HEALTHY FAMILIES

The practice of sending a sweeper into a family’s home to provide information, health care, psychological assistance or support services dates at least to Elizabethan times in England. In the United States the home visiting service model has existed since at least the 1800’s (Behrman, 1993). Each year in the U.S., as many as 200,000 children and families are enrolled in home visiting programs which adopt different names and in some cases, different goals and focus. Typically the programs provide in-home services during some period ranging from pregnancy to when the child enters kindergarten.

Many more children could potentially benefit from home visiting programs. Approximately one in five children we raise in poverty, one in four children are born to a single parent, only one quarter of infants have mothers who received early prenatal care and less than half of children starting school in a sample of nine major cities were fully immunized (Dax, 1996).

A contemporary program, started in 1972, is the Family Infants and Preschool Program (FIPP). Located in western North Carolina, the program serves families of young children who have been diagnosed as having developmental disabilities or who are at risk of developing a disability. Services may extend from birth to five years rather than a specific set of program services and activities, treatment is indi-

visualized. Home visitors assess families in developing and implementing interventions. Other services available include case management, parent-child community groups, home-based programs for children, parent support groups, pediatric services, physical therapy, respite care services, equipment for special needs children and an adult learning center.

By 1991, the FIPP program had served 1,300 children. Case loads in a given year are 200-300. Approximately 25 programs based in the FIPP model have started across the country and serve 9,000 families.

Another well-established program is the Mobile Child Home Program. Started in 1975 by Phyllis Lernerstein, the program consists of two visits per week for 23 weeks in each of two years (a total of 46 visits). Visits occur during the child’s third and fourth years. Techniques and verbal interaction are taught to the mother. Twelve books and 11 toys are furnished throughout the program. Low income mother-child dyads are targeted. Carrying costs 29 replications of the program serve an estimated 4,500 mother-child pairs around the United States.

A more recent program is Patria as Teachers (PAT). This program began in Missouri in 1991-92 as an adaptation of the parent education model developed by Burton White. The curriculum begins prenatally and emphasizes various developmental stages. In addition to home visits there are group parent meetings which allow parents to discuss common concerns, participate in parent-child activities and learn about community resources. The program also screens the child’s vision, hearing and development. Many states offer toy, book and video resources centers. Specialized curriculae have been developed for teen parents and for parents of children three to five.

More than 1,140 PAT programs operate in 42 states and serve approximately 9,000 families a year. The program is offered statewide in Missouri.

VCNP has reported before about Resource Mothers Programs. These are another example of home visiting. The first Resource Mothers Program was established in 1980 in South Carolina. Since then, more than 300 programs have formed across the nation. Several of Virginia’s pilot programs for teen pregnancy prevention (see article, this issue) are establishing Resource Mothers Programs.

Resource Mothers work individually is the main to improve birth outcomes, to decrease injuries to children and to lower child abuse rates by providing information about maternal and child health and development and by linking mothers with health and other community services. Resource Mothers serve as mentors to the expectant mother throughout her pregnancy, delivery and the first year of the baby’s life. The Resource Mothers Program has been endorsed by the National Commission to Prevent Infant Mortality.

IS HOME VISITING EFFECTIVE?

A comprehensive review of evaluation studies was compiled by Olds and Kitzman (1993). These authors examined all studies published in English which employed randomized trial and associated cost-benefit analysis. Bod-Medsine and Psychological Abstracts were searched from 1987 through 1992.

Olds and Kitzman divided their review into five major sections: a) prenatal pro-
One name has consistently been linked
to child abuse prevention efforts in Virginia.
That name is Barbara Rawn.

Barbara Rawn has, for the past 13 years,
been the Executive Director for Prevent
Child Abuse, Virginia.

Who is this remarkable person who
stepped up Prevent Child Abuse, Virginia
from a small group of dedicated volunteers,
working in a kitchen, to its present day
prominence?

Born in 1943, Barbara is the oldest of six
children. After graduating from Central
Connecticut State University in 1968 with
a major in English education, Barbara mar-
rried and spent the next 14 years raising
three children. She returned to school
for graduate work at age 36 in 1981. Influenced
by her sister who was hearing impaired,
Barbara enrolled in Gallaudet planning to
obtain training to counsel hearing-impaired
individuals.

It was happenstance when, in 1980, a
neighbor woman convinced Barbara and
her husband to become a “safe house” for
battered women and their children. Their
experiences as a safe house led Barbara to
enroll in a class about child abuse and
neglect through Richmond Family and
Children’s Services. Soon Barbara was her-
self, helping with trainings. The trainer,
Joann Tisdale, was also on the Board of Di-
rectors for what is now Prevent Child
Abuse, Virginia. She encouraged Barbara
to apply for the just-available coordinator’s
position.

“I knew in my heart I could do this job
in child abuse prevention. It was
synchronicity—every time I turned around I
met someone who could help” says Rawn.

PCAV had been started by Sue Gibson
in 1980. Gibson had been to a national con-
ference of NCPCA and decided she wished
to start a state chapter. In the early years,
the group had no permanent location. Who-
ever was president of the Board stored
the mixer records and worked from their
home.

Barbara describes her starting day of
work. “My first day on the job was in
Harrington Russell’s kitchen. She handed me
four shopping bags, a checkbook with a
balance of $6500 and a reimbursable grant
for $26,000 from the Virginia Family Vo-
lence Prevention Program. I moved every-
thing to my kitchen and began to search for
office space.”

The Junior League offered space and the
organization remained at this location three
years. In 1987 they moved into a little row of
attached town houses on west Main
Street. They had been there about 3 years
when Parents Anonymous of Virginia
moved in next door. That fortuitous move
eventually led to the merger of the two or-
ganizations in April, 1991. “We cut a hole
in the wall to complete the merger!” Bar-
bara recalls.

Prevent Child Abuse, Virginia moved in
1992 after the merger to the United Way
of Richmond then on to their current location
in the Central Fidelity Bank Building in
downtown Richmond.

With Barbara at the helm, PCAV
achieved many accomplishments. A small
sampling includes:

1984 A $10,000 grant to begin “Proud
Parents” for teenage moms.
1989 In partnership with Theatre IV,
“Hugs & Kisses” (a child sexual
abuse prevention play) has been
performed for over 300,000 chil-
dren.
1989 Published a guidebook evaluating
child sexual abuse curricula.
1990 Coordinated the Blue Ribbon
Campaign for Child Abuse Pre-
vention Month. Now the cam-
paign is a national focus for Pre-
vention Month Activities.
1992 TG2 service placed on the State
Child Abuse Hotline
1993 Kidwise - copy-ready sheets of
parenting tips, PCAV offers new
each month which reach over
200,000 households.
1994 Coordination of Healthy Families
Virginia begins
Healthy Families

[Text from page 1 continues]

grams aimed at preventing preterm delivery, and (c) programs which endeavored to improve health-related behaviors. (i) programs designed to improve the health and development of low birth weight or preterm infants; (ii) programs established to enhance the well-being of children from families at social or economic risk; (iii) programs to offer support and training to parents of children born with developmental disability or chronic illness; and (iv) studies offering a cost-benefit analysis.

Improving pregnancy outcomes: There were seven studies of prenatal programs designed to reduce rates of preterm pregnancy and low birth weight. None of the studies showed overall significant effects for these goals. One study (Olds et al., 1986) did show positive effects for two subgroups: women who smoked and very young adolescents. Olds and Kitzman suggest that to be effective in preventing preterm delivery and low birth weight, home visitors must not only teach women about risks and values, they must also devise individualized strategies for behavioral change, especially in adverse behaviors such as cigarette smoking, alcohol consumption and illegal drug use. Home visiting programs have the potential to make a difference in such specific risks, as well as improving diet, identifying pregnancy complications early and assisting women in properly taking medication. The authors suggest that programs concentrate services to women with specific risks that are currently observable.

Improvements of health-related behaviors: There is little research that measures changes in health-related behaviors in pregnant women due to intervention by home visitors. Only two studies were found. In one, the women reduced smoking and improved their diets. The other failed to find significant changes. Likewise, only two studies examined obstetrical complications, with mixed results.

Psychosocial factors, however, measured by these studies showed positive responses. These included parents showing greater interest in the pregnancy, partners being more likely to be in the labor room, fewer worries and more favorable expectations about delivery. In one study, women visited by nurses made better use of the Supplemental Food and Nutrition Program for Women, Infants and Children (WIC) and attended childbirth education more frequently.

Olds and Kitzman conclude that prenatal home visiting programs can, but do not always, produce positive results. For programs to improve pregnancy outcomes, home visit protocols should be designed with specific goals and the intervention should focus on these goals. Staff must have sufficient contact with the women to be able to achieve specific goals.

Improving status of low birth weight or preterm infants: Programs in this category aimed to improve cognitive, intellectual, social, motor, physical health, maternal caregiving and the home environment. Studies of four programs designed to improve the infant's cognitive and physical development of low birth weight or preterm infants showed that programs can increase the intellectual test performance of preterm and low birth weight newborns. Three studies looked at physical health. While the data are limited, they do suggest that the additional stimulation or improved physical care provided by parents as a result of home visiting can accelerate small newborns' physical growth. Three studies examined the impact of home visiting on aspects of maternal caregiving and all found that visited families, at the end of the program, provided homes that were more stimulating for the child's development.

Programs for parents and children at social or economic risk: There were 19 studies aimed at improving the health and well-being of children born to low-income families. Of these, 15 programs focused upon cognitive and linguistic development. Six found significant overall benefits. Aspects of parental caregiving also showed modest gains. Low-income, unmarried teenagers appear especially able to benefit. Of the six successful programs, five used professionals or highly trained staff (nurses, professional teachers, psychology graduate students). Five of the seven programs using paraprofessionals failed to produce positive results.

Olds and Kitzman conclude that programs based upon a comprehensive service model and which employ professionals stand a greater chance of influencing parental caregiving, and enhancing the child's intellectual function than do narrowly focused programs or those employing para-professionals.

There were also six trials of programs designed to prevent child maltreatment in low-income or families at risk. It is particularly difficult to determine whether or not an intervention has prevented child abuse because of a lack of standardized definitions. Most studies rely upon a combination of state child protective service records and children's medical records.

One study showed a reduction in rates of state-verified child abuse and neglect. For at least two other programs, it is thought that maltreatment was reduced by the home visiting, but the effects were obscured by increased detection of abuse and neglect by the home visitor who is a mandated reporter.

Other positive results included improvements in child behavior in seven of thirteen studies, increased use of preventative or well-care child in seven out of ten studies, and single studies reporting reduced use of the emergency room, reductions in hospitalizations and higher infant weights. The results clearly indicate that home visiting can have positive effects on health care utilitarian and health status of children.

Programs for parents of developmentally disabled and chronically ill children: In this category, the three randomized trials of home visiting examined yielded promising data. Families receiving home visiting services managed disabilities and chronic illness more effectively and were successful in preventing exacerbations and complications associated with these special conditions.

Costs and benefits: Olds and Kitzman found three studies which calculated cost-savings. Two were designed to test the cost benefits of home visiting and early discharge for low birth weight infants in contrast to longer stays in the hospital. One study found that home visiting infants spent 11 fewer days in the hospital, resulting in a cost savings of $18,560 for each infant. The second study showed approximately equal costs for those discharged at 26 hours compared to those discharged at 48 hours. Thus, for significant cost savings, the hospital stay in this later study must be reduced by more than two days to be cost-effective. The third program figured the cost of avoided hospitalization.

SUMMARY OF MAJOR FINDINGS FOR HOME VISITING

- Remarkably successful in promoting qualities of positive parental caregiving and improving children's intellectual functioning.
- Programs are most successful when they serve families at greatest risk (such as teenagers).
- The most successful programs are comprehensive in scope.
- The most successful programs employ professional staff.
- Successful programs are intense and meet frequently with families (although programs should remain flexible and adjust the frequency of contact to family need).
- Program duration is important. Families should be followed from pregnancy at least through a child's first birthday.
- Opportunity to observe and model positive interactions is an essential component of successful programs.

Continued on page 4.
Healthy Families

Healthy Families

The National Committee to Prevent Child Abuse (NCPCA) in partnership with Ronald McDonald Children's Charities launched Healthy Families America (HFA) in January 1992. The vision of HFA is to provide universal support and education to all first time parents.

At present HFA programs operate in over 265 communities in 37 states and the District of Columbia. HFA programs initiate services prenatally or at birth by screening all expectant or delivering parents and then offering services to those families identified as being at risk for child maltreatment or poor developmental outcome based upon a standardized risk assessment protocol. Those whose scores indicate high risk are referred through the HealthNet system. All services are voluntary and offered in a positive manner. Service is available at least once a week and long-term (available for three to five years). The approach is strength-based and recognizes parents as the primary decision-makers for their children. Child needs are assessed within a family context and intervention plans are tailored individually to each family. However, a focus on child health and child readiness is universal.

Clinic targeting is a critical issue for child abuse prevention services. At time of limited resources and increasing demands to lower public expenses and channel resources to those most in need. Hawaii’s Health Start program developed a method to target their limited funding. First, program managers focused services on geographic regions with the highest rates of negative health outcomes for children. Service was further limited through a two-tiered risk assessment process. A hospital record screen covered demographic and socioeconomic factors. New mothers were referred for an in-person interview if they a) alone; b) received late or no prenatal care; c) received about 12 months present birth; or d) had a positive score on any two of 15 items. About 40 percent of mothers were referred for the in-person interview.

The in-person interview of the mother (and the father, if available) was typically conducted in the hospital. Trained interviewers administered a Family Stress Checklist developed by C. Henry Kempe, M.D. and Janet Davis. A summary of parent’s responses to ten items: parental history of criminal behavior, substance abuse or mental illness; prior contact with child protective services; current low self-esteem, social isolation or depression; current multiple crises or stressors; violent interactions between partners; rigid or unrealistic child expectations; behavioral or emotional punishment for a child; perception of their child as provocative or difficult; and parental ambivalence about the baby. Each item is based upon scores. Typically, about half of those interviewed (or 20 percent of all families, initially screened) are offered services (NCPCA, 1996).

A study by NCPCA addressed the ability of the program to accurately identify families at risk. For a sample of 94 mothers who agreed to participate in the study, 60 percent completed a six month assessment and 55 percent completed a 12 month assessment. Outcomes included measurement of: parental skills (measured by the Child Abuse Potential Inventory); the Michigan Screening Profile of Parenting and a parental interview); parental self-assessment (measured by Niciping Child Assessment Satellite Training and the Home Observation Measurement Environment Scale); and (c) utilization of social supports and prevention services (measured by the Maternal Social Support Index). Several findings were notable. Only 10 percent of families “screened out” through the hospital screening program (“no visible risk” group) comprised most of the high risks at six months or 12 month assessment points. Thus, the adoption of a widely used hospital screening protocol for all new births appears to provide a useful mechanism for initially narrowing the potential pool of prevention recipients.

Second, participants in the no visible risk group tended to improve over time while participants in the low risk group (screened out with the FSC) declined or stayed the same. At 12 months, the low risk mothers strongly resembled mothers who were eligible for Healthy Start Services. The most common predictors of elevated stress were young maternal age, low income status and single parent status. The low risk sample, as a group, also reported increased frustra- tion with child-starting responsibilities, decreased social support, and more frequent use of slapping, hitting and yelling in discipline of one-year-olds.

Overall, the misclassification error with the Family Stress Checklist appears to be equally distributed between false positives (those identified as needing service who had less positive assessments than those considered not in need of service) and false negatives (those screened out of service who had more positive assessments than those accepted for service). A comprehensive evaluation of Hawaii’s Healthy Start program yielded positive results. Early and intensive home visitation contributes to measured gains for families in the areas of parental attitudes toward children, parent-child interaction patterns and type and quantity of child maltreat- ment. In particular:

- Mothers who received home visits reduced their potential for physical child abuse (as measured by the Child Abuse Potential Inventory) three times faster than non-visited mothers.
- Visited mothers displayed significantly greater maternal involvement
and sensitivity to their child’s needs at six months.

- Children of visited mothers were significantly more responsive to their mothers than controls. At age 12 months, HFA visits were effective in achieving a positive cycle of interaction between parent and child.

- Visited families had fewer and less severe health contacts or treatment (less than half the rate of control families).

There were only limited impacts in terms of social support, child development and child health in the U.S., thus, certain children in other states may show different patterns of health care.

A long-term follow-up of a small group of 34 families showed average to above-average scores in multiple measures of parental functioning and parent-child interaction. However, participants at greatest initial risk had difficulty maintaining gains once they were no longer actively engaged in the program. The majority of parents possessed a good working knowledge of positive, non-physical methods of child discipline and 80 percent expressed no use of physical discipline whatsoever.

These findings highlight the potential for home-visit programs to provide substantial benefits for families. The Hawaii Healthy Start approach to preventing child abuse was successful in enhancing the lives of children and reducing stress for families.

The gains were maintained over time.

Healthy Families America has developed a series of "best practice standards" called Critical Elements which are based on the Hawaii experience and over 20 years of research on the positive effects of visiting programs. The employment of the Critical Elements in a Healthy Families site is now required by HFA to ensure standards of quality in the provision of services. A core group of 10 is the minimum of adult staff, counted as one in a quality assurance mechanism which all sites who wish to use the Healthy Families name must complete by the time they are 2-3 years old.

In addition, HFA provides technical assistance to Taylor organizations such as Prevent Child Abuse Virginia, in coordinating the development of Healthy Families training, as well as directly to local sites themselves. Through the HFA Training Institute they coordinate training and maintain trainers who are then nationally certified to train all local staff. A research institute has also been developed to continue intensive study of the model. Every eighteen months, HFA sponsors a national conference for Healthy Families sites and other interested parties. They conduct a variety of advocacy activities including the development of national partners which number over twenty-five organizations currently. A variety of public awareness materials have also been created to assist states and localities with education efforts.

Healthy Families Critical Program Elements

- Initiate services prenatally or at birth
- Use a standardized assessment to identify families in need of services
- Offer services voluntarily and in a positive manner
- Intensive service (at least once a week) should be offered long-term (3 to 5 years)
- Service should be culturally relevant
- Link families to a medical provider and other needed services
- Limit staff caseloads
- Select staff who are non-judgmental, compassionate and able to establish trust
- Select staff with education and training for working with at-risk families
- Provide staff with intensive training
- Provide ongoing effective supervision to staff

All but one program targets families rather than offering the screening to every new mother in their geographic area. All are creating plans for growth so that all eligible parents can be assessed. All complete assessments by the time the infant is two weeks of age. After a family accepts services, home visits must begin before the baby is three months of age. All programs will serve families until age five; however, some programs indicated that service was generally a much shorter time period, three years or less. Length of service and frequency of home visits is determined by individual family needs, although circumstances such as a second pregnancy generally signal a need for continued service.

**SUMMARY**

Johanna Schuchert is the state-wide director for Healthy Families Virginia. She is very enthusiastic about the approach. "Virginia communities are independently choosing, in spite of shrinking resources, to begin investing in prevention. Virginia is becoming a leader in the implementation of the Healthy Families model with 25 creative funding sources which support local efforts," says Schuchert.

Schuchert believes the Healthy Families initiative is effective. "Healthy Families evaluations from Virginia and across the country are showing stunning results," states Schuchert.

More information about Virginia's Healthy Families Initiatives is available from: Johanna Schuchert, Prevent Child Abuse Virginia, P.O. Box 12308, Richmond, VA 23231, (804) 775-7777, FAX: (804) 775-0010, E-mail: PCAV@virgin.com Website: preventchildabuse.org

References Available Upon Request
HEALTHY FAMILIES

Healthy Start, the Healthy Families America program in Hampton, provides in-home parenting education and support services to parents who need individualized and comprehensive support. Families participating in Healthy Start are assigned Family Support Workers who monitor and follow up prenatal, perinatal and pediatric care. In addition, Healthy Start provides preventive health care, parent education and screening and coordinates community services.

Healthy Start has implemented universal screening of all pregnant women served by the Hampton Department of Health since September, 1992. From mothers who were available for families enrolled between September 1, 1992 and June 30, 1996, during this time period, 828 mothers were screened and 79% of those received the comprehensive health assessment. From the group of 79%, six-hundred women qualified for the program. Of these, 353 were first-time mothers and 280 were mothers who already had children. Of the 600, 426 were invited to participate in Healthy Start with 392 accepting services. A core group of 174 families was formed. The control group received the usual services as given by the Hampton Health Department. The women enrolled in Healthy Start were predominantly African American (70 percent) with difficult life circumstances, few life skills (only 40 percent had completed high school) and few social supports. Less than 25 percent of the mothers agreed with the most recent year's study. They found the results very encouraging. "Implementation of a multi-agency, community collaboration as comprehensive as this one takes time to establish, even under ideal circumstances. Considering these preliminary findings and the changes that have occurred in the way these agencies work together and in their approach to the problem of child abuse and neglect, the results are very positive. While many challenges remain, Healthy Start appears to have made an excellent start toward having a positive impact on the lives of Hampton's high-risk families." (Galano, T. & Huntington, L., 1996, p.2).
Spotlight on Alexandria

The Healthy Families Alexandria program adopted the Hawaii Healthy Start model by providing outreach and supportive services to women and first-time parents.

City of Alexandria is an affluent area with more than 111,000 residents. However, in 1993, disturbing trends were evident in available indices of children's birth and social well-being. These indices included:

- one in four children living in poverty,
- among Virginia's highest rates in incidence of both child maltreatment and teen pregnancy,
- higher proportion of low birth weight babies born to non-white women,
- high rates of vaccine-preventable disease, and
- alarming increases in proportions of preschool children with development delays, handicapping conditions, and other difficulties.

Having been a founding partner of Healthy Families in adjacent Fairfax county, Northern Virginia Family Service (NVFS) designed Healthy Families Alexandria to address the needs of some of Alexandria's at-risk population.

Risk factors included teenage mothers (46 percent), single parents (57 percent), low educational levels (average of 10.7 years) and physical risk conditions during pregnancy relating to alcohol, tobacco and other drug use, weight problems or anemia of the mother. All of the women enrolled in the program were at risk of poor parenting outcomes as measured by the C.H. Kempe Family Stress Checklist (FSC). Among the enrollees, 39 percent scored at severe high risk, 35 percent at moderate risk and 6 percent at low risk, but enrolled because of a partner's risk.

"We serve an ethnically diverse population," explains Sally Campbell, program manager. "Cultural competence is very important in our program. We provide extensive training in cultural practices related to pregnancy and child rearing and hire staff who are bilingual and bicultural. We teach each other." Non-Caucasians were 89 percent of the first 267 enrollees. Of 40 countries of origin are represented, with the largest representation being Hispanic (39 percent), African-American (30 percent), Black-African (14 percent) and Asian-Pacific Islander (6 percent).

"Our referrals come through the Alexandria Health Department prenatal class," says Campbell. "Very few refuse the voluntary services." Evaluation data show that less than 12 percent declined services.

Campbell notes that the program has four major evaluation goals: 1) ensuring adequate prenatal care; 2) ensuring preventive, well-child care; 3) improving the mother's knowledge of parenting skills; and 4) preventing child abuse and neglect.

In March, 1997 the HFA completed a 42-month evaluation. The results were reassuring. For each of the following analyses, the sample includes only women enrolled in the program for 2 months or more prior to the tabulation of that objective. Thus, the sample size is different for each analysis.

Almost 82 percent of 114 mothers attended the scheduled prenatal visits, reaching the target goal. Almost 98 percent of 169 mothers obtained a medical provider for the baby by two months after birth, meeting the target goal. Also, 91 percent of the 169 children received the recommended immunizations, exceeding the 80 percent target. Well-baby visits were not maintained at target rates at the 30 month evaluation (visits were completed at about a 75 percent rate, below the criterion of 85 percent) and these were dropped as an unmeasurable objective.

Some local health providers felt it was difficult to motivate parents to keep a well-baby appointment when the baby was healthy and no immunizations were scheduled.

At the 30-month evaluation, the Healthy Families Alexandria participants had a similar rate of low birthweight babies as a comparison group (7.7 and 7.2 percent respectively). Therefore, the objective of obtaining 50 percent less low birthweight babies in Alexandria, met the 42-month evaluation, a similar percentage (8 percent) of low-birthweight babies were noted. Nationwide no study to date was found that documented a reduction in low birthweight babies due to home visiting (see main article).

Regardless, the babies in Alexandria's project developed well, with over 96 percent exhibiting age-appropriate skills in all developmental areas.

Only eight percent of the mothers became pregnant again within the first postnatal year (far exceeding the 15 percent goal). The program adopted a goal of a 24-month interval between the first and subsequent births. Of 114 women, 87 percent did not give birth to another child during that time period, exceeding the 85 percent goal. Among the 15 enrollees who had a second child within 24 months, over half (54 percent) were teenagers.

Finally, data is being gathered on child abuse complaints. The goal is for 95 percent of enrolled families to have no findings of child abuse or neglect. This goal was exceeded with 98 percent of 186 enrollees lacking a founded complaint.

Those enrolled in the first or second trimester of pregnancy receive biweekly visits from their workers. Visits increase to weekly during the last trimester. After the baby's birth, weekly visits are maintained. When the family is ready, visits move to biweekly, then monthly, then quarterly.

"Family needs and fulfilling the requirements of each program service level determine how long each family remains in our particular level," explains Campbell. "The average family will take 19 months to progress to monthly visits. Having a second child and lack of support systems are two variables which trigger a need for longer service.

Campbell is pleased with the program results. "The findings are very positive," she states. "The evaluation is one of the most comprehensive in the state."

More information is available from: Sally Campbell, Program Manager, Healthy Families Alexandria, 2449 Duke Street, Suite 308, Alexandria, VA 22304, (703) 833-8153, Fax: (703) 755-5197.

Continued on page 8
for grades six, seven, nine, and ten. Each curriculum provides age-appropriate information about the social, emotional, financial, and legal consequences of teen pregnancy. School-based programs reach every teenager enrolled in Family Life Education in the 8th, 9th and 10th grades. The community-based programs are more intensive and accept referrals.

The Healthy Stages Newsletter. This newsletter is filled with tips, reminders and useful information. The 28 editions are available to parents of the 30,000 children and youth in Hampton. The first 14 editions begin during the mother's second trimester of pregnancy and continue until the child's fifth birthday. Beginning this fall, 14 new editions are available to parents with children in kindergarten through high school graduation.

SECRETS OF SUCCESS

The Hampton Healthy Families Partnership has been successful in providing a wide variety of innovative and popular programming. The Partnership continues to grow and evolve with a new program, "Welcome Baby!". Why is Hampton's approach successful? Russell seems certain of the answer to this question. "Everything we do is strength-based," she replies. "The question is not What is your deficiency? The question is Where are you now and how do you want to go?" Secondly, instead of providing a program and hoping for attendance, the staff actively works to eliminate barriers to participation. Healthy Families Partnership has become proficient in making it easy, or at least making it possible, for interested and at-risk parents to attend classes. A mother of two young children herself, Russell is only too aware of the battle involved in juggling jobs, children and family responsibility. "If I have to leave work, rush to pick up my children and then take them for fast food in order to feed them before a meeting or class, I might not make it to that class. I have to decide if I can stand to hear the kids argue about what fast food restaurant we choose and who gets which boy with their meal and then have to get them settled at a sitter's or friend's house, go to the class and then pick them up at the way home. That's a way too much stress for everyone and is logistically impossible." So, instead, the Healthy Families Partnership asked local restaurants to donate meals for parents and children attending the classes. The family can eat a nutritious meal together and child care is provided during the class. "With the addition of the meals, our retention rates doubled," explains Russell. Currently, retention rates range from 90 to 100 percent depending upon the curriculum used.

A third strategy is to involve the parents in the learning process. By taking an active part, parents feel an ownership of the program. Russell tells an example. "A facilitator had to miss a session. However, the group did not want to skip the weekly meeting. One member volunteered to obtain a guest speaker, another said she would organize the snack, another offered to clean up." Russell notes that when this group started, they had to stretch to find enough participants. Now, there is a waiting list. Partnership with the community can be instrumental to a program's success. The classes for AFQT mothers are an example. These are part of the parent education component and are sponsored in conjunction with the department of social services. The five-week course is offered once per year to women who wish to become child care workers. It requires 80 hours internship at a day care site in addition to the course work. The program is offered in the summer so that the department of parks and recreation can offer its camp to the children of the women enrolled. The provision of child care has allowed 150 women to complete this course since 1993. It is not surprising to learn that Hampton's success story has already traveled across the country. Last spring the Hampton Healthy Families Partnership was featured in a special television series. Those seeking to learn more about Hampton's successful programs will be glad to learn that May 6 & 1998 a technical assistance conference will be held. The format will be that of an elaborate site visit. Practitioners and agency heads will learn the "nuts and bolts" of implementation of activities and groups while elected officials and administrators will learn from Hampton counterparts about how to use business partnerships to promote Healthy Start and Healthy Community programs.

For more information about Hampton Healthy Families Partnership, contact Debbie Russell, Hampton Healthy Families Partnership, 127 Franklin St., Hampton, VA 23669, (757) 727-1882, Fax: (757) 727-1823.
PREVENTING TEENAGE PREGNANCY

The extent of the problem:
Approximately 12 percent of young women ages 15-19 become pregnant. This equals over one million American teenagers pregnant each year. The United States has the highest rate of teenage pregnancy of any Western industrialized country. Among girls younger than 15, the birth rate is five times higher in the U.S. than other developed countries for which data is available (American College of Obstetricians & Gynecologists, 1999; MacFarlane, 1997). The higher birth rate in the U.S. exists despite U.S. and foreign countries reporting similar rates of sexual activity and similar ages of onset of sexual activity. Differences between the U.S. and foreign countries include the degree of poverty (far greater in U.S. than in Canada or Western Europe), the availability of contraceptives (more available in foreign countries than in the U.S.A.), and education about sexuality (more widespread in other countries) (Brockman, 1997).

Still, interpreting their national statistics is not a simple task. In 1992, thirty percent of teen mothers were married (compared to 35 percent in 1981) and 70 percent in 1979. While the majority (85 percent) of teen pregnancies are unplanned (APA, 1995), that does not necessarily mean that the babies are unwanted. More than 90 percent of teen parents choose open adoption. In Virginia, teen pregnancy rates have changed since 1980, when an overall rate of 47.7 per 1000 was recorded. In 1987, the rate fluctuated between 49.5 and 45.6 with 43.3 per 1000 in 1990. Since then, rates have steadily dropped to the rate of 37.4 per 1000. However, a breakdown by age shows a rate of 2.5 per 1000 for 10 to 14-year-olds, a rate of 51.2 per 1000 for 15 to 17-year-olds, and a rate of 97.1 per 1000 for 18 to 19-year-olds.

Another way of looking at Virginia's data is to consider what percentage of births are to women. According to Dr. Brockman, 12 percent of Virginia births are to teens. In 1995, there were 10,479 live births to Virginia teens. Of those, 30 percent will have another baby within a few years.

Nationally, birth rates for teenagers declined to 3 to 4 percent from 1994 to 1995. The 1995 rate was 3.0 per 1,000 females aged 15-19.

Continued on page 10
Preventing Teen Pregnancy

15-17 years and 18-19: 1 per 1,000 females aged 15-19. The overall rate was 56.8 per 1,000, a percent lower than in 1994 (Ventura et al., 1997).

National teen birth rates have declined steadily by 9 percent between 1991 and 1995. Despite recent declines, the 1995 rate is still considerably higher than during the early to mid-1980's when the rate was 50-53 per 1,000 (Ventura et al., 1997).

It is important to note that, nationally, teen pregnancy rates have also declined. The recent declines have been accompanied by declines in the abortion rates. Birth rates for second births by teens also declined in 1995.

Sexually transmitted diseases (STDs) are also part of the problem of adolescent sexuality. Approximately 3 million teenagers contract an STD each year. Teens account for one quarter of the estimated 12 million STD cases annually. One-quarter of all new HIV infections in the U.S. are thought to occur in young people under age 22. The World Health Organization estimates a world-wide total of 6 to 7 million people ages 15-24 have been infected with HIV. In the U.S., each day between 27 and 34 young people under 20 will become HIV-infected (Advocates for Youth Fact Sheet, 1996).

Reports of STDs for Virginia teenagers in 1995 showed for the 10 to 14-year-old group, 3% had syphilis, 30% chlamydia and 14% of gonorrhea. For teens age 15-19, there were 66 cases of early syphilis, 4.8% of chlamydia and 2.58% of gonorrhea.

According to Dr. Bukowski, AIDS and HIV figures are cumulative since reporting of these conditions first begin. For teens 15-19 there are 42 cases of AIDS, 266 of HIV and 627 HIV in pregnancy. It should be noted that AIDS has a long insidious period. Most individuals diagnosed in their 20's will have contracted HIV as teens. According to the Centers for Disease Control, HIV infection is now the leading cause of death in the U.S. for persons aged 25-44 (Anderson, Kochanek & Murphy, 1997).

POVERTY AND ADOLESCENT PREGNANCY?

Part of the debate concerning how to prevent teen pregnancy centers upon disagreement about what factors contribute to teen pregnancy. Prevailing themes include:

- Lack of knowledge about sexuality.
- Lack of open discussion about risk.
- Lack of information on prevention.
- Lack of society's social involvement.
- Lack of education on the consequences of pregnancy.
- Lack of desire to have a baby.
- Lack of education to practice consent due to limited opportunities.

Indeed, there is every reason to view teen pregnancy as a very complex occurrence. Behaviors that lead to teen pregnancy are related to other risk factors such as school failure, violence, alcohol and drug use. There are continuous media messages that may contradict messages from parents and schools to delay sexual activity. In selected areas where economic conditions are worsening, teens will perceive a lack of opportunities which heightens the risk of teen pregnancy (Phullibor & Nahorn, 1995).

HISTORY OF PREGNANCY PREVENTION

The National Parent Teacher's Association has advocated sex education since its earliest founding in 1946. Gallup polls indicate an increase in support for sexuality education in the home and community. Many parents prefer to be proactive in regards to pregnancy and disease prevention (Sowers, 1991).

Efforts to prevent adolescent pregnancy have adopted one or more of the following objectives:

1) Use education and skills training to help adolescents delay the onset of sexual activity.
2) Promote abstinence.
3) Increase use of contraceptives for those who are already sexually active.
4) Increase access to early childbearing by providing financial options and opportunities (American College of Obstetricians and Gynecologists, 1995).

Efforts to prevent adolescent pregnancy have adopted one or more of the following objectives:

1) Use education and skills training to help adolescents delay the onset of sexual activity.
2) Promote abstinence.
3) Increase use of contraceptives for those who are already sexually active.
4) Increase access to early childbearing by providing financial options and opportunities (American College of Obstetricians and Gynecologists, 1995).

Prevention programs have been offered in youth organizations, health care facilities, religious groups and schools. Program designs designed to improve school performance and youth employment programs. While such programs may be useful, there are not yet evaluation data demonstrating the effectiveness in preventing pregnancy (MacFarlane, 1997).

Educational programs in schools have varied on many dimensions. Some have focused on the biological information and...
facts of human reproduction. Others have focused on the negative consequences of early sexual activity. Some have included information about "safe sex" and how to protect oneself against STDs. Other programs have taken a broader perspective, concentrating on self-esteem, problem-solving, communication skills and correct decisions.

Programs have also varied in teaching of values. Some have emphasized an abstinence-only approach while others have provided information on a value-free context. Some programs rely upon classroom exercises and discussions; others extend outside the classroom through assignments such as extending a computer-programmed "baby".

**HOW EFFECTIVE ARE PROGRAMS?**

It is not easy to determine the effects of education programs designed to prevent teen pregnancy. There are a number of choices as to what measurement is most appropriate. These include:

- **Pregnancy rates**
- **Birth rates**
- **Self-reported use of contraceptives**
- **Rates of STDs**
- **Self-reported sexual behavior**
- **Knowledge of sexual topics**
- **Attitudes and beliefs**

Pregnancy rates can be affected by many factors. Birth rates do not include pregnancies that are terminated by miscarriage or abortion. Rates of STDs can vary and may not accurately capture changes in adolescent sexual behavior. Increased use of contraception, important for health and pregnancy prevention, is usually assessed by self-report, as is sexual activity. Self-report is subject to bias. For example, some feel they need to hide their knowledge of sexual behavior whereas females may under-report.

Knowledge about sexual topics may be a precursor to behavior change but appears only weakly related to actual sexual behavior. Also, changes in attitudes, norms, skills and intentions may precede behavior change but are not adequate in predicting behavior [Kirkby et al., 1994].

Since different evaluation studies use different criteria, it is not always possible to compare studies. There have been a number of recent studies that have identified programs that have achieved success and have attempted to determine the factors common to successful programs.

One review was commissioned by the Division of Adolescent and School Health within the Centers for Disease Control and Prevention of the Public Health Service. Kirkby, et al. (1994) identified 23 programs which met criteria of a) being implemented in schools; b) including an evaluation research published in a peer review journal; and c) demonstrating effectiveness by changes in pregnancy rates, birth rates or STD rates.

According to Kirkby, et al. (1994), national survey data suggests that the relationship

**THE NATIONAL CAMPAIGN TO PREVENT TEEN PREGNANCY**

Founded in February 1996, this is a nonprofit, nonpartisan initiative supported entirely by private donations. The mission of the Campaign is to prevent teen pregnancy by supporting and encouraging state and local efforts that are consistent with a pregnancy-free adolescence. The Campaign's goal is to reduce the teen pregnancy rate by one-third by the year 2005. To achieve this mission, the Campaign has adopted a five-pronged strategy: a) create a strong stand against teen pregnancy, enlist the help of the media, support and stimulate state and local action, bring a national discussion on the role of religion, culture and public values in an effort to build common ground, make sure that local community efforts are based on research showing effectiveness.

More information is available from:


**CONGRESSIONAL ADVISORY PANEL TO THE NATIONAL CAMPAIGN TO PREVENT TEEN PREGNANCY**

In April, Representative Michael Castle (R-DE) and Representative Nita Lowey (D-NY) formed with twenty-two House colleagues and the National Campaign to Prevent Teen Pregnancy to authorize the creation of a bipartisan Congressional Advisory Panel. The Panel aims to help create public-private partnerships necessary to reduce teen pregnancy. Compromising bipartisan legislation will be crafted as well as briefings for members of Congress. Forums and town meetings are planned for discussion about the issue. More information is available on the Internet at http://www.house.gov/lowey/pregnant.html
unprotected intercourse and methods to avoid this. Active learning methods rather than didactic information were utilized. Active learning involved small group discussion, brainstorming, role-playing, covert rehearsal, written rehearsal, verbal feedback, coaching, visits to family planning clinics and interviewing parents. Use of peer education and videos helped students personalize the information.

It is worth noting that approaches and curricula had to be tailored to the age and experience of the students in order to be effective. Postponing Sexual Involvement, which emphasizes delay in initiating sexual activity, was effective for middle school youth who has not yet begun sexual activity. However, Postponing Sexual Involvement did not reduce frequency of intercourse or increase use of contraceptives among students who had already begun sexual activity. Ineffective curricula tended to be less focused and more comprehensive, failing to emphasize particular values, norms and skills necessary to avoid sex or unprotected sex. Less effective programs taught decision-making steps and allowed students to make their own decisions rather than presenting a clear plan and emphasizing clear values and norms. Length was not as important. Some 6-session and 10-session programs were as effective as longer programs. As has been noted by many other studies (Sowers, 1991) knowledge alone was ineffective in causing behavior change. Other reviewers have isolated additional factors important to success. General approaches felt to affect teen pregnancy and its preludes include:

- strong one-on-one support from a responsible adult;
- attention to basic cognitive skills and educational achievement;
- attention to the world of work;
- attention to specific skills necessary to avoid pregnancy;
- involvement of community members who can help choose culturally appropriate and locally relevant interventions;
- giving attention to the importance of peer influences;
- some very early interventions since sexual activity begins early for some (Thilliber & Nameren, 1995).

There were five studies in the Kirby, et al. (1996) review that examined the effectiveness of school-based clinics which combined education with the delivery of health and reproductive services. The presence of a health clinic and reproductive health services was not significantly associated with initiation or frequency of intercourse. At schools that had a strong educational component and dispensed contraceptives, there was higher rate of contraceptive and condom use. Thus, the presence of a strong educational component was critical to program success. However, no single school-based clinic model has emerged as superior (Dryfoos, 1992).

The combination of both contraceptive services and education/life options is thought to be crucial for influencing youth most at risk for early pregnancy (Dryfoos, 1992). Programs with this combination have achieved positive results. For example, students in St. Paul schools where clinics were located showed a decline in birth rates from 59 per thousand in 1977 to 26 per thousand in 1983-84 while national birth rates for both 1977 and 1982 were 45 per thousand adolescents. Dryfoos (1992) reports that parents are typically very supportive of school-based clinics with only 3 percent opposed to prescribing and dispensing contraceptives with parental permission. Most studies and those who have reviewed prevention efforts agree that education about sexuality and contraception does not hasten onset of sexual behavior (Eisen & Zellman, 1987; Kirby et al., 1994; Yawson & Yawsn, 1997). There is also evidence that heightened contraception availability increases adolescent sexual activity (Frisco & Forest, 1995; MacFarlane, 1997; Kirby, et al., 1994; Kirby, et al., 1991). Rather comprehensive programs can be successful in delaying the onset of intercourse (Kirby, et al., 1994).

For example, results from Postponing Sexual Involvement showed that by the end of eighth grade, students who had not had the program were as much as five times more likely to have begun sexual activity than those who were both through the program. In 1990, 30 percent of those who had not had the program were sexually active or had had sex, compared to 39 percent of those who had, were sexually active (Howard & McCabe, 1990).

Programs can also be successful in lowering pregnancy rates. A program in Denmark, South Carolina, successfully decreased pregnancy rates for teens from 77 per 1,000 to 37 per 1,000. When the program was discontinued, the rates rose to 69 per 1,000 (Koo, et al., 1994).

LIMITATIONS OF TEEN PREGNANCY PREVENTION INITIATIVES

There are a number of related factors. These include lack of male involvement, poverty, the impact of adult male/teenage female intercourse, and after-effects of child sexual abuse.

Efforts to involve adolescent males in comprehensive sexual and reproductive health programs have been small, "precisely short-lived and largely unsuccessful." (Carrera, 1992, p. 270). The absence of males as active participants in sexual and reproductive health decision-making makes it more difficult for prevention programs to succeed.

Examination of populations of adolescent fathers suggests that these young men are a difficult population to engage. They are more likely than nonfathers to report academic, drug and conduct problems, regardless of race or socio-economic status (Carrera, 1992). Societal messages to young men have in the past, supported their lack of involvement in pregnancy prevention, defining contraception as a female problem. "Boys will be boys" is one belief that sustains a stereotype of pregnancy and childbirth being women's issues. Discussing or delaying sexual or reproductive activity is seen by many males as a threat to the very core of their masculinity and many believe it is "unnatural" to even discuss contraception with a sex partner much less to assume primary responsibility for contraception (Carrera, 1992).

Changing deep-rooted, complex attitudes and values is not easy or quick. Programs must help both adolescent males and females. Delaying or reducing sexual activity is seen by many as a threat to the very core of their masculinity and many believe it is "unnatural" to even discuss contraception with a sex partner much less to assume primary responsibility for contraception (Carrera, 1992).

Changing deep-rooted, complex attitudes and values is not easy or quick. Programs must help both adolescent males and females. Delaying or reducing sexual activity is seen by many as a threat to the very core of their masculinity and many believe it is "unnatural" to even discuss contraception with a sex partner much less to assume primary responsibility for contraception (Carrera, 1992).

Changing deep-rooted, complex attitudes and values is not easy or quick. Programs must help both adolescent males and females. Delaying or reducing sexual activity is seen by many as a threat to the very core of their masculinity and many believe it is "unnatural" to even discuss contraception with a sex partner much less to assume primary responsibility for contraception (Carrera, 1992).

Changing deep-rooted, complex attitudes and values is not easy or quick. Programs must help both adolescent males and females. Delaying or reducing sexual activity is seen by many as a threat to the very core of their masculinity and many believe it is "unnatural" to even discuss contraception with a sex partner much less to assume primary responsibility for contraception (Carrera, 1992).
more than half of the babies are post-high school aged men. Men older than 23 years are more likely to be fathered by middle school girls than by middle school boys (Males, 1993). The youngest mothers are the most likely to have a partner five or more years older with one study showing 40 percent of 14 to 15-year-old mothers having partners at least five years older (Lindberg, et al., 1997).

Among all teen mothers, two-thirds of the fathers are over age 19 (Moore, no date; Neergard, 1996). The younger the mother, the greater the age gap. Girls in high school conceived babies with men who averaged 4.2 years older, while middle school girls were 5.5 years older with men who averaged 6.7 years older on average. Among 10 to 14-year-old girls, about 27 percent of fathers were 20 to 24 (Neergard, 1996). A more modest estimate is offered by the 1995 U.S. Department of Health and Human Services National Survey of Family Growth. For those reporting voluntary first intercourse prior to age 16, 13 percent reported partners over age 20. (It is important to note that an additional 3 percent indicated that their age sexual intercourse was not voluntary, but no age of partners was noted) (ACOG, 1997). This data is similar to that of Lindberg, et al. (1997) where 21 percent of births to unmarried mothers were fathered by much older men. About 23 percent of minors who have a child with a partner who is much older, however, may not be aware of the potential effects on the infants’s birth.

Older males who father babies with teens are likely to have troublesome behaviors, including arrests, and lowered school grades (Moore, 1993). Young teens may find older males attractive due to a likelihood that they have more spendable income (if they are employed) than their younger counterparts who are still in school. This increased spending potential of the older fathers appears lower than men who father children with adult women (Lindberg, et al., 1997). Girls attracted to older males also show behavioral difficulties.

A SAMPLE OF VIRGINIA’S APPROACHES

RESOURCE MOTHERS - This approach is a secondary prevention technique designed to prevent a subsequent teen pregnancy and to discourage early parenthood of non-parenting siblings or friends of the pregnant teen. Each teen is matched with an experienced mother who provides assistance in obtaining health care and linking the teen mother with needed services. The resource mother provides support and instruction in child care and life skills. More information needed? Contact Alexandria Petersen, Pettigrew School. For additional information, please contact your local health department.

BABY, THINK IT OVER - This is a doll which is programmed to simulate a real baby. It is designed to disrupt sleep and require the nonte attention a baby would require. To guard against cheating, the electronics are programmed to respond only night or abuse. The teen takes the doll and related equipment (cuddle, car seat, diaper bag) and assumes care for the doll for several days. More information is available from Crater from Roanoke or from Richmond programs. Richmond and Roanoke also use an “Empathy Baby” (a twenty-five pound belly that is strapped to the adolescent to simulate pregnancy) in schools.

SCHOOL-BASED HEALTH CLINICS - Roanoke has established health clinics in two schools plus a clinic in a public housing project affiliated with a school. Clinics offer services to teens free of charge. They perform physicals for sports and other school-sponsored activities, do health screening and immunizations, offer treatment for acute conditions, assist with health education and offer information and referral for family planning. Sponsored by the Roanoke Adolescent Health Partnership, the clinics are staffed with medical doctors, nurse practitioners, nurses, public health employees and medical interns. “It is truly a partnership between the housing authority, the schools, the health department and a private provider, Carilion Health Systems,” says Kathy LaMotte, director of the teen pregnancy prevention initiative “Adolescents are notoriously poor in obtaining health care and the easy access helps. Plus, the entire service is oriented to adolescents, so they feel more comfortable than in a hospital, clinic or a doctor’s office.”

ADOLESCENT SEXUALITY TRAINING PROGRAM - Norfolk offers one day a staff training by a certified sex education specialist to local youth service agencies and organizations. The curriculum includes adolescent development, sexuality, communication skills, abstinence, contraception and STD, HIV and AIDS prevention. There is also an abstinence-based training for groups of parents. The program uses its own curriculum, “Teens Education Program,” to train educators to become the primary sexuality educators for their children. This program is offered in 6-8 sessions.

MINI AWARDS - In order to encourage and support community-based teen pregnancy prevention initiatives, Norfolk offers mini grants to community agencies and organizations. To date, over $20,000 has been granted to 18 community programs. The Eastern Shore has also used this approach and has granted $80,000 to community programs. They have chosen eight organizations (2 community groups, 1 church and 2 branches of the Virginia Cooperative Extension) for funding for 1997.

TEEN OUTREACH PROGRAM - Based on a national model, Roanoke is offering this comprehensive, intensive program which allows adolescents to become involved in community service. “This allows teens to view themselves as people with something to contribute,” says Kathy LaMotte, Teen Pregnancy Coordinator. The Roanoke coalition offers TOP as part of the school day (as a high school class or credit).

VIRGINIA MALE ADOLESCENT NETWORK (V-MAN) - This initiative seeks to provide culturally sensitive and age-appropriate group programming for adolescent males at the community and neighborhood level. Empathy groups are provided as well as sessions dealing with preparing for the world of work and sessions dealing with sexuality. For more information, call Portsmouth. To date, 137 teens and 53 adults have participated.

FOR MALES ONLY - This project is committed to educating teen males in a variety of settings (at school during lunch or before school, in housing developments). One group is devoted to adolescent dads. To date, 66 youth have attended four groups. Call Roanoke for more information.

For more information on any of the initiatives contact the program directors:

Alexandria - Darby Jasper (501) 588-4009
Norfolk - Tracy Knight (757) 531-2181 ext. 263
Richmond - Todd Bernister (804) 698-3311
Crater - Kathy Parrish (804) 861-6955
Eastern Shore - Jacqueline Emondell (757) 442-6228 ext. 246
Portsmouth - Hugh Franks (757) 786-6826
Roanoke - Kathy LaMotte (540) 985-9898

Continued on page 16

© Commonwealth of Virginia
Department of Social Services

VCNP is copyrighted but may be reproduced or reprinted with permission. Write for "Request to rephrase" forms. Request or inquiry is addressed to: Joann Grayson, Ph.D., Department of Psychology, MSC-7401, James Madison University, Harrisonburg, VA 22807, or call (540) 588-6482. E-mail: jgrayson@jmu.edu. When requesting an address change, please include a copy of your old mailing-label.
Teen pregnancy prevention activities in the Commonwealth of Virginia have an extensive history. Recently, seven health districts in Virginia have been selected by the General Assembly as pilot sites for teen pregnancy prevention programs. These areas include Alexandria, Eastern Shore, Crater (Petersburg area), Norfolk, Portsmouth, Richmond and Roanoke.

Each locality formed a community-wide coalition to determine program type and direction. The coalitions were guided by a needs assessment, designed to identify the nature of the local problem, available resources and any potential barriers to program development. Each locality developed and submitted a program proposal for review and approval by the interagency advisory committee.

The advisory committee adopted guidelines, or "best practice" expectations for all pilot programs. These were:
- emphasis on sexual abstinence
- emphasis on role responsibility
- emphasis on young teenagers
- parental involvement
- life skills training
- access to health care services
- appropriate educational programming
- use of mentors and role models

The first pilot programs started in 1994 in Alexandria, Richmond and Norfolk. However, several programs had already been in operation. For example, the Alexandria program had been in existence for six years. Pilot programs in Crater, Eastern Shore, Portsmouth and Roanoke started in 1995. Evaluation data on the pilot is being gathered by researchers at Virginia Commonwealth University (VCU). VCPM staff was able to interview six of the program co-ordinators.

Localities are very diverse in their programming and a variety of sites and curricula are in use in the pilot programs. For example, Petersburg offers a school-based program, "Best Friends" for 120 girls in grades 5 to 8, as well as a "Resource Mothers" program for 30 to 40 pregnant teens at the health department and also contracts with a private provider to offer 12 session educational groups for 44 teens ages 12 to 15. Recreation centers and an elementary school are sites for Alexandria's ProYouth/ProTeen Ille-skills development program while Postponing Sexual Involvement (PSI) is offered after school to 13 to 15 year olds in high schools. There is a separate program for males titled "Male Teen Responsibility." Another Alexandria program is "Project Stopout" which is offered at churches, recreation centers and schools. Alexandria offers a Non- Parent's Mother's Program and Postponing Sexual Involvement. In all, 679 Alexandria youth were involved in the five different programs.

Roanoke has four programs in two settings. The health department offers "Resource Mothers" who work with pregnant teens to prevent a second pregnancy. This program has served 167 teens. They also target adolescent dads in a program stressing male responsibility. Schools offer the "TOP" program (Teen Outreach Program) which serves 70 to 80 youth per year and some schools house teen health centers.

Norfolk appears to have the greatest variety of sites. Educational programs are conducted at Boys and Girls Clubs, recreation centers, schools, Norfolk Skills Center, Norfolk Marine Institute, group homes, detention centers, court service units, churches, at the American Red Cross, Norfolk State University, the Urban League of Hampton Roads and summer youth camps.

The Eastern Shore program has also subcontracted to many community groups, churches and to cooperative extensions. There are 14 programs in a wide variety of sites, they also offer in-church of curriculum. For example, in Rich- mond, several public programs use "Sex Education Program." Portsmouth has a Girls, Inc., program "Will Power, Won't Power" and "Growing Together." Alexandria uses the "Life Options" from Advocates for Youth. In contrast, programs offered in the Eastern Shore do not address sexuality but instead help youth by mentoring, tutoring and goal-setting.

Data from a 1996ickle, that Alexandria's five projects have served from 12 (Male Teen Responsibility Program) to 414 (ProYouth). Norfolk's four programs have served from 7 (Parent Training Program) to 105 (Teen Counseling Program) for a total of 569 youth. Richmond's Town Council has served 600 adolescents and the two adolescent health clinics have served 394. A male responsibility program, "For Good Times Only", has been attended by 27 males. Petersburg's programs have reached 113 youth. Crater's projects have involved 193 youth. Eastern Shore's eight projects reached 21 girls (at a church) to 126 youth (in Newport News). In Richmond, two projects, "Girls Inc." and "Life Options" have attracted 337 teens to the Girls, Inc., program, 191 to "Good Beginnings" for teen parents, 157 adolescent males to the Virginia Male Adolescent Network and 46 to Resource Mothers. Finally, Roanoke has served 566 boys in For Men Only, 167 Resource Mothers for pregnant teen, 68 in TOP, and 2,031 have utilized the teen health centers (two in schools and one at a public housing development).

Most programs are engaged in both community education about the problem of teen pregnancy. According to Terri Wilberly of Virginia's Department of Health, community education efforts have made in Alexandria, 1,274 in Norfolk, 2,116 in Crater, 3,475 in the Eastern Shore, 191 in Portsmouth and 277 in Richmond. Wilberly is utilizing a media campaign to assist in community education. Thus nearly every teen in these areas have reached by community programming.

In summary, Virginia programs have thus far reached approximately 6,000 teens in the more intensive education programs. The focus is on younger teens, with the majority being between the ages of 11 and 15. Nearly two-thirds of the participants in the programs are female and 36 percent are male. Most programs report difficulty attracting males. Parents also appear reluctant to become involved. Even programs with a primary goal of parent involvement have not been successful in attracting parents.

However, programs are making positive gains. For example, Kathy Fairy, Director of the Crater project, is enthusiastic about her achievements. She states in regards to the two local coalitions in Cra- ter, they've had tremendous progress since initial funding in March 1995. Both have been very successful with positive mea- sures. Fairy reports that for the past two years, they have focused mainly on coalition building, needs assessment and the ability to market the coalition. The local coalitions are very aware that they could not solve the problem, but that the community as a whole must not only be aware of the problem, but accept ownership of it. Fairy adds that the money is not sufficient to fund both staff and pro- gram implementation. Thus, formal program implementation is just now beginning as additional funding sources become available.

Some program director discussed obstacles to increasing the teen pregnancy rate. Various factors were mentioned. These included poverty and youth who feel they have no future. Single parents concerned earning a living were another factor, as these parents have limited time to be with their adolescents or to be involved in parent-child programs. The prevalence of fa- thers who are very much older than the teen mothers was also mentioned. "These men are not interested in programs," noted one director. "Some are not paying child sup- port either. The girls do not want to iden- tify because they fear these men will be prosecuted." One program director noted that there are cases of one male impregnating several young girls. However, not everyone agrees that older fathers are prevalent. Stephen Conroy, M.A., M.Ed., is Director of the Adolescent Health Program for the Virginia Department of Health. While no one can support older...
males having relations with teens, older fa-
ters are a red herring", he stated. "Focus on
this issue ignores the majority of cases and
promotes a punitive orientation." 
stead, researchers appear to agree that ado-
escents child bearing is the result of an in-
tricate web of factors which include limited
opportunity, poverty and low self-esteem,
which interacts with other risk factors and
high-risk behaviors.

SUMMARY
Reducing teen pregnancy is a compli-
cated task. There are no "magic bullets" or
simple approaches that will markedly re-
dause adolescent pregnancy. Programs that
focus on a single aspect or skill are unlikely
to succeed. "Silent" programs that are too
broad and general will not teach skills spe-
cific to handling sexuality and are unlikely
to succeed. Rather, programs need to focus
dearly on reducing behaviors that lead to
untended pregnancy and consider the char-
acteristics of effective programs iden-
tified to date in research.
Reducing teen pregnancy is possible, but
challenging. Leaders in Virginia's efforts are
cautiously optimistic. Steve Conley of the
Virginia Department of Health captures the
ideas of others in his analysis. "Teen-
age pregnancy is an economic problem.
Conley states, "With a comprehensive ap-
proach, a community can reduce the teen
pregnancy rate by half. However that isn't
easy. There must be opportunities for youth.
Young people need to see a positive future
and to have many activities and opportu-
nities available. It requires dedication and
much effort to create caring communities".

References Available Upon Request

LOOKING FOR A
PREVENTION PROGRAM?
"Strategies for Adolescent Pregnancy Pre-
vention" is a review of programs that are avail-
able free of charge from Lisa Smith, MS at The Ameri-
can College of Obstetrics and Gynecology,
402 12th Street, SW, P.O. Box 9629, Wash-
ington, DC 20040-0926, (202) 639-2497, E-Mail:
lsmith@acog.org

The Program Archive on Sexuality, Health
and Adolescence (PASS) has assembled its
is disseminating materials from promising teen-
age pregnancy and STD/HIV/AIDS prevention
programs. Sociometric Corporation, 170 State
Street, Suite 260, Los Altos, CA 94022-2812,
(415) 949-3282, FAX (415) 949-3288 or ord
 toll-free 1-800-846-DISK.
Preventing Teen Pregnancy

continued from page 13

ties, a higher likelihood of school dropout and earlier sexual experience than girls involved in intimate peer relationships (Males, 1993).

The problem of adult-teen intercourse is a neglected one in the literature. Teen sexuality is generally portrayed as an issue between adolescent partners. It is not likely that programs aimed solely at adolescents will impact those pregnancies caused by adult males. It appears that the majority of fathers are not in school or in contact with pregnancy prevention programs. If this is the case, then pregnancy prevention efforts may rest with mothers. However, it may be difficult for young girls to insist that older men use birth control. Among some cultural groups, young girls dating and sometimes marrying older men is acceptable. Teens from dysfunctional and abusive families may seek escape from their families through relationships with older males.

Although the youngest teens account for the smallest percentage of teen births (about two percent), they are an extremely vulnerable population. There are legitimate questions about a young adolescent's ability to give meaningful consent to sexual relationships with much older men (Lindberg et al., 1997). Those who become sexually active at an early age are especially likely to have experienced coercive sex (APA, 1995). Of those who had intercourse prior to age 14, 74 percent reported the contact was forced and for those age 15, 60 percent reported forced sexual experience (Donovan, 1997). In order to learn more about sexual activity between adult males and young teen girls, the American Bar Association's Center on Children and the Law has conducted an exploratory study. The project analyzed state laws, prosecutorial policies and practices and social welfare and health system responses to sexual activity between adult males and teen girls. The report is now available from ABA Publications (800-285-2221) for $9.95 plus $3.95 postage, order number 540277. More information is available from Sharon Ettison, Project Director, ABA Center for Children and Law, (202) 662-1702, Fax: (202) 662-1765.

While some advocate punishment for older males who father children with teens, others question a punitive approach. Punishment of older fathers could deter some pregnant or sexually active teens from seeking prenatal health care. Punishing what may be culturally acceptable in some families could also be difficult. Finally, some fear that other more important factors in teen pregnancy will be overlooked if there is a focus on legal sanctions for older fathers.

There is also a relationship between early sexual activity, teenage pregnancy and child sexual abuse. Not all incest victims engage in a pattern of dysfunctional sexual relationships. However, one consequence of victimization is lowered self-image and the belief that one's value is offered relationships to others. It is not uncommon for incest victims to learn to relate adversely through sexual activity and continue to pattern with others outside the family. Some incest victims are impregnated by family members. Others may be in the group that chooses to leave home early through an intimate relationship with an older male. It is likely that programs aimed at adolescents-to-adolescent sexual behavior will have little effect on pregnancies caused by or secondary to incest.

Summary

Some feel that past efforts to prevent teenage pregnancy, even when promising, have been "too simple, too weak, too short and overall, not up to the task" of dealing with complex behaviors and societal trends (Philliber & Namarow, 1985, p.31). No single effort is likely to be effective for all teens. It is unlikely that an intervention will remain effective for the entire span of adolescence. Therefore, a program offered in early teens without continued education and support is unlikely to maintain impact during later teen years. Some programs lack effectiveness because of timing. Since some youth begin sexual activity early, interventions that reach these individuals prior to beginning sexual activity are needed. There is reason for optimism. Effective programs are available for communities.

References Available Upon Request

James Madison University
Department of Psychology
MSC 7811
800 S. Main Street
Harrisonburg, VA 22807
Attn: J. Grayson

Address Correction Requested

Nonprofit Organization
U.S. POSTAGE PAID
Harrisonburg, VA 22801
PERMIT NO. 4

500-205