

# Involving Schools in Teen Pregnancy Prevention

## Why involve schools in teen pregnancy prevention?

Because young people spend so much time in school, it is appropriate to ask what this major institution can do to help prevent teen pregnancies—especially when school failure, school disengagement, and dropping out are principal predictors of this problem. At the same time, schools have become battle grounds in many communities, the sites of intense struggles over many issues, such as teacher competence, student scores and

academic performance, safety, vouchers, and sexuality education.

There are ways in which schools can help, many of which are not at all controversial and are directly consonant with their core mission of education. This chapter describes five strategies that schools can pursue. These strategies help give students support, knowledge, and a sense of the future, all of which will help them delay sexual activity and avoid unprotected sex.

## Strategies for involving schools

Several of these strategies will be acceptable to many communities, others less so. Some schools will have the resources and time to concentrate on only one type of intervention; others can do several simultaneously. A few schools are already doing all of them. Communities will choose those activities best suited to their own values, their own children, and their own schools. However, regardless of which activities are chosen, parent involvement is critical.

The five strategies are:

- promoting educational success and providing an enhanced sense that life holds positive options;

### RESEARCH AND EXPERIENCE SHOW...

- **educational failure is a key predictor of teen pregnancy**
- **a strong connection to school and higher achievement is associated with delayed sexual intercourse**

- helping youth create and maintain strong connections to parents and other adults;
- providing knowledge, reinforcing positive social norms, and enhancing social skills through various types of abstinence or sex education;
- offering contraceptive services (either in school or nearby) or making referrals for them; and
- carrying out multiple approaches through school/community partnerships.

### **Promoting educational success and providing an enhanced sense that life holds positive options**

Young people are more likely to avoid teen pregnancy when they believe in a positive future for themselves. Schools and communities must formulate powerful strategies for those young people who live on the margins, who are unsuccessful in school,

who do not have nurturing families, and who live in disadvantaged communities. These very high-risk young people must be convinced that delaying parenthood will have benefits, *and* that not having a baby will improve their chances in life.

But this strategy is not just a matter of motivating young people to abstain from sex until they are older or to avoid unprotected sex. It is a matter of changing their circumstances so that they truly do have access to quality education and employment opportunities, so they can set and meet high goals for their lives, so that they feel that the future holds the promise of positive options.

Teachers, guidance counselors, and other school personnel are in an excellent position to identify young people who are at high risk of teen pregnancy. One sure marker of vulnerability is

FOR MORE ON THESE STRATEGIES, SEE OTHER CHAPTERS IN *GET ORGANIZED*

**Previous chapters have highlighted promising pregnancy prevention programs. Many of these are school-based; others, which are community-based, can be adapted for school use.**

**Some of the school-based programs described here are specifically focused on pregnancy prevention; others are not, even though they have been shown to prevent pregnancy.**

**Note: While all of these efforts take place in school buildings, most of them represent shared responsibilities between the school and one or more outside organizations.**

## THE LINK BETWEEN PREGNANCY PREVENTION AND YOUTH DEVELOPMENT

**Involving youth—particularly high-risk youth—in thinking about and planning for higher education and career opportunities decreases their vulnerability to high-risk sexual activity and other problems.**

**Youth development programs convey high expectations to young people, and then give them the chance to achieve those expectations.**

being left back in school. Young people who are two or more years older than their classmates are more likely to drop out and become parents while teenagers. Once high-risk teens are identified, it is essential to make sure that they receive early and intense interventions that will help them overcome the odds.

Many school systems have programs targeted to high-risk youth. There are thousands of alternative schools, schools-within-schools, mentoring programs, full-service community schools, and special projects that attempt to give needy young people individual attention and that tailor classroom experiences for different learning styles. Many of these schools are open from early in the morning until late at night and offer an array of health, mental health, social, and recreational services for the student and his or her family.

A new federal initiative, the **21st Century Community Learning Centers**, will provide support for after-school programs in many needy school districts

for middle-school children who are particularly vulnerable to risky behaviors during the hours after school. After-school programs can effectively offer educational enrichment and creative recreational opportunities that expand life options.

Community service is another way to expand the life options open to young people while they are still in school. Examples include:

- assigning students to community agencies, such as nursery schools, hospitals, or senior citizen's homes, where they provide services to clients under the supervision of the agency staff, and bring back their experiences to the classroom; this exposes young people to the world of work and helps them to understand how to prepare for careers; and
- encouraging high-risk students to participate in school-based peer programs, such as tutoring; such arrangements can help both groups because the peers gain confidence and

## SUCCESS LEADS TO SUCCESS...

- **More than 80 Beacon Schools have been funded by the New York City Department of Youth and Community Development.**
- **The Beacon model has also been widely replicated around the country, as has the TOP program.**

status and the tutored students do better in school.

The **Teen Outreach Program (TOP)**, originally sponsored by the Association of Junior Leagues, combines volunteer community work assignments for high-school students with school-based group counseling and discussion groups. The discussions are guided by a curriculum emphasizing life planning and goal setting. Recent research from the program has shown that participating students have lower rates of school failure, school dropout, and pregnancy (The Association of Junior Leagues International, 1995).

The **Countee Cullen Community Center** is a Beacon School in New York City. This school-based program operates from 8 a.m. to 11 p.m. every day of the week, serving hundreds of youth and their families. It:

- has a Teen Youth Council that works on community beautification;
- sponsors workshops on job readiness and employment skills;

- runs a peer mediation program to prevent youth violence; and
- houses Narcotics Anonymous, Boy Scouts, and a Family Development Program with case managers who work with high-risk families.

An evaluation of the program has demonstrated its diverse benefits, including improved students' performance on reading tests and improved community safety.

### Helping youth create and maintain strong connections with adults

Both research and everyday experience teach us that every young person needs at least one strong, authoritative, and dependable adult in his or her life. For most young people, this will be parents, but some parents have great difficulty communicating with their own children, not just about sex, but about many issues. School personnel, such as teachers, guidance counselors, coaches, school nurses, and other support staff, can play a significant role in helping to fill this gap, guiding young people and helping them to make responsible decisions about their futures.

Aware that vulnerable students in particular benefit from a connection with an adult, many schools attempt to link each

student to a school staff member, case manager, or volunteer. Some schools are organized around “family” groups in the homeroom, with the teacher taking the responsibility for checking in with each student every day to make sure everything is going well. For example, school/community partnerships that focus on mental health often bring outside counselors into the school for prevention and treatment. In a few schools, teachers or special outreach workers make home visits when parents need to be involved.

Along these same lines, “student assistance” workers or case managers are another strategy for preventing school dropout, delinquency, and substance abuse.

**Communities-in-Schools** (formerly Cities-in-Schools) has established hundreds of sites

where social workers are relocated from community agencies into schools. They focus specifically on high-risk youth and give them plenty of individual attention.

**Quantum Opportunities, Inc.**, is an intensive program, originally created as an after-school intervention in five pilot community-based sites. High-risk 9th graders join the program for a four-year intervention that includes daily educational remediation, life skills training, community service, and family involvement. Participants are paid an hourly rate for attendance and the money is banked until graduation to help pay for college or vocational school. This program has been shown to prevent high school dropout, delinquency, and teen childbearing. Replications are now underway in seven cities, and some of them are located in schools in order to

WAYS TO DISPROVE THE WELL-KNOWN AXIOM, “THE OLDER THE STUDENT, THE HARDER IT IS TO INVOLVE PARENTS.”

**Some middle and high schools have established good connections with parents by offering them needed services, such as:**

- **English as a Second Language classes;**
- **individual guidance on family problems; and**
- **family recreational experiences.**

**Other schools have organized workshops that bring together parents with other people’s children. This often makes adult-child communication easier.**

link together the classroom and after-school experiences.

A few school-based programs involving outside social workers that focus specifically on teen pregnancy prevention have been identified.

**Teen Choice** is a pregnancy prevention program operated by Inwood House, a voluntary social service agency in the New York City public schools. Specially trained social workers staff three components: small groups, individual counseling and referral, and classroom dialogues.

The small groups meet once a week for a semester and cover sexuality issues, birth control, values clarification, and peer pressure. The workers are assigned to a school where they have private offices, ensuring confidentiality.

## STATE LAWS ON SEXUALITY EDUCATION

- **19 states and DC require schools to provide sexuality education**
- **Of these, 4 states require abstinence education and 10 require abstinence education and information about contraception**
- **34 states and DC require schools to provide STD/HIV/AIDS education**

NARAL, 1999

## Increasing knowledge and social skills through various types of sexuality education

Young people need the knowledge and skills to make responsible decisions about whether and when to initiate sex, with whom, and under what circumstances. Schools are one of the places where they can receive this information and guidance, supplementing what parents, faith communities, and others teach.

These programs come in many different varieties, and they vary a lot in whether and how contraception is presented:

- Most of these programs address how to delay sexual activity or avoid unwanted sex.
- Some are considered “abstinence-only,” meaning they emphasize abstinence as the 100-percent effective way to avoid pregnancy and STDs, while others are called “abstinence-plus” because they also include discussion of contraception.
- Some, often called “comprehensive” sexuality education programs, teach young people about human sexual development, pregnancy and reproduction, and contraceptives and how they work. They also help teens learn how to refuse

sex if they are not ready for it and how to negotiate contraceptive use. STD/HIV education programs focus especially on “safer sex” practices.

Many well-regarded programs focus on helping young people learn how to make decisions about their behaviors, and carry out those decisions through experiential education, such as role playing about real-life situations, exposure to media influences, and dealing with peer influences. An emphasis on abstinence has new visibility, however, because of provisions in the 1996 welfare reform law, which allocated \$250 million over five years (fiscal years 1998-2002) to states to develop and to put in place a set of abstinence-only education programs to prevent teen and out-of-wedlock pregnancy and births.

In the past, curricula that focused on family life decisions were quite popular. For example, Advocates for Youth promulgated the **Life Planning Curriculum**, which required students to produce detailed plans about their careers, marriage, family life, and budget.

In recent years, to strengthen the message about the difficulties of early parenthood, some school systems have invested in the purchase of “Baby Think it Over” dolls, which are plastic

replicas of infants. They cry frequently and are, in some ways, as demanding as a young baby. Students are asked to take care of these dolls (or other surrogate babies such as eggs or flour sacks) for short periods of time, to acquaint them with the demands of infant care. No strong evaluation has been conducted of the effectiveness of this approach, although many teachers and students report that such tools (when used as part of a broader curriculum) can help break through adolescent disinterest in the burdens of early parenthood.

In addition to providing classroom curricula, some schools use their resources to support in-service teacher training in sexuality education, though the focus has been primarily on HIV prevention. Among health education teachers, one-third of middle school and senior high school teachers reported training in HIV prevention during the preceding two years, while only 6 percent received training in pregnancy prevention (CDC, 1996).

Only a few school-based programs of any type have been evaluated and have proved that they can influence behaviors, such as the onset of sexual intercourse or contraceptive use. Many programs affect knowledge and attitudes about these issues, but have not been

## RESEARCH SHOWS THAT...

**more than knowledge is required to effect behavior change**

*Kirby, 1997*

proven to have much impact on actual sexual behavior. However, more recently designed AIDS prevention and pregnancy prevention curricula have seemed to produce better results (Kirby, 1997).

It has become clear from considerable study of prevention programs, not only in regard to teen pregnancy but also substance abuse and violence prevention, that more than knowledge is required to effect behavior change. The most recently developed classroom-based approaches focus more on what is called social skills training—helping teens develop the skills they need to act responsibly in social settings, using the knowledge they have acquired. Most important, they give a clear message about abstinence or avoiding unprotected sex.

**Reducing the Risk** uses a 16-session curriculum to change high-school students' norms about unprotected sex, as well as to strengthen parent-child communication concerning abstinence and contraception. Experiential components, such as role playing, are featured. Evaluation of Reducing the Risk showed that the program reduced the likelihood that students would become sexually active, although it had less effect on those who

were already sexually experienced (Barth et al., 1992).

**AIDS Prevention for Adolescents in School** provides a six-session curriculum for 9th–11th graders that focuses on teaching the correct facts about AIDS; promoting cognitive skills to appraise the risk of transmission; increasing knowledge of prevention resources; and teaching skills to delay intercourse and consistently use condoms. An evaluation found a decrease in high-risk behaviors (Kirby, 1997).

**Safer Choices** is a multi-component, school-based program designed to reduce pregnancy, STD, and HIV by reducing sexual activity or increasing the use of condoms or other forms of protection. It includes a school council to produce school-wide change, a 20-session curriculum spread over two years (9th and 10th grade), peer and school-wide activities, a parent component, and a community component. It has increased condom use and decreased the frequency of unprotected sex (Kirby, 1997).

### **Offering reproductive health services and contraception**

A fourth approach to reducing teen pregnancy that some schools have chosen is to provide direct access to contraception to prevent early pregnancy and

STDs. Traditionally, schools are not expected to provide reproductive health care to teenagers, and most school systems do not assume formal responsibility for ensuring that sexually active students have access to birth control services. In other schools, sexually active students are referred to local Planned Parenthood facilities, family planning clinics in health facilities, or private physicians. School personnel may refer students to outside health agencies and, in some cases, follow up with the agency to make sure that the student arrived at the facility and received the necessary care. Parental consent, notification, and involvement are important issues to address in this approach.

Family planning services offered by public health clinics, community-based agencies, private physicians, and school-based clinics can provide the necessary counseling, physical examination, prescriptions, and, in particular, follow-up that young people need to ensure adequate protection against pregnancy and STDs.

In recent years, the country has seen a substantial growth in the number of school-based primary health care clinics—only about one-third of which provide contraception. In 1983, only 10 such programs could be identified.

The most recent survey showed that close to 1,200 schools now house school-based clinics, about half in high schools, with a growing number in middle and elementary schools.

Although these clinics exist in only a small percentage of the 85,000 public and 25,000 religious and independent schools in the United States, they currently serve about 2 million students, more than half of whom are probably old enough to be at risk for pregnancy. The clinics typically serve about half of the students in any given school.

These primary care facilities are operated by health centers, hospitals, and other community providers. Most are staffed by nurse practitioners and social workers.

#### RESEARCH SHOWS...

- **48 percent of 15- to 19-year-olds report having had sexual intercourse**

#### MANY SCHOOLS ARE RESPONDING...

- **about 1,200 have primary health clinics**
- **some make condoms and medically prescribed contraceptives available**
- **many refer students to clinics and physicians in the community**

*Making the Grade, 1998*

Almost all such high-school clinics provide treatment for minor illnesses, offer immunizations, and do comprehensive health assessments and sports physicals. More than three-fourths include mental health counseling services, such as case management and crisis intervention, and many conduct group counseling sessions on specific topics related to drugs, sex, violence, and interpersonal relationships (Dryfoos et al., 1996; Fothergill, 1998; Making the Grade, 1998).

**Self Center**, a school/community agency program in Baltimore, Maryland, combined sexuality and contraceptive education and individual and group counseling in schools with family planning services in a nearby clinic site. The staff (a social worker and a

nurse practitioner) worked in both places.

The **In Your Face Program**, run by New York's Columbia University Center for Population and Family Health, emphasizes group counseling with Hispanic students who are at high risk of early unprotected sex. Specially trained Hispanic health educators work intensively with students to develop ways to prevent unwanted pregnancies, including abstinence. The educators escort the students to a hospital-based family planning clinic if they are sexually active and want contraception.

The Pinelands Regional High School, in New Jersey, has a state-supported **School-Based Youth Services Program**. A family planning educator from the local Women's Health and Counseling Center teaches 9th and 11th graders as part of the school's comprehensive family life education program. The four-part presentation includes information about methods of birth control and disease prevention and introduces the availability of individual confidential counseling as part of the school program. The family planning counselor who comes to the school is also at the community-based center, so that if students choose to go to the center they meet the same person they know from the school.

## FACTS ABOUT HIGH SCHOOL-BASED PRIMARY HEALTH CLINICS

- **85 percent offer pregnancy tests**
- **74 percent offer birth control counseling and gynecological exams**
- **1/3 provide birth control pills or condoms**
- **more than 400 schools allow condoms to be made available in the school building**
- **more than one-half have referral agreements with community family planning clinics**
- **many staff provide sexuality education in the classroom**

*Fothergill, 1998;  
Making the Grade, 1998*

## Carrying out multiple approaches through school/community partnerships

As seen in the following examples, recognition is growing within schools and community agencies that partnerships that include schools can go even farther to strengthen initiatives to help children and families.

Florida supports **Full Service Schools**, encouraging public agencies—health, mental health, and social services—to relocate and integrate services in school buildings. Some Florida schools have used the money to develop comprehensive family resource centers, while others have opened school-based primary health care centers.

The federal Centers for Disease Control and Prevention has created the **Joint Work Group on School-based Teen Pregnancy Prevention**, which includes representatives from such national organizations as the National School Boards Association, the Council of Chief State School Officers, and the National Education Association. This group is exploring the roles of state and local education and health policymakers, administrators, and school personnel.

The **School/Community Program for Sexual Risk Reduction Among Teens** is a multi-component program piloted in South Carolina. The program has nine components, including:

- teacher training;
- K-12 sexuality education;
- access to health services and contraception;
- collaboration with school administrators;
- use of the media;
- training of peer leaders;
- alternative activities for youth;
- community linkages; and
- programs in religious organizations.

The theory underlying this program is that the greater the number of changes in schools and community, the greater the likelihood of reducing teen pregnancy. The original research, which developed the model, showed lower pregnancy rates in the target area, but the rates returned to high levels after the intervention was over. The Kansas Health Foundation has supported a replication of the program in three Kansas counties.

## THE IMPORTANCE OF SCHOOL-COMMUNITY PARTNERSHIPS

**“The ‘full-service school’ as a community-based vehicle for organization and delivery of educational, social, and health services provides an excellent framework for community planning and action to address the health and educational needs of young people who are highly distressed and engaged in serious health-compromising behaviors.”**

*Resnick et al., 1997*

The **Hartford Action Plan on Infant Health**, a partnership between the City of Hartford and the Hartford Public Schools, seeks to eliminate births to those younger than 15 and reduce the birth rate among older teens by half. Among its offerings are:

- the *Postponing Sexual Involvement* curriculum to all 5th graders;
- a *Plain Talk* youth/adult community communication program;
- the *Adult Advisors Academy* to train volunteers to work with youth;
- a Males Forum;
- health care interventions; and
- youth activities.

The Plan includes a number of components in its recommended

comprehensive approach to reducing teen pregnancy, only some of which involve the schools. These include:

- annual screening exams for all adolescents and guidance and health education for youth and parents on pregnancy issues;
- a comprehensive set of “teen-friendly” preventive health services, including family planning;
- use of school clinics for reproductive health services or referral, and to ensure follow-up;
- use of satellite clinics where youth congregate (including malls and community centers);
- case management for high-risk youth;
- use of Medicaid managed care for funding health services and case management; and
- efforts to promote an understanding within the community that the vast majority of Hartford students are sexually active and need protection.

The Children’s Aid Society in New York City has joined forces with the local community school district in Washington Heights to create four **Community Schools**. These “settlement

houses in schools” include the following features:

- They are open long hours and include family resource centers and primary health, mental health, and dental services.
- At the middle-school level, the clinic focuses on the need for reproductive health care and can refer students for family planning if necessary.
- “Town Meetings” enable small groups of students to discuss dating, violence, and peer and parent relationships.

- An extensive after-school program augments the classroom experience.
- Parents are involved in classrooms, community activities, family counseling, and extended learning programs.

The goal of these community schools is to improve academic outcomes, enhance the safety of the community, and help young people and their families reduce their vulnerability to problems. Preliminary results show promising gains in meeting these goals.

## Putting the strategies into action

With these five possible strategies in mind, communities can develop a variety of approaches for preventing teen pregnancy through schools. Doing so is similar in many respects to developing a community-wide initiative. In large measure, careful attention to the details involved in two major phases is important: planning and designing the program and carrying it out.

### Planning and designing a program

Several steps specific to an educational environment are involved in planning and designing a

successful pregnancy prevention program that is school-based or, at a minimum, closely tied to schools.

### ***Create an inclusive planning committee that represents the community***

All the key players on the planning committee need to be involved from the beginning. These players include:

- parents;
- students;
- school board members;

- the school superintendent;
- the principal;
- teachers;
- school nurses;
- counselors;
- other school employees;
- service providers in the community;
- youth development organizations;
- community members;
- religious leaders;
- business leaders; and
- the media.

An effort should not proceed without the support of the school principal, for he or she is the pri-

mary gatekeeper for the school building and the person who has to take the lead in developing a comprehensive program.

If a school health advisory committee or other decision-making body already exists, a pregnancy prevention effort should build on it, rather than organizing another committee.

### ***Gather data on the need for pregnancy prevention in the school—make the issue personal***

It is probably clear how many students are already parents, but it is also important to determine how many are sexually active, pregnant, and expecting to give birth. The local health department has information that may be useful for studying a school community. In addition, compiling information about achievement, attendance, promotion, dropout, and expulsion and suspension rates at the school will help in designing a pregnancy prevention program because academic failure is a key indicator of teen pregnancy risk. Communities may be interested in broad national and state data, but, at the end of the day, it is information on “our own kids” that really moves people.

Other sources of data can be helpful in ascertaining student attitudes and behaviors. For example, many school systems

## USEFUL DATA FOR PLANNING AN INTERVENTION

### ***How many students are:***

- **parents?**
- **expectant parents (boys as well as girls)?**
- **sexually active?**
- **using contraception?**
- **low achievers?**
- **often absent?**
- **2 or more years older than their classmates?**

### ***Who has recently:***

- **dropped out?**
- **been suspended?**
- **been expelled?**

and states now use some form of the Youth Risk Behavior Survey, introduced by the Centers for Disease Control and Prevention in 1990. This survey elicits confidential responses about sex, drugs, violence, suicidal intentions, nutrition, and exercise, and can be adapted locally.

The planning committee may also want to consult national research, which can clarify certain issues and help schools develop a strong case for instituting a pregnancy prevention program. For example, current research shows that sexuality education programs do not stimulate sexual activity, that school-based clinics require parental consent, and that youth programs can be effective at changing behaviors (Kirby, 1997).

### ***Assess the current status of pregnancy prevention in school***

The planning committee should make an unbiased assessment of any existing pregnancy prevention efforts. In addition to gathering information on sexuality education programs of various types, it should look at other prevention programs in the school, including drug education, conflict resolution, and after-school activities that have a potential influence on youth development. A careful review means not only making an inventory of the programs, but

also beginning an assessment of whether they are effective in achieving their stated goals.

If the interventions being considered include new or expanded sexuality education or school-based health services of some type, the committee should also:

- review the state and local policies on sex education and reproductive health care in schools; states have many different policies regarding what can or cannot be included in sexuality education and HIV/AIDS prevention programs, and many also regulate the distribution of medical contraception and condoms in school-based clinics;
- determine whether the local school board has regulated the sexuality education curriculum or school-based health care; and
- determine whether the school system supports the kind of in-service training for its teachers that new programs might require.

### ***Learn about alternative programs***

This chapter has described a number of types of programs to be considered. To help in this decision, members should be encouraged to visit prevention

efforts in nearby communities. Another source of information is the many videos that are available about innovative programs in operation. This information should help to raise consciousness in the community about the wide array of programs and activities that could be introduced to make the school climate more conducive to responsible student behavior.

When looking at other programs, planning committee members should pay particular attention to how successful relationships between schools and other organizations are structured, where their financing comes from, and who makes decisions about what.

Members of the planning committee should be given any available information about evaluation so that they can distinguish between programs that have proven effective and those that show promise. There's a big difference.

### ***Develop a plan***

Once the planning committee has gathered the information it needs and decided on potential actions, it can begin to draft a preliminary plan for a school-based intervention to reduce teen pregnancy. The plan should clearly explain each component of the initiative, address how the components fit together, and how they link to other aspects of the school experience. The box below lists a number of key questions that can guide the

## **Nine key questions to ask when developing a plan**

1. What program components should be included?
2. Who should be responsible for providing those components? Who are the potential partners in this endeavor? How will they relate to each other?
3. What elements of existing policies will support the plan and what revisions are needed?
4. What are the expected results? What kind of accountability system is there for monitoring and evaluating the program?
5. What will the program cost? What resources can be shared?
6. Will additional space in the school be required and, if so, how can it be made it available?
7. What staffing is required? What training is necessary?
8. How do the pregnancy prevention components fit in with school improvement and/or school reform plans?
9. Are there some components that should be made available outside of the school?

committee in developing a clear and practical plan.

### ***Present the plan***

After all the key players have reviewed the plan, the committee should present it to the community as a working document and ask for their comments, ideas, and suggestions. It may well take time and patience to develop a wide consensus on the plan so that it can be implemented with broad-based support. Describing this school effort as an important part of a solution to a community-wide problem will be essential for gaining broad support. Planning committee members need to remember that the school doesn't have to do it all. Individuals and agencies usually respond well to invitations to participate in school/community partnerships.

### **Carrying out the program**

Even the best plans can falter if certain implementation issues are not addressed properly.

### ***Expect and deal with controversy***

Developing a school-based pregnancy prevention program is not an easy task. The subject of sex is fraught with conflict in our society—and when sex gets put into the context of the school, controversy is almost sure to follow.

If the planning committee's members fairly represent the school and community, and they have reached consensus on the main elements of the plan, the task of carrying out the program will be easier than if a non-representative group is in charge. Even so, tensions often exist. Sometimes controversy can be defused through openly sharing information about the problem and the proposed solutions, but whatever the approach to reducing conflict, it often takes time and success is not assured.

### ***Maintain support and financing***

Schools hesitate to add programs that require the expenditure of school funds. In general, abstinence or sexuality education is included in the school budget, but most of the other programs described in this chapter, such as after-school programs, are "add-ons," which require funding from non-educational sources. School-based health centers are largely funded by states and through third-party reimbursement systems, such as Medicaid and, more recently, managed

**FOR MORE INFORMATION  
ON DEALING WITH  
CONTROVERSY...**

**See Chapter 17 (Volume 3),  
"Moving Forward in the  
Face of Conflict."**

care contracts. The average cost per year for a such a health center is about \$150,000. Family or youth service centers can be established for about \$75,000 if they concentrate primarily on counseling and referral to community agencies.

### ***Ensure quality***

If a school chooses to use a pre-packaged curriculum as part of its teen pregnancy prevention initiative, it must be careful to implement it faithfully in the classroom and ensure that teachers are thoroughly familiar with the content and teaching components. The curriculum may have proven effective when the program developer supervised the teachers directly, but if teachers only have a manual or video to turn to for instruction, the results may be less successful. Teacher training is critical to the success of classroom-based prevention programs.

If the chosen intervention includes abstinence or sexuality education of some type, it is sometimes possible to get local community agencies (such as local health departments, colleges, or other youth-serving groups) to help out in the classroom. Mobilizing such outside help has the added advantage of liberating those teachers on staff who would rather not teach sexuality or abstinence education.

### ***Build partnerships***

A powerful consensus is emerging around the country that only through combining the forces of families, schools, and communities can we ensure that all children will grow into responsible adults. Clearly, schools cannot (and should not) take the full responsibility for preventing teen pregnancy and sexually transmitted diseases.

Partnerships between schools and community agencies can produce innovative and integrated programs. But it is essential that areas of contention be recognized and resolved. For example, turf issues, such as the position of the school nurse when an outside clinic comes into a school, should be clarified and resolved through careful negotiation of contractual relationships, specifically identifying who does what.

### ***Encourage parental involvement***

Parents must know what is going on in the school with their children's education and development. Many of the efforts described here require parental consent for participation. But consent is not the only role for parents. Often parents need help communicating with their children, especially about tough issues like sexuality. Programs that invite parents into the school for workshops and lectures have

met with limited success, but they are not the only possibility for outreach:

- Home visits by trained case managers can produce open communication between the school, the parents, and the students.
- Encouraging parents to volunteer in the school as classroom aides or to organize after-school programs in literacy, computers, or aerobics are effective ways to bring other adults into the school setting.

## Conclusion

Schools are a vital part of any community and a logical place to reach teens with pregnancy prevention programs. An increasing number of schools, in conjunction with their communities, are recognizing that they can have an important impact

### ***Ensure coverage during non-school hours***

If the complete package of prevention programs takes place in a school, it means that the doors of the school must be open for extended hours (including vacations and summer) and that residents other than students might participate in these school-based events. Schools need to plan for this. Provisions for staffing and security also must be made, and transportation schedules may have to be adjusted so that students can stay after school for enrichment programs and tutoring.

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## Programs mentioned in this chapter

### **Children's Aid Technical Assistance Center for Community Schools**

Rosa Agosta  
The Children's Aid Society  
c/o IS 218 4600 Broadway  
New York, NY 10040  
(212) 569-2880

### **Countee Cullen Community Center**

Geoffrey Canada  
Rheedlen Center  
2770 Broadway  
New York, NY 10005  
(212) 866-0700

### **Hartford Action Plan on Infant Health**

Laura Stone  
30 Arbor Street  
Hartford, CT 06106  
(860) 236-2872

### **In Your Face Program**

Lorraine Tiezzi  
Columbia University Center for Population and Family Health  
School of Public Health  
60 Haven Ave.  
New York, NY 10032  
(212) 305-5240

**National Assembly on School-Based Health Care**

John Schlitt  
1522 K St., NW, Suite 600  
Washington, DC 20005  
(202) 289-5400

**Pinelands Regional High School**

Roberta Knowlton  
New Jersey School-Based Youth  
Services Program  
New Jersey Department of Human  
Resources  
222 S. Warren St.  
Trenton, NJ 08625  
(609) 292-7901

**Quantum Opportunities**

Benjamin Lattimore  
OICA  
1415 N. Broad St.  
Philadelphia, PA 19122  
(215) 236-4500

**Reducing the Risk**

ETR Associates  
PO Box 1830  
Santa Cruz, CA 95061-1830  
(800) 321-4407

**School/Community Program for Sexual Risk Reduction Among Teens**

Murray Vincent  
School of Public Health  
University of South Carolina  
Columbia, SC 29208  
(803) 777-7096

**Self Center**

Laurie Zabin  
Johns Hopkins School of Public  
Health  
615 N. Wolfe St.  
Baltimore, MD 21205  
(410) 955-5753

**Teen Choice**

Patricia Maloney  
Inwood House  
320 E. 82nd St.  
New York, NY 10028  
(212) 861-4400

**Teen Outreach Program**

Sharon Lovick  
Cornerstone Consulting  
PO Box 710082  
Houston, TX 77271-0082  
(215) 572-9463

**Work Group on Health Promotion and Community Development**

Adrienne Paine Andrews  
The University of Kansas  
4082 Dole Center  
Lawrence, KS 66045-2930  
(785) 864-0533

## Other useful resources

### **Coalition for Community Schools**

Martin Blank  
Institute for Educational Leadership  
1001 Connecticut Ave., NW, Suite 310  
Washington, DC 20036  
(202) 822-8405

### **National Institute for Out of School Time**

Michelle Seligson  
Wellesley College Center for  
Research on Women  
106 Center St.  
Wellesley, MA 02481-8203  
(781) 283-2424

### **21st Century Community Learning Centers**

U.S. Department of Education  
555 New Jersey Ave., NW  
Washington, DC 20208-5644  
(202) 219-2088

### **Youth Development Institute**

Michele Cahill  
Fund for The City of New York  
121 Sixth Ave.  
New York, NY 10013  
(212) 678-3369

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