

**PROGRAM APPROACHES IN TEEN  
PREGNANCY PREVENTION:**

**BEST PRACTICES  
AND  
EFFECTIVE AND PROMISING PROGRAMS**

**The Cornerstone Consulting Group, Inc.  
2001**

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## **INTRODUCTION**

Teen pregnancy and childbearing, adolescent sexuality, and abortion are among the most divisive and emotionally charged social issues in American life. In fact, these issues have been in the forefront of public policy debate for almost three decades, involving many organizations and government agencies and hundreds of programs in efforts to count, explain, and reduce the high numbers of pregnancies and births to teens.

After years of study and countless attempts to reduce adolescent pregnancy by affecting both its consequences and its antecedents, we now know a good deal about the factors that increase a young woman's chances of becoming pregnant and a young man's chances of causing a pregnancy. We also know a good deal about the kinds of programs and policies that help young people avoid pregnancy. There is good news: rates of births and pregnancies to teens are declining. However, these rates continue to be high, many times higher in the United States than they are in the rest of the industrialized world. And they are higher among some groups of the U.S. population than among others. In addition, sexually transmitted diseases are a serious health threat to a huge number of teens.

Many communities across the country continue to be concerned about high numbers of pregnancies, births, and STDs among local adolescents. They are interested in providing youth with the services and programs they need to avoid early pregnancy and childbearing and disease. This report discusses what we know about these efforts. It describes various strategies that have been used and evaluated for their effectiveness. It is designed to assist those who plan programs and those who deliver services to incorporate "best practices" and proven and promising program models into their efforts for young people.

This report was prepared in conjunction with a larger inquiry conducted by the Cornerstone Consulting Group, Inc., to develop a countywide plan and identify strategies to reduce teenage pregnancy and childbearing in Palm Beach County, Florida.

## **LOOKING AT THE NUMBERS: THE EFFECTS OF SEXUAL RISK TAKING AMONG TEENS**

In the United States in 1996 (the latest year for which complete data are available), there were

**9 million women ages 15 to 19.**

Nearly one out of every ten of these young women became pregnant: there were

**859,000 pregnancies.**

And more than half of these pregnant teens gave birth: there were

**492,000 births.**

More than three-fourths of the babies born to teen mothers in 1996 were born to unmarried women: there were

**373,920 births to unmarried mothers.<sup>1</sup>**

In order to understand the impact of these numbers it may be useful to think of a high school classroom, which contains about a dozen teen women (we'll consider the boys later). In 1996, on average, at least one young woman in every class became pregnant. About four of these young women would be pregnant at least once before they reached age twenty.

The numbers above translate into the following rates of teen pregnancy and childbearing. Florida's rates are included for comparison.

**Table 1  
Rates of Births and Pregnancies to U.S. and Florida Teens, 1996<sup>2</sup>**

	U.S.	Florida
Pregnancy Rate	97	115
Birth Rate	54.4	55
% Unmarried	76	79

Rates are expressed as the number per 1,000 women ages 15 to 19.

Rates of pregnancy and birth to teens, which peaked in the late 1950s, have been declining steadily over the past decade. The national birth rate reached 49.6 in 1999, the lowest level since the statistic was first recorded 60 years ago.<sup>3</sup> Abortion rates began to fall in the 1980s, and in 1996 reached the lowest level in at least two decades.<sup>4</sup>

While these falling rates are good news, comparisons with other developed countries indicate that teen pregnancy and childbearing continue to be serious problems in the United States. In 1995, U.S. teen birth and pregnancy rates were half those in Canada and England and one-fifth those in France. Declines in these rates over the years between 1970 and 1995 were two or more times as great in these countries as they were in the U.S.<sup>5</sup>

Further, pregnancy and birth rates continue to be especially high in certain segments of the U.S. population. Hispanic teens have the highest birth rates among major ethnic groups,<sup>6</sup> while black teens have the highest pregnancy rates. These differences are largest for younger teens. Birth rates for Hispanic teens have declined the least during the past decade.<sup>7</sup>

- **Despite declines over the past decade, the United States has among the highest rates of pregnancy, abortion, and childbirth in the developed world.**
- **High pregnancy, birth, and abortion rates are more common among certain segments of the population, in particular, minority teens.**

## **FACTORS THAT CONTRIBUTE TO PREGNANCY AND OTHER NEGATIVE BEHAVIORS AMONG YOUTH**

A large body of research has attempted to identify factors that are associated with adolescent sexual and contraceptive behavior, pregnancy, and childbearing. Several recent reports summarize these studies.<sup>8</sup> They find that these factors are numerous and complex.

Early studies focused on characteristics of individual youth, looking at factors in the young person's personality or biology or in relationships with family and peers that were associated with early sexual activity and pregnancy.<sup>9</sup> A number of biological and psychological characteristics of individual teens were found to be associated with these negative behaviors.

Among biological antecedents are gender, age, testosterone level, and timing of puberty. Research has shown that these factors are causally related to adolescent sexual and contraceptive behavior and pregnancy, and they have moderate effects.<sup>10</sup> A second group of antecedents includes attitudes and beliefs about sexual behavior, pregnancy, and childbearing, such as opinions, personal values, and perceived norms and intentions concerning abstinence and contraception. Research has shown that most of these factors are weakly or moderately associated with sexual behavior and pregnancy.<sup>11</sup>

In the course of these studies, practitioners observed and research confirmed that problem behaviors often clustered in adolescents; in other words, a young person who engaged in one risky behavior was very likely to be engaged in others as well. Comparisons of youth who developed various problem behaviors with those who did not led researchers to identify a common set of risk factors for negative development. Although **risk factors** include individual characteristics and elements of adolescents' relationships with family and peers, researchers noted that the factors underlying negative behaviors are complex and include broad social and environmental conditions—early childhood and educational experiences, conditions of poverty and discrimination, and impoverished or inappropriate services.<sup>12</sup> In fact, poverty is associated with every sort of adolescent risk-taking behavior: early and unprotected sexual activity, substance use, school failure, truancy, and delinquency. Regardless of ethnic group, age, or sex, disadvantaged youth are most at risk of negative outcomes.

As researchers studied the factors associated with adolescent risk-taking behavior, they noted that many teens exposed to these negative influences somehow managed to remain problem free. That is, many adolescents growing up in distressed families and communities reach adulthood without an early pregnancy, without school failure, without drug abuse, and the like. Evidence suggests that these youth are shielded from risk by a number of **protective factors** that give them the supports and opportunities they need to grow into independent, productive adults. In order to be protected against negative outcomes, youth need to have their basic needs met. In addition, they need many supportive relationships with adults and peers; meaningful opportunities for involvement and membership; challenging and engaging activities and learning experiences; and

physical and emotional safety.<sup>13</sup> Like risk factors, many protective factors are part of the social and environmental conditions in which young people live.

Thus, a whole variety of factors—both individual and environmental—contribute to adolescent pregnancy and childbearing. One analysis of recent declines in pregnancy and birth rates suggests the complexity of the task of reducing these and other negative behaviors among teens. The report identifies at least a half dozen factors contributing to declining rates, among them: a clear message from adults that young teens should remain abstinent until they are older; more conservative attitudes about sex among teens; fear of sexually transmitted diseases, particularly AIDS, perhaps reflecting AIDS education programs; changed perceptions about condoms; increased use of contraception, especially long-lasting methods; and the strong economy offering improved job prospects to poor teens, young men as well as women.<sup>14</sup>

It is clear that pregnancy is the direct result of the decision to engage in sexual activity that is either unprotected or inadequately protected. Recent declines in pregnancies among teens are thought to most directly reflect these two factors: a decline in the level of adolescent sexual activity or improvement in teens' use of contraceptives or a combination of both.<sup>15</sup> These factors are often referred to as the “proximal causes” of teen pregnancy, and efforts to influence them are referred to as primary pregnancy prevention programs. In the discussion that follows, while we emphasize programs designed to affect these direct causal factors in teenage pregnancy, we also describe program approaches that address environmental contributors to youth development. Readers should keep in mind that efforts to reduce pregnancy among adolescents will not succeed if they only address the proximal causes. Communities working to reduce teen pregnancy must not lose sight of the larger context and must work to implement comprehensive approaches that reflect the complexity of the causes of these problems.

- **The factors that contribute to teen pregnancy and childbearing are complex.**
- **They include characteristics of individual teens and of their relationships with family and peers.**
- **In addition, poverty and the social disorganization that accompanies poverty are important contributors.**
- **These same risk factors are associated with many other kinds of negative adolescent behavior.**

## **PREVENTING TEEN PREGNANCY: PROGRAMS & BEST PRACTICES**

Today there are hundreds of local, state, and national programs designed to affect in some way the problem of adolescent pregnancy. Many early programs attempted to improve the lives of adolescent mothers and their children. More recently, programs have been designed to assist teen fathers, as well. In the late 1970s some programs began to focus on prevention. For more than two decades, organizations, government agencies, and community groups have used a variety of program approaches aimed at prevention.

Among these approaches, we identify four general types: educational programs, programs that affect the use of contraception, youth development programs, and multi-component programs. These classifications are useful for this discussion; however, many programs do not fall neatly into one category. We will discuss separately programs designed to reach several special populations—young men and pregnant and parenting teens. Each of these types of program has a place in community efforts to prevent early sexual activity, pregnancy, and disease among youth.

Our review identifies best practices for each program type and recommended programs—programs whose evaluations suggest that they are effective. The Division of Adolescent and School Health (DASH) of the Centers for Disease Control and Prevention and the Program Archive on Sexuality, Health & Adolescence (PASHA) sponsor expert reviews of research on a variety of prevention programs. Each group has established criteria for credible evidence of a program's effectiveness and of its application to other settings. Both maintain lists of recommended programs.<sup>16</sup> We include programs from these two lists among our recommended programs, along with other efforts that have shown evidence of effectiveness. The mix of programs implemented in a community depends on several important factors that are taken up in the last section of this report.

## EDUCATIONAL PROGRAMS

Educational programs fall into two broad groups: those that teach only abstinence and those that teach abstinence plus effective contraceptive practice. There is widespread public support for abstinence-plus, or comprehensive sexuality education, programs. In a recent poll, 93 percent of the public supported comprehensive sexuality education in high schools, and 84 percent supported it in junior high schools.<sup>17</sup> Over 90 national organizations believe children and youth should receive such education. Twenty-three states mandate comprehensive sexuality education, and 13 others encourage it.<sup>18</sup>

The federal government has long favored abstinence-only programs. Under 1996 welfare reform legislation, \$50 million is available to states each year from 1998 until 2002 for education that “has as its exclusive purpose teaching the social, psychological, and health gains to be realized by abstaining from sexual activity.” The law also includes funding to evaluate programs. *To date none of the studies of abstinence-only educational programs have found consistent and significant effects in delaying the initiation of sexual activity. One study provided strong evidence that the program did not delay sexual initiation.* Most of the studies had methodological shortcomings. At this time, there is not enough evidence to determine the impact of abstinence-only programs.<sup>19</sup>

Abstinence-plus programs vary widely in length and intensity, in their context (school or community based), in their focus (HIV/AIDS prevention, pregnancy prevention, health education or life skills). Evaluations of these programs have yielded mixed results. None resulted in earlier initiation of sexual activity; none increased the frequency of sexual activity; and none increased the number of sexual partners. Some either delayed the onset of sexual intercourse, reduced the frequency, or reduced the number of partners. Some increased use of condoms or other contraceptives.<sup>20</sup>

Limitations in the methods used to evaluate the programs—in particular their long-term effects and effects on pregnancies—make further study essential. Nevertheless, a review of research on comprehensive sexuality programs indicates that effective programs have several characteristics in common. And a number of programs have been judged worthy of replication by experts.

## Educational Resources<sup>21</sup>

Guidelines for Comprehensive Sexuality Education – a report that broadly identifies six key concepts in sexuality education: human development, relationships, personal skills, sexual behavior, sexual health, and society and culture. At four developmental levels, the report identifies topics, sub-concepts, and developmental messages within each concept.

Guidelines for Effective School Health Education to Prevent the Spread of AIDS – essential information children need in early elementary school, middle school and high school.

Human Sexuality: What Children Should Know and When They Should Know It – a guide to essential information and skills appropriate for ages five through adolescence.

## Education Best Practices<sup>22</sup>

### **Program Content**

- Effective education programs focus on reducing a small number of specific sexual behaviors that lead to unintended pregnancy or STD infection, and they take a definite stand on these behaviors.
- They are appropriate for the age, sexual experience, and culture of their audience.
- They are based on theoretical models, such as social learning theory, that have been shown to have an effect on other health-related risk behaviors.
- They include accurate but not necessarily comprehensive information about the risks of unprotected intercourse and methods of avoiding unprotected sex.
- They deal with social pressures—from the media and peers—on sexual behavior.

### **Program Implementation**

- They include modeling and practice of communication, negotiation, and refusal skills.
- They use teaching strategies that involve students and help them personalize the material.
- They are long enough—at least 14 hours—unless they take place in small group settings where a shorter duration appears effective.
- They are led by trained and committed teachers and peers.

## Recommended Education Programs

### Primary Pregnancy Prevention

Human Sexuality—Values and Choices: A Values-Based Curriculum for Seventh and Eighth Grades – a program that promotes seven core values to support sexual abstinence and healthy social relationships: equality, self-control, promise keeping, responsibility, respect, honesty, and social justice. The curriculum includes 15 student lessons and three adult-only lessons. It emphasizes parent-child communication and the use of a standardized video format that includes role-playing, group discussion, and behavioral skills exercises. The program has been tested in urban schools. Middle School (PASHA)

Postponing Sexual Involvement – a program for junior high/middle school students that encourages young teens to remain abstinent. The curriculum includes relationships, sources of sexual pressure, and assertive responses for high-risk situations. Classes are led by trained peer leaders and emphasize interaction and role-playing. The program has been tested with 8<sup>th</sup> graders from low-income, urban communities. Middle School (PASHA)

Project Taking Charge – a program that integrates family life education with vocational exploration, interpersonal and family relationships, decision-making, and goal setting. The program promotes abstinence and includes no material on contraception. It includes 27 lessons and three parent-youth sessions. The program has been tested in junior high school home economics classes in low-income communities with high rates of teen pregnancy. Middle School (PASHA)

Reducing the Risk: Building Skills to Prevent Pregnancy, STDs, and HIV – a 16-session program designed to delay sexual activity or reduce the frequency of intercourse, and to increase awareness about and use of methods that protect against pregnancy and STDs. The curriculum also encourages parent-youth communication. The program uses role playing, homework activities, quizzes, and skill-building activities. It has been tested with students in grades 9 and 10 in California schools. High School (CDC & PASHA)

Teen Talk – a sexuality and contraception education program for 13 to 19-year-olds. The curriculum includes reproductive physiology and contraceptive methods and effectiveness. Small group discussions allow students to understand and personalize information, develop and practice skills that will make abstinence easier to maintain and that will strengthen contraceptive knowledge. The sessions include role-playing, games, and films. The program is a collaborative effort between schools and community health centers. It has been tested in rural and urban communities among students of diverse ethnic backgrounds. Middle & High School (PASHA)

### **STD/HIV/AIDS Prevention**

AIDS Prevention for Adolescents in School – a six-session program for high school students. The curriculum is designed to improve students' knowledge, beliefs, self-efficacy, and risk behavior related to HIV/AIDS. Sessions include values clarification, role-playing, and building negotiation skills as well as discussion of buying and using condoms. The program has been tested with predominantly minority teens in urban high schools. High School (PASHA)

AIDS Risk Reduction Education and Skills Training Program (ARREST) – a program that includes three small group sessions with information about the transmission and prevention of HIV/AIDS, instruction on purchasing and using condoms with spermicide, guidance in self-assessment of risk behaviors, training in decision-making, communication, and assertiveness skills, and peer-group support. Activities include role-playing, skill building, and homework. The program has been tested with minority teens in urban community-based organizations. (PASHA)

AIDS Risk Reduction for College Students – a program of three two-hour sessions led by trained peer educators. The curriculum includes information, motivation, and behavioral strategies for AIDS risk reduction. (PASHA)

Becoming a Responsible Teen (B.A.R.T.) – an eight-session program that uses small-group discussion, role-playing, games, and video segments. The curriculum stresses the importance of condom use for those who are sexually active and incorporates education with training and practice in sexual assertion, self-management, problem solving, risk recognition, refusal, and partner negotiation skills. Students are separated by gender. The program has been tested with and designed for African-American youth, ages 14 to 18, and other youth in high-risk situations, such as delinquent and drug dependent adolescents. High School (CDC & PASHA)

Focus on Kids: HIV Awareness – a program for African-American youth ages 9 to 15, and other youth, especially those living in low-income, urban areas. The curriculum includes information, values clarification, communication and negotiation skills, and correct condom use, as well as developing community projects. The program consists of seven one and one-half hour sessions and one all day activity. The sexes were separated for small group sessions but combined for the outing. The program has been tested with low-income African American youth in naturally occurring friendship groups. Middle & High School (CDC)

Get Real about AIDS – a 14-session program that emphasizes behavioral skills development. The first seven sessions cover the transmission and prevention of HIV, teenage vulnerability to the virus, and determinants of risky behaviors. In the remainder of the sessions, students learn and practice skills to help them identify, manage, avoid, and leave risky situations. The program has been tested with students in grades 9 through 12 in urban, suburban, and rural schools. High School (CDC & PASHA)

The Safer Sex Efficacy Workshop – a three-hour workshop led by trained peer educators designed to increase students’ self-efficacy, or belief in their own ability to act successfully to prevent HIV/AIDS and other STDs. The workshop emphasizes discussion, role modeling, and social persuasion. Students role-play safer sex discussions and learn about correct condom use. The program has been tested with and designed for college students enrolled in a health education class. (PASHA)

Youth AIDS Prevention Project – a program designed to prevent STD/HIV/AIDS and substance abuse among high-risk junior high school students. Ten sessions in seventh grade health or science classes cover transmission and prevention, the importance of using condoms for those who have sex, and the development of decision-making, resistance, and negotiation skills. Sessions emphasize active learning, with small-group exercises and role-playing. There are also homework activities, videos, and opportunities for parental involvement. A five-session booster program is provided one year later. The program has been tested with high-risk, urban students. Middle School (PASHA)

## PROGRAMS THAT PROVIDE ACCESS TO CONTRACEPTION

Contraceptive use by teens is the result of the complex interaction of many factors, including knowledge and skills, access, motivation, and peer, partner, parent, and public influences. We have noted above that educational programs that include information about the risks of unprotected sex and methods of protection, as well as the skills needed to make decisions, negotiate with partners, and the like, have had a positive effect in some cases on teens' contraceptive use. The results of these programs, as well as theories of human behavior, suggest that knowledge, by itself, is not sufficient to ensure effective and consistent contraceptive use. Various skills are also essential. In addition, many issues of access may prevent teens from using contraception even when they have both the necessary knowledge and skill. The effective use of each method of contraception is a complicated process with many steps. Use of oral contraceptives, for example, involves, among other actions, visiting a health care provider to obtain a prescription, visiting a pharmacy to fill the prescription, paying for the medical visit and the pills, taking a pill each day at the right time, obtaining refills on time, stopping and starting cycles at the correct time, interpreting side effects correctly, and taking action to resolve problems.<sup>23</sup>

Programs that provide teens with access to contraception and the specific skills to use particular methods include family planning clinics, managed care providers, school-based or school-linked clinics, and condom distribution programs, along with private physicians and pharmacies. Teens are varied, and more of them are likely to access family planning services if there are a variety of service providers in the community serving their various needs.<sup>24</sup> Although it is difficult to show a direct link between the services provided by clinics and teen pregnancies and births, various estimates suggest that family planning services have prevented hundreds of thousands of pregnancies.<sup>25</sup>

There are more than seven thousand publicly subsidized clinics in the United States, serving about 1.8 million adolescents each year, nearly 63 percent of all teens who use reversible methods of contraception. Yet it is estimated that only 37 percent of teens who need services currently receive contraceptive care through these sources.<sup>26</sup> Nearly one-fourth of the school-based clinics in the country provide contraception on site.<sup>27</sup> There are also a number of school-linked health centers, which are more likely to offer full family planning services.

Clinics connected to schools incorporate a number of the features that contribute to improved contraceptive use by teens: their locations and schedules are convenient; they are free; their staff are usually well-trained and specialize in treating adolescents, and they can provide integrated education, counseling, and medical services.<sup>28</sup> Studies of school-based and school-linked clinics have reported mixed results. The clinics do not contribute to the early timing or frequency of sexual activity, nor do they appear to produce changes in school-wide pregnancy or birth rates. A few studies have shown a positive effect on the use of contraception, but others have not.<sup>29</sup> One school-linked clinic that worked in partnership with educational and counseling programs in the schools is included in the Program Archive list of recommended programs below.

Condom availability programs, present in more than 300 schools, are another method of providing teens with access to contraception. These programs have also shown mixed results: while many students do obtain condoms from school programs, students in only some of these schools were more likely to use condoms. In none of the studies did the availability of condoms lead to increased sexual activity or earlier initiation.<sup>30</sup> In one community, widespread marketing and availability of condoms led teens to use condoms more often with casual sex partners.<sup>31</sup> In another community, AIDS classroom instruction combined with school-wide activities, and condom availability led to increased condom use at last intercourse without increasing the initiation of intercourse.<sup>32</sup>

A number of studies have identified the characteristics of programs that increase adolescents' use of clinics, their compliance with contraceptive methods, and their continuing use of effective contraception. These are listed below as best practices. The discussion of programs to increase male involvement also includes information on best practices in condom availability.

### **Contraceptive Care Resources<sup>33</sup>**

Assessing and Planning for Youth-Friendly Reproductive Health Services – a comprehensive, four-part guide for practitioners and planners to determine the level of access to reproductive health services that their programs provide to young people and the quality of their services and to help them develop youth-friendly programs.

Improving Contraceptive Access for Teens – a comprehensive guide that includes information on the factors influencing teens' use of contraception and barriers to contraceptive use; detailed guidelines for youth friendly services; step-by-step descriptions for planning, implementing, and evaluating programs; and various resources, including reproductive health history questionnaires and a guide for clinicians.

## Contraceptive Care Best Practices<sup>34</sup>

### **Provider Characteristics**

- Staff have been specially trained to work with youth, particularly in counseling skills, in respect for teens and their needs, and in adolescent development.
- Staff recognize the critical importance of privacy and confidentiality to young people.

### **Health Center Characteristics**

- Separate time and/or space are set aside for adolescents.
- Clinic times are convenient for youth.
- Facilities are conveniently located, including places where teens are, such as schools, workplaces, recreational centers, and the like.
- There is adequate space to protect privacy.
- Surroundings are comfortable, not medical, and appealing to youth.
- Confidentiality is protected.

### **Program Design Characteristics**

- Appointments are available quickly.
- Provisions are made for drop-ins.
- Waits are short, and facilities are not overcrowded.
- Fees are affordable.
- Partners are welcomed, and special services are offered for males.
- Appointments are long enough to allow for questions and concerns to be addressed.
- Educational materials on a variety of health and social issues of concern to young people are available in waiting areas.
- Follow-up visits are scheduled and monitored.
- Clinic programs are widely and openly publicized.

### **Less Common or More Experimental Characteristics**

- Trained peer counselors work with youth.
- A variety of health services are offered, including substance abuse counseling, prevention education and treatment, nutritional services, sexual abuse counseling, pregnancy care, and well care.
- There is active outreach to youth.
- Small group discussions are organized.
- Physical exams may be delayed, and contraceptives are immediately available.

## Recommended Contraceptive Access/Care Programs

Adolescent Compliance in the Use of Oral Contraceptives – a program using trained peer counselors to educate and support family planning patients ages 14 to 19 in a reproductive health clinic. During an initial visit, patients receive their first cycle of oral contraceptives, and peer counselors provide instruction and guidance and schedule follow-up visits. (PASHA)

AIDS Prevention and Health Promotion among Women – a program of four small-group sessions over a period of three months conducted with women using medical center obstetric services. Group discussion, role-playing, cognitive rehearsal and guided exercises lead women to make healthy choices about sexual practices. Emphasis is on partner negotiation skills. The program has been tested with low-income women, ages 16 to 29 in an urban area. (PASHA)

New Adolescent Approach Protocols: Tailoring Family Planning Services to Meet the Special Needs of Adolescents – a program to provide family planning services in a way that increases teenagers' comfort and self-confidence and reduces fears that may discourage regular and effective use. The first appointment is divided into two visits: the first for education and counseling, the second for medical examination and contraceptive prescription (if appropriate). Individual education, visual aids, follow-up schedules, and the encouragement of participation by family members, partners, and friends are also included. The program has been tested with youth under age 18 in family planning clinics. (PASHA)

School-Linked Reproductive Health Services (Self Center) – a partnership between a junior and a senior high school and a neighborhood clinic, combining education, counseling, and reproductive health services. The school-based components include at least one presentation to each homeroom class per semester to introduce the program and discuss values clarification, decision-making, and reproductive health; informal discussion groups on themes such as physical development, drug use, and parenting; and individual counseling sessions with a social worker. At the clinic, reproductive and extended counseling services are provided, and referrals are given for teens needing medical care. The program has been tested in a low-income urban neighborhood. (PASHA)

## **YOUTH DEVELOPMENT PROGRAMS**

Youth development programs focus on the opportunities, supports, services, and resources that young people need in order to develop into independent and productive adults. They are designed to improve life skills and life options rather than prevent specific problems. They embody now widely held beliefs that the most effective prevention strategy is to provide youth with an enriched, supportive environment.

Such programs may include considerable sex education and contraceptive information or very little. Usually, youth development programs include some combination of small group activities, peer teaching/counseling, job readiness training, academic tutoring, recreation, mentoring, employment, community service work, life skills training, and other forms of opportunity and support. The great diversity of programs makes comparisons difficult, and evaluations of program effectiveness have shown variable results. Some programs have had positive effects, lowering birth or pregnancy rates and levels of sexual and other types of risk-taking behaviors. Other programs have not shown positive effects.

The positive effects shown by some youth development programs, the often observed links among various types of adolescent risk taking, and the strong negative correlation between the education and employment goals of young women and their likelihood of becoming pregnant all make the youth development approach a promising area for further study. A number of reviews of youth development programs have identified practices that are likely to ensure success. In general, the more opportunities and supports youth have, the less likely they are to engage in risk-taking behaviors. Thus, programs are advised to strive to meet many of adolescents' needs and to meet them with sufficient intensity and duration. Those adolescents most at risk for negative development will need the most intensive services. In addition to directing the practice of programs intended specifically to contribute to positive youth development, youth development best practices should be used to guide the implementation of all types of community programming for young people.

## Youth Development Resources<sup>35</sup>

Linking Pregnancy Prevention to Youth Development – a comprehensive guide that presents support for a youth development approach to teen pregnancy prevention and provides a guide for communities and organizations to use in planning, implementing, and evaluating such programs. The report also includes a variety of resources.

PEPNet Effective Practices Criteria Workbook 2000 – a description of the criteria established by the National Youth Employment Coalition's Promising and Effective Practices Network for effective practices in youth employment and development programs. A detailed program self-assessment questionnaire is included.

## Youth Development Best Practices<sup>36</sup>

### **Safe Environment**

- Activities take place in safe, predictable & accessible spaces.
- Activities take place in areas that are secure & supervised.
- Programs provide consistent & dependable activities, with structure, order & schedules.
- Programs eliminate discrimination, rejection & physical threats.
- Programs provide continuing support and follow-up, especially at transitions such as the move from middle school to high school and from high school into the workforce.

### **Meaningful Involvement**

- Programs involve youth in decision-making for the organization, the group & themselves.
- Programs develop a sense of group membership through group goals and identity.
- Programs provide opportunities for experimentation, with support for less successful efforts.
- Programs provide opportunities to discuss and formulate values.
- Programs provide opportunities for feedback, peer review & self-reflection.
- Programs view youth as contributors & engage them in meaningful service activities.
- Programs provide opportunities for paid work or internships.
- Programs recognize & celebrate successes and accomplishments.

### **Supportive Relationships**

- Staff are trained to understand youth characteristics & needs.
- Staff empathize with, respect & are responsive to youth.
- Staff build trust, establish boundaries, articulate & uphold high expectations, maintain consistency.
- Staff have time to develop trust & relationship & create continuity & consistency of contact.
- Staff provide individual attention.
- Programs involve peers as role models.
- Programs involve parents, as well as schools and the community.

### **Challenging Activities**

- Programs offer activities that are learning centered, not just places to hang out.
- Programs offer activities that use intensive, hands-on, experiential forms of learning that are engaging & informal.
- Programs offer a variety of activities that are age-appropriate, sensitive to gender, culture, lifestyle & based on the abilities & interests of youth.
- Programs promote decision making, problem solving, communication, conflict resolution & other life skills.
- Programs take an indirect approach to problem prevention.
- Programs link to work/intern opportunities.

## **Recommended Youth Development Programs<sup>37</sup>**

The Quantum Opportunities Program – a program that includes educational activities (such as, tutoring and computer-based instruction), community service activities, and development activities (such as, arts and career and college planning). Participants receive a small stipend and bonus payments for participation and completion of activities and matching funds for approved activities after high school. The program has been tested with high school students from families receiving public assistance.

Teen Incentives Program – an after-school program that includes eight weekly small group sessions that focus on self-esteem, decision-making, communication, relationships, and sexuality topics. This is followed by a six-week career mentorship program involving health care professionals. The final segment includes extensive role-playing. The program has been tested with mostly female, poor and minority students in an urban setting.

Teen Outreach Program – a program that combines small group discussions with community service-learning activities to prevent teen pregnancy and encourage academic progress among 12 to 17 year old students. Curriculum guided classroom activities include topics such as growth and development, values clarification, communication skills, parenting issues, family and peer relationships, and community resources. The program has been tested with students, mostly female, of different ages and ethnic/racial groups across the country. (PASHA, National Campaign to Prevent Teen Pregnancy Effective Program)

The Youth Incentive Entitlement Pilot Program – a national program to guarantee jobs to economically disadvantaged youth. Youth receive part-time jobs during the school year and full-time summer jobs with the requirement that they remain in school. The program has been tested with female students ages 14 to 19 in one rural and six urban areas.

## **COMPREHENSIVE PROGRAMS**

Because teen pregnancy results from a complex and interrelated array of causes, comprehensive programs that address several of the factors underlying adolescent risk-taking have been widely recommended.<sup>38</sup> A variety of multi-component programs have been attempted. Again, their diversity makes them difficult to compare, and some have had positive effects while the results of others have been difficult to measure and document. Research suggests many factors may contribute to the effects of these approaches.

Family Influences: Beyond factors of family socio-economic status and biology, a number of studies have tried to assess the influence that families, particularly parents, have on the timing and outcome of teens' sexual behavior.<sup>39</sup> Most of these studies show that teens who are close to their parents have a reduced risk of a teen pregnancy. In addition, teens who are closely supervised by parents (but not those with overly strict parents) are more likely to be older when they first have intercourse, to have fewer

partners, and to use contraception. On the other hand, results of studies of parent/child communication about sex have been mixed. Communication is most likely to be associated with reduced risk of pregnancy when parents and youth have close relationships and when parents have clear values about the benefits of abstinence and the dangers of unprotected intercourse. It is important that the teen accurately receives the parents' message and is willing to accept it.

Adolescents and children often cite parents as their most important or preferred source of information about sex. A majority of teens and their parents report having discussed sexuality or AIDS/HIV infection.<sup>40</sup> Many teens feel that parents are the source they consider "most reliable and complete."<sup>41</sup> Yet, in a recent survey, more than one-third of teens report that they have not had a single helpful conversation with a parent about sex.<sup>42</sup>

When surveys asked about the content of parents' conversations with their children they found that alcohol, drugs, and violence are the most frequently discussed topics. AIDS and sexual reproduction are discussed less often; relationships/becoming sexually active and preventing pregnancy and STDs are the least discussed.<sup>43</sup> Many preteens and teens say they want more information from their parents on difficult issues, such as protecting themselves against HIV/AIDS, handling pressure to have sex, knowing when they are ready to have sex, the effects of alcohol and drugs on decisions to have sex, and preventing pregnancy and STDs.<sup>44</sup> The very topics that youth say they need more information about are the topics their parents avoid discussing.<sup>45</sup> Teens also report that the information they get about sex and birth control from adults often comes too late.<sup>46</sup>

While most parents and their children report that they are talking about sex, or at least about HIV/AIDS infection, it is clear that many parents are not comfortable in the role of sexuality educators. In a recent study, nearly half of all parents and a fourth of those who were already talking to their children said they could use help in knowing how and when to raise issues.<sup>47</sup> Two of the comprehensive programs listed among those recommended below include strategies for increasing parents' skill in addressing these issues with their children.

Media Influences: Parents compete with a number of other sources of information about sexual issues, beginning quite early in their children's lives. When preteens and teens were asked to identify where they had learned "a lot" about sex, AIDS, violence, drugs and alcohol, preteens ranked mothers, teachers, and television/movies equally in first place, with fathers a close second. However, among teens, parents slipped into fourth place (tied with the Internet) following friends, television/movies, and teachers or school.<sup>48</sup> For the most part, media influences on adolescent sexual behavior are thought to be negative. Sexual activity and sexual situations are ubiquitous on television and in film and in magazines, but these portrayals rarely include consideration of responsibility and contraception.

Although a majority of states have some sort of media campaign designed to reduce or prevent teen pregnancy, few of these programs have been evaluated. However, there is considerable evidence from other public health campaigns—for example, cardio-vascular

health, anti-smoking, drinking and driving, HIV/AIDS prevention among homosexual men—that such efforts can be successful over the long term when they are combined with other educational and behavior-change programs. Such efforts help change public opinion, establish public policy goals, and educate the audience. They can be an important element in comprehensive, community-wide initiatives. Because they are expensive, special care must be taken in planning media campaigns. Several guides to planning media efforts provide valuable advice; they are listed below.

Community Influences: Beyond the very important influences of community characteristics like poverty level, unemployment rate, educational level, crime rate, and the availability of services, supports and opportunities on teenage sexual behavior, communities and the larger society influence local youth through the messages they convey. Studies of the success of developed countries in reducing teen pregnancy rates cite the direct and unambiguous messages that adolescents in these countries receive about using contraception.<sup>49</sup>

Recently, an expert panel of professionals involved with youth<sup>50</sup> was asked to rate a variety of community characteristics that increase adolescents' motivation and capacity to avoid pregnancy and help teens become competent and productive adults. They identified five clearly stated community norms as very important, second only to those related to reproductive health services. The norms are

- The belief that unmarried teenagers should avoid unintended pregnancy and sexually transmitted diseases.
- The belief that education should be a priority for boys and girls.
- The belief that unmarried teenagers should not have sex without using contraception.
- The belief that unmarried teenagers should not become pregnant.
- The belief that unmarried teenagers should not engage in unprotected sex, which might lead to sexually transmitted diseases.

Unfortunately, most American adults are not comfortable articulating messages such as these to young people. For many adults, the tension lies in trying to give teens factual information without seeming to condone early sexual activity or sex outside of marriage. For others, cultural norms make discussions of issues related to sexuality unacceptable. The great majority of adults simply do not have the knowledge of human and sexual development and the skills they need to do this important job. Parents will quickly admit they need help, but many youth work professionals would also benefit from skill-building activities to increase their capacity to handle these discussions.

Several of the comprehensive prevention programs recommended below include components designed to help community adults become comfortable communicating with youth on these issues.

## Comprehensive Program Resources<sup>51</sup>

Involving Parents and Other Adults in Teen Pregnancy Prevention – a guide to planning, implementing, and evaluating efforts to involve parents and other adults in pregnancy prevention. It includes information on promising approaches.

The Media and the Message (Full Report) – a comprehensive guide to developing, launching, and evaluating media campaigns. It includes information on determining goals and objectives, conducting formative research, defining an audience, designing campaign messages, selecting media outlets and maximizing exposure, and conducting process and outcome evaluation.

Working with the Media to Promote Teen Pregnancy Prevention – a guide to planning, implementing, and evaluating a media campaign. It includes examples from a variety of current campaigns.

## Recommended Comprehensive Programs<sup>52</sup>

The Children’s Aid Society’s Pregnancy Prevention Program (Carrera Model) – a program that combines 30 hours of classes in family life and sex education with medical and health services, employment and career awareness, academic assessment and tutoring, guaranteed college admission, and self-esteem enhancement through the arts, sports, and counseling. The program has been tested with low-income high school students in community centers in a large urban area. It is currently being tested in other settings.

Plain Talk – a program that involved community adults in developing plans to lower teen pregnancy rates by mapping community attitudes and programs. Communities initiated activities to help parents and other adults communicate with teens and services to provide sexually active teens with quality, age-appropriate reproductive health care. Program activities varied among the five low-income, largely minority, urban communities that were part of the initiative.

Poder Latino: A Community HIV Prevention Program for Inner-City Latino Youth – a program to increase awareness of HIV/AIDS and promote the use of condoms. Activities include saturating neighborhoods with public service announcements with risk-reduction messages; using trained peer leaders to conduct workshops in schools, community organizations, and health centers; holding group discussions in teens’ homes; making presentations at large community centers; and canvassing door-to-door. (PASHA)

School/Community Program for Sexual Risk Reduction among Teens – a program that combines a community-wide public outreach campaign to prevent pregnancy among unmarried teens with extensive training in human physiology, sexual development, self-concept and sexual awareness, values clarification, and communication skills for community adults. Teens receive classroom instruction designed to increase knowledge, decision-making skills, communication skills, and self-esteem and to align values with those of the community. The program includes peer education and classes and activities in community groups and churches. Abstinence is promoted as the preferred sexual health decision, but contraceptive information and services are provided to sexually active teens. The program has been tested in a rural, predominantly minority, low-income community and retested in other settings. The original test group was all female. (PASHA)

## **MALE INVOLVEMENT PROGRAMS**

Until quite recently, most programs designed to prevent teen pregnancy focused on adolescent women, who bear the largest share of the burden of too early pregnancy and childbearing. Yet clearly young men are an essential component of the pregnancy equation. The great majority of young men agree that preventing a pregnancy, talking about contraception before sexual intercourse, using contraception to protect against unwanted pregnancy, and taking responsibility for a child they fathered are male responsibilities.<sup>53</sup> The dramatic recent increases in the use of condoms confirm the willingness of young men to make responsible sexual choices.

In the last ten years, a variety of programs have been designed specifically for boys and men. Forty states are implementing, planning or piloting efforts to prevent teen fatherhood. Male involvement programs vary widely; some use advertising to spread messages about sexual responsibility throughout a community; some engage young men in examining their values and goals; still others focus on the use of contraception. Few of these programs have been fully evaluated. Several reviews of male involvement activities have identified broad principles to guide program practice.

## Male Involvement Resources<sup>54</sup>

Involving Males in Preventing Teen Pregnancy: A Guide for Planners – includes complete descriptions and contact information on 24 programs that focus on the male perspective in the prevention of pregnancy and have been operating for at least one year. Few programs have been formally evaluated. The guide also includes a listing of other male involvement programs and examples of curricula, videos, and other materials used in selected programs.

### Best Practices in Male Involvement Programs

#### Program Implementation

- Incorporate the male perspective in all aspects of the teen pregnancy prevention initiative, tailoring some messages and activities specifically and separately for males.
- Fit programs to the characteristics of the participants—their age, developmental stage, cultural, ethnic and religious background, and their current level of knowledge and access to services.
- Make programs accessible, taking them to the places in the community where males naturally congregate at times when they are available.
- Provide opportunities for male-only activities where young men can develop an atmosphere safe for open discussions of their hopes and fears about sexuality and their relationships with women.
- Provide opportunities for male-female discussion of these issues.
- Involve adult males, including or especially somewhat older peers, as mentors and role models.
- Include male staff, at least as health educators or outreach workers or facilitators, so that program activities are not perceived to be only about women.

- Provide consistency and reliability through longer programs that offer extended contact with staff.
- Offer employment training or recreational services in addition to reproductive health and sexuality education.
- Involve the community in planning programs, and nurture relationships with the community.
- Extend efforts beyond school-based programs to reach the older partners of teen women.

#### **Program Content**

- Use direct, concrete language to convey information and use active learning techniques, including group activities, discussions and peer facilitation.
- Avoid scare tactics and blaming or stigmatizing; appeal to hopes and aspirations.
- Clarify the difference between media images of the “real man,” who is aggressive and “scores” with many women and “manhood,” the characteristic of men who have a responsible, caring commitment to family and respect for women.
- Make the connection between sexuality and procreation.

### **Recommended Male Involvement Programs**

BE Proud! Be Responsible! Strategies to Empower Youth to Reduce their Risk for AIDS - a program designed to increase knowledge of STDs/HIV/AIDS, enhance feelings of pride, and build support for safer sexual behaviors. Students meet in small groups with an adult facilitator, and participate in games, role-playing, and other oral and written exercises. Condom use is discussed. The program has been tested with and designed for male inner-city black, Hispanic, and white youth, ages 13 to 18. (CDC & PASHA)

Reproductive Health Counseling for Young Men – a clinic-based program of a single one-hour session for sexually active and inactive adolescent men ages 15 to 18. The session promotes abstinence as well as contraceptive use and includes a slide/tape presentation and an individual consultation with a health care professional. The consultation varies with the interests of the patient and may include sexuality, fertility goals and reproductive health risks, and rehearsal and modeling of sexual communication. (PASHA)

Rikers Health Advocacy Program – a four-session program that uses facilitator-led small group discussions of general health, HIV and AIDS, drug abuse and its consequences, sexual behavior, health and AIDS risk behavior, and strategies for seeking health and social services. The sessions emphasize active learning through discussion, role-playing and rehearsal activities. The programs has been tested with predominantly minority incarcerated male drug users ages 16 to 18. (PASHA)

Santa Cruz County Male Involvement Program – a program focusing on a community-wide information campaign that distributes posters and pamphlets about the importance of male involvement in teen pregnancy prevention and the rights and responsibilities of fathers. The program also includes events and media messages. Program participants help design the program, which is a collaborative effort of schools, the community, and local clinics. (PASHA)

Stay Safe for Gay, Lesbian and Bisexual Adolescents – a program that combines case management, comprehensive health care, risk assessment counseling, and 25 small-group discussion sessions to provide education, social and medical services and peer support to youth ages 14 to 19. Discussion sessions include information on HIV/AIDS transmission and prevention and behavioral and cognitive skills training for coping with high-risk situations. The program has been tested with urban teens from various ethnic/racial backgrounds. (PASHA)

Youth and AIDS Project's HIV Prevention Program – a program to provide education, peer support, counseling and case management to gay and bisexual males ages 13 to 21. Individual risk-assessment and risk-reduction counseling are followed by a 90-minute interactive peer education program. An educational video provides reinforcement, and weekly peer support groups are available. The program includes a one-hour follow-up visit for reassessment and referrals. The program has been tested with a group of predominantly white males. (PASHA)

Wise Guys – a comprehensive eight to 12-week workshop designed to prevent pregnancy and dating violence among 10 to 19-year-olds. The program promotes responsibility and teaches life skills, such as setting goals, making decisions, communication, and resisting peer pressure. (PASHA)

## **PROGRAMS TO PREVENT REPEAT PREGNANCIES**

The rate of second births to teens peaked in 1991 at 220.9 per 1,000. It then declined, more rapidly than the overall birth rate, dropping 21 percent by 1997. Despite these declines, more than one in five teen births are to young women who already have one child. Nearly one out of three adolescents who first gives birth before age 17 has a second birth within two years.<sup>55</sup> Young women who are parenting more than one child are less likely to overcome the negative consequences of too-early parenthood than are teens who parent a single child during adolescence. The risks to the children of these young women are also increased.

Despite the clear need for programs that provide care for pregnant and parenting teens and that help them prevent repeat pregnancies, federal funding for such efforts was cut substantially by the requirement for abstinence education in the 1996 welfare reform legislation. On the other hand, welfare reform offered states a bonus for reducing rates of out-of-wedlock births and waivers allowing states to use welfare funds for pregnancy prevention. These opportunities have led a number of states to promote and expand reproductive health services for poor mothers, including teens.

### **Best Practices in Programs to Prevent Repeat Pregnancies<sup>56</sup>**

#### **Program Characteristics**

- Programs adopt an overall health focus.
- They set clear expectations for participation in activities and often use financial consequences to support them.
- Educational programs are flexible, youth-centered, and integrated with life or job training and experiences.
- Programs include or provide referrals to intensive, on-going family planning services; some emphasize long-acting forms of contraception.
- They assist with support services, such as child-care and transportation.
- They often include intensive case management to help teen mothers assess needs for education, training, employment, treatment, etc., coordinate services, intercede with other agencies.
- They include or provide access to intensive services for the children of teen parents.

### **Staff Characteristics**

- Staff are interested in working with teen parents and receive on-going training, supervision and support.
- They build relationships with teens and give them individual attention and support.
- They help teen mothers set goals and commit to achieving them.
- They are direct and authoritative concerning contraception, provide clear messages about the undesirability of having more children, and provide support and guidance in contraceptive options and use.

### **Recommended Programs to Prevent Repeat Pregnancies**

Elmira Nurse Home Visiting Program – a comprehensive program of prenatal and postpartum care for first-time mothers with limited social resources. Nurses visit the homes of pregnant teens on average nine times before the birth to provide information about fetal and infant development, to arrange for care and support for the new mother from family and friends, and to link family members to other health and social services. The program has been tested with mostly white women in a small town and replicated with a group of low-income black young women in an urban area. (PASHA)

A Health Care Program for First-Time Adolescent Mothers and Their Infants – a clinic-based program to help first-time mothers prevent repeat pregnancies, return to school, improve immunization rates for their infants, and reduce use of the emergency room for routine health care. The program includes well-baby care, discussion of family planning and referral to a birth control clinic, instruction in parenting skills, informal parenting education through video tapes, slides and discussions with a professional or trained volunteer. The program has been tested with low-income black women under age 17 at an urban teaching hospital. (PASHA)

Queens Medical Center's Comprehensive Teenage Pregnancy Program – a clinic-based program that provides medical care, psychosocial support and education to teen mothers, their partners, and their families. A team of providers, including an obstetrician-gynecologist, pediatrician, social worker, and health educator, remain with the teen throughout the program, which includes a 24-hour on-call system, a reproductive health and family life education program in biweekly classes for the participant, her partner, and her family. The program has been tested with low-income urban teens. (PASHA)

A School-Based Intervention Program for Adolescent Mothers – a program based in an alternative public school for pregnant students. Services include social and medical care, childbirth education, and counseling. Teachers, nurses, and social workers of diverse backgrounds work with adolescents. The program has been tested with low-income students in an urban setting. (PASHA)

## **GENERAL GUIDELINES FOR DEVELOPING EFFECTIVE PROGRAMS**

Each community must develop a set of pregnancy prevention programs to meet the specific needs of local youth and the identified goals of the community. In order to identify the mix of program approaches best for the community, broadly representative planning groups must define the problem(s) they wish to solve and specify the population(s) they will serve. In addition, there are three constants of community efforts to prevent teen pregnancy and childbearing: provide for teens who are sexually active, involve adults as educators and advocates, and implement comprehensive approaches.

### **1. COMMUNITIES MUST CLEARLY DEFINE THE PROBLEMS THEY HOPE TO SOLVE.**

The history of teen pregnancy prevention efforts is often a story of programs, campaigns, and initiatives that attempted to satisfy all constituencies but failed to satisfy any. Many other efforts hoped to affect one problem when they were really designed to do something else entirely. “Teen pregnancy” is, in fact, a number of related problems, among them:

- The rate of sexual activity among adolescents.
- Sexual activity among very young teens.
- The rate of pregnancies and births to teenage mothers.
- The rate of births to unmarried teenage mothers.
- The spread of sexually transmitted diseases.
- The rate and availability of abortion.
- The trend toward marriage at later ages.

- The quality of life for teen parents and their children.
- The decrease in the prevalence of adoption for children of unwed teens.

As part of the process of planning an approach to teen pregnancy prevention, community members must identify the specific problems that exist locally. In addition, they must realistically assess which of these problems community residents and institutions are willing and able to address. Underlying these choices is the decision about whether one is attempting to prevent teenage sex, pregnancy, or childbearing. These choices are not necessarily mutually exclusive: a community may resolve to prevent teenage sex among youth who are under 17 and, at the same time, work to prevent pregnancy among older and sexually active teens. However, the community must be clear about its goals and clear that specific programs are appropriate to meet these goals.

## **2. COMMUNITIES MUST CLEARLY DEFINE THE POPULATIONS THEY INTEND TO SERVE.**

To some extent, identifying the problem to be solved helps focus the selection of the target population. Choices are guided by the development of adolescents themselves. For example, programs attempting to influence adolescent sexual behavior might intervene at a number of points:

- In early childhood—with sex education and health promotion activities.
- In early adolescence—with abstinence or “delay the onset” programming.
- With sexually active teens—with increased access to contraception and education in its proper use.
- With pregnant and parenting teens—with sexuality and life skills training, contraceptive access, and support services.

In addition, these choices should be driven by the facts about teen pregnancy. Only certain teens are likely to initiate sexual activity at very young ages. Focusing early efforts on these groups is the best use of resources. Certain youth are more likely than others to engage in various sorts of risk-taking behaviors. Focusing especially intense youth development activities on these groups is wise policy. In addition, programs need to be appropriate for particular age, ethnic, socioeconomic, and gender groups.

## **3. COMMUNITIES MUST INCLUDE STRATEGIES TO REACH TEENS WHO ARE HAVING SEX.**

Amidst the controversy that frequently surrounds programs to prevent teen pregnancy, adults sometimes lose sight of the fact that an adolescent must be having sex to become pregnant. Any effort that hopes to succeed in reducing pregnancies must include contraceptive education and access as part of the program.

Contraceptive knowledge is a prerequisite to use, yet many Americans are misinformed about the risks and benefits of various contraceptive methods and also lack knowledge about fertility and the correct use of the methods. Formal sexuality education that includes explicit information regarding contraception continues to be controversial in many parts of the country. Media coverage tends to focus on the problems with

contraceptives rather than the benefits, and these reports, over the years, directly influence public perceptions. One of the most common reasons sexually active teens report for delaying a visit to a family planning clinic is concern about the safety of contraception. Sexually active teens—both young men and women—must have information about and access to affordable contraceptive services. In addition, they need the training to negotiate contraceptive use with a partner and the knowledge to use contraception consistently and correctly. Finally, they need social support for their decision to act responsibly.

#### **4. COMMUNITIES MUST INVOLVE ADULTS IN PREVENTION EFFORTS.**

To a large extent, the problem of teen pregnancy is an adult issue, for adults shape the messages youth receive about sexual activity. Through clear and consistent messages from adults about the importance of both delaying sexual activity and acting responsibly to prevent pregnancy and disease, communities can help change youth behavior. It is important that adults in all sectors of the community be involved in this effort: clergy, teachers, youth workers, elected officials, community leaders, and residents, as well as parents, should understand these issues and be prepared to discuss them.

Such efforts must also prepare adults to become advocates for local youth. Educated members of the community will support the provision of services for teens in the face of opposition of those who would limit such programs because of their personal beliefs. In addition, engaged adults will work to provide youth with supports and opportunities they need to develop positively.

If communities want parents and other adults to be sexuality educators and advocates for youth, resources need to be made available so that adults have the knowledge and skills they need to comfortably talk with young people about these issues.

#### **5. COMMUNITIES SHOULD DEVELOP COMPREHENSIVE APPROACHES.**

Because the factors that underlie adolescent sexual and contraceptive behavior, pregnancy, and childbearing are numerous and complex, effective programs must focus on multiple factors, including beliefs, perceived norms, skills and intentions, and environmental factors that interfere with intentions to be abstinent or use contraception. In addition, programs must address antecedents related to poverty and social disorganization. As one study concluded: “Most of our past efforts have been too simple, too weak, too short, and overall, not up to the task of dealing with these complex behaviors and the societal trends surrounding them.”<sup>57</sup> By clearly identifying the needs of community youth and the programs that are likely to meet these needs, communities can combine a variety of programs into a comprehensive, community-wide effort that will truly serve their diverse youth.

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## ENDNOTES

<sup>1</sup> Population figure and total births and births to unmarried teens are from Annie E. Casey Foundation, *When Teens Have Sex: Issues and Trends*, A Kids Count Special Report (Baltimore, MD: Author, 2000); figure for total pregnancies is from Curtin, S.C. and Martin, J.A., "Births: Preliminary Data for 1999" (*National Vital Statistics Reports*, Vol. 48, No. 14, Hyattsville, MD: National Center for Health Statistics, 2000).

<sup>2</sup> All figures except pregnancy rates from Annie E. Casey Foundation, note 1; pregnancy rates are from The National Campaign to Prevent Teen Pregnancy, "Facts and Stats 2000" (Washington, DC: Author, 2000).

<sup>3</sup> Curtin, S.C. and Martin, J.A., "Births: Preliminary Data for 1999."

<sup>4</sup> Ventura, S.J., Curtin, S.C., Mathews, T.J., "Variations in Teenage Birth Rates, 1991-1998: National and State Trends" (*National Vital Statistics Reports* Vol. 48, No. 6, Hyattsville, MD: National Center for Health Statistics, 2000).

<sup>5</sup> Singh, S. and Darroch, J.E., "Adolescent Pregnancy and Childbearing: Levels and Trends in Developed Countries," (*Family Planning Perspectives* 32(1): 14-23, 2000).

<sup>6</sup> The Hispanic population of the United States is itself a diverse groups, comprising native born citizens and recent immigrants from many countries and cultural and socioeconomic backgrounds. Patterns of pregnancy and childbearing vary among these populations. Details can be found in Ventura, S.J., Mosher, W.D., et al., "Trends in Pregnancies and Pregnancy Rates by outcome: Estimates for the United States 1976-1996" (National Center for Health Statistics, *Vital Health Statistics* 21 (56), 2000).

<sup>7</sup> Curtin, S.C. and Martin, J.A., "Births: Preliminary Data for 1999."

<sup>8</sup> Dryfoos, J., *Adolescents at Risk: Prevalence and Prevention* (New York, NY: Oxford University Press, 1990); Kirby, D., *No Easy Answers* (Washington, DC: National Campaign to Prevent Teen Pregnancy, 1997); Moore, K.A., et al., *Adolescent Sex, Contraception and Childbearing: A Review of Recent Research* (Washington, DC: Child Trends, Inc., 1995); Miller, B.C., "Risk Factors for Adolescent Nonmarital Childbearing" (Report to Congress on Out of Wedlock Childbearing, DHHS Publication No. 95-1257, Washington: DC: US Dept. of Health and Human Services, 1995); Santelli, J. and Beilenson, P., "Risk Factors for Adolescent Sexual Behavior, Fertility, and Sexually Transmitted Diseases" (*Journal of School Health* 62(7): 271-279, 1992)..

<sup>9</sup> Lerner, R.M. and Galambos, N.L., "Adolescent Development: Challenges and Opportunities for Research, Programs and Policies" (*Annual Review of Psychology* 49: 413-446, 1998); Compas, B.E., Hinden, B.R., and Gerhardt, C.A., "Adolescent Development: Pathways and Processes of Risk and Resiliency" (*Annual Review of Psychology* 46: 265-293, 1995); Kirby, D., *No Easy Answers* (Washington, DC: National Campaign to Prevent Teen Pregnancy, 1997).

<sup>10</sup> Kirby, D., *No Easy Answers*.

<sup>11</sup> *Ibid.*

<sup>12</sup> Benard, B., "Fostering Resiliency in Kids: Protective Factors in the Family, School, and Community" (Portland, OR: Western Regional Center for Drug-Free Schools and Communities, 1991); Benson, P.L., et al., *A Fragile Foundation: The State of Developmental Assets among American Youth* (Minneapolis, MN: Search Institute, 1999); Cairns, R.B. and Cairns, B.D., *Lifelines and Risks: Pathways of Youth in Our Time* (New York, NY: Cambridge University Press, 1994); Dryfoos, J., *Safe Passage: Making it through Adolescence in a Risky Society* (New York, NY: Oxford University Press, 1998); National Research Council, *Losing Generations: Adolescents in High-Risk Settings* (Washington, DC: National Academy Press, 1993); Carnegie Council on Adolescent Development, *Great Transitions: Preparing Adolescents for a New Century* (New York, NY: Carnegie Corporation, 1995); Dryfoos, *Adolescents at Risk*; Kipke, M.E., ed., *Risks and Opportunities: Synthesis of Research on Adolescents* (Washington, DC: National Academy Press 1999); Jessor, R., Van Den Bos, J., et al., "Protective Factors in Adolescent Problem Behavior: Moderator Effects and Developmental Change" (*Journal of Developmental Psychology* 31(6): 923-933, 1995); Kipke, M.E., ed., *Risks and Opportunities: Synthesis of Research on Adolescents* (Washington, DC: National Academy Press, 1999).

<sup>13</sup> See above and Gambone, M., "Community Action and Youth Development: What Can Be Done and How Can We Measure Progress?" (Draft prepared for Aspen Roundtable on CCIs and the Center for Youth Development and Policy Research, June 1999); Connell, J.P. and Gambone, M., "Youth Development in Community Settings: Challenges to Our Field and Our Approach (Community Action for Youth Project, 1999); Zeldin, S., "Opportunities and Supports for Youth Development: Lessons from Research and

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Implications for Community Leaders and Scholars” (Washington, DC: Academy for Educational Development, Center for Youth Development and Policy Research, 1995).

<sup>14</sup> Donovan, P., “Falling Teen Pregnancy Birthrates: What’s Behind the Declines?” (*The Guttmacher Report on Public Policy* 1(5): 1-6, 1998).

<sup>15</sup> Alan Guttmacher Institute, “Why is Teen Pregnancy Declining?” (Occasional Report, New York, NY: Author, 1999).

<sup>16</sup> The CDC web site includes descriptions and ordering information on the five programs they have deemed “programs that work” as well as their criteria: [www.cdc.gov/nccdphp/dash/rtc/hiv-curric.htm](http://www.cdc.gov/nccdphp/dash/rtc/hiv-curric.htm). The PASHA criteria and programs are described in Card, J.J., et al., “The Program Archive on Sexuality, Health and Adolescence” (*Family Planning Perspectives* 28: 210-220, 1996).

. Whenever possible PASHA recommended programs have been packaged into ready-to-implement sets that include all curriculum and program materials, a user’s guide, and evaluation instruments. The Sociometrics web site ([www.socio.com/pasha](http://www.socio.com/pasha)) contains detailed information on most of the PASHA approved programs, user’s guides for each, and ordering information for the packages. We include brief descriptions of these programs throughout this report according to program type.

<sup>17</sup> Siecus/Advocates for Youth, “Survey of Americans’ Views on Sexuality Education. (Washington, DC: Authors, 1999).

<sup>18</sup> National Guidelines Task Force, *Guidelines for Comprehensive Sexuality Education*, 2<sup>nd</sup> edition (New York, NY: SEICUS, 1996).

<sup>19</sup> Kirby, D., *No Easy Answers*; Baldo, M., Aggleton, P. and Slutkin, G., “Does Sex Education Lead to Earlier or Increased Sexual Activity in Youth?” (Presented at the 9<sup>th</sup> International Conference on AIDS, Berlin, June 1993).

<sup>20</sup> Kirby, D., *No Easy Answers*; Baldo, M., Aggleton, P. and Slutkin, G., “Does Sex Education Lead to Earlier or Increased Sexual Activity in Youth?” Miller, B.C., et al., Eds., *Preventing adolescent Pregnancy: Model Programs and Evaluation* (Newbury Park, CA: Sage Publications, 1992).

<sup>21</sup> Sex education guidelines: National Guidelines Task Force (New York, NY: Seicus, 1996). HIV/AIDS education guidelines: Centers for Disease Control (online at: [www.cdc.gov/nccdphp/dash/aids.htm](http://www.cdc.gov/nccdphp/dash/aids.htm), 1998). Human Sexuality: Planned Parenthood Federation (New York, NY: Planned Parenthood Federation, 1999).

<sup>22</sup> Kirby, D., *No Easy Answers*.

<sup>23</sup> Oakley, D., “Rethinking Patient Counseling Techniques for Changing Contraceptive Use Behavior” (*American Journal of Obstetrics and Gynecology* 170: 1585-1590, 1994).

<sup>24</sup> Hout, M., “Determinants of Program Enrollment, 1969 and 1971,” in P. Cutright and F.S. Jaffe (eds.) *Impact of Family Planning Programs on Fertility: The U.S. Experience* (New York, NY: Praeger Press, 1977) pp. 33-46.

<sup>25</sup> Forrest, J.D. and Amara, R., “Impact of Publicly Funded Contraceptive Services on Unintended Pregnancy and Implications for Medicaid Expenditures” (*Family Planning Perspectives* 28: 188-195, 1996) estimates that publicly funded services prevented nearly 400,000 combined births, abortions, and miscarriages among teens in 1996.

<sup>26</sup> Alan Guttmacher Institute, *Contraception Counts: State-by-State Information* (New York, NY: Author, 1998). Online at: [www.agi-usa.org/pubs/ib22.html](http://www.agi-usa.org/pubs/ib22.html), revised 8/1999. Frost, J.J., “Family Planning Clinic Services in the U.S., 1994” (*Family Planning Perspectives* 28: 92-100, 1996) reports the percentage of teens using contraceptives who access them through publicly funding clinics.

<sup>27</sup> Fothergill, K., *Update 1997: School-based Health Centers* (Washington, DC: Advocates for Youth, 1998).

<sup>28</sup> Kirby, D., *No Easy Answers*.

<sup>29</sup> *Ibid.*

<sup>30</sup> Kirby, D. and Brown, N.L., “Condom Availability Programs in U.S. Schools” (*Family Planning Perspectives* 28: 196-202, 1996); Kirby, D., *No Easy Answers*.

<sup>31</sup> *Ibid.*

<sup>32</sup> Guttmacher, S., et al., “Condom Availability in New York City Public High Schools: Relationship to Condom Use and Sexual Behavior” (*American Journal of Public Health* 87: 1427-1433, 1997).

<sup>33</sup> *Assessing & Planning* is available from FOCUS on Young Adults, Communications Coordinator, 1201 Connecticut Avenue, N.W., Suite 501, Washington, DC 20036, 202-835-0818,

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www.pathfind.org/focus.htm. *Improving Contraceptive Access* is by Brindis, C. and Davis, L. (Washington, DC: Advocates for Youth, 1998).

<sup>34</sup> Senderowitz, J., “Making Reproductive Health Services Youth Friendly” (Washington, DC: Focus on Young Adults, 2000), and Nelson, K., MacLaren, L. and Magnani, R., *Assessing and Planning for Youth-Friendly Reproductive Health Services* (Washington, DC: Focus on Young Adults, 2000); see also Jaccard, J., “Adolescent Contraceptive Behavior: The Impact of the Provider and the Structure of Clinic-based Programs” (*Obstetrics and Gynecology*, 88(3, Suppl.): 57-64, 1996).

<sup>35</sup> *Linking* is from Advocates for Youth (Washington, DC, 1998). *PEPNet 2000* is available from www.nyec.org. Each year the Coalition provides information on effective youth employment initiatives. These are also available on their web site.

<sup>36</sup> These characteristics come from various sources: American Youth Policy Forum, *Some Things DO Make a Difference for Youth* (Washington, DC: Author, 1997); America’s Promise, “What Is America’s Promise and the Five Basic Promises?” (Online at: www.americaspromise.org, 2000); Benson, P.L., et al., *A Fragile Foundation*; Carnegie Council, *Great Transitions* (New York, NY: Carnegie Corporation, 1995); Connell, J.P. and Gambone, M., “Youth Development in Community Settings”; Dryfoos, J., *Adolescents at Risk*; Family and Youth Services Bureau, CRS Associates, *Understanding Youth Development* (Washington, DC: Authors, 1997); Gambone, M., “Community Action and Youth Development”; Konopka, G., “Requirements for Healthy Development of Adolescent Youth” (*Adolescence*, 8(31): 291-317, 1973); McLaughlin, M.W., *Communities Count* (Washington, DC: Public Education Network, 2000); National Research Council, *Losing Generations*; National Youth Employment Coalition, *PEPNet 99: Lessons Learned from 51 Effective Youth Employment Initiatives* (Washington, DC: Author, 1999); O’Brien, R., et al., “Building Supportive Communities for Youth” (Washington, DC: Academy for Educational Development, 1992); Pittman, K.J., “Promoting Youth Development” (Washington, DC: Academy for Educational Development, 1991); Price, R. H., et al., “School and Community Support Programs that Enhance Adolescent Health and Education” (Working paper prepared for the Carnegie Council on Adolescent Development, ERIC Document 323019, 1990); Public/Private Ventures, *Community Ecology and Youth Resilience* (Philadelphia, PA: Author, 1994); U.S. Dept. of Education and Justice, *Safe and Smart* (Washington, DC: Authors, 1998).

<sup>37</sup> These and other programs are described and contact information is provided in American Youth Policy Forum, *Some Things DO Make a Difference for Youth*.

<sup>38</sup> Kirby, D., No Easy Answers; Philliber, S. and Namerow, P., “Trying to Maximize the Odds” (New York: Philliber Research Associates, 1995).

<sup>39</sup> Miller, B.C., *Families Matter* (Washington, DC: National Campaign to Prevent Teen Pregnancy, 1998), reviews and synthesizes most of this research. His conclusions are summarized here.

<sup>40</sup> Kann, L., et al., “Youth Risk Behavior Surveillance—United States, 1997” (CDC Surveillance Summaries, *MMWR* 47 (SS-3), 1998); Schoenborn, C.A., et al., “AIDS Knowledge and Attitudes for 1992” (*Advance Data from Vital and Health Statistics* 243, Series 16, No. 25, Hyattsville, MD: National Center for Health Statistics, 1994); Kaiser Family Foundation, “Teens on Sex” (Menlo Park, CA: Author, 1996); Kaiser Family Foundation, “Sex in the 90s” (Menlo Park, CA: Author, 1998).

<sup>41</sup> Kaiser Family Foundation, “Teens on Sex.”

<sup>42</sup> *The Cautious Generation*, 2000.

<sup>43</sup> Kaiser Family Foundation, “Teens on Sex.”

<sup>44</sup> Kaiser Family Foundation, “Teens on Sex”; Kaiser Family Foundation, “Talking to Kids about Tough Issues” (Menlo Park, CA: Author, 1999).

<sup>45</sup> Kaiser Family Foundation, “Teens on Sex”; Kaiser Family Foundation, “Talking to Kids.”

<sup>46</sup> Kaiser Family Foundation, “Sex in the 90s.”

<sup>47</sup> Kaiser Family Foundation, “Talking to Kids.”

<sup>48</sup> *Ibid.*

<sup>49</sup> Singh, S. and Darroch, J.E., “Adolescent Pregnancy and Childbearing.”

<sup>50</sup> Kirby, D., Denner, J., and Coyle, K. “Building the Ideal Community or Youth Program” (Washington, DC: The National Campaign to Prevent Teen Pregnancy, 2000).

<sup>51</sup> “Involving Parents and Other Adults” is by L. Hoeschele, in *Get Organized: A Guide to Preventing Teen Pregnancy*, Vol. 2 (Washington, DC: The National Campaign to Prevent Teen Pregnancy, 1999). *The Media and the Message* is by W. DeJong and J.A. Winsten (Washington, DC: The National Campaign to Prevent Teen Pregnancy, 1998). “Working with the Media” is by J. Hutchins, in *Get Organized: A Guide to*

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*Preventing Teen Pregnancy*, Vol. 3 (Washington, DC: The National Campaign to Prevent Teen Pregnancy, 1999).

<sup>52</sup> A Replication Manual for the Carrera Program is available from the Bernice and Milton Stern National Training Center for Adolescent Sexuality and Family Life Education, The Children's Aid Society, 350 E. 88<sup>th</sup> Street, New York, NY 10129, 212-876-9716. Information on Plain Talk is available from The Annie E. Casey Foundation, online at: [www.aecf.org/publications/plaintalk/index.htm](http://www.aecf.org/publications/plaintalk/index.htm).

<sup>53</sup> Sonenstein, F.L., et al., *Involving Males in Preventing Teen Pregnancy: A Guide for Planners* (New York, NY: The Urban Institute and the California Wellness Foundation, 1997).

<sup>54</sup> *Involving Males*, F.L. Sonenstein, et al. (Washington, DC: Urban Institute, 1997).

<sup>55</sup> Dailard, C., "Reviving Interest in Policies and Programs to Help Teens Prevent Repeat Births" (*The Guttmacher Report on Public Policy*, New York, NY: AGI, 2000).

<sup>56</sup> Maynard, R., "Building Self-Sufficiency among Welfare-Dependent Teen Parents: Lessons from the Teenage Parent Demonstration" (Online at: <http://aspe.os.dhhs.gov/hsp/isp/tpd/folup1/synes1.htm>).

<sup>57</sup> Philliber, S. and Namerow, S., "Trying to Maximize the Odds," p. 3.