality.

Use the following form to order:

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Family Life Matters, c/o DEK Associates, P.O. Box 909, Sudbury, MA 01776

For Information Call: The Network for Family Life Education, School of Social Work, Rutgers University.
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Sex, etc. This newsletter is written by teenagers for teenagers. While the focus of the newsletter is sexuality, the articles address a range of psychosocial problems that affect many teens (e.g. teen pregnancy, HIV/AIDs, teen runaways, addiction to gambling) as well as information about healthy development and healthy lifestyles.

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We hope you found this to be a useful resource. There's more where this came from!

This packet has been specially prepared by our Clearinghouse. Other Introductory Packets and materials are available. Resources in the Clearinghouse are organized around the following categories.

CLEARINGHOUSE CATEGORIES

Systemic Concerns

- Policy issues related to mental health in schools
- Mechanisms and procedures for program/service coordination
  - Collaborative Teams
  - School-community service linkages
  - Cross disciplinary training and interprofessional education
- Comprehensive, integrated programmatic approaches (as contrasted with fragmented, categorical, specialist oriented services)
- Issues related to working in rural, urban, and suburban areas
- Restructuring school support service
  - Systemic change strategies
  - Involving stakeholders in decisions
  - Staffing patterns
  - Financing
  - Evaluation, Quality Assurance
  - Legal Issues
- Professional standards
- Other System Topics: _____

Programs and Process Concerns:

- Clustering activities into a cohesive, programmatic approach
  - Support for transitions
  - Mental health education to enhance healthy development & prevent problems
  - Parent/home involvement
  - Enhancing classrooms to reduce referrals (including prereferral interventions)
  - Use of volunteers/trainees
  - Outreach to community
  - Crisis response
  - Crisis and violence prevention (including safe schools)
- Staff capacity building & support
  - Cultural competence
  - Minimizing burnout
- Interventions for student and family assistance
  - Screening/Assessment
  - Enhancing triage & ref. processes
  - Least Intervention Needed
  - Short-term student counseling
  - Family counseling and support
  - Case monitoring/management
  - Confidentiality
  - Record keeping and reporting
  - School-based Clinics
- Other program and process concerns: _____

Psychosocial Problems

- Drug/alcoh. abuse
- Depression/suicide
- Grief
- Dropout prevention
- Learning Problems
- Pregnancy prevention/support
- Eating problems (anorexia, bulim.)
- Physical/Sexual Abuse
- Neglect
- Gangs
- Self-esteem
- Relationship problems
- Anxiety
- Disabilities
- Gender and sexuality
- Reactions to chronic illness
- School Adjustment (including newcomer acculturation)
- Other Psychosocial problems: _____

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