HB

125

Alaska State Legislature

REPRESENTATIVE BILL HUDSON

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February 2, 1989

Representative Johnny Ellis,
Chairman - House Health, Education
and Social Services Committee
Alaska State Legislature
Juneau, Alaska

Dear Representative Ellis:

Enclosed is a copy of a letter from Carol Everett, Alaska PTA Legislative V.P. I'd like to draw your attention to the health safety and juvenile justice legislative recommendations, which include comprehensive health education, programs for awareness of and instruction in prevention of aids, programs dealing with suicide prevention, environmental health, safety and accident prevention, instruction in drug and alcohol abuse prevention, and instruction in nutrition.

In addition, I'm also enclosing a copy of materials just received today from the Division of Public Health, Section of Epidemiology, relating to a recent poll in which 95.8 percent of the respondents favored AIDS education in public schools.

The final enclosure is a copy of an article from NEA Today, in which C. Everett Koop, M.D., Surgeon General, is interviewed and responds to questioning relating to aids education in public schools.

Landa is still waiting for additional information, and will forward it to you as it arrives.

Respectfully,

Bill Hudson,

BH:lkh

Enclosures

PTA
PO Box 142095
Anchorage, AK 99514-2095
907-337-9345

January 26, 1989

Dear Representative:

Attached is the Alaska PTA's Legislative Program and copies of two resolutions, which were adopted at our statewide convention last April. Each statement was considered by local PTA units, representing over 14,000 members, and voted on individually by the convention body.

The issues which we feel deserve priority attention are:
* Forward funding and adequate, equitable and accountable state funding for education
* Early childhood education and child care issues
* Restricting access to minors of drugs, alcchol, tobacco, and other harmful substances
* Prohibiting the use of corporal punishment in public schools.

We hope you will take time to read through these position statements. These are the issues which the Alaska PTA supports. We hope you will support them as well in considering legislation.

Sincerely yours,

Carol Everett

Carol Everett
Alaska PTA Legislative V.P.

ALASKA PTA LEGISLATIVE PROGRAM

Adopted by Alaska PTA Convention, April 23, 1988

BASIC POLICY STATEMENT

One of the Objects of the Alaska PTA, in common with the National PTA, is to secure adequate laws for the care and protection of children and youth. The Alaska PTA will support legislation and regulations which promote the Objects of the PTA. This legislative program is the authority for selecting those fields of legislation with which the Alaska PTA will be concerned. Positions taken on state and federal legislation will conform to policies adopted in this basic program, plus resolutions adopted at Convention and Alaska PTA Board positions.

SCHOOL GOVERNANCE

The Alaska PTA supports legislation and regulations which will:

1. Maintain local school district autonomy and citizen control of public schools.

2. Encourage cooperation among school districts through regional approaches toward resolving mutual problems.

3. Encourage parent participation on committees pertaining to school government and policy.

FUNDING FOR PUBLIC EDUCATION

The Alaska PTA supports legislation and regulations for state and local funding for public education which is adequate, equitable, and accountable. To achieve this, we support the following concepts:

1. Public education should be a primary responsibility of both the state and local government units and should be a top funding priority.

2. The Alaska legislature should consider new sources of revenue to fund education and initiate forward funding for education.

3. The state funding formula for education should be reformed to minimize disparities created by local contribution and federal funds among poor and wealthy districts.

4. The state should provide funding for districts adequate to enable them to provide both basic educational programs and special programs mandated by the state. The state should fund special programs mandated by federal law if these are deemed a priority and sufficient revenues are available.

5. The per-pupil funds available to a district for education should be adjusted by a multiplier (area differential) which is based on the actual data-based cost-of-doing-business differences in different areas of the state. The method for computing this multiplier should be established by law. The multipliers should not be set individually for each district by the legislature.

6. The funding formula should be such that politicians and administrators are not tempted to manipulate it to get more money.

7. The Department of Education should annually compile data on the expenditures and programs of school districts and make this information readily available to the public in a comprehensible form. Uniform accounting procedures should be required by the state in order that district expenditures for programs and overhead can be computed.

8. The Department of Education should adopt regulations setting minimum program standards for both basic education programs and mandated special programs.

9. Revenue for a district should not increase or decrease disproportionately with the gain or loss of a single student.

10. The legislature should consider consolidating small school districts and setting a minimum size for a school district. The funding formula should not subsidize districts for being small by providing funding for administrative overhead which is significantly higher than average.

11. Required dates for districts to finalize their budgets should fall after the date by which the legislature has finalized the appropriations for school districts. School funding should not be cut after the fiscal school year begins.

12. Reform in educational funding would result in reduced funding for some school districts. The legislature should allocate the money necessary to smooth the transition for these districts, preventing massive cutbacks without sufficient time for prudent trimming.

13. State and federal funds for education should be appropriated only for public schools that are publicly controlled and tax-supported.

EDUCATIONAL ISSUES

The Alaska PTA supports legislation and regulations which will:

1. Guarantee for all children equal educational opportunities for mastering basic skills and developing their individual potential.

2. Provide special educational opportunities, including early childhood intervention when appropriate, for children with handicaps and learning disabilities and for gifted students.

3. Provide access to vocational-technical programs for all secondary students.

4. Provide access to accredited public correspondence programs for all students.

5. Include kindergarten in the mandatory school attendance law.

6. Improve the curriculum and program evaluation at all levels of public education.

7. Provide competent, state-certified, professional staff at all levels of public education.

8. Encourage local school districts to provide qualified elementary and secondary counselors.

9. Prohibit the use of corporal punishment in public schools. Encourage school districts to establish supportive behavior-management procedures for principals and teachers to provide viable alternatives to the use of corporal punishment. The use of reasonable and necessary physical restraint to protect persons or property from harm should not be considered corporal punishment and should be permitted.

10. Provide opportunities for constructive use of leisure time.

11. Encourage television broadcasters to air appropriate programming for childen. Provide opportunities for children to develop critical TV viewing skills.

12. Ensure the rights of parents and students to access to personal test data and protection of confidentiality in the use of test results.

13. Provide appropriate opportunities in Alaska for post secondary academic, vocational, avocational, and technical education.

HEALTH, SAFETY, AND JUVENILE JUSTICE

The Alaska PTA supports legislation and regulations which will:

1. Ensure comprehensive and continuous health education programs, including human sexuality.

2. Strengthen school nutrition programs and promote good nutritional habits.

3. Restrict access to minors of drugs, alcohol, tobacco, and other harmful substances. Foster educational programs on the health risks involved in the use of drugs, alcohol, tobacco, and abuse of other substances known to be harmful. Ban the sale to minors of "look-alike" drugs and paraphenalia for use with illegal drugs.

4. Make possession of marijuana a crime.

5. Regulate the use of three/four wheel recreational vehicles and snow machines and require use of helmets and driver registration, with a minimum age of 14 years for operators.

6. Prohibit driving with an open container of alcoholic beverage in the vehicle.

7. Provide materials and workshops to inform parents about child protection measures and laws concerning missing children.

8. Provide educational and prevention programs to protect children from physical, sexual, mental, and emotional abuse or neglect. Fund an adequate number of social workers to work with victims of child abuse and neglect.

9. Improve the system of juvenile justice, including detention and rehabilitation centers.

10. Provide programs designed for the prevention of youth delinquency. Encourage provision of workshops to improve relationships between parents and children.

11. Support community programs dealing with domestic violence, and providing shelters, resources, and protection for families disrupted by domestic violence.

12. Provide resources to develop programs for runaways in major cities.

13. Provide resources to develop programs for awareness of and instruction in prevention of AIDS.

14. Provide resources to develop programs dealing with suicide prevention.

15. Provide adequate protection for children and adults from environmental hazards and toxic substances, including asbestos, PCB, radon, and lead.

16. Require the use of seat belts in automobiles and trucks.

17. Promote safety on school buses.

18. Require all school buses purchased or leased for use in Alaska's school districts to be equipped with seat belts and have 28" seat backs.

EARLY CHILDHOOD EDUCATION AND CHILD CARE

The Alaska PTA supports legislation and regulations which will:

1. Support a comprehensive program to provide support and training for parents of all children from birth to age 3 to provide child development information, improve parenting skills, strengthen families, and improve educational opportunities for Alaska's children.

2. Provide high-quality, developmentally-appropriate preschool programs, such as Head Start, administered by the Department of Commerce and Regional Affairs, for all at-risk children age 3 - 5.

3. Improve licensing standards for day care and preschool programs to ensure quality.

4. Provide adequate day-care assistance to families in need to allow them to pay for quality programs.

5. Support a statewide system of resource and referral centers to help parents find accessible, affordable, quality child care.

6. Improve opportunities for training for early childhood educators and child care providers, including college-level courses leading to a Child Development Associat degree or CDA certificate.

7. Make comprehensive health and developmental screening available to all children in Alaska to identify problems as soon as possible.

8. Make courses in early childhood education a part of the curriculum for elementary teacher and administrator certification programs in Alaska.

PUBLIC INVOLVEMENT

The Alaska PTA supports legislation and regulations which will:

1. Encourage parent participation in all aspects of education.

2. Limit personal liability for negligible acts of volunteers and protect them from suit.

PRIORITY ISSUES

The Alaska PTA has designated these as the issues of highest priority for legislative activity for the year following the 1988 convention.

1. The Alaska PTA will support forward funding and adequate, equitable, accountable state funding for education.

2. The Alaska PTA will support legislation and regulations which address our concerns on early childhood education and child care issues.

3. The Alaska PTA will support legislation and regulations which restricts access to minors of drugs, alcohol, tobacco, and other harmful substances.

4. The Alaska PTA will support legislation and regulations which prohibit the use of corporal punishment in public schools.

RESOLUTIONS ADOPTED BY THE 1988 ALASKA PTA CONVENTION

CURRICULUM FOR NUCLEAR EDUCATION

Whereas, The Alaska PTA has a purpose "To develop between educators and the general public such united efforts as will secure for all children and youth the highest advantages in physical, mental, social, and spiritual education;" and

Whereas, The National PTA has established the need for the development of nuclear education programs; and

Whereas, Our democratic society needs informed voters as a cornerstone to success; and

Whereas, Nuclear energy issues are important now and in our children's future; therefore be it

Resolved, That the Alaska State PTA, its units and councils, encourage the Alaska Department of Education, school districts, teachers, and parents to identify appropriate nuclear energy instructional programs that would improve and update curriculum in the areas of health, science, and social studies; and be it further

Resolved, That any proposals reflect the multiple viewpoints on this issue and every effort be made to obtain input from all interested individuals and organizations in the review process.

EARTHQUAKE PREPAREDNESS PROGRAM IN PUBLIC SCHOOLS

Whereas, One of the Objects of the Alaska PTA is "To promote the welfare of children and youth in home, school, community, and place of worship;" and

Whereas, The Alaska PTA has members who are parents and advocates for children; and

Whereas, The majority of Alaska's population resides in seismic zones where major earthquakes are likely to occur; and

Whereas, The safety of children would be increased by implementing and practicing an earthquake preparedness program; and

Whereas, Many school districts in Alaska's danger zones do not have an emergency response plan for earthquakes or a program to teach children what to do during an earthquake to increase their chance for survival and to decrease injury; therefore be it

Resolved, That the Alaska PTA, its units and councils, encourage schools to hold an earthquake preparedness drill at least twice during the school year and instruct teachers and staff in earthquake preparedness yearly at staff meetings; and be it further

Resolved, That the Alaska PTA, its units and councils, encourage each school district to adopt an earthquake response plan commensurate with the risk in its seismic zone and an earthquake safety curriculum; and be it further

Resolved, That PTA parents support teachers and staff in initiating these programs.

STATE OF ALASKA

STEVE COWPER, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF PUBLIC HEALTH
SECTION OF EPIDEMIOLOGY

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INFECTIOUS DISEASES
AIDS/STD
TUBERCULOSIS
IMMUNIZATION 561-4406
CHRONIC DISEASES
DIABETES
INJURY CONTROL

February 1989

FOR IMMEDIATE RELEASE

By an overwhelming majority, Alaskans approve of AIDS education in their schools. In addition, they endorse instruction on condom use as a preventative measure for controlling the spread of the AIDS virus and other sexually transmitted diseases (STDs). These two findings are contained in a recent poll conducted by Hellenthal and Associates for the State of Alaska AIDS Program.

Of those responding, 95.8% answered "yes" to the question, "Should education about AIDS be taught in schools as part of a comprehensive health education curriculum?" In addition, 85.2% answered "yes" to the question, "Do you think that a comprehensive health education curriculum should include instruction on condoms as a preventative measure?"

Hellenthal called the level of support for AIDS education "unprecedented." For instance, he continued, "on a statewide basis only 82.5% support local hire." He noted "only 83.9% support continuing the Permanent Fund Dividend Program," and added, "I've never seen such support for any issue in all my years of polling in the State of Alaska."

Dr. John Middaugh, state epidemiologist and director of the Alaska AIDS Program, described the findings as "very encouraging, but not surprising." Middaugh linked the level of support for AIDS education to efforts spearheaded by Senator Tim Kelly in 1987 to

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send U.S. Surgeon General Koop's Report on AIDS to all Alaskan households. "We had a tremendously positive response to the Surgeon General's Report and found a much higher level of awareness about AIDS among those who read it than among those who hadn't."

The Alaska AIDS Program, said Middaugh, has been working to implement the recommendations contained in the Surgeon General's Report, the strongest of which relates to AIDS education in schools.

Koop's Report states:

"Education concerning AIDS must start at the lowest grade possible as part of any health and hygiene program. The appearance of AIDS could bring together diverse groups of parents and educators with opposing views on inclusion of sex education in the curricula. There is now no doubt that we need sex education in schools and that it must include information on heterosexual and homosexual relationships. The threat of AIDS should be sufficient to permit sex education curriculum with a heavy emphasis on prevention of AIDS and other sexually transmitted diseases."

Middaugh said results of this poll will be provided to all school districts across the state. "School districts have control of the content of all curricula, but we feel these results may be useful to educators, parents, and others in implementing AIDS-related education."

Unquestionably education is the key to controlling the AIDS epidemic, said Middaugh. "The polls we've conducted since the AIDS Program began in late 1986 tell us we're making progress," said Middaugh, "even though we still have much to do." Since 1986 we've been able to allay some unwarranted fears and misconceptions about AIDS. For instance, we have seen a significant increase in the number of respondents who indicated they would let their child attend school ev they knew another child there had AIDS. And

we've seen a corresponding increase in the number who realize you cannot get AIDS by donating blood, he said.

The source of AIDS-related information is of extreme importance, said Middaugh. "Our latest poll, for example, showed that those who get their information about AIDS from family and friends are most likely to be misinformed about methods of transmitting the virus." On the other hand, he continued, those who receive their information from public health sources, medical professionals, and reliable media are much better informed about AIDS. Our advantage now, he said, lies in the fact that with program staff we have been able to become visible in the state and to disseminate information to all groups, from physicians to school-age youth.

According to Middaugh, the Surgeon General's advice is still the best, said Middaugh:

> "Be prepared. Learn as much about AIDS as you can. Learn to separate scientific information from rumor and myth. The Public Health Service, your local public health officials and your family physician will be able to help you."

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Contact Person:

Marvin Bailey
561-4405

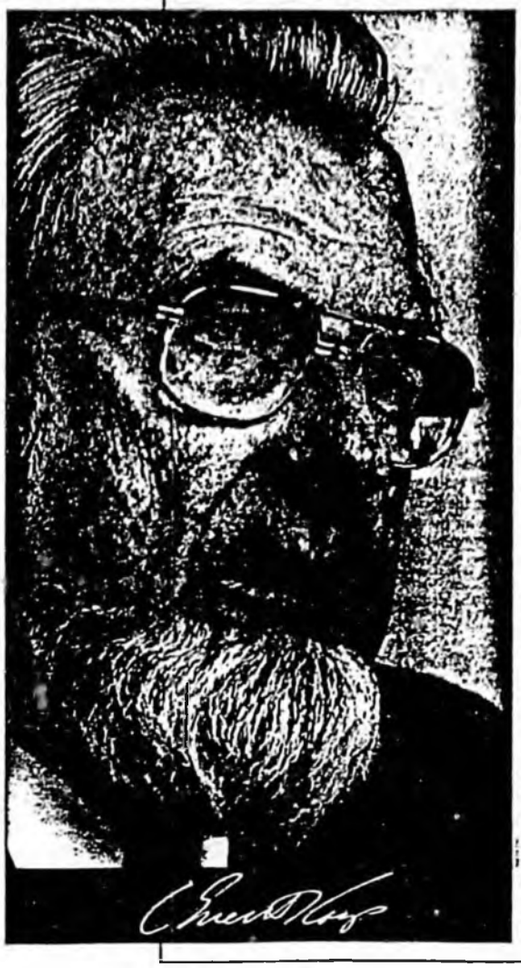
SELECTED SURVEY QUESTIONS ON ALASKANS' KNOWLEDGE AND ATTITUDES ON AIDS (Compared by Year)

Month/Year Survey Conducted*	Question and Percent Agreeing/Disagreeing		
	You can get AIDS by donating blood.		
	Agree	Disagree	Unsure
December 1988	14.1%	83.8%	2.1%
December 1987	15%	82%	3%
January 1987	29%	69%	2%
	I would let my child attend school with a child who has AIDS.		
	Yes	No	Not Sure
December 1988	83.9%	11.5%	4.6%
December 1987	81%	10%	9%
January 1987	59%	25%	15%
	Would you eat in a restaurant if you knew a food handler there had AIDS?		
	Would	Would Not	Not Sure
December 1988	46.2%	50.2%	3.7%
December 1987	37%	55%	8%
January 1987	33%	61%	5%
	If you share a drinking glass with someone who has AIDS, you can get it.		
	Yes	No	Not Sure
December 1988	14.5%	79.6%	5.9%
December 1987	18%	73%	9%
January 1987	21%	61%	18%

*Sample size: December 1988 - 513
December 1987 - 521
January 1987 - 450

Meet:

Gruff, Tough, and No Bluff



The Surgeon General says we should stop being a nation of risk takers—starting with the biggest risk takers of all, our kids.

C. Everett Koop, M.D., Surgeon General of the United States since 1981, has been making the point—forcefully—that personal behavior has consequences for health. The former professor of pediatrics and pediatric surgery has sent a letter about AIDS into every American home, said that to avoid AIDS teenagers should know how condoms work, and labeled cigarette smokers as drug addicts.

Dr. Koop's second term as Surgeon General (not coterminous with that of the President) runs until November 1989. Recently NEA Today staff writer Nancy Needham asked Dr. Koop what teachers need to know about the health status of our nation's youth as the year 2000 approaches.

Can teachers expect any sudden changes in student health in the next decade?
That's a tough question. In 1979, I would have said no. Then we had a surprise like AIDS. And I think our hopes for a cure will have to be postponed until after 2000.

What are the AIDS estimates for children?
A new federal report predicts that by 1992 between 10,000 and 20,000 children under 13 will be infected with HIV [human immunodeficiency, or AIDS, virus]. AIDS could soon become one of the five leading causes of death for U.S. children. It's already among the top 10.

So far only 1,278 cases of AIDS have been diagnosed in children under 13 and 322 cases in teenagers 13-19. But we have to assume that many more are asymptomatic.

What kids are HIV-positive?
Older ones—aged 15 to 24—are most at risk for HIV infection. And the risk is greatest in inner cities, where AIDS continues to be spread by intravenous drug abuse as well as sexual behavior. Most of these kids probably don't know they're infected.

The other expanding group is children born with HIV. Two out of three children of infected mothers—usually those same young drug abusers or sexual partners of drug abusers—have HIV at birth. Three-quarters of the children diagnosed with AIDS are Black or Hispanic.

Will kids born with AIDS survive to reach school age?
Right now 65 percent of children born with the AIDS virus survive their first year. Unlike children with leukemia, say, children with AIDS respond worse than adults to drug treatment.

But now we can identify the HIV virus—as opposed to antibodies—directly. So we can start treatment of children born with HIV before they get sick.

This will at least prolong their lives, not cure them. But because different children react differently to the virus, some will survive longer—maybe long enough to reach school age.

What will happen to kids infected with AIDS by the blood supply?
Some of these youngsters will die; others may survive and graduate from high school. Eventually this group will disappear from the schools, because the blood supply has essentially been safe since 1985 and there won't be new cases.

Kids who were infected before 1985 and haven't yet gotten sick with an AIDS-related disease may still develop symptoms. AIDS has been known to show up as long as eight years after infection.

What about teens who get AIDS because of their own sexual or drug-abusing behavior?
So far we haven't been able to

get a handle on prevalence in high school students. In November the group picked up preliminary figures from a CDC study of HIV-infected college students. On the basis of one fifth of the sample, they calculated the rate at 3 cases per 1,000 students — much higher than any of us thought. Compare the rate of 4 cases per 1,000 prisoners.

When you say college kids like this and they turn out to be savvy naive—to have HIV in their blood—the likelihood that they were infected while in high school is very great. The final rate may be higher or lower. But it doesn't augur well for the future.

Assuming there are asymptomatic HIV-positive students in school, are there circumstances—on the football field, say, or in a knife fight—where blood-to-blood passage of the virus could occur?

I don't think teachers should worry about blood and semen—the two carriers of the AIDS virus—in school.

Danger from semen is minimal. As for blood in a knife fight, transmission is possible.

But AIDS is a tough disease to pass. The chances on the athletic field would be extraordinarily low. You could possibly pass hepatitis that way, but not AIDS.

What does the spread of AIDS among youth imply for teachers?

The message for teachers is that we can't slacken teaching about sexually transmitted diseases (STDs)—especially AIDS. It looks as if high school kids are getting AIDS—and that's frightening.

I think everyone would agree that in 1987 teens heard more about avoidance of STDs than ever before in their lives. Yet that was the year that rates of infectious syphilis and penicillin-resistant gonorrhea rose more steeply than in any of the previous 16 years.

How would you structure a school health curriculum on STDs?

I'd identify three stages of teaching about contagious disease.

When kids are young, you explain that you cover a cut with a Band-Aid because something in the environment is dangerous to them.

In the next stage you tell them not to *someone* or grandma. The child learns there's something in him or her that can harm others.

Then maybe in grades 7-9, depending on preparation, you recall the earlier lessons about the Band-Aid and the sneeze and talk about another way to get another kind of disease—AIDS—through sex and blood contact. You tell them this disease is incurable and 100 percent fatal.

You've said that the best defense against sexually transmitted AIDS is abstinence for teenagers, monogamy for sexually active adults, and a latex condom with spermicide for the others.

As a doctor, would you want your grandchildren to be told in school how to use a condom?

I don't fear my grandchildren being told that, because their parents have trained them in morality: in taking responsibility for their sexual behavior.

But since no one can guarantee abstinence and monogamy, you have to let people know about the alternative. I have discussed that with clergy of all faiths; most understand.

The ideal instruction in human development, including sex, would involve a partnership of parents, schools, clergy, and civic groups. If one is weak, the others can take up the slack.

But I think parents shouldn't be frightened about what their children learn in school. They should use the occasion to teach their own values. There are sex education curricula to help parents do that.

What about disease prevention generally? How do we train children for "wellness?"

Let me start at the other end of life. There's a mismatch between our aspirations for health care and our resources to pay for it. Because of that, there's a good chance that traditional medical ethics are going to be overrun, and the elderly will be disenfranchised. So people need to be in the best shape possible when they reach old age.

All kids have their lives in their own hands. Sound practices and life styles will affect how they'll live and what diseases they'll get.

Right now, the factors that most affect—one way or the other—the chance of getting disease are smoking, alcohol use, drug abuse, exercise, nutrition, screening for blood pressure and cholesterol, and stress avoidance.

Notice that all except the two types of screening are in the hands of individuals, and children can be taught about them throughout childhood.

You've set as a goal the "Smoke-Free Class of 2000"—which the NEA Health Information Network is also working for. What about drinking?

Drinking is different from smoking. With smoking you can assume that everyone is at risk for developing disease, so no one should smoke.

In families without special risks from alcohol use, should parents train their children to be just social drinkers—i.e., people who don't drink to get high?

I think they should trust their children to postpone drinking until they see what happens to them. In my day you could promise a kid a gold watch if he or she didn't drink until age 21. Now I suppose it would take a BMW, but parents should encourage postponement.

As educators we're dealing with risk takers—young people under 21—who don't know the word don't.

Look at the risks kids are willing to accept—and for what? Teenagers don't all drink from peer pressure; many drink to achieve a condition—a high.

Drug use may be going down, but alcohol use is going up. The average age of first use of alcohol is dropping—it's down to 12.8 years. Especially when kids come home to an empty house, if there's a liquor supply where they can get at it, it's easy for them to get started.

What are the priorities for health care for youth?

Health priorities vary in different places. For many kids the problem is access. There are 33 to 37 million people in this country who are uninsured or underinsured for health care. A decade ago 65 percent of poor Americans were covered by Medicaid. Recently the figure has been less than 40 percent.

A related chronic problem that AIDS has made clear: there are people—drug abusers, some homosexuals, prostitutes—who have always gotten their medical care outside the system—often in emergency rooms. Poor families use emergency rooms the same way. We need to give everyone—including children—access to continuous medical supervision.

Children injured, dead as a result of their own behavior? Have adults left young people too much to their own devices in recent years?

One piece of evidence is the number of hours kids are allowed to spend in front of the TV set—or what they see.

In a study of ninth graders in four Michigan cities, kids averaged 1.3 hours a day on soaps, 3 hours on prime time TV. Sexual intercourse was depicted 1.5 times an hour on the soaps, 1.3 times an hour on prime time. About 80 percent of the girls said they had seen the top six X-rated movies. Nobody had asked them their age.

And cable is worse. It's unbelievable what you can see if you have 40 cable channels.

From all of these influences, kids have developed a whole different attitude toward life than a proper. That's what teachers must help to change.

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF PUBLIC HEALTH
SECTION OF EPIDEMIOLOGY

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STEVE COWPER, GOVERNOR

INFECTIOUS DISEASES
AIDS/STD
TUBERCULOSIS
IMMUNIZATION
CHRONIC DISEASES
DIABETES
INJURY CONTROL

561-4406

February 8, 1989

The Honorable Bill Hudson
Box V
Juneau, Alaska
99811

Dear Sir:

The Alaska AIDS Prevention Program (administered by the Alaska Department of Health and Social Services through the division of public health, section of epidemiology) targets various audiences to deliver health education and/or risk reduction messages. Among the audiences are the general public, Alaska Natives, and school-age youth.

We conduct a yearly survey among several of these audiences to assess levels of AIDS-related knowledge, attitudes, and beliefs. One audience is the general public. This year, in addition to questions related to knowledge and beliefs, we asked the following:

1. Should education about AIDS be taught in school as part of a comprehensive health education curriculum?

2. Do you think that a comprehensive health education curriculum should include instruction on condoms as a preventative measure?

Of those responding (513) 95.8 % said "yes" to question one; 85.2% said "yes" to question two.

Of those who said AIDS education should be taught in some other curriculum, 9% said in clinics, 1.2% in homes, 2% in church, and 2% said it should not be taught at all.

Our survey also found that those who rely on family or friends for information about AIDS constituted the most misinformed group about AIDS and transmission of the virus that causes AIDS, the human immunodeficiency virus (HIV).

Education is the only prevention strategy available to us to slow or stop the spread of the AIDS epidemic. People must have accurate information about AIDS and HIV transmission if they are to protect themselves. The AIDS Program has been working closely to implement the recommendations of the U.S. Surgeon General which include sex education in schools.

In addition, a recently published report issued by the U.S. Secretary of Health's Work Group on Pediatric HIV Infection and Disease recommends establishing AIDS education as part of a comprehensive health and safety education program. The group also recommends that state governments consider requiring HIV education as a condition for funding at the local school level. The report cites many reasons for its recommendations. Among them are the following:

*AIDS has become the 9th leading cause of death among children 1 to 4.

*AIDS is the 7th leading cause of death among young people 15 to 24.

*AIDS will become one of the top 5 causes of death among children within the next 3 to 5 years.

*Every 31 seconds in the U.S. an adolescent becomes pregnant.

*Nearly half of all high school seniors nationwide have used an illegal drug at least once and almost 90% have used alcohol.

*Every 78 seconds an adolescent attempts suicide.

*Every 90 minutes one completes suicide.

Every 20 minutes an adolescent is killed in an automobile crash.

*Every 80 minutes an adolescent falls victim to a homicide.

*Nearly 25% of all reported cases of sexually transmitted diseases (STDs) occur in adolescents.

*2.5 million teenagers (one out of 7 teens aged 15 to 19) contract an STD each year.

The report also notes that heterosexual transmission may play a greater role in passing HIV in adolescents than in adults. Nationally among adults with AIDS, the male to female ratio is 12:1; in adolescents it is 7:1.

Nationally 84,133 cases of AIDS have been reported to the federal Centers for Disease Control as of January 16, 1989. Of these 337 (less than one percent) were in the 13 to 19 year olds. However, 17,399 (21%) were 20 to 29. Because of the long incubation period between the time of infection by HIV and development of AIDS, it is certain that some of the 21% contracted the virus while teens.

The figures relating to behaviors among young people nationwide warn us of the potential for HIV transmission in a group which could pass the virus to another generation. The cohort of young people currently between 11 and 24 is unusually small to begin with. If AIDS makes serious inroads into this group, the economic consequences will be disastrous.

I am happy to share this information with you and enclose a copy of the Report of the Secretary's Work Group on Pediatric HIV Infection and Disease. I also enclose a copy of our survey and a copy of the federal Centers for Disease Control study on "HIV-Related Beliefs, Knowledge, and Behaviors among High School Students."

Sincerely,

Marvin E. Bailey, Ph.D.
Health Education/Risk Reduction Coordinator
Alaska AIDS Program

Enclosures

HB/ts

January 26, 1989

Copy of Representative Hudson's Floor Speech

Today I introduced legislation relating to health education in our public schools. The measure requires the state Board of Education to work with local advisory committees in each school district to implement health education addressing community health, environmental health, family life, growth and development, nutritional health, mental health, personal health and fitness, prevention and control of diseases and disorders, safety and accident prevention, substance use and abuse, and reproductive health.

Section 14.30.366 on page 4 provides for an exemption from instruction in reproductive health, family life, pregnancy prevention and from instruction in sexually transmitted disease, at the discretion of parents.

Children of all ages need to learn how to make valid and informed decisions regarding their health, emotions and life styles. They must be informed of risks, their responsibilities and how to make life choices. By educating children, they will be able to make responsible decisions and we will begin prevention of unplanned teenage pregnancy which causes school drop out, high risk infants with high public medical costs, increased welfare expenditures and teen parents with little or no employment skills.

The government is asked to pick up the pieces and solve the problems we face because of drug and alcohol abuse, AIDS, higher rates of suicide and child abuse, and we pay a high price financially. We also pay a high price socially.

Some statistics you all have seen before:

- Every day six Alaskan teenagers become pregnant.

- Alaska's teen pregnancy rate is 13 percent higher than the national average.

- The teen pregnancy rate of Alaska Natives is 70 percent higher than the national average.

- The suicide rate among adolescent parents is seven times that of non-parenting teens.

- Alaska Natives have the highest rate of Fetal Alcohol Syndrome (FAS) of any population studied in the world.

- Although teen mothers make up nine percent of all babies born in Alaska, they account for seventeen percent of all infant deaths between the ages of six months and one year.

- Sixty percent of all Aid to Families with Dependent Children (AFDC) recipients had their first child as a teen.

- Pregnancy is the most common cause of female student's dropping out of school.

- There were 708 drug arrests in Alaska in 1986. Thirty three percent of the arrests were for youth under age 18.

- Between July 1985 and December 1987 625 Alaskan IV drug users were identified as being at risk of AIDS.

- There were 641 youth age 17 and under treated for substance abuse in Alaska in 1987.

- Teens are more susceptible to sexually transmitted diseases due to increased probability of multiple partners.

- The number of 10 to 14 year old youth with gonorrhea in Alaska in 1985 was 30.

- The number of 15 to 19 year old youth with gonorrhea in Alaska in 1985 was 510.

It's time our communities started a realistic plan to help our children, and to decrease hazardous behavior patterns affecting each of us. The consequences of children having children is enormous for our kids, but stop and consider for a moment that tomorrow's work force and leaders are being born today. We must have them healthy, educated and well

adjusted. According to Ms. Edelman of the Children's Defense Fund, "in 1950 there were 17 workers for each retiree, but by the year 2000 there will be five workers for each retiree. If current trends continue, at least one out of every four will have lived in poverty and one out of every five will have been a teen parent."

This bill is modeled after legislation passed in 1988 by South Carolina. Like most legislation, it came to me through concerned citizens: a public health administrator and two parenting community leaders. Because there were so many organizations who supported the legislation in that state, I'll only name a few:

the American Association of University Women
the Columbia Medical Society;
the Council on Child Abuse and Neglect;
the Episcopal Diocese
the League of Women Voters;
the Lutheran Church
the March of Dimes,
the South Carolina Education Association;
the South Carolina Christian Action Council;
the South Carolina Baptist Convention and
the South Carolina Association of School Administrators.

Attached is a complete list of organizations who supported passage in South Carolina.

It's time we assert some leadership in this growing problem and start arming our kids through education, through early knowledge, during their most normative years to avoid early pregnancy, the spectre of suicide, school drop out and the terrible shadow of AIDS.

Let's give them hope and confidence

Let's take the challenge other states have already taken. I invite you to join me in the effort to address the problems facing our children and our great state by cosponsoring this bill.

Thank you.

BH:lkh

ADVOCATES FOR COMPREHENSIVE HEALTH EDUCATION LEGISLATION

American Association of University Women S.C. Division

American Association of Sex Educators, Counselors and Therapists

American Heart Asso., S.C. Affiliate

American Lung Association

Baptist Educational & Missionary Convention of S.C.

Charleston YWCA

Clemson Extension Service

Columbia Medical Society

Community Care - Columbia

Council on Child Abuse and Neglect

Episcopal Diocese of Upper S.C.

Family Service Center

Greenville Council on Teenage Pregnancy

Greenville YWCA

League of Women Voters of S.C.

Lutheran Church in America, S.C. Synod

Lutheran Church Women of S.C.

Lutheran Social Services of Central S.C.

Lutheran Theological Southern Seminary

March of Dimes, S.C. Chapter

Mental Health Asso. of Aiken Co.

Mental Health Asso. of S.C.

National Association of Social Workers

National Council of Negro Women

Palmetto State Teachers Assoc.

Planned Parenthood of Central S.C.

S.C. Academy of Pediatrics

S.C. Academy of Family Physicians

S.C. Asso. for Health Education

S.C. Asso. for Health, Physical Education, Recreation and Dance

S.C. Asso. of School Administrators

S.C. Baptist Convention

S.C. Business & Professional Women's Clubs

S.C. Christian Action Council

S.C. Commission on Women

S.C. Congress of Parents and Teachers

S.C. Council on Family Relations

S.C. Dietetic Asso.

S.C. Dept. of Education

S.C. Dept. of Health & Env. Control

S.C. Dept. of Youth Services

S.C. Developmental Disabilities Council

S.C. Education Association

S.C. Healthy Mothers/Healthy Babies Coalitio

S.C. Home Economics Asso.

S.C. Medical Association

S.C. Medical Asso. Auxiliary

S.C. National Organization for Women

S.C. Nurses Association

S.C. Perinatal Association

S.C. School Boards Association

S.C. State Board of Education

State Council, Maternal, Infant, and Child Health

Teen Pregnancy Reduction Network

United Methodist Church, S.C. Conference

YWCA of the Midlands

YWCA of Sumter

2/25/88

Our Greatest Natural Resource

Investing in the Future of Alaska's Children

A report of the Governor's Interim Commission on Children and Youth

TEEN PREGNANCY

Teenagers who come from lower socioeconomic backgrounds, don't go to school, have difficulties in school, are unemployed or live with only one parent begin sexual activity earlier and are less likely to use contraception than other teenagers. Alaska Natives are affected far out of proportion to their percentage of the population. While divorce and single parenting cut across ethnic and economic lines, Alaska's divorce rate is 60% higher than the national average, second only to Nevada's, and no one comes here to divorce.

Although family life and sex education alone cannot prevent teenage pregnancy, national research shows that states with a higher proportion of high school seniors who have taken sex education have white teenage pregnancy rates 5 points lower than other states. Across and within Alaska's school districts the timing and comprehensiveness of health, sex and life skills education varies widely.

Low birth weight accounts for two of every five Alaska infant deaths. Teenagers have a higher risk of bearing low birth weight babies because of their physical immaturity and because they receive significantly less adequate prenatal care compared with older women.

More than a third of Alaskans are under 18, and the state has the second highest birth rate in the country. Unless we take strong and clear actions now, teenage pregnancy in Alaska will increase and so will the social and economic problems that accompany it: school dropout, unemployment or low wage employment, infants enrolled on Aid to Families of Dependent Children with higher than national rates of anemia and fetal alcohol syndrome, child neglect, single parenting and unstable marriages. These problems cost us money. So teenage pregnancy is a major emerging threat to Alaska's economic health.

- Alaska's teenage pregnancy rate is 13% higher than the national average, the ninth highest in the country.

- The Native teenage pregnancy rate is estimated at 70% higher than the national average.

- Alaska's infant mortality rate is ninth highest in the nation.

- The children of teenagers account for 10% of births, but they account for 16% of infant deaths.

- Only 41% of non-white and 50% of white Alaska teenagers receive adequate prenatal care, resulting in low birth weight babies with a higher chance of death.

- While improvement has been made, Alaska still serves only 27% of those eligible for the federal Women and Infant Care program that provides basic nutrition, education and other services, placing us 48th lowest in the nation.

Child Care for Teenage Parents: 74

Teenagers who become parents simply cannot stay in school without adequate child care. Teenage pregnancy is the primary reason young women drop out of school. While research shows that a teenager who drops out also has a higher chance of then getting pregnant, a teenager who first gets pregnant and then drops out has half the chance of ever completing her diploma. The occupational, parenting, health and social effects of that failure are well-documented.

Funds need to be appropriated to support a variety of child care options for teenage parents. Teenagers who are not yet parents can also learn parenting skills and the enormous demands of young children if child development centers are housed in schools. Parenting and life skills education that teenage parents receive in school can be made more realistic in the real setting of a good center.

Child care and other supports for teenage parents should be provided to enable them to stay in school.

Teenagers who become parents simply cannot stay in school without adequate child care.

Sex Education and Family Planning Services: 75

Alaska's gonorrhea rate is seventh in the nation and our teen pregnancy rate is the ninth highest. AIDS is an emerging issue in our state as well. Despite these facts, and our best intentions, half of all teens have sexual intercourse before they leave high school. Since research shows that only one-third of sexually active teens regularly use contraception, an increase in contraceptive education as well as increased funding for family planning services for teens is essential as part of a comprehensive pregnancy prevention plan. Education can provide the skills to make choices about sexuality and a forum for discussing the health and emotional risks of early sexual involvement, as well as information about contraceptives that includes both risks and benefits in preventing teen pregnancy and sexually transmitted diseases. Preventing pregnancy among those teens who choose not to abstain is an important goal.

Education about sexuality should be more widely available to teenagers, as should family planning counseling and services to help prevent pregnancy. These programs should stress the health and emotional risks of early sexual involvement and ways to prevent pregnancy and disease if youth choose to engage in sexual activity. Education for parents to help them as sex educators of their own children should also be supported to help delay the onset of sexual activity and improve family communication.

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Letters

First, We Must Recognize Problems of Children

To the Editor:

I was pleased to see "The Candidates and Poor Children" (Sept. 25), which began your series of editorials on disadvantaged children. I agree with it and with Senator Daniel Patrick Moynihan's Op-Ed article the same day, but I think the problem requires an even broader, more radical change than you and he advocate.

Americans cling to the myth that they love children, but more and more of our children are born drug-addicted, grow up homeless and become "emotionally disturbed."

As a children's counselor, I work with children 5 to 16 years old, who live in residencies and hospitals and are labeled "emotionally disturbed." In many ways they seem like "normal," "healthy" children. One of the key differences is how much anger and fear they have. They express these feelings by temper tantrums, hallucinations, running away, stealing, lying, setting fires and in general causing harm to themselves, to others, to animals or property.

The histories of the children where I work are often similar. A tremendously high percent come from alcoholic or drug-addicted homes and have been abused. At the hospital where I work it costs $400 a day to shelter, feed, supervise and counsel each "emotionally disturbed" child. Staff members help them express their fear and anger, build self-esteem and develop abilities to control their behavior. Without help (and often despite the help), these children commonly grow up to be pregnant teen-agers, prostitutes, abusive and neglectful parents, alcoholics, drug addicts, rapists and other criminals.

I agree that most Americans are unwilling to look at the contradictions between our beliefs and the reality in this country. People are immersed in their own lives and have bought too willingly a belief that nothing can be done. This denial and lack of passionate, active response to the problems of children in this country is itself an "emotional disturbance" plaguing our nation.

CAROL WINTLE
Cambridge, Mass., Sept. 25, 1988

A Staggering Bill

To the Editor:

"A Fair Chance for the Mother" (editorial, Sept. 26) inadvertently misstated figures from the Center for Population Options describing the cost to taxpayers of families begun by teen-agers. We have mixed news to tell.

The good news is that taxpayers need not expect to spend $38,700 a year for 20 years to support a family begun by a teen-ager. This figure describes the total Federal bill for a family started by a teen-ager in 1987, assuming the mother receives welfare for about eight years.

The bad news, however, is that we spend more than $5.7 billion a year on families begun by teen-age mothers. The actual figure is staggering — more than $19 billion. The $5.7 billion figure refers to families started in 1987 only and describes welfare costs over 20 years, adjusted for probable length of welfare dependency and the likelihood of the mother's having more children.

However, $19 billion is what we paid in 1987 alone for all families started by teen-age mothers, whether the mother had her first baby in 1968, 1976 or any other year. It's the cumulative bill we pay for adolescent pregnancy. Next year we will pay at least $19 billion more, and we will pay another $19 billion the year after that.

Compare that $19 billion with how much we spent on prevention programs in 1987 — a mere $136 million for family planning services, for example. We need to spend money on preventive programs and break the horrible cycle of poverty.

We urge both Gov. Michael S. Dukakis and Vice President Bush to make children at risk one of their top priorities.

JUDITH SENDI ROWITZ
Executive Director
Center for Population Options
Washington, Sept. 28, 1988

Punish the Parents

To the Editor:

You are terribly mistaken if you believe that more government programs to care for children will solve the problems of poverty, illegitimacy, school failure, crime and drugs. As you point out ("A Fair Chance, Even Before School," editorial, Sept. 28), "much has changed in two decades." We are becoming a child-directed, immoral society, in which parents increasingly lack the character to control the behavior of their children and accept responsibility for their own failure.

You say that "social attitudes have changed" because churches and civic organizations now support day care. The fundamental change is that illegitimacy, irresponsibility and immorality are becoming quite acceptable — not in one particular social stratum, but to you as well.

You don't propose spending money to prevent teen-age pregnancy, nor to abort the products of teen-age immorality, nor to take bastard children away from parents who handicap them so badly and to bring them up by the state in sanitary, controlled conditions with a chance to avoid early pregnancy, disease, crime, drugs. No! You propose further reducing the responsibility of individuals for their acts by making it all right to bring up a child on welfare without a father, living among prostitutes and drug addicts in a welfare hotel, and dependent on a brainless, immoral child-mother who is herself almost a ward of the state.

It may indeed be true that all those nice programs you support improve "the life chances of poor children." But even you, wearing your best do-good hat, must know that in the long run they can never do more than slightly slow the swelling tide of parentless, uncontrolled, rootless, uneducated, poor, drug-driven criminals we are raising.

Let's spend the money on the children — not on the parents, who caused the tragedy. Save the children before they become just like their parents. Punish the parents, don't encourage them!

EDWARD PFIZER
Pinehurst, N.C., Sept. 29, 1988

Problem Is Global

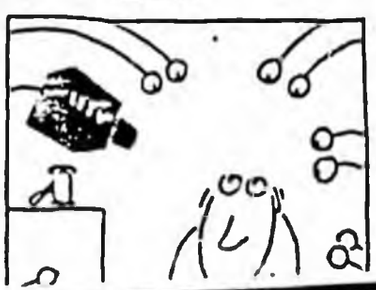
To the Editor:

"The Candidates and Poor Children" (editorial, Sept. 25) speaks eloquently on one of the great issues of our time. Although you speak of poor children domestically, it is a global tragedy. In our children die daily of hunger and malnutrition. If the pundits gets filled with [illegible]

Cameras Go Into Court Looking for Drama

To the Editor:

You report that 88 percent of the applications for coverage of New York State courts by television, radio and newspapers have been approved by presiding judges (news story, Sept. 22). But you fail to address the coverage that is most intrusive: how the trial and likely its outcome are [illegible]



AMERICAN ASSOCIATION OF UNIVERSITY WOMEN
SOUTH CAROLINA DIVISION

STATEMENT BEFORE K-12 SUBCOMMITTEE OF HOUSE EDUCATION & PUBLIC WORKS COMMITTEE

April 21, 1987

I am Barbara W. Moxon, State Legislative Chairman of the American Association of University Women, representing 900 members in 21 communities across S.C. We have long held a position supporting health, family life and sex education in the public schools so we strongly back H.2734. As a mother of 3, grandmother of 4 and active churchwoman I have felt personally for many years that all schools need to be involved in teaching these subjects. The need is overwhelming when you realize what our youth are exposed to in the media everyday. They are surrounded by overly-romanticized and sexually stimulating messages and activities on radio, TV, in magazines, on billboards, in newspapers, in music, and yes, in school lavatories. Schools must teach children how to use their bodies and emotions responsibly. This does not mean to exclude parents. Parents, churches and schools must all be involved, especially recognizing that some parents won't or can't, and churches do not reach all youth.

But this bill is not primarily a sex education bill. The bill establishes a comprehensive health education program in our public schools. Yet no where except in the bill have I read or heard this defined. I am convinced most people who talk about it or take a stand do not know what the bill says. So I shall spell out its definition here: it says that for grades K thru 8 comprehensive health education must include: community health, consumer health, environmental health, growth and development, nutritional health, personal health, prevention & control of diseases & disorders, safety & accident prevention, substance use & abuse, dental health, and mental & emotional health. Can there be reasonable parents anywhere who would not want their children to learn about these subjects? Considering that accidents are the #1 cause of death for older teens, don't we want to save lives by teaching safety & accident prevention?

We also strongly back the reproductive health, family life and pregnancy prevention education, but want to point out that the bill allows the latter two to be included at the discretion of the local school district. We heartily agree with the Governor that family life education should be required in grades 9-12. Reproductive health education is mandated only for grades 6 thru 8 and at least once during grades 9 thru 12. But parents may exempt their children from this if they wish.

It is important to understand that this bill gives local control to school boards which is important because of the diversity amongst our 92 school districts. They may develop their own curriculum depending on the needs of their community with in-put from parents, clergy, health professionals, and teachers. OR a school district may choose a curriculum developed by the State Dept. of Education.

It seems to us that education in all of these areas is as important to today's students as history and geography. It involves knowledge needed for healthy and successful living. And the use of this knowledge will prevent problems & save lives and money, money for example spent for teen mothers who have high risk infants requiring high medical costs, and who go on welfare.

A most important feature of the bill is that parents who believe the health education program conflicts with their family's beliefs may exempt their children from any portion of it. So how can any parent object to this bill.

However, we recommend the bill be amended to allow such exemptions only for

12/87
Teen Pregnancies

INTRODUCTION

Teen-age childbearing is very costly. It is estimated that teen-age pregnancies cost the United States $16.6 billion in 1985. By the time a child born to a teen-ager in 1985 reaches 20 years of age, taxpayers will have paid $15,620 in AFDC, Medicaid, food stamps, public housing and social services costs.[1] A study completed of California public schools estimated the cost of providing child care, transportation and support services to parenting teen-agers at $5,000 to $8,000 per person per year.[2] With nearly 500,000 yearly births to teen-agers, the long-term economic impact of delivering services to this population is staggering.

Equally important is the social impact. Teen-age mothers are more likely to experience low educational achievement, unemployment, single parenting, poverty and welfare dependency, pregnancy-related complications, infant mortality and child abuse.[3] With the potential benefit of saving millions of dollars and averting human tragedy, prevention of teen-age pregnancy is an important issue on state legislative agendas.

This legislative report will review three teen-age pregnancy prevention strategies. These strategies were selected because of their easy access to teen-agers and to illustrate the cost of implementation.

BACKGROUND

Most experts agree that early and comprehensive prevention strategies can be cost-effective. Options available to teen-agers once pregnancy occurs are all difficult and costly; therefore, there is an increased emphasis on preventing pregnancy in the first place.[4] A recent report by the National Governors' Association on teen-age pregnancy noted that "by most any social or financial measure, it is less costly and more effective to prevent pregnancy than to intervene in the consequences."[5]

Specifically, one expert estimates that seven million at-risk teen-agers could be reached with comprehensive prevention programs providing health services, drop-out prevention and job placement. This could be accomplished at a cost of $2 billion, compared to the $16 billion paid annually for families headed by teen-age parents, a one to eight ratio.[6]

The State Legislative Role. Legislatures are in an excellent position to have an impact on reducing teen-age pregnancy. The legislative roles in this regard are that of authorizing, financing and evaluating prevention programs. First, services and programs can be offered through the legislature's authorizing power. This authorization can be a mandate for the formation of a task force, a study or a program.

State legislatures' financing roles vary from state to state, but can involve earmarking federal pass-through funds, directly allocating state funds, and setting fee-for-service charges. A legislature can be responsible for determining the appropriate level, as well as combination of funding, for teen-age pregnancy prevention programs.

Legislatures also can perform important oversight and evaluation functions. Legislative committees may conduct hearings to evaluate program progress and determine the impact on the target population. They may also

commission a study or conduct an actual site evaluation of prevention programs.

Accessibility and Acceptability. Two important considerations for legislatures examining prevention programs are the issues of accessibility and acceptability.[7] Services may not always be readily accessible to teen-agers because they are located in areas where teens do not congregate. Program planners should consider placing services in locations that are easily reached and are comfortable to teen-agers. This will increase the likelihood of the services being used.

The second consideration in program design is acceptability. Programs should reflect the teen-agers' needs and attitudes if they are to be utilized. Additionally, parents, legislators and community leaders should find pregnancy prevention programs that are acceptable within their community.

PREVENTION STRATEGIES

Schools can be a good place to reach teen-agers with pregnancy prevention programs. First, teen-agers are required to attend school until they are 16 years of age in most states. Schools, therefore, provide a captive audience; access is excellent. Secondly, the successful school programs require parent, student and community input, so acceptability can also be excellent.

Family Life Education. One school-based program that may prove to be an effective prevention strategy is family life education (FLE). Family life education encompasses instruction in human sexuality, family planning, interpersonal relations, decision-making skills and positive role-modeling. Instruction is provided as part of the regular curriculum and can be adapted to any grade level.

A comprehensive family life education curriculum encourages responsible sexual decision-making and explains human sexual development in a supportive learning environment. Researchers and practitioners agree that this approach helps to dispel many myths about human sexuality and provides transferable decision-making skills to teen-agers. New Jersey has had a great deal of success with its family life education program.

The New Jersey Initiative. In 1980, the New Jersey State Board of Education required that all public school districts provide programs in family life education in both junior high and senior high school. Four areas of instruction are addressed: interpersonal relationships, human sexual development, responsible personal behavior, and the creation of strong families.[8]

This initiative has received wide acceptance and support. All students, regardless of ethnicity, socio-economic status and school location receive FLE instruction, making it a nonstigmatizing program. The program provides for community involvement in the development of curriculum and selection of books, and parents have the option of excusing their children from participating in the classes. Most important, full responsibility is given to local school districts for curriculum development and program implementation.[9]

The Irvington Public School System in Essex County, New Jersey, has been cited for its innovative comprehensive family life education program. Irvington serves 10 schools with nearly 9,000 students. A recent survey of

parents in the school district demonstrated that most were aware of and approved of the FLE program. Less than one percent of all parents excused their children from even one lesson.[10]

The cost of implementing the program was estimated at $20,000 for materials plus the salary of a coordinator. The funds were raised by the local school board and most of the start-up money was spent acquiring materials for specific grade levels. The proposed budget for 1987-88 is $22,500.

The family life education program was initiated by the State Board of Education and therefore, the legislature did not perform any authorization or financing functions. However, there are three states--Illinois, Michigan and Tennessee--that have legislative mandates to provide family life education programs.

School-Based Health Clinics. A second prevention strategy that offers high accessibility is school-based health clinics. The clinics are designed to provide health screening, diagnosis and education programs to all students, thereby meeting overall health care needs while working to reduce teen-age pregnancies.

Currently, there are 101 school-based clinics operating in 28 different states, with several scheduled to open this year.[11] Recently, Michigan approved funding for 100 new clinics, New Jersey allocated $6 million for its school-based youth services program, and Wisconsin authorized $1 million for teen-age pregnancy prevention, including school-based clinics.*

Most school-based clinics offer a variety of services aimed at serving an entire school population. Services may include, according to local preferences, athletic physicals, health assessment, laboratory and diagnostic screening, immunizations, first-aid and hygiene, family planning counseling and services, prenatal and postpartum care, day care, drug and alcohol abuse programs, and nutrition and weight reduction programs. In nearly all clinics, written parental consent is required to receive services.

Funding for school-based clinics is usually obtained from three sources. The typical clinic derives approximately 64 percent of its support from public sources (48 percent federal and 16 percent state), 36 percent from private sources such as foundations, and 2 percent from patient fees.[12] The actual cost of operating a school-based clinic ranges from $25,000 to $250,000 per clinic, or $100 to $125 per student annually for reasonably comprehensive care.[13]

St. Paul School-Based Health Clinic. The St. Paul School-Based Health Clinic Program is a cooperative effort between the school district, the health-care facility and the public welfare system that began in 1973. Health services are offered at four local high schools with staff provided through the St. Paul-Ramsey Medical Center and the local social services agency. Services are comprehensive, ranging from minor illness treatment to more extensive counseling and referral. Clinic staff also have developed a human sexuality curriculum for both junior and senior high students.

* Information gathered from the Center For Population Options.

The St. Paul clinics are often cited for their expertise in adolescent health education and for the longevity of the program. Over 2,000 students are seen annually through the clinics and many more are reached through the educational programs. Results indicate teen-age pregnancy and repeat pregnancies have continually declined; teen-agers who are sexually active are more careful about contraceptive use; and increasing numbers of teen-age mothers are graduating from high school.[14] Expenditures for calendar year 1986 were $1.3 million, which included day care and prenatal and post-partum care.

The Minnesota Legislature has an important relationship to the program, since it appropriates federal pass-through funds the clinics will receive. Additionally, the legislature is conducting public state-wide hearings on the possible expansion of school-based health clinics.

Community-Based Prevention Strategies. At-risk teen-agers, who are not being reached at school or who have left school, may be reached through community-based programs. These programs may be particularly important for reaching teen-age males, since studies indicate that males are typically older than their female counterparts and are therefore sometimes out of high school.

Community-based strategies are designed to provide coordinated, comprehensive services to the at-risk teen-age population. They require wide community participation by local community agencies, health departments, interested citizens and political leaders, which reduces duplication of services and creates an expanded network for outreach to teen-agers. The outcome can be effective and economical service delivery.

Illinois has initiated just such a comprehensive and coordinated teen-age pregnancy prevention strategy that has several community-based programs.

The Illinois Parents Too Soon Program. Initiated by Governor James Thompson in April 1983, Parents Too Soon is a multi-agency cooperative program designed to prevent teen-age pregnancies and assist those teen-age parents who do become pregnant. The program funds 125 community-based programs and operates a toll free hot-line that teens can call for referrals to programs in their area.

Medical, social, nutritional, educational and vocational services are offered through contracts with the Department of Public Health and the Department of Children and Family Services. The contracting agencies represent local health departments, hospitals, community health agencies, mental health agencies, family planning agencies, Catholic Charities, Lutheran Services, YMCAs and YWCAs, and local school districts. Services include helping teen-agers with their communication, decision-making and job skills. An educational component also helps teen-agers evaluate the consequences of an unwanted pregnancy.

Another service offered through the Parents Too Soon program is family planning counseling. Community-based family planning clinics provide pregnancy prevention information for teen-agers outside the school system. For comparative purposes, the cost of providing basic family services in these clinics is estimated to be $12 to $27 per visit.[15]

In 1984, Illinois secured 100 percent federal funding for developing these community programs. A total of $12.9 million was obtained through the Maternal and Child Health Grant, Social Services Block Grant, and Women, Infant and Children programs. Figures for FY 87 indicate that $1.9 million of the total program funds are now state-appropriated, with the remaining amount coming from federal sources.*

The Illinois Legislature conducts annual hearings on the progress and impact of the Parents Too Soon initiative. Lawmakers are also directly responsible for the allocation of both state and federal appropriations for the program.

POLICY IMPLICATIONS

Pregnancy prevention strategies targeted at teen-agers can be cost-effective alternatives to the financial burden of early childbearing. Family life education, school-based health clinics and coordinated community-based pregnancy prevention programs are three popular options available to legislators.

Three issues of vital concern to lawmakers in evaluating prevention programs for use in their states are cost of the program, accessibility of the program to the at-risk teen-agers, and the expected impact of the prevention program.

In terms of cost, family life education programs are perhaps the least expensive, costing approximately $5 per student per year (refer to Table 1). They are highly accessible to teens because they are located in the schools and are a part of the general curriculum (refer to Table 2). Due to their recent introduction and lack of standardization, these programs have received mixed evaluations in terms of their impact on teen-age pregnancy. Most experts agree, however, that the decision-making component of the course has a slightly positive impact on teen-age pregnancy prevention, while the biological facts component has neither a positive or negative impact.[16]

The family life education approach may be useful to those states that wish to begin a long-term prevention program with low start-up costs and high accessibility.

Community-based programs are more expensive than FLE programs. For example, family planning counseling alone costs around $25 per student per visit. The programs may have less of an impact than FLE programs because they are not located in the schools and adolescents must make more of an effort to seek out their services. Nevertheless, evaluation of the Parents Too Soon program indicates positive results: teen birth-rates have dropped, repeat pregnancies are down, children born to teens are healthier, and teens show higher educational attainment levels.[17]

These community-based programs may be attractive to states and communities where initiating prevention programs within the school system is a problem. They also may be useful in communities where there is a history of success in working together to solve local problems.

* Linda P. Miller, Parents Too Soon Program, September 1987, personal communication.

The school-based clinic is an alternative that may serve many different concerns. It is expensive relative to the other two options, averaging nearly $125 per student, but is highly accessible to teen-agers and appears to have a high impact on reducing pregnancy rates. Studies show that these clinics have a high usage rate and that they reduce fertility, drop-out and repeat pregnancy rates.[18]

School-based health clinics may be desirable in states interested in providing better health care to adolescents. They are helpful to communities where health care may be inadequate or inaccessible to teen-agers, such as in high-density urban areas or sparsely-populated rural areas.

Each state has individual needs and political climates which must be considered in developing teen-age pregnancy prevention strategies. There is no single answer to the question of which prevention strategy is the best. Deciding on a prevention strategy will depend upon the relative importance of cost, access and impact desired by the particular state. For the most part, legislators will be challenged to develop the best program for the least amount of money.

The Teenage Pregnancy Project joined the NCSL state services program in June 1987. The project has been funded by the Ford Foundation and is designed to provide state legislators and legislative staff with information and resources related to teen-age pregnancy and parenting, drawing from experiences in the 50 states. Major project activities are providing technical assistance, producing publications and contributing to the NCSL Annual Meeting.

On-site technical assistance is being offered to three different states each year. The assistance must be requested by a legislator, and typically takes the form of presentations, workshops or bill drafting. The project also includes writing and disseminating three publications a year describing successful state experiences. Topics to be explored in the first year are prevention of teen-age pregnancy, services for teen-age parents, and the results of a legislative survey.

Other activities include:

- Organizing an information clearinghouse, within a national computerized legislative information system, comprised of state legislative committee reports, interim reports, legislation and other pertinent resource materials that legislators can use in making policy decisions; and

- Developing a forum, by way of an advisory committee of organizations working in the field, for ongoing discussions of current research, model programs and successful state strategies.

For more information, contact Patrick Bustos or Heather Maggard in the Denver office at (303) 623-7800.

Table 1.
Prevention Program Costs

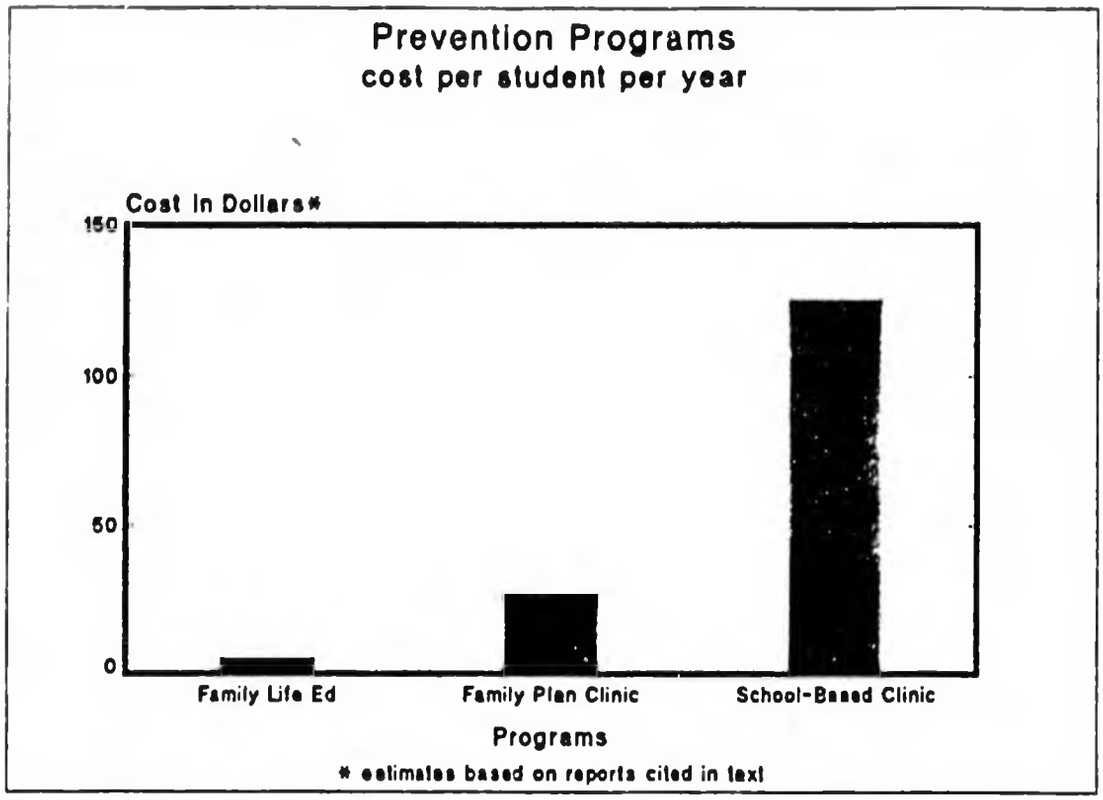


Table 2.
Program Evaluation Based On Selected Criteria

	Evaluation Criteria		
Program	Cost	Access	Impact
Family Life Education	Low	High	Inconclusive
Community-Based	Moderate	Moderate	Moderate
School-Based Health Clinic	High	High	High

Table 3.
States With School-Based Health Clinic Programs

Arizona	Maryland	New York
California	Michigan	Ohio
Colorado	Minnesota	Oregon
Connecticut	Missouri	Pennsylvania
Delaware	Mississippi	South Carolina
Florida	Montana	Tennessee
Illinois	North Carolina	Texas
Indiana	New Jersey	Virginia
Louisiana	New Mexico	Wisconsin
Massachusetts		

Source: The School-Based Clinic Update 1987, Support Center for School-Based Clinics

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FACTSFACTSFA

AT A GLANCE

Corrected version

NOVEMBER 1988

BIRTHS

In 1986, teens had 472,081 births. The number of births has declined since 1980 among all teens except those 14 and younger.

	1986	1980
births to females 14 and younger:	10,176	10,169
births to females 15-17:	168,572	198,222
births to females 18-19:	293.333	353,939
	472,081	562,330

BIRTH RATE

The smaller number of births is due primarily to a smaller number of teens; however a gradual decline in the birth rate has also contributed. By 1986, the birth rate among females aged 15-19 had declined to 51 births per 1000 females.

BIRTH RATE: BIRTHS PER 1000 FEMALES BY RACE AND AGE

	All Races				Whites				Blacks			
	<15	15-17	18-19	15-19	<15	15-17	18-19	15-19	<15	15-17	18-19	15-19
1986	1.3	31	81	51	0.6	23	70	42	4.6	70	141	98
1980	1.1	33	82	53	0.6	25	72	45	4.3	74	139	100
1975	1.3	36	85	56	0.6	28	74	46	5.1	86	152	112
1970	1.2	39	115	68	0.5	29	102	57	5.2	101	205	141

CHILDBEARING AMONG UNMARRIED TEENS

The proportion of teen births occurring outside of marriage has quadrupled since 1960, from 15% to 61%. The percent out-of-wedlock has increased among both black and white teens. The proportion outside marriage also increased among women in their twenties, but remains considerably lower than among teens.

PERCENT OF BIRTHS TO UNMARRIED MOTHERS	MOTHERS UNDER AGE 20			MOTHERS 20-24		
	Total	White	Black	Total	White	Black
1986	61%	49%	90%	29%	20%	66%
1980	48%	33%	86%	19%	12%	56%
1970	30%	18%	64%	9%	5%	31%

MARRIAGE AND COHABITATION

- In 1970, 69% of all women age 19 were single. By 1986, 85% were still single, enlarging the population at risk of premarital pregnancy.

- Cohabitation has become increasingly common among young Americans. Among youth in their early twenties, 15 percent had lived with a partner.

BIRTH WEIGHT

The proportion of young mothers having low birth weight babies, while still higher than among mothers in their twenties or thirties, has declined since 1970.

PERCENT LOW BIRTH WEIGHT (UNDER 5-1/2 POUNDS)

	Mothers <15			Mothers 15-19			Mothers 20-24		
	Total	White	Black	Total	White	Black	Total	White	Black
1986	13.8	11.1	15.8	9.3	7.6	13.2	7.0	5.7	12.2
1980	14.6	11.2	17.2	9.4	7.7	14.0	6.9	5.7	12.6
1970	16.6	12.5	19.1	10.5	8.6	15.7	7.4	6.4	13.4

OTHER FACTS

In the U.S., 8 percent of all teen mothers are foreign-born. This proportion varies by region: the Midwest = 3%; the South = 5%; the Northeast = 11%; and the West = 19%.

• Of all births, the proportion occurring to teen mothers declined from 18% in 1970 to 13% in 1986. Considering just first births (those that establish a family), the proportion born to teen mothers declined from 36% in 1970 to 23% in 1986.

• The proportion of first births accounted for by teenagers ranged from 2% among Chinese Americans, 6% among Japanese Americans, 20% among whites (all white ethnic groups combined), to 41% among American Indians, and 42% among blacks.

• Teen problem behaviors such as delinquency, substance abuse, and early parenthood have several common predictors: poverty, coming from a large or a single parent family, early school failure, and having a teenage mother or poorly educated parents.

• By age 18, half of all females and two-thirds of all males have had sex. Youth who have had sex are more likely to also use alcohol or drugs. For example, among girls turning 18, 38% of virgins and 69% of non-virgins have used alcohol monthly or have ever used marijuana.

	% EVER HAD SEX	% USED ALCOHOL/MARIJUANA AMONG YOUTH WHO:	
		Ever Had Sex	Never Had Sex
Females by age 16	17%	54%	22%
Females by age 18	51%	69	38
Males by age 16	29%	60	31
Males by age 18	65%	82	52

While many sexually active teens and teen parents have multiple problems, service programs and funding agencies frequently focus on only one problem.

ABORTION

In 1983, more than 4 percent of U.S. females aged 15-19 had an abortion. Teens 15-19 had 489,000 births and 411,000 abortions in 1983. Data on the incidence of abortion among teens after 1983 are still not available.

INTERNATIONAL COMPARISONS

• Declining teenage birth rates have been achieved in comparable countries. United Nations' data show that teen fertility rates in other industrialized democracies are much lower than in the U.S.

BIRTHS PER 1,000 FEMALES AGED 15-19

	Canada	Sweden	New Zealand	Nether-lands	Japan	Great Britain	France	United States
1985	23	11	31	7	4	30	12	51
1977	31	22	48	10	3	30	22	53

• The lower birth rates in other industrial democracies do not result from greater resort to abortion. An Alan Guttmacher Institute study shows that U.S. teens have higher abortion rates than teens in comparable nations. In 1982, the U.S. abortion rate was 44 per 1,000 females aged 15-19, compared to 20 in Sweden, 19 in Canada, 17 in Great Britain, 15 in France, 13 in New Zealand, and 6 in the Netherlands.

Compiled by Kristin A. Moore, Ph.D., Child Trends, Inc.
Charles Stewart Mott Foundation, Sponsor

TABLE 1: BIRTHS IN 1986 TO MOTHERS UNDER AGE 20

	NUMBER OF BIRTHS TO MOTHERS AGED:				OF BIRTHS TO YOUNG MOTHERS, PERCENT TO UNMARRIED MOTHERS, BY AGE				OF ALL FIRST BIRTHS, PERCENT TO A MOTHER UNDER AGE 20
	Under Age 15	15-17	18-19	Total Under 20	Under Age 15	15-17	18-19	Total Under 20	
ALABAMA	286	4,044	6,032	10,362	94	68	50	58	31
ALASKA	12	341	704	1,057	-	70	51	58	18
ARIZONA	151	2,915	5,318	8,384	96	76	53	62	27
ARKANSAS	186	2,423	3,938	6,547	94	65	43	53	34
CALIFORNIA	903	18,374	33,499	52,776	85	73	55	62	21
COLORADO	83	1,953	3,609	5,645	96	76	51	60	19
CONNECTICUT	105	1,396	2,439	3,940	88	71	56	62	15
DELAWARE	36	490	754	1,280	-	84	61	71	24
DIST. OF COLUMBIA	74	651	986	1,711	97	98	89	93	29
FLORIDA	648	8,596	13,837	23,081	95	75	55	63	24
GEORGIA	466	6,364	9,878	16,708	93	69	51	59	29
HAWAII	18	488	1,244	1,750	-	84	55	64	18
IDAHO	19	592	1,169	1,780	-	56	33	41	25
ILLINOIS	526	8,201	13,359	22,086	99	86	67	75	24
INDIANA	199	3,808	7,115	11,122	96	74	50	59	27
IOWA	36	1,133	2,400	3,569	-	80	50	60	19
KANSAS	73	1,475	2,949	4,497	99	69	45	54	23
KENTUCKY	175	3,328	5,530	9,033	78	52	37	44	32
LOUISIANA	407	4,975	7,738	13,120	95	76	57	65	32
MAINE	28	598	1,313	1,939	-	79	53	62	22
MARYLAND	235	2,962	4,959	8,156	99	86	71	77	21
MASSACHUSETTS	97	2,282	4,476	6,855	98	86	67	74	15
MICHIGAN	335	5,970	10,569	16,874	93	74	49	59	24
MINNESOTA	54	1,576	3,178	4,808	98	87	62	71	15
MISSISSIPPI	343	3,406	4,850	8,599	96	77	60	68	38
MISSOURI	172	3,550	6,397	10,119	96	73	52	60	25
MONTANA	7	396	877	1,280	-	79	49	59	22
NEBRASKA	31	644	1,489	2,164	-	81	54	62	19
NEVADA	27	649	1,219	1,895	-	64	37	47	22
NEW HAMPSHIRE	9	375	843	1,227	-	86	50	61	15
NEW JERSEY	251	3,718	6,273	10,242	95	89	71	78	16
NEW MEXICO	69	1,532	2,593	4,194	87	69	54	60	30
NEW YORK	475	8,944	16,245	25,664	98	88	69	77	17
NORTH CAROLINA	358	5,240	8,756	14,354	91	71	50	59	27
NORTH DAKOTA	11	232	625	868	-	80	46	56	17
OHIO	394	7,265	13,419	21,078	98	78	57	65	25
OKLAHOMA	134	2,852	4,920	7,906	89	58	39	47	30
OREGON	65	1,370	2,793	4,228	91	77	51	60	22
PENNSYLVANIA	359	6,450	11,388	18,197	98	84	63	71	22
RHODE ISLAND	21	442	920	1,383	-	83	60	68	19
SOUTH CAROLINA	251	3,168	5,176	8,595	93	76	57	65	30
SOUTH DAKOTA	12	366	753	1,131	-	77	48	58	22
TENNESSEE	292	4,173	6,800	11,265	92	64	45	53	30
TEXAS	1,131	17,601	27,940	46,672	82	54	37	44	28
UTAH	30	1,084	2,290	3,404	-	55	32	40	24
VERMONT	7	213	531	751	-	84	55	64	18
VIRGINIA	287	3,502	6,693	10,482	92	75	53	61	21
WASHINGTON	114	2,419	4,719	7,252	95	78	53	62	20
WEST VIRGINIA	42	1,400	2,537	3,979	-	57	39	46	31
WISCONSIN	121	2,341	4,684	7,146	100	85	63	71	20
WYOMING	11	305	610	926	-	59	39	47	23
U. S. TOTAL	10,176	168,572	293,333	472,081	93%	73%	54%	61%	23%

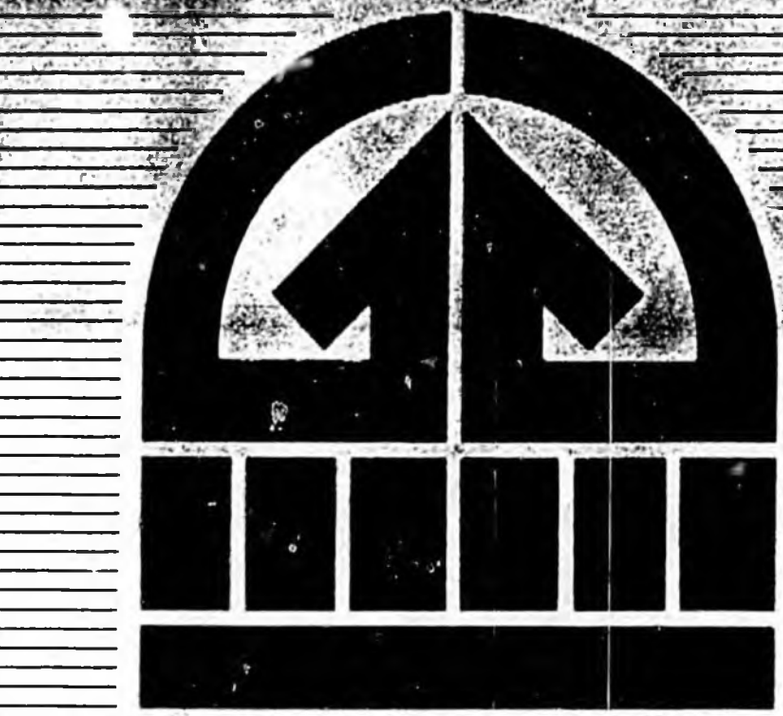
Percentages are not calculated where there is a base of fewer than 50 such births.

Source: Unpublished data from the National Center for Health Statistics, Department of Health and Human Services; forthcoming in Vital Statistics of the United States, Vol. 1, Natality.

TABLE 3. BIRTHS TO TEENAGE MOTHERS IN 110 LARGEST CITIES IN 1986

CITY	BIRTHS TO TEENS			BIRTHS TO UNMARRIED TEEN MOTHERS			OF ALL BIRTHS, PERCENT TO MOTHERS UNDER AGE 20	OF ALL TEEN BIRTHS, PERCENT TO UNWED MOTHERS	NUMBER OF BIRTHS TO TEENS	
	TOTAL UNDER 20	17 AND YOUNGER	AGES 18-19	TOTAL UNDER 20	17 AND YOUNGER	AGES 18-19			WHITE	BLACK
							%	%		
AKRON, OH	584	244	340	477	219	258	17	82	271	307
ALBUQUERQUE, NM	989	379	610	661	286	375	13	67	897	41
AMARILLO, TX	509	196	313	176	95	81	16	35	446	53
ANAHEIM, CA	479	160	319	243	100	143	9	51	446	14
ANCHORAGE, AK	381	121	260	208	85	123	8	55	257	47
ARLINGTON, TX	411	129	282	150	78	72	9	36	366	37
ATLANTA, GA	1,770	799	971	1,615	758	857	21	91	140	1,625
AURORA, CO	344	110	234	219	96	123	8	64	246	85
AUSTIN, TX	1,253	526	727	542	303	239	13	43	930	309
BALTIMORE, MD	2,880	1,291	1,589	2,639	1,239	1,400	22	92	540	2,320
BATON ROUGE, LA	797	332	465	599	285	314	15	75	217	574
BIRMINGHAM, AL	854	405	449	687	361	326	18	80	153	700
BOSTON, MA	1,166	492	674	1,012	457	555	13	87	516	603
BUFFALO, NY	1,011	398	613	850	373	477	17	84	443	562
CHARLOTTE, NC	882	412	470	711	371	340	16	81	248	626
CHATTANOOGA, TN	519	228	291	383	194	189	22	74	198	320
CHICAGO, IL	9,955	4,300	5,655	8,560	4,015	4,545	18	86	2,985	6,892
CINCINNATI, OH	1,351	580	771	1,123	535	588	19	83	499	848
CLEVELAND, OH	2,031	849	1,182	1,697	781	916	20	84	751	1,269
COLORADO SPRINGS, CO	652	192	460	274	125	149	11	42	534	98
COLUMBUS, GA	562	216	346	337	160	177	19	60	274	287
COLUMBUS, OH	1,585	634	951	1,184	539	645	15	75	838	729
CORPUS CHRISTI, TX	683	274	409	281	152	129	14	41	626	55
DALLAS, TX	4,001	1,723	2,278	2,684	1,328	1,356	19	67	2,005	1,947
DAYTON, OH	708	276	432	573	248	325	20	81	302	405
DENVER, CO	1,310	557	753	981	485	496	14	75	954	314
DES MOINES, IA	413	161	252	279	137	142	12	68	335	62
DETROIT, MI	3,991	1,739	2,252	3,395	1,612	1,783	21	85	627	3,343
EL PASO, TX	1,459	538	921	666	332	334	14	46	1,302	65
FLINT, MI	689	307	382	469	263	206	22	68	247	438
FT. LAUDERDALE, FL	674	291	383	572	272	300	16	85	163	511
FORT WAYNE, IN	477	200	277	349	179	170	15	73	289	182
FORT WORTH, TX	1,866	803	1,063	930	538	392	19	50	1,152	692
FRESNO, CA	1,216	497	719	760	359	401	16	63	875	172
GARLAND, TX	399	163	236	196	91	105	12	49	334	58
GARY, IN	513	223	290	463	216	247	23	90	74	438
GRAND RAPIDS, MI	590	252	338	359	176	183	15	61	334	245
GREENSBORO, NC	361	154	207	283	136	147	14	78	122	226
HIALEAH, FL	196	77	119	75	38	37	9	38	181	15
HONOLULU, HI	438	118	320	275	99	176	8	63	80	18
HOUSTON, TX	5,585	2,293	3,292	3,395	1,632	1,763	15	61	3,260	2,262
HUNTINGTON BEACH, CA	128	39	89	66	28	38	5	52	117	2
HUNTSVILLE, AL	322	125	197	193	91	102	14	60	174	147
INDIANAPOLIS, IN	2,206	868	1,338	1,622	744	878	17	74	1,247	952
JACKSON, MS	620	287	333	533	270	263	18	86	91	529
JACKSONVILLE, FL	1,716	716	1,000	1,058	551	507	16	62	819	891
JERSEY CITY, NJ	657	270	387	571	256	315	16	87	262	383
KANSAS CITY, KS	555	241	314	402	199	203	19	72	292	249
KANSAS CITY, MO	1,256	520	736	969	443	526	16	77	475	770
KNOXVILLE, TN	395	158	237	254	122	132	17	64	259	135
LAS VEGAS, NV	771	274	497	397	192	205	13	51	545	210
LEXINGTON-FAYETTE, KY	426	177	249	272	128	144	13	64	292	133
LINCOLN, NE	211	69	142	137	63	74	8	65	190	17
LITTLE ROCK, AR	499	211	288	402	186	216	17	81	123	375
LONG BEACH, CA	1,044	371	673	654	271	383	12	63	632	293
LOS ANGELES, CA	8,877	3,430	5,447	6,353	2,727	3,626	12	72	6,237	2,419
LOUISVILLE, KY	858	397	461	708	356	352	20	83	367	489
LUBBOCK, TX	601	253	348	245	133	112	18	41	484	115
MADISON, WI	162	50	112	117	44	73	6	72	127	29
MEMPHIS, TN	2,151	1,008	1,143	1,843	942	901	19	86	340	1,805
MESA, AZ	560	196	364	306	144	162	11	55	527	11
MIAMI, FL	2,350	969	1,381	1,827	843	984	15	78	748	1,594

STATE LEGISLATIVE REPORT



TEEN-AGE PREGNANCY LEGISLATION IN THE STATES

by

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TEENAGE PREGNANCY PROJECT

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TEEN-AGE PREGNANCY LEGISLATION IN THE STATES

INTRODUCTION

Teen-age pregnancy and parenting is a major economic and social problem confronting state lawmakers. Nearly 500,000 births to teen-age mothers occur each year, costing taxpayers billions of dollars annually. Legislators are becoming increasingly aware of the economic burdens and human tragedy associated with this problem. Many are interested in how other states use the legislative process to minimize teen-age pregnancy's impact on society. This report, therefore, examines recent legislative initiatives related to the problem of adolescent pregnancy and parenting.

With funding from the Ford Foundation, the Teenage Pregnancy Project of the National Conference of State Legislatures recently collected this information by conducting a 50-state survey. Each state's legislative research agency provided information on bills and acts from the 1986 and 1987 legislative sessions, programs and task force activity related to teen-age pregnancy.

The results of the NCSL survey indicate that recent legislative initiatives address all areas of this multi-faceted problem. Thirty-five states introduced teen-age pregnancy legislation in 1987, compared to 23 in 1985. While only nine states had enacted teen-age pregnancy legislation in 1985, by 1987, 22 had legislation. Legislative task forces to study the teen-age pregnancy problem have been proposed in nearly one-fourth of the states. Funding from the state legislature for teen-age pregnancy programs is also increasing.

LEGISLATIVE TRENDS

The steady increase in teen-age pregnancy legislation reflects two trends. First, bills emphasize coordinating services and programs for the pregnant and parenting teen-age population. For example, legislation requiring state departments to work together and integrate new programs with existing services has increased. Legislators are bringing together agencies and personnel in an attempt to provide better services at reduced costs.

Second, schools are a focal point for many pregnancy prevention strategies. Students are generally required to attend school; therefore schools provide a captive audience. Legislators are capitalizing on this situation, proposing programs that are linked to the school system. Such programs include family life education and school-based health clinics, as well as day care services for parenting students.

LEGISLATIVE ACTIVITY: 1986-1987

Teen-age pregnancy and parenting receives substantially more legislative attention today compared to just three years ago. In 1985, 46 bills related to the problem were introduced, while in 1987 the number had jumped to 148--a 256 percent increase. A closer examination reveals the specific issues on

legislative agendas. These fall into four main categories: education, health care, social services and coordinated services legislation.

In the area of education, bills being introduced are related to: family life education; alternative education/dropout prevention; health education; and additional education strategies. The health care category encompasses legislation on: parental consent or notification for abortion services; comprehensive medical care; dispensing of contraceptives; maternal and child health services; and school-based health clinics. The social service topics include: financial liability; counseling services; job training; day care services; and case management services. The final area consists of coordinated state-wide services legislation.

Topics with the most bills passed center on prevention issues: grant programs for reducing teen-age pregnancy rates (9); parental consent/notification for abortion services (7); and alternative education and dropout prevention programs (7). Areas with the most bills introduced are: grant programs (21); parental consent/notification for abortion (18); and alternative education strategies (15). Areas with the fewest number of bills introduced are: school nurse programs (4); family planning services (4); and teen males programs (5). These low numbers may indicate that the importance of these topics is not clear to legislators at this time, or that lawmakers' priorities lie elsewhere. The main categories of education, health care, social services and comprehensive legislation are described in more detail below.

EDUCATION LEGISLATION

Legislators are placing more emphasis on education strategies in addressing the teen-age pregnancy problem. Working within the established school system can provide early and easy access to at-risk youth. School programs offer the opportunity to impart decision-making and goal-setting skills that are important to pregnancy prevention, as well as provide basic human sexuality information.

Family Life Education. Family life education (FLE) is a comprehensive approach to teaching human sexuality. It typically covers the topics of human development and reproduction, family planning, interpersonal relations, decision-making skills and positive role-modeling. Instruction is provided as part of the regular curriculum and can be adapted to any grade level.

Twelve bills were introduced on this topic in 1986 and 1987, two of which were enacted in Tennessee and Virginia. An example of this type of legislation is the Virginia act (1987 Va. Acts, Chap. 371), directing the board of education to develop FLE standards and curriculum guidelines and to prepare a fiscal analysis.

Alternative Education/Dropout Prevention. Dropout prevention and alternative education legislation aims to help pregnant or parenting students obtain a high school degree through either the regular school or a non-traditional program. Twelve bills on this topic were introduced in 1986 and 1987 and six were passed. States that passed legislation are Florida, Massachusetts, Minnesota, Rhode Island, Tennessee and Wisconsin.

The Wisconsin law (1987 Wisconsin Laws, Chap. 27) is an innovative approach. It requires all teen-agers under 20 years of age to attend school as a condition for receiving AFDC benefits.

Health Education. Health education is designed to teach adolescents the biological facts of human sexuality and the risks of sexually transmitted diseases. Unlike the more comprehensive FLE, very little training in decision-making or family planning is provided.

Eight states introduced health education legislation in 1986 and 1987, with four states--Massachusetts, Mississippi, Missouri and Nevada--passing bills. The Mississippi initiative (1987 Miss. Laws, Chap. 505) establishes a school nurse intervention program to provide reproductive health education.

Other Education Strategies. Legislation in this area seeks to combine education programs or offer additional programs such as parenting courses, counseling services for teen parents or outreach to teen-age males. Although 13 states introduced bills of this type in 1986 and 1987, only one state--California--passed legislation.

HEALTH CARE LEGISLATION

Health care for pregnant teen-agers and their infants is the second major topic receiving legislative attention. Teen-age mothers are at high risk for pregnancy complications and have higher rates of delivering low birthweight babies than older mothers. These health risks have prompted legislative activity related to parental consent for abortion services, comprehensive medical care, dispensing of contraceptives, pre- and postnatal care, well-baby care and school-based health clinics.

Parental Consent/Notification for Abortion Services. Parental consent or notification for abortion services is one of the most lively teen-age pregnancy issues. Such legislation requires unemancipated minors to receive parental permission or to notify parents before receiving abortion services. Of 18 states introducing bills in 1986 and 1987, seven--Alabama, California, Georgia, Kentucky, Mississippi, Missouri and Ohio--passed legislation. The Georgia law (1987 Ga. Laws, p. 1013) requires an unemancipated minor to provide proof of parental notification and to be accompanied by a legal guardian to obtain an abortion. Exceptions to the law can be obtained with a court-ordered waiver or in cases of medical emergency. Many of these acts are being challenged in the federal courts on the basis of undue hardship, mental anguish and potential scheduling delays in providing abortions.

Comprehensive Medical Care. Comprehensive medical care combines existing services with new components to meet the health needs of the pregnant or parenting teen-ager more effectively. Health services for a pregnant teen-ager or young mother and her child are handled by one department or agency. For example, the use of one medical professional for all health care concerns may be required to coordinate similar services and provide improved health care. Seven bills were introduced in 1986 and 1987 and five states--Missouri, New Jersey, Tennessee, Virginia and Washington--passed legislation on this topic. The New Jersey law (N.J. Laws, Chap. 115) establishes the Health Care Program for Pregnant Women and Children to provide comprehensive and coordinated health care services to adolescent mothers and their infants.

Dispensing of Contraceptives. Legislation to prohibit dispensing of contraceptives to minors in schools and in community clinics received moderate attention during 1986 and 1987. Eight states introduced legislation with four states--Iowa, North Carolina, South Carolina and Wisconsin--enacting bills. The South Carolina initiative (1987 S.C. Acts Chap. 167) prohibits school districts from contracting with any providers for distribution of contraceptives in schools or on school grounds.

Maternal and Child Health. Providing for teen-agers' pre- and postnatal health needs and care of their infants is the major thrust of maternal and child health legislation. Twelve bills were introduced in 1986 and 1987, with legislation enacted in Missouri, New York, Tennessee, Virginia and Washington. In New York, the law (1987 N.Y. Laws Chap. 882) establishes a prenatal care assistance program for pregnant women. The act targets grant funds for adolescent mothers.

School-Based Health Clinics. School-based health clinics (SBHCs) provide comprehensive health services to students in or near the schools they attend. Minimal legislative activity has occurred in this area. Seven states introduced bills for the establishment and funding of SBCHs in 1986 and 1987, but none were enacted. While many states have school-based health clinics, most are developed by local entities.

SOCIAL SERVICES LEGISLATION

Social services legislation includes financial support, career and personal counseling, job training, day care for the children of teen-age parents and case management services. Pregnant and parenting teen-agers often need such services because they lack job skills, have low levels of education and have limited financial resources. Faced with expanding welfare expenditures and state budget constraints, legislators are seeking programs to move parenting teen-agers toward financial independence.

Financial Liability. Requiring parents to be financially responsible for the offspring of their minor children is a relatively new legislative strategy. Eleven bills were introduced during the last two sessions seeking financial assistance or insurance coverage from the parents of teen-agers. Two states--Hawaii and Wisconsin--enacted laws that provide for parental financial liability, while Massachusetts, Texas and Wisconsin require a parent's insurance provider to cover a pregnant or parenting minor's child.

Under the Wisconsin act (1985 Wis. Laws Act 56, section 49.90), grandparents can be asked to reimburse public agencies for any care provided to their minor children, and they may be ordered to provide for the maintenance of their grandchildren. In Texas, the law (1987 Tex. Gen. Laws, Chap. 848) allows the grandchild of a policyholder to be eligible for health insurance benefits.

Counseling Services. Counseling services for personal problems, career planning, job placement or other areas received increased legislative attention in 1986 and 1987. Although 11 bills were introduced, only one state--Illinois--enacted legislation.

Job Training. Job training legislation assists teen-age parents in obtaining the necessary skills for entry into the work force. Six states

introduced job training legislation in 1986 and 1987, with Connecticut, Hawaii, Minnesota and Virginia enacting legislation. The Minnesota law (1987 Minn. Laws, Chap. 403) targets teen-age AFDC clients as a priority group for job training services.

Day Care Services. Teen-age parents often lack the financial and informational resources needed to obtain day care for their children so that they can continue their education or seek employment. Ten bills were introduced over the last two sessions in this regard, but only one state, Rhode Island, passed legislation. Rhode Island House Resolution 123, introduced in 1987, requests that the Department of Human Services, Department of Elementary and Secondary Education, and the Rhode Island Health Center Association provide child care information to teen parents who wish to continue their high school education.

Case Management Services. Increasingly, lawmakers are considering legislation to improve case management for pregnant and parenting teen-agers. This usually involves having one counselor, or case manager, who assists the teen client on all applicable services. Six states introduced such legislation in the 1986 and 1987 sessions, but only two states--Minnesota and Missouri--enacted legislation. Minnesota's law (1987 Minn. Laws, Chap. 403, Art. 3), requires that teen-age mothers participate in comprehensive case management services. The county service provider and teen client must develop a specific plan for family self-sufficiency.

COORDINATED SERVICES LEGISLATION

The problem of teen-age pregnancy contains educational, health and social service elements and, therefore, more than one approach is necessary to effectively combat the problem. In response, a greater number of lawmakers are sponsoring bills to coordinate strategic programs into a comprehensive approach.

Statewide Coordination. Statewide coordination legislation brings together the relevant state departments to improve services to the teen-age population. Seven bills were introduced during the 1986 and 1987 legislative sessions, with two states--North Dakota and Tennessee--passing legislation to coordinate service delivery. The North Dakota law (1987 N.D. Sess. Laws, Chap. 185) establishes the Children's Services Coordination Commission. Among the commission's specified functions is to coordinate state initiatives with local school district efforts to prevent adolescent pregnancies.

LEGISLATIVE TASK FORCES, COMMISSIONS, BOARDS AND STUDIES

States usually initiate a task force, commission, board or special study group to examine the problems of adolescent pregnancy and parenting. The groups either study the problem as a whole or one small aspect of it, such as family life education, health programs or early prevention strategies.

While most task forces are initiated by governors, more state legislatures are creating their own task forces. By 1987, 14 states had a legislative study group examining this issue. These states--California, Connecticut, Delaware, Louisiana, Maryland, Missouri, Montana, New Jersey, New Mexico, North Carolina, North Dakota, Rhode Island, Tennessee and Virginia--had a

variety of study mandates. For example, under a New Jersey law (1987 N.J. Laws, Chap. 19), a task force on adolescent pregnancy was established to collect information on current programs, and to recommend policies to coordinate and improve services related to adolescent pregnancy. The increasing number of task forces with legislative authority indicates a growing interest among state legislators in the state policy aspects of the problem.

PROGRAMS

A variety of programs at both the state and local level provide services to pregnant or parenting teen-agers. Although most programs are funded from various federal, local and private sources, many receive state legislative appropriations.

Grant Programs. State grant programs provide money for pilot projects to test new approaches to solving the problem of teen-age pregnancy. A dramatic rise in the number of such grant programs has occurred in the states. Although only six bills were introduced in 1986, 15 were introduced in 1987. Nine states--California, Iowa, Massachusetts, Minnesota, North Carolina, Ohio, Rhode Island, Tennessee and Wisconsin--enacted legislation that funds innovative programs to reduce adolescent pregnancies. The Wisconsin act (1987 Wis. Laws, Act 27) targets funding to communities with high teen-age pregnancy rates and the highest number of teen-age AFDC clients.

State Appropriations for Programs. At least 12 states have surpassed the $1 million mark in appropriating funds for teen pregnancy programs: California, Connecticut, Florida, Illinois, Massachusetts, Minnesota, New Jersey, New York, North Carolina, South Carolina, Tennessee and Wisconsin. For example, Illinois has appropriated $13.9 million state and federal funds for its Parents Too Soon Program for FY 1988. This program is a multi-agency cooperative effort, with 125 community-based initiatives to prevent teen-age pregnancies.

SUMMARY

Legislative initiatives in the area of teen-age pregnancy and parenting are part of most state legislative agendas. If current trends continue, the growing number of state public policy strategies will provide new models for interested legislators across the country.

This document was prepared under a grant from the Ford Foundation. Heather Maggard, Senior Project Manager, Teenage Pregnancy Project, contributed to this State Legislative Report.

A. TEEN-AGE PREGNANCY LEGISLATION SUMMARY

	1985		1986		1987	
	Introduced	Passed	Introduced	Passed	Introduced	Passed
Alabama			2	0	1	1
Alaska						
Arizona						
Arkansas						
California	4	3	11	3	9	3
Colorado						
Connecticut	9	3	2	0	7	2
Delaware	1	1				
Florida	3	0	9	0	2	0
Georgia	1	0			2	1
Hawaii			7	2	3	0
Idaho						
Illinois	3	1	4	0	4	0
Indiana	1	0	2	0	1	0
Iowa					2	0
Kansas					2	0
Kentucky			3	2		
Louisiana			3	0	2	2
Maine	2	0				
Maryland			3	1		
Massachusetts	1	0	7	4	5	2
Michigan						
Minnesota			1	0	3	2
Mississippi			10	2	5	1
Missouri			1	1	1	1
Montana	1	1				
Nebraska					1	0
Nevada	1	1			1	1
New Hampshire	1	1			1	0
New Jersey	4	0	5	0	2	2
New Mexico			1	1		
New York	1	0	24	1	20	2
North Carolina	2	1	1	1	12	5
North Dakota					1	1
Ohio	3	0	1	1	2	1
Oklahoma					1	0
Oregon	1	0			2	0
Pennsylvania			4	0		
Rhode Island					6	6
South Carolina			2	1	11	1
South Dakota	1	0			2	0
Tennessee	1	0	2	2	16	8
Texas	2	1			6	2
Utah					3	1
Vermont	1	0			1	0
Virginia	1	0	1	1	6	6
Washington	1	0			3	1
West Virginia						
Wisconsin					2	2
Wyoming						
TOTALS	46	13	106	23	148	54

B. State Acts on Teen-Age Pregnancy & Parenting

1985 - 1987

	AL	AK	AZ	AR	CA	CO	CT	DE	DC	FL	GA	HI	ID	IL	IN	IA	KS	KY	LA	ME	MD	MA	MI	MN	MS	MO	MT	NB	NV	NH	NJ	NM	NY	NC	ND	OH	OK	OR	PA	RI	SC	SD	TN	TX	UT	VT	VA	WA	WV	WI	WY
RECOGNITION OF THE PROBLEM																																																			
Task Force, Committees, Studies					7		5	5											7		6				6	5				7	6		5/7	7							5			6/7					5/7				
EDUCATION LEGISLATION																																																			
Family Life Education														5									5												5										5/7				7				
Health Education																						7			7	7																												
Alternative Education/Dropout Prevention					5		5			7												6	5	7																			7			5/7								7	
Additional Education Strategies					6/7																																															
HEALTH CARE LEGISLATION																																																			
Abortion: Parent Consent/Notification	7				7					7				5			6								6	5/6				5						6									5							5	
School-Based Health Clinics																																																			
School Nurse Programs																									7																												
Family Planning									5							6																													7							
Maternal and Child Health					5												7				6													5/7								6	7	5						5	
Comprehensive Medical Care																									7					7													6			7	7				
Dispensing of Contraceptives															7																			7							7								6	
SOCIAL SERVICES LEGISLATION																																																			
Day Care				5	5																																			7											
Job Training						5/7					7												7																						7							
Counseling/Transportation Services													6																																							
Case Management Services																							7	7									5																			
Group Residential Facilities						5/7																																														
Financial Liability										6											6																														5/6	
Teen Males Programs																																																			
COMPREHENSIVE LEGISLATION																																																			
State-Level Coordination						5														5												5		7										6/7								
Grant Programs				7											7						6		7										7	7									7							7	

KEY

7 1986-87 Legislative Session
6 1985-86 Legislative Session
5 Legislation Prior to June 1985

NOTE: Entries do not reflect single pieces of legislation. Each act and bill is categorized according to the various topics addressed by the act or bill. Therefore, a single piece of legislation containing provisions for several programs, for example, is recorded in several categories.

A. TEEN-AGE PREGNANCY LEGISLATION SUMMARY

	1985		1986		1987	
	Introduced	Passed	Introduced	Passed	Introduced	Passed
Alabama			2	0	1	1
Alaska						
Arizona						
Arkansas						
California	4	3	11	3	9	3
Colorado						
Connecticut	9	3	2	0	7	2
Delaware	1	1				
Florida	3	0	9	0	2	0
Georgia	1	0			2	1
Hawaii			7	2	3	0
Idaho						
Illinois	3	1	4	0	4	0
Indiana	1	0	2	0	1	0
Iowa					2	0
Kansas					2	0
Kentucky			3	2		
Louisiana			3	0	2	2
Maine	2	0				
Maryland			3	1		
Massachusetts	1	0	7	4	5	2
Michigan						
Minnesota			1	0	3	2
Mississippi			10	2	5	1
Missouri			1	1	1	1
Montana	1	1				
Nebraska					1	0
Nevada	1	1			1	1
New Hampshire	1	1			1	0
New Jersey	4	0	5	0	2	2
New Mexico			1	1		
New York	1	0	24	1	20	2
North Carolina	2	1	1	1	12	5
North Dakota					1	1
Ohio	3	0	1	1	2	1
Oklahoma					1	0
Oregon	1	0			2	0
Pennsylvania			4	0		
Rhode Island					6	6
South Carolina			2	1	11	1
South Dakota	1	0			2	0
Tennessee	1	0	2	2	16	8
Texas	2	1			6	2
Utah					3	1
Vermont	1	0			1	0
Virginia	1	0	1	1	6	6
Washington	1	0			3	1
West Virginia						
Wisconsin					2	2
Wyoming						
TOTALS	46	13	106	23	148	54

C. State Bills Introduced on Teen-Age Pregnancy & Parenting

1985 - 1987

	AL	AK	AZ	AR	CA	CO	CT	DE	DC	FL	GA	HI	ID	IL	IN	IA	KS	KY	LA	ME	MD	MA	MI	MN	MS	MO	MT	NE	NV	NH	NJ	NM	NY	NC	ND	OH	OK	OR	PA	RI	SC	SD	TN	TX	UT	VT	VA	WA	WV	WI	WY
RECOGNITION OF THE PROBLEM																																																				
Task Force, Committee, Study						6			6	7		7		7				6												5		7		7	7	6				5/7											
EDUCATION LEGISLATION																																																			
Family Life Education						5												6			7			7						7		6/7		5/7			6	7	7	5/7											
Health Education																	6							6										7				7														
Alternative Education/Dropout Prevention				6/7					6				6																	5		5/7			5																
Additional Education Strategies				6					6			6/7									7			7			7					7	7				7				7		7	7	7					
HEALTH CARE LEGISLATION																																																			
Abortion: Parent Consent/Notification	6			5/6					5/6	5				7				5						7								6	7		5		5		7	7					5	5			
School-Based Health Clinics				6/7		7					6/7			6																		6					7									7				
School Nurse Programs																							6/7																7												
Family Planning				5/7		5							5																				5							5	7									
Maternal and Child Health				7		5/7					7		7							6	5											6		5/7											5					
Comprehensive Medical Care						7															5																														
Dispensing of Contraceptives											7		7																									6	7											
SOCIAL SERVICES LEGISLATION																																																			
Day Care				6/7					5/6				6								6										6		5/7					6												
Job Training						7					6																																								
Counseling/Transportation Services				6/7		7					5/7										6/7		5/7	6																											
Case Management Services				6/7		5					6																7		6																					
Group Residential Facilities									7																				5/6		6																			
Financial Liability						6			7														6	6											7			6						7						
Teen Males Programs				7																6	6										6		6																
COMPREHENSIVE LEGISLATION																																																			
State-Level Coordination				6/7									5																															7	7						
Grant Programs				7									6	6	7						6								7	6	6/7		7	7												7				

KEY

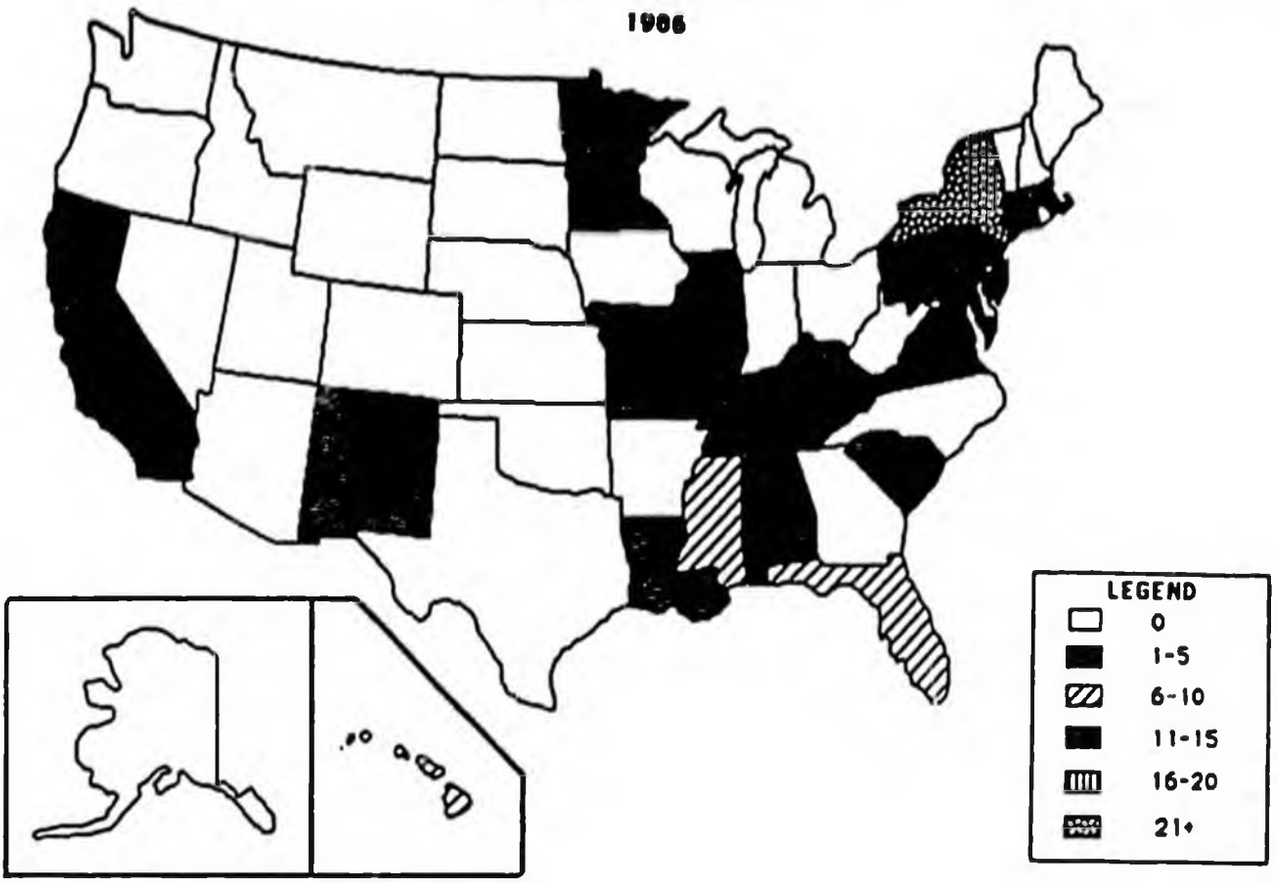
7 1986-87 Legislative Session
6 1985-86 Legislative Session
5 Legislation Prior to June 1985

NOTE: Entries do not reflect single pieces of legislation. Each act and bill is categorized according to the various topics addressed by the act or bill. Therefore, a single piece of legislation containing provisions for several programs, for example, is recorded in several categories.

D. STATE LEGISLATION ON TEEN-AGE PREGNANCY AND PARENTING

Number of Bills Introduced

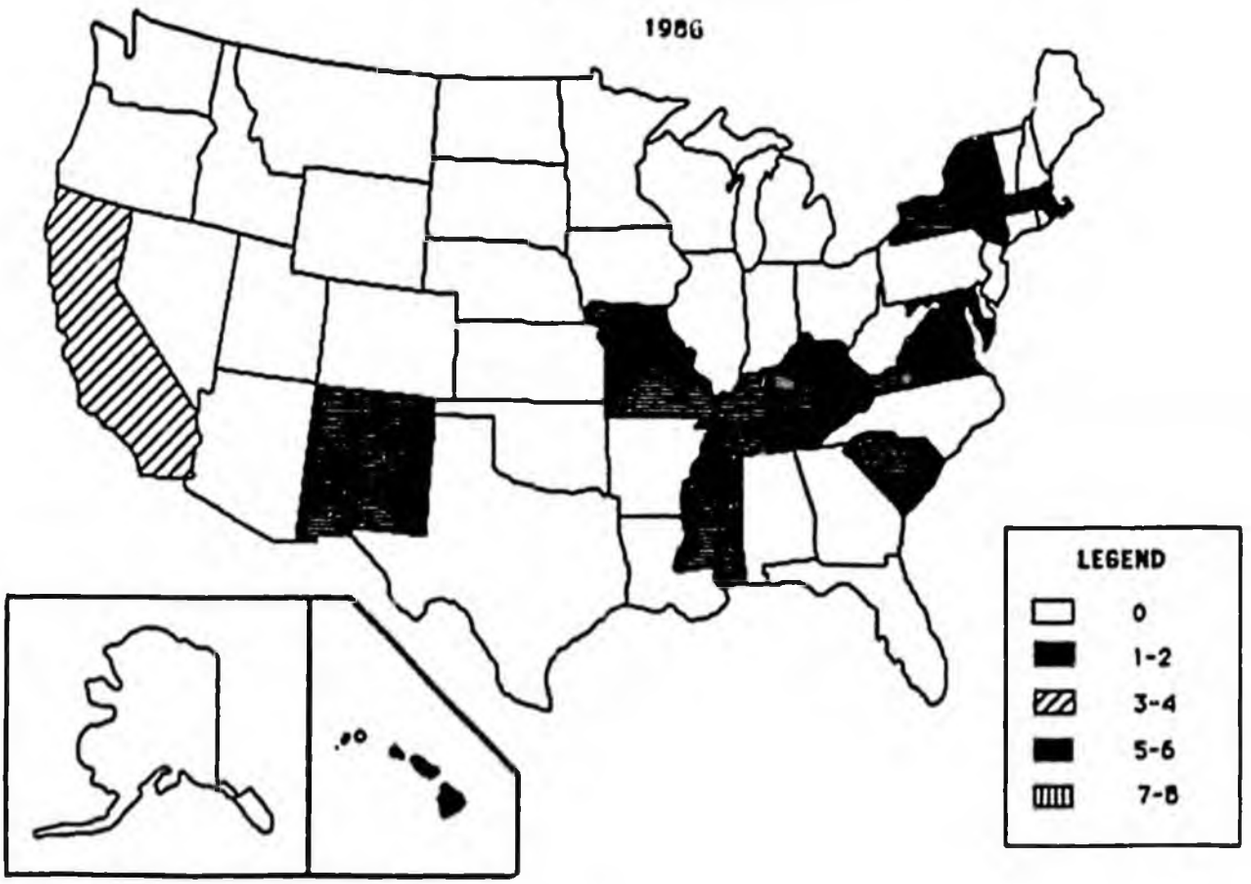
1986



E. STATE LEGISLATION ON TEEN-AGE PREGNANCY AND PARENTING

Number of Bills Passed

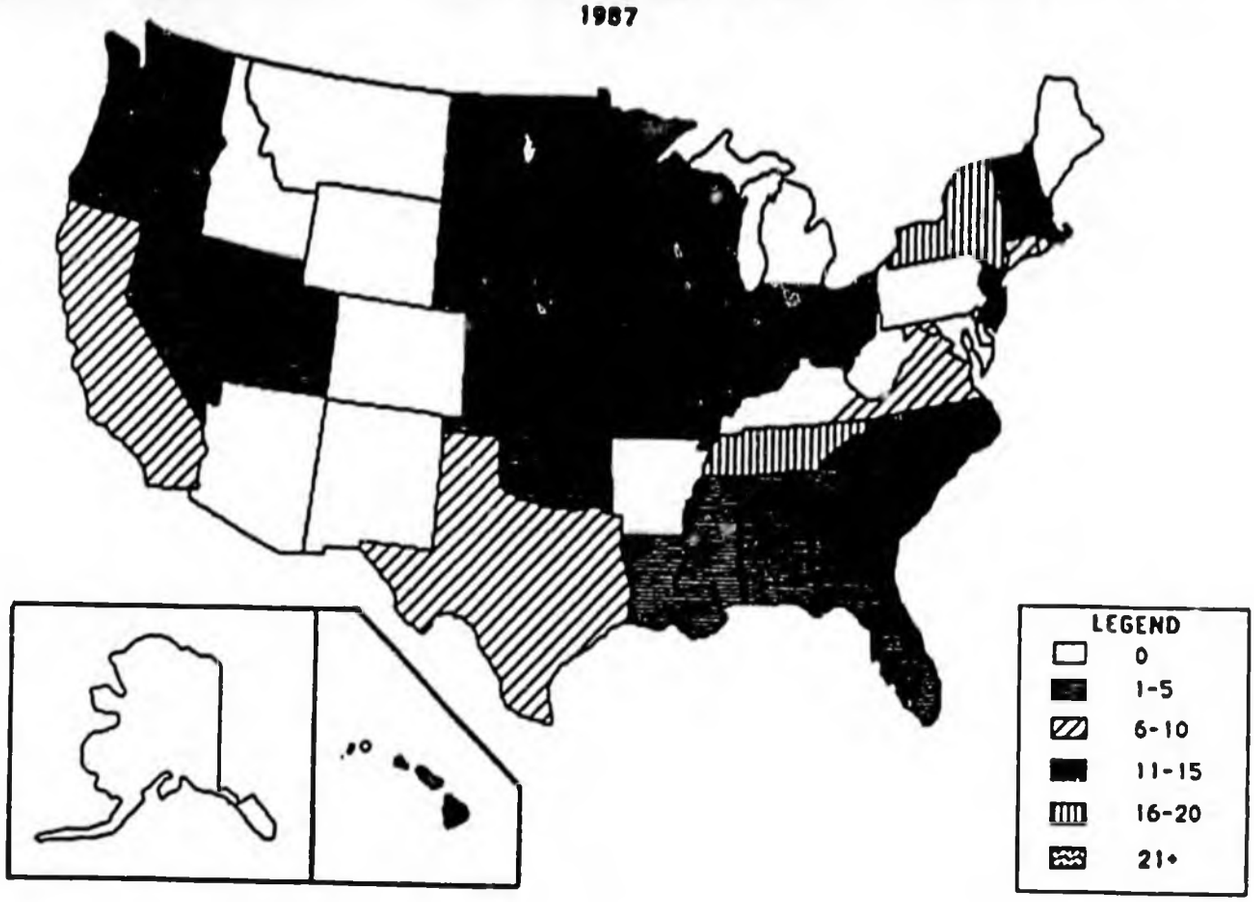
1986



F. STATE LEGISLATION ON TEEN-AGE PREGNANCY AND PARENTING

Number of Bills Introduced

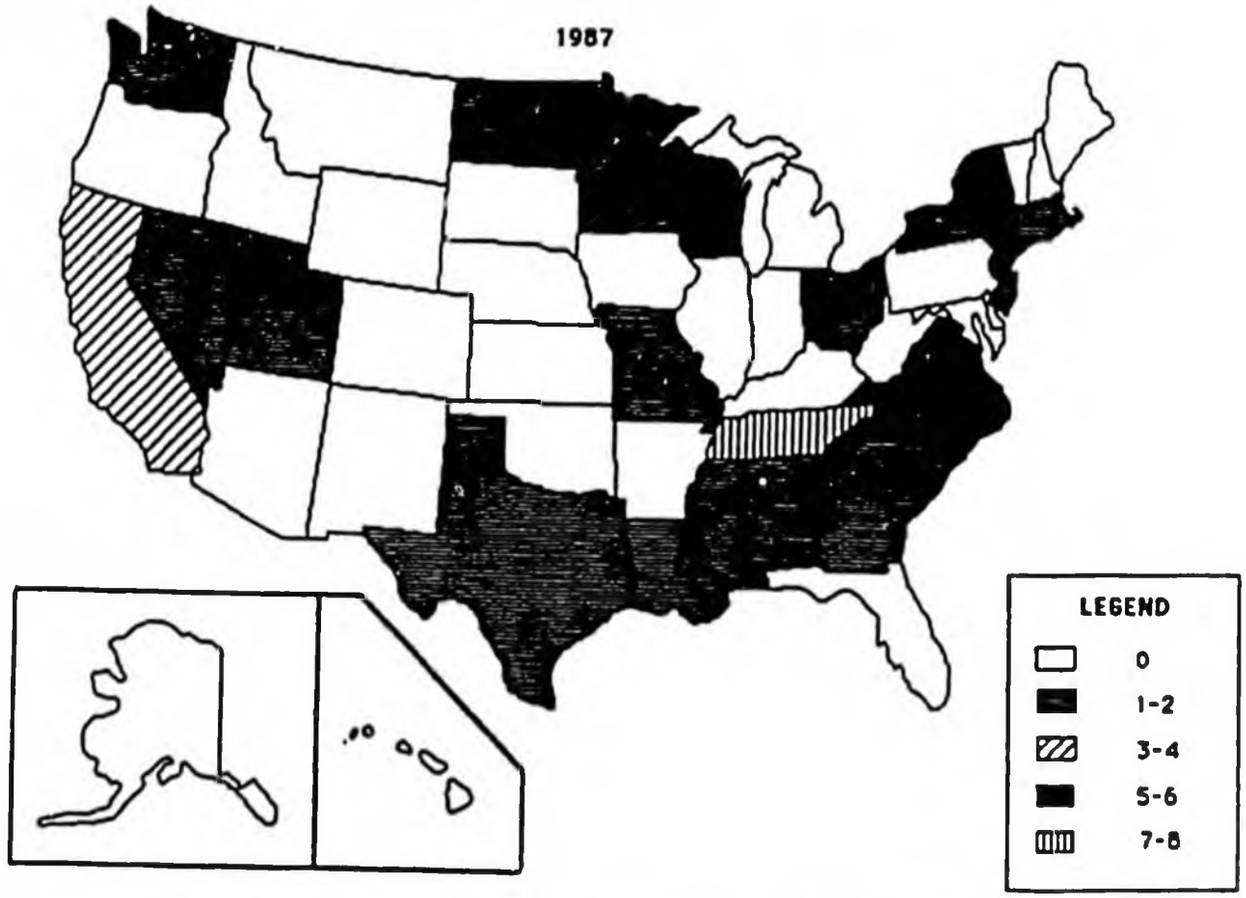
1987



G. STATE LEGISLATION ON TEEN-AGE PREGNANCY AND PARENTING

Number of Bills Passed

1987



The Teenage Pregnancy Project joined the NCSL state services program in June 1987. The project has been funded by the Ford Foundation and is designed to provide state legislators and legislative staff with information and resources related to teen-age pregnancy and parenting, drawing from experiences in the 50 states. Major project activities are providing technical assistance, producing publications and contributing to the NCSL Annual Meeting.

On-site technical assistance is being offered to three different states each year. The assistance must be requested by a legislator, and typically takes the form of presentations, workshops or bill drafting. The project also includes writing and disseminating three publications a year describing successful state experiences. Topics to be explored in the first year are prevention of teen-age pregnancy, services for teen-age parents, and the results of a legislative survey.

Other activities include:

- Organizing an information clearinghouse, within a national computerized legislative information system, comprised of state legislative committee reports, interim reports, legislation and other pertinent resource materials that legislators can use in making policy decisions; and

- Developing a forum, by way of an advisory committee of organizations working in the field, for ongoing discussions of current research, model programs and successful state strategies.

For more information, contact Patrick Bustos or Heather Maggard in the Denver office at (303) 623-7800.

ADOLESCENT PREGNANCY FACT SHEET

There were over 1 million adolescent pregnancies in the United States in 1984. The adolescent pregnancy rate in the United States is:

- Twice as high as the rates found in Britain, France, and Canada
- Almost three times the Swedish rate
- Seven times the Dutch rate (1)

The problem of adolescent pregnancy is part of a complex series of changes in the reproductive health behavior of American women of childbearing age.

- The median age of marriage for women in the United States has increased from just over 20 in 1960 to just over 23 in 1983 (2).
- The percentage of first births that are nonmaritally conceived and born to unmarried women has increased for women up to age 29 (3).
- Birth rates for women up to age 29 (with the exception of those of adolescents under 15) declined over the past several years, with a small increase between 1984–1985 (4).
- Abortion rates for all age groups increased from 1973–1979, leveling off after that time (5).
- Over half of all pregnancies in the United States are described as unintended—either mistimed or unwanted (6).

MARRIAGE AMONG ADOLESCENTS

The proportion of adolescent girls (aged 15–19 years) who have married has decreased from 1970, when it was 11.9%; it dropped in 1980 to 8.6% and in 1984 to 6.6% (7).

SEXUAL ACTIVITY OF UNMARRIED ADOLESCENTS

The proportion of unmarried female adolescents who are sexually active increased steadily from 1971–1979, leveling off by 1982 (7).

Year	Unmarried Sexually Active Women Aged 15–19 Years (%)
1971	27.6
1976	39.2
1979	46.0
1982	42.2

By age 20, over 70% of unmarried adolescent girls are sexually active (7).

Age	Sexually Active (%)
15	5.4
16	12.6
17	27.1
18	44.0
19	62.9
20	73.6

PREGNANCY RATES OF ADOLESCENTS

Sexually Active Adolescents

The pregnancy rates for sexually active adolescents have decreased, primarily due to increased use of contraception (7).

Year	Pregnancy Rate in Sexually Active Women Aged 15–19 Years (per 1,000)
1972	272
1978	245
1982	232
1984	233*

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
409 12th STREET, SW
WASHINGTON, DC 20024-2188 (202) 638-5577

Overall Pregnancy Rates

Since so many more adolescents are sexually active, however, the overall pregnancy rates for this age group rose from 1970-1980, with a slight decline by 1984 (7).

Year	Pregnancy Rates in All Women Aged 15–19 Years (per 1,000)
1972	94
1978	105
1982	110
1984	109*

*Estimates

By age 18, 2 out of 10 adolescents have had a pregnancy. By age 20, 4 out of 10 adolescents have had a pregnancy (2).

Pregnancy in adolescents under age 15 is of special concern. The number of pregnancies for girls 14 years old and under increased in 1983, as did the pregnancy rate for this age group (5).

The great majority of adolescent pregnancies are unintended. In 1979, of the 30,000 pregnancies in girls under age 15, virtually none was intended; 87% of those occurring in girls aged 15–17 years and 65% of those occurring in girls aged 18–19 years were also unintended (8).

CONTRACEPTIVE USE

The percentage of adolescent girls aged 15–19 who had ever used contraceptives rose from 66% in 1976 to 85% in 1982. The proportion who said they never used contraceptives declined from 35% to less than 15% over the same period (2).

Use of contraceptives at first intercourse was still low in 1982, with only 19.9% of girls aged 15–19 reporting the use of a prescription method at first intercourse, and less than half reporting the use of any method at all. Those in the youngest age groups had the lowest rates (2).

Older teenagers are more likely to use more reliable methods of contraception at first intercourse (2).

The delay between the initiation of intercourse and the use of a prescription method of contraception averages 1 year. Within 2 years of initiating intercourse, nearly 50% of those who use no contraception become pregnant (2).

PREGNANCY RESOLUTION

Of the slightly over 1 million pregnancies in 1984, there were:

469,682 live births
401,128 abortions
134,049 miscarriages (7)

Births to Adolescents Aged 15–19 Years

The number of actual births to women aged 15–19 have been decreasing for many years, and the birth rates of this age group continued to decrease up to 1984. The declining size of the adolescent population, the increase in contraceptive use, and the increased numbers of abortions have all contributed to these declines (2, 4).

Year	Births to Women Aged 15–19 Years	Birth Rate Among Women Aged 15–19 Years (per 1,000)
1970	644,708	68.3
1980	522,161	53.0
1984	469,682	50.9
1985	467,485	51.3

Births to Unmarried Adolescents Aged 15–19 Years

The percentage of births that occur to unmarried adolescents has increased (4, 7).

Year	Births to Unmarried Women Aged 15–19 Years (%)
1970	30
1980	48
1984	56
1985	58

Births to Adolescents Aged 14 and Under

Although the number of infants born to adolescents aged 14 and younger is relatively small, the birth rate for this group did not decline from 1970-1984. In fact, there has been a small increase since 1980. In 1985, 92% of these births were to unmarried adolescents (4).

Abortion

Adolescents demonstrate a high utilization of abortion to resolve pregnancy, although in 1983 the abortion rate declined for the first time (5, 9).

Year	Abortion Rate in Women Aged 15–19 Years (per 1,000)
1973	22.8
1980	42.9
1983	41.8

Of all abortions reported in 1983, 27.1% were performed on adolescents under 19; 1% were performed on those under 15 (9). However, over 50% of pregnancies in adolescents under 15 end in abortion (5).

Adoption

Few adolescents choose adoption as a means of pregnancy resolution. In 1982, an estimated 93% of all unmarried mothers aged 15-19 kept and raised their children (2).

State Rates

Pregnancy, abortion, and birth rates of adolescents vary dramatically by state. Appended to this fact sheet is a state-by-state listing of these rates for 1980 (10).

HEALTH PROBLEMS OF ADOLESCENT PREGNANCY

Although adolescents experience higher levels of pregnancy complications than older women and are more likely to have a low-birth-weight baby, these poor outcomes occur primarily because they do not receive prenatal care early in pregnancy. The younger the adolescent, the less likely she is to receive adequate prenatal care. In 1985, the percentages of adolescents who entered into prenatal care programs were as follows (4):

Age Group	1st Trimester	3rd Trimester	No Care
<15	36.0	14.2	6.3
15-17	48.8	9.7	3.9
18-19	56.7	8.0	3.1
20-29	77.6	3.8	1.5

IMPACT OF TEENAGE CHILDBEARING

Only half of teenaged women who give birth before age 18 complete high school, compared with 96% of those who do not have children before age 20 (11).

Women who have their first baby as a teenager have lower-status occupations, accumulate less work experience, receive lower hourly wages, and earn less annually than women who delay childbearing (2).

In 1986, $17.93 billion in public program expenditures (AFDC, Foodstamps, and Medicaid) went to families in which the women had first given birth as a teenager (12).

All the families begun by adolescents having their first baby in 1986 will cost the United States $55 billion over the next 20 years (12).

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Table 1. Rates of pregnancy, birth and abortion among women aged 15–19, ranked in descending order, by state, 1980

State	Pregnancy†						Birth						Abortion					
	Total		White		Black		Total		White		Black		Total		White		Black	
	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank
Number of states	50		32		22		50		50		34		50		32		22	
U.S. total	111.2	na	u	na	u	na	53.3	na	u	na	u	na	42.9	na	u	na	u	na
Ala.‡	117.3	16	u	na	u	na	68.3	10	52.5	15	102.9	18	32.2	31	u	na	u	na
Alaska‡	124.2	9	u	na	u	na	64.4	15	48.2	23	u	na	42.7	15	u	na	u	na
Ariz.	123.2	10	114.7	4	194.5	8	65.5	12	59.6	9	124.3	7	40.6	17	39.3	12	41.2	14
Ark.	117.2	17	103.6	9	167.6	16	74.5	5	62.9	8	118.2	10	25.3	40	25.5	26	23.4	21
Calif.	140.2	2	126.8	2	271.9	1	53.3	25	51.0	18	89.1	28	69.3	1	59.6	2	150.0	1
Colo.	113.7	18	104.9	8	192.0	10	49.9	31	47.6	24	90.8	25	48.9	8	43.4	6	75.5	6
Conn.‡	80.7	45	u	na	u	na	30.5	49	24.4	49	89.6	27	40.1	19	u	na	u	na
Del.	105.6	25	u	na	u	na	51.2	28	36.9	38	110.4	14	40.1	19	u	na	u	na
Fla.‡	131.2	4	u	na	u	na	58.5	18	42.5	30	125.7	5	55.4	5	u	na	u	na
Ga.	130.9	5	111.0	6	171.6	15	71.9	8	53.7	14	109.9	15	40.5	18	42.3	8	36.1	16
Hawaii	105.6	25	81.2	26	u	na	50.7	30	30.6	45	u	na	40.7	16	40.4	11	u	na
Idaho	96.4	34	95.5	14	u	na	59.5	17	58.9	10	u	na	22.7	44	22.6	28	u	na
Ill.	100.6	33	77.5	28	190.0	12	55.8	24	41.4	32	122.0	8	30.6	34	25.3	27	39.6	15
Ind.	101.9	29	92.1	20	192.7	9	57.5	21	52.2	16	111.7	13	29.9	35	26.8	23	53.3	10
Iowa‡	79.0	48	u	na	u	na	43.0	39	41.3	33	u	na	25.0	41	u	na	u	na
Kan.	101.0	31	92.9	19	198.6	7	56.8	23	51.2	17	125.4	6	29.8	36	28.6	21	43.8	12
Ky.‡	110.7	21	u	na	u	na	72.3	7	69.3	2	107.3	17	21.8	47	u	na	u	na
La.	118.1	15	93.1	18	162.6	17	76.0	3	57.8	11	109.7	16	24.4	42	21.6	30	28.1	19
Maine	86.9	40	85.9	24	u	na	47.4	34	46.8	25	u	na	27.3	38	27.0	22	u	na
Md.	122.5	11	102.7	10	174.4	14	43.4	38	31.4	44	75.9	32	64.0	3	59.1	3	75.7	5
Mass.	85.7	42	u	na	u	na	28.1	50	25.7	48	73.9	34	47.3	10	u	na	u	na
Mich.	102.4	28	u	na	u	na	45.0	37	37.2	37	92.0	23	44.0	12	u	na	u	na
Minn.	77.0	49	72.8	31	240.1	2	35.4	44	32.7	43	126.3	3	31.4	33	30.5	18	80.5	4
Miss.	125.0	8	96.7	13	162.4	18	83.7	1	56.2	12	120.3	9	22.3	46	26.6	24	16.4	22
Mo.	106.4	24	91.9	22	204.6	6	57.8	20	49.6	20	114.9	11	33.6	28	29.4	20	60.7	9
Mont.	93.3	38	85.1	25	u	na	48.5	32	42.0	31	u	na	31.9	32	31.6	17	u	na
Nebr.	80.7	45	u	na	u	na	45.1	36	41.2	34	u	na	24.2	43	u	na	u	na
Nev.	144.0	1	133.8	1	225.8	3	58.5	18	50.3	19	128.0	1	67.1	2	66.8	1	65.6	7
N.H.‡	80.7	45	u	na	u	na	33.6	47	33.4	42	u	na	36.7	24	u	na	u	na
N.J.	95.8	35	73.6	30	209.8	4	35.2	45	23.4	50	97.0	21	48.7	9	41.3	10	84.9	3
N.M.	125.6	7	118.0	3	u	na	71.8	9	66.3	5	u	na	35.8	25	34.9	14	u	na
N.Y.	100.7	32	77.6	27	207.2	5	34.8	46	26.2	47	74.2	33	53.6	6	42.0	9	107.4	2
N.C.	110.3	22	92.1	20	152.5	20	57.5	21	44.8	27	87.7	29	37.5	23	34.8	15	42.9	13
N. Dak.	74.8	50	67.9	32	u	na	41.7	40	36.2	39	u	na	22.5	45	22.2	29	u	na
Ohio	101.3	30	88.0	23	190.3	11	52.5	27	48.1	26	100.2	20	34.8	26	29.7	19	63.7	8
Okla.	119.5	13	106.6	7	186.5	13	74.6	4	64.4	7	126.3	3	27.3	38	26.6	24	31.7	18
Oreg.	118.7	14	112.4	5	u	na	50.9	29	49.0	21	u	na	52.4	7	48.7	4	u	na
Pa.	90.3	39	u	na	u	na	40.5	41	34.5	41	90.7	26	37.9	22	u	na	u	na
R.I.	83.1	44	u	na	u	na	33.0	48	29.8	46	u	na	39.6	21	u	na	u	na
S.C.	113.7	18	98.0	12	139.8	22	64.8	14	48.7	22	91.9	24	32.7	30	35.9	13	26.9	20
S. Dak.	86.4	41	74.0	29	u	na	52.6	26	43.2	29	u	na	21.2	48	20.2	31	u	na
Tenn.	113.0	20	101.7	11	156.9	19	64.1	16	55.0	13	100.4	19	32.8	29	32.5	16	33.1	17
Tex.‡	137.0	3	u	na	u	na	74.3	6	68.3	3	112.0	12	43.5	13	u	na	u	na
Utah	94.6	37	93.5	17	u	na	65.2	13	64.9	6	u	na	14.9	50	14.2	32	u	na
Vt.	94.8	36	94.4	15	u	na	39.5	42	39.5	35	u	na	43.1	14	42.7	7	u	na
Va.	107.4	23	93.7	16	151.5	21	48.3	33	38.2	36	82.2	30	44.9	11	43.5	5	48.0	11
Wash.	122.3	12	u	na	u	na	46.7	35	43.9	28	96.9	22	60.3	4	u	na	u	na
W. Va.‡	103.6	27	u	na	u	na	67.8	11	67.4	4	80.0	31	20.2	49	u	na	u	na
Wisc.‡	84.8	43	u	na	u	na	39.5	42	34.6	40	127.8	2	34.0	27	u	na	u	na
Wyo.	126.6	6	u	na	u	na	78.7	2	76.7	1	u	na	29.2	37	u	na	u	na

†In order to take into account miscarriages and stillbirths, pregnancy rates are estimated as follows: (1.2 × birthrate) + (1.1 × abortion rate).

‡Abortion data estimated, based on the proportion of all abortions obtained by teenagers in similar states.

Notes: u = data unavailable or, in the case of blacks, that the black population was under 50,000; these states are omitted from the ranking. Na = not applicable.

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Adolescent Pregnancy Prevention

JUDITH D. RUBIN MD and PRASANNA NAIR MD

Preventing unintended pregnancies in young teenagers can be accomplished by delaying the age of initiation of sexual activity and by effective use of contraception. Physicians can participate in adolescent pregnancy prevention through direct patient contact and interaction with other community programs. In the United States, school-based units and community programs have been associated with significant reduction in adolescent pregnancy rates.

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Adolescent pregnancy, which often has significant adverse consequences for teenage parents, for their offspring, and for society as a whole, has been identified as an important public health problem.[1] Of the 226 health objectives targeted by the Public Health Service for achievement by the year 1990[2] the following relate to adolescent pregnancy

- there should be almost no unintended births to girls 14 years of age and under
- the fertility rate for girls 15, 16, and 17 years of age should be reduced to 10 per 1000, 25 per 1000, and 45 per 1000 respectively.

Prevention is customarily divided into three components: primary prevention: health promotion and disease prevention; secondary prevention: early detection and prevention of full clinical manifestations; and tertiary prevention: measures to reduce impairment and disability, to minimize adverse effects, and to prevent complications. We address interventions aimed at primary prevention of adolescent pregnancy, which include interventions to encourage delayed initiation of sexual activity and interventions to encourage use of effective means of contraception by sexually active adolescents.

From studies of factors associated with early sexual activity and unintended pregnancy among adolescents[3-5] have come ideas for preventive measures: increase knowledge of reproductive function and contraceptive methods; enhance self-esteem, self-awareness, and assertiveness; improve interpersonal communication skills; improve decision-making skills, including the ability to deal with peer pressure; align personal values with those of family, church, and community; provide educational and vocational opportunities; strengthen parental knowledge, involvement, and communication.

Among medical professionals, as is true of the general public, there is a spectrum of attitudes toward adolescent pregnancy prevention ranging from the view that only abstention is an appropriate form of birth control for adolescents to acknowledgment that a multifaceted approach to the problem is required.

Consistent with their own beliefs and values, physicians have many opportunities to be instrumental in adolescent pregnancy prevention, both through direct patient care[6] and through interactions with other programs. Physicians who care for young people over a long period and have the opportunity to develop close relationships with children and their families may he in a unique position to act as role models and counselors. However, in a recent study[7] while compliance with contraception was better in a suburban private practice than in clinics serving lower socioeconomic groups, it was by no means optimal and the authors cautioned against "complacency" on the part of private providers.

Like other preventive measures, successful family planning depends on the patient's ability to act responsibly to improve his or her own health by altering behavior and therefore reducing risk. The physician assists in behavior change in three phases.[8] First the physician must assess the patient for both risk and readiness to change. This requires awareness of risk factors for the condition in question and time spent taking a careful history to ascertain the presence and degree of risk. Factors indicative of readiness to change include the patient's general concern for his or her health; the patient's knowledge, attitudes, and beliefs; the patient's perception of personal risk; the availability of cues to action; the existence of social supports; and the level of self-esteem.

The second role is to facilitate intervention. This task consists of counseling the patient regarding risk factors: providing education, helping to motivate the patient toward behavior change, and negotiation with the patient to decide on a course of action. The steps in this process include setting goals, developing skills, and establishing a system of feedback to enable the patient to maintain the new behavior. The final stage of intervention is follow-up and maintenance, a stage in which close supervision and appropriate feedback are critical for the patient to continue the new pattern of behavior.

While reproductive decision making is complex at any age, special considerations apply to adolescents. Physicians providing services to teenagers must take into account four major developmental tasks of adolescence:[9] separation-individuation, that is, the process of gaining independence from parents and other adults;

acquiring skills for economic independence; psychosexual differentiation; and identity formation.

Cognitive and problem-solving skills are usually achieved by the mid-teen years. The ability to reason abstractly is generally followed by an increasing capacity to be less self-centered and to recognize the consequences of one's actions. The adolescent patient must be assessed for his or her ability to be motivated by long-term *v* short-term consequences of behavior.

The path to completion of these developmental tasks is not necessarily smooth. The adolescent can be expected to try out various roles and to experiment with various patterns of behavior. Strasburger[10] points out that the two complex behaviors of teenage sexual activity and drug use share common ground in that they probably represent a constellation of acting-out behaviors in which certain teenagers feel compelled to engage; both are transition-marking behaviors whereby ties with family are loosened in favor of friends and independence and nonconventionality are prized. Attempts to discourage adolescents from experimentation may contribute to the very attractiveness of the behaviors involved. Some alternatives include minimization (limitation of experimentation to a moderate level), insulation (prevention of serious long-term consequences of experimentation), and delayed onset of experimentation until the teen is better able to handle the particular involvement.

Physicians may find useful such office educational aids as a new brochure for teenagers from the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists[11] that incorporates several points of view and combines medical information with developmentally appropriate behavioral messages. The first bold-type statement is "You can postpone sex." The overall themes are: the choice is yours; you should know the consequences of your decision (pregnancy, sexually transmitted diseases, hurt feelings); it's okay to say "no"; if you intend to have sex there are effective contraceptives for young women and young men.

Many factors influence the reproductive behavior of adolescents: peers; sexual partners, family, church, school, the media, the health care system. The media, especially television, exert a powerful influence on today's teenagers. Sex on TV is "impersonal, emotionless, and exploitative,"[10] often offering unrealistic portrayals that are potentially harmful to young people. Similarly, numerous motion pictures during the last several years have had scenes that exploit teenage sexuality. Professional organizations have suggested guidelines for positive use of the media in promoting responsible sexual behavior.[12]

Providing information about pregnancy and birth control through formal sex education programs increases knowledge of human reproduction and methods of contraception. Sex education programs alone, however, do not appear to change either values or behavior.[13,14] Integrating sex education programs with a service component may be more effective, as seen in adolescent health programs located in or near schools. A number of advantages underlie this approach: the availability of a "captive audience" for educational programs, the potential for confidential services, the ability to use peer groups in a positive way, integration of family planning services with other health-care needs. Such school-based programs report substantial success in reducing pregnancy rates in their target populations.[15]

The traditional public health/preventive medicine approach determines risk factors, identifies possible interventions, and applies them to individuals at risk. Adolescent pregnancy, a problem that has multiple causal elements, may require a communitywide approach aimed at lowering the overall risk in the population.

A comprehensive program involving an entire community (parents, teachers, church and community leaders, and public school children) was directed toward the dual goals of reducing teenage sexual activity and decreasing the teen pregnancy rate.[5] The individual components of the program were not unique; rather the innovative aspect was the multilateral communitywide involvement. A significant reduction in the pregnancy rate among 14- to 17-year-olds was attributed to the program.

Ethical Issues

Reproductive behavior is an arena of life in which self-determination is highly valued by patients and health-care providers alike. The latter are admonished to provide nondirective counseling about choices and options, imparting information but remaining detached from the decision-making process.

This seems problematic when dealing with adolescents. While biological maturity and therefore reproductive capability occurs by the mid-teen years or even sooner, our society requires its young people to undergo significant education and training before they achieve final economic and social independence. Ought we to regard them as mature and self-directed concerning their own sexuality or as still-growing children who require rules and regulations? The adolescent may not always be able to answer this question. In a recent study of compliance with prescribed oral contraceptives, the most successful contraceptors were the adolescent women who expected and received "authoritative guidance," that is, the most directive counseling.[16]

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Birth Cycle

For Poor Teen-Agers, Pregnancies Become New Rite of Passage

How a Clinic at a High School In Los Angeles Attempts To Stem the Rising Tide

Some Boasting by the Boys

By Eileen White Read
Staff Reporter of The Wall Street Journal

LOS ANGELES—A tiny, timid 15-year-old girl traipses into the health clinic here at Jordan High School and complains of dizziness. The staff soon discovers that she is four months pregnant.

A counselor, Hazel Black, makes the difficult phone call to the girl's mother. Then, she takes the teen-ager into a private room, closes the door and, in exasperated tones, tells her: "No wonder your mother is hysterical; you've already had one baby for her to raise. Now, you're giving her another."

Fighting illegitimacy is a major problem in the ghetto. Teen-age pregnancy—once taboo—has become a rite of passage for many children of the poor. "Back in the '60s, babies were mistakes. Now, if you haven't had a kid by the age of 18, [they think] there's something wrong with you," says Lannie Foster, a teacher and administrator at Jordan High for 22 years.

Major Implications

The issue, although often cast in moral terms, is wider. Teen-age motherhood hobbles social and economic advancement for the largely black and Hispanic population of poor neighborhoods. Generations of women have lost opportunities for education and work because of their own out-of-wedlock children and then their children's children.

Unwed black teen-agers are nearly five times more likely to have a baby than are white teen-agers, despite a slight overall decline in teen-age births recently. About 80% of the black children of Watts, the Los Angeles ghetto seared by riots in 1965, are born out of wedlock. Many junior-high-school students here have babies. And at Jordan High, in the heart of this south-central Los Angeles community, the birthrate is stunning: One-fourth of the school's 2,700 girls have babies each year.

The problem of teen-age pregnancy is national, and it is being addressed by organizations ranging from the NAACP to many churches to the White House. But it is schools like

Los Angeles school board, searching for solutions, recently opened a free clinic at Jordan High. There's little talk of abstinence, although staffers say they favor it, and sex is treated forthrightly. The clinic both teaches students who are confused about sexual facts and counsels those who are knowledgeable but don't care. A team of counselors, including students acting as "peer" counselors, meets regularly with the most at-risk students to convince them that parenthood doesn't solve problems. Sexually experienced teen-agers are urged to use birth control.

More Facilities Planned

Educators in many cities are taking this tack. There are about 120 such facilities; dozens more are planned. The Robert Wood Johnson Foundation, based in Princeton, N.J., has aided more than 40 clinics, including Jordan High's.

The clinics have sparked debate despite growing indications that they work. Roman Catholic clergymen object to distribution of birth-control devices and argue that the clinics encourage promiscuity. Church-related anti-abortion groups have picketed the facilities, deriding "contraceptives between classes." On the Jordan High clinic's opening day last September, several dozen pickets paraded before television cameras in protest. Since then, they have been back to pressure the school board to close the facility.

Reacting to the emotional debate, the Jordan High clinic offers a variety of services. A clinic handbill advertises 11 of them, listing pregnancy tests and contraception ninth, well below things like dental care and treatment of minor diseases.

Clear Priority

But the school board's priority is to bring down birthrates. Just down the hall from the principal's office, the suite of white-walled rooms, with their examining tables and detailed anatomical posters, is close to the clanging of students' lockers and the classrooms. Among cabinets of medical paraphernalia, aspirin and unguents, counselors and other health professionals dispense birth-control pills, diaphragms and condoms to children, many of whom aren't old enough to drive.

At a big wooden counter in the waiting room, an assistant—one of almost a dozen staffers—sets up appointments. Students jostle with one another between classes and at lunch time. Parental permission is required to use the clinic, although parents rarely object.

Clinic staffers decline to disclose statistics, fearing that the numbers will help opponents. But after five months, the clinic is believed to be serving more than a third of Jordan's students—three times the number expected by this time.

A 16-year-old dressed in skin-tight jeans slips into the clinic on her first visit. Jeffrey Thompson, the physician's assistant, ushers her into an examination room for a physical. Shy at first, the girl slowly admits that she plans to sleep with her 23-year-old boyfriend and wants birth-control pills. When the physical is over, the girl must sit through a counselor's half-hour

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3/17/88 Wall Street Journal

th Cycle: Teen-Age Pregnancies Become a Rite Passage Among the Poor, Spurring School Clinics

Continued From First Page

nation of how the body's reproductive em—and the pill—works. The coun- gives her a month's supply of pills an appointment for a follow-up visit. Girls using the clinic outnumber boys more often ask directly for contracep- n. Many boys visit for an athletic physi- al, not contraception, and, Mr. Thompson says, "I always have to bring it up." Few want condoms for birth control; so he urges their use to prevent acquired im- mune deficiency syndrome and gonorrhea. (No one has tested positive for the AIDS virus yet, but Jordan has one of the highest gonorrhea rates in the city's schools.)

The atmosphere here is friendly but di- rect, as the 15-year-old pregnant with her second baby discovers. Mrs. Black, the counselor, begins explaining various birth- control methods with the aid of plastic ana- tomical models and sample contraceptives. By school-district policy, any mention of abortion is taboo.

It's too late this time for this student, and Mrs. Black—suspecting a motive be- hind the second pregnancy—adds a stern admonition: "Don't think this boy is going to marry you—your first baby's father didn't." Then she softens it with a folksy recollection of teaching her own son about birth control when he was a teen-ager.

The teary-eyed girl says little and stares at the door; outside it, her boyfriend sits in the waiting room. In the hallway be- yond, the shouts of students changing classes reverberate, reminding Mrs. Black that this soon-to-be mother of two needs an excuse to give her teacher for missing a class.

Shortly before the clinic opened, school officials took a survey and found that nearly two-thirds of the students who said they were sexually active had never used birth control. One, a 17-year-old with or- ange hair spiked upward like a crown and heavy eye makeup, contends, "Raising a baby isn't hard; with my baby, I don't need nobody else." She and her 16-year-old sister have three babies between them.

Bowing to reality, school officials have opened a day-care center to encourage teen-age mothers to stay in school. It cares for the babies of 22 students, but Patricia Connor, its 32-year-old manager, worries that it may only perpetuate a life style that she wants to discourage. Looking over the toddlers, she says, "Their grandmothers are my age. They have five kids, all by dif- ferent men, and they have no skills."

Fighting that cycle, the clinic staff hus- tles for patients. The facility is run by the local Watts Health Foundation, and most of the staff members are from the area and familiar with its problems. Director Donzella Lee—a street-smart Watts native with a master's degree in public health— mixes with Jordan's students in the halls, in the schoolyard, even at dances. "Kids won't come to a place they don't know, and they won't deal with adults they don't trust," she points out.

At times, the clinic happens on clients. One girl was brought in not long ago after an assistant principal found her scraping her arm with a knife in a fruitless effort to remove a tattoo. At the clinic, she said she had been sexually active for two years without birth control and had had one abortion. The clinic arranged a pregnancy test and birth-control counseling. However, she never showed up. Like two sisters be- fore her, she dropped out of school.

Despite such failures, school clinics do make a difference. A project in St. Paul, Minn., has cut the birthrate at four high schools by two-thirds over a decade. More strikingly, a Baltimore clinic focusing on education and counseling changed younger teens' sexual habits and attitudes; a re- searcher found that participating girls postponed their sexual initiation an aver- age of seven months.

But so strongly ingrained is the cycle of "babies having babies" that clinic officials expect to achieve only a 25% drop in preg- nancy rates over the next six years. Pov- erty and hopelessness weigh heavily at Jordan, where police patrol the halls and fears of gang warfare are rampant.

Although the vast majority of teen preg- nancies are unintended, researchers find that the girls most likely to become preg- nant are those with few academic aspira- tions or job skills and little sense that preg- nancy would blight their future. Some are trying to escape childhoods troubled by missing fathers or drug-addicted mothers. And the welfare system makes pregnancy seem almost like a job. Jordan has several adolescent welfare mothers, including two 16-year-olds who get a total of $1,040 a month and share their own apartment.

Many Jordan girls seem nonchalant about the risk of having sex without con- traception. Asked whether they know they can easily get birth-control help, a pretty 15-year-old replies, "If I went to the clinic to get the pill, everybody would know I was having sex." What about caring for a baby? A 17-year-old giggles and shrugs, "My mother would take care of it."

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New York Art Dealers Fac[illegible]

cle: Teen-Age Pregnancies Become a Rite ge Among the Poor, Spurring School Clinics

: *First Page*
ody's reproductive works. The coun- h's supply of pills a follow-up visit. ic outnumber boys ectly for contracep- r an athletic physi- and. Mr. Thompson bring it up." Few th control; so he vent acquired im- me and gonorrhea. sitive for the AIDS is one of the highest city's schools.) e is friendly but di- l pregnant with her s. Mrs. Black, the ining various birth- e aid of plastic ana- nple contraceptives. By school-district policy, any mention of abortion is taboo.

It's too late this time for this student, and Mrs. Black—suspecting a motive behind the second pregnancy—adds a stern admonition: "Don't think this boy is going to marry you—your first baby's father didn't." Then she softens it with a folksy recollection of teaching her own son about birth control when he was a teen-ager.

The teary-eyed girl says little and stares at the door; outside it, her boyfriend sits in the waiting room. In the hallway beyond, the shouts of students changing classes reverberate, reminding Mrs. Black that this soon-to-be mother of two needs an excuse to give her teacher for missing a class.

Shortly before the clinic opened, school officials took a survey and found that nearly two-thirds of the students who said they were sexually active had never used birth control. One, a 17-year-old with orange hair spiked upward like a crown and heavy eye makeup, contends, "Raising a baby isn't hard; with my baby, I don't need nobody else." She and her 16-year-old sister have three babies between them.

Bowing to reality, school officials have opened a day-care center to encourage teen-age mothers to stay in school. It cares for the babies of 22 students, but Patricia Connor, its 32-year-old manager, worries that it may only perpetuate a life style that she wants to discourage. Looking over the toddlers, she says, "Their grandmothers are my age. They have five kids, all by different men, and they have no skills."

Fighting that cycle, the clinic staff hustles for patients. The facility is run by the local Watts Health Foundation, and most of the staff members are from the area and familiar with its problems. Director Donzella Lee—a street-smart Watts native with a master's degree in public health—mixes with Jordan's students in the halls, in the schoolyard, even at dances. "Kids won't come to a place they don't know, and they won't deal with adults they don't trust," she points out.

At times, the clinic happens on clients. One girl was brought in not long ago after an assistant principal found her scraping her arm with a knife in a fruitless effort to remove a tattoo. At the clinic, she said she had been sexually active for two years without birth control and had had one abortion. The clinic arranged a pregnancy test and birth-control counseling. However, she never showed up. Like two sisters before her, she dropped out of school.

Despite such failures, school clinics do make a difference. A project in St. Paul, Minn., has cut the birthrate at four high schools by two-thirds over a decade. More strikingly, a Baltimore clinic focusing on education and counseling changed younger teens' sexual habits and attitudes; a researcher found that participating girls postponed their sexual initiation an average of seven months.

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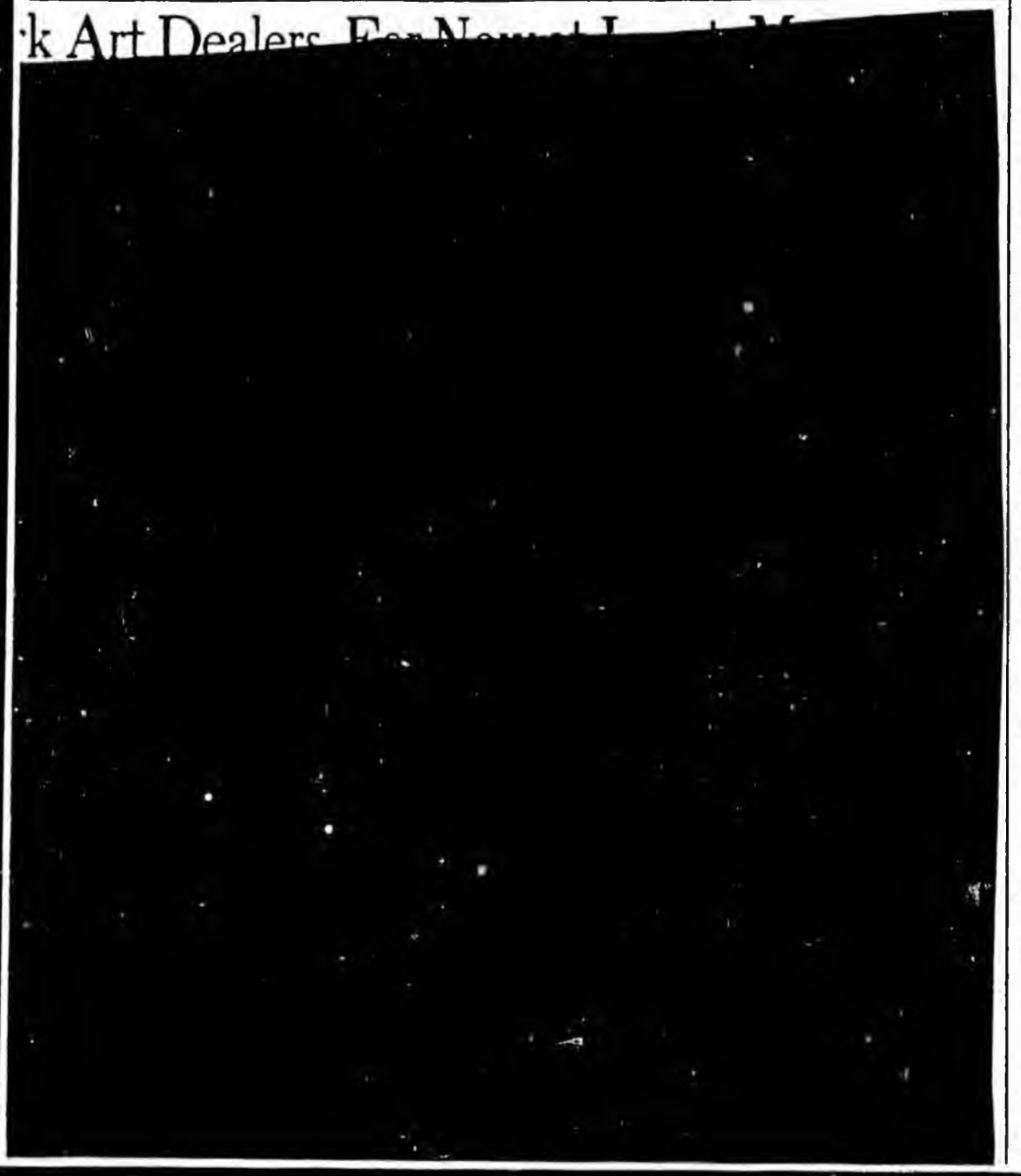
Although the vast majority of teen pregnancies are unintended, researchers find that the girls most likely to become pregnant are those with few academic aspirations or job skills and little sense that pregnancy would blight their future. Some are trying to escape childhoods troubled by missing fathers or drug-addicted mothers. And the welfare system makes pregnancy seem almost like a job. Jordan has several adolescent welfare mothers, including two 16-year-olds who get a total of $1,040 a month and share their own apartment.

Many Jordan girls seem nonchalant about the risk of having sex without contraception. Asked whether they know they can easily get birth-control help, a pretty 15-year-old replies, "If I went to the clinic to get the pill, everybody would know I was having sex." What about caring for a baby? A 17-year-old giggles and shrugs, "My mother would take care of it."

Peer pressure, too, is intense. "It's a put-down to a girl to say, 'You can't have no baby,' " says Miss Lee, the clinic's director. And in the macho folkways of Watts gangs, fathering a child is proof of manhood—although child support has little cachet. Not far down the hall from the clinic, a 17-year-old gang member is bragging that his girlfriend is pregnant.

Grinning, he cradles the air with his arms and coos over and over again, "A baby, a baby." His 14-year-old girlfriend is in junior high school. He himself has no plans for the future.

Though the Los Angeles school board is expanding the clinic system to other schools, some leaders of the project are cautious. Robert L. Smith, the community health director at the Watts Health Foundation, worries about inflated hopes. Two decades ago, he says, "People thought busing was going to solve everything. What if people expect too much?"



Combating teen pregnancies

School-based clinics offer controversial remedy

by Kate Albert and Patty Spangler

Next year, more than a million teenage girls are expected to become pregnant, giving the United States the third highest adolescent pregnancy rate in the developed world. It is a social problem of staggering proportions. To remedy it, some states are funding controversial school-based clinics that offer traditional health services as well as birth control counseling and contraceptives.

Pregnancy among teenage girls has reached startling proportions in America, with an estimated 40 percent becoming pregnant once before they reach age 20. Next year, approximately 1.1 million girls will become pregnant, giving the United States the third highest adolescent pregnancy rate in the developed world.

The problem represents a staggering $16 billion drain on social welfare resources and a loss of human potential and productivity that is inestimable. What makes adolescent pregnancy a difficult social and economic problem for policymakers is that the search for innovative strategies to reduce teen pregnancy inevitably generates enormous controversy.

One such effort, increasing in popularity as well as stirring controversy in school districts throughout the nation, is the school-based comprehensive health clinic. Currently, 75 clinics operate throughout the United States and, according to the Center for Population Options, a nonprofit organization devoted to reducing unintended teen pregnancies, 100 more will open in the next year. Available data for 62 clinics indicates that 52 percent prescribe contraceptives, 28 percent actually dispense them, and 20 percent refer patients to family planning agencies.

Establishment of the clinics has predictably stirred the considerable fervor that has historically surrounded adolescent sexuality and sex education in public schools. Many of those who oppose school-based clinics claim that the availability of family planning services in schools encourages promiscuity and usurps the traditional role of the family in educating children about sex and birth control.

In a recent debate on school-based clinics between U.S. Secretary of Education William Bennett and former First Lady Rosalyn Carter, Bennett called the dispensing of birth control at school-based clinics an example of how social programs dilute the academic mission of schools as well as undermine family authority.

The relatively few clinics now in the United States operate on or near junior and senior high schools located in economically depressed school districts with high rates of adolescent pregnancy. Each is unique in terms of staffing, services, and funding sources. The clinics are commonly staffed by nurse practitioners, social workers and/or physicians. Generally, they provide an assortment of services including athletic physicals, health assessments, laboratory work, immunizations, first aid, drug and alcohol abuse programs, nutrition and weight reduction programs, family counseling, and suicide prevention programs in addition to family planning, prenatal and postpartum care. Almost all require written parental consent before the youth can receive medical services.

According to Dr. Alwyn T. Cohall of St. Luke's Roosevelt Hospital Center in New York, in an excerpt from the *New York Times*, the provision of a wide range of medical services has an important dual purpose. Full medical services are frequently needed for low-income students, many of whom have not seen a doctor since childhood. Furthermore, if the clinics exclusively provided birth control, students would be reluctant to visit for fear of being labeled "sexually active."

Clinics may be either privately or publicly funded, or a combination of both. The average clinic derives 64 percent of its support from public sources. Overall, public funding is divided between state government which provides ap-

proximately 16 percent and federal grants and entitlement programs which provide roughly 48 percent. The remaining 36 percent comes from private entities such as foundations, corporations and nonprofit organizations. Only 2 percent comes from patient fees.

Regional Initiatives. Programs exist in 18 states including Arizona, California, Colorado, Connecticut, Florida, Illinois, Indiana, Massachusetts, Minnesota, Mississippi, Michigan, Maryland, Missouri, New Mexico, New York, Ohio, Oregon and Texas.

In Oregon, the state legislature appropriated $250,000 for comprehensive health clinics on school campuses. In New York City, nine state-financed clinics provide health care to low-income students and birth-control counseling at high schools around the city.

Los Angeles school board members with opposing political views reached agreement on a joint resolution in support of a privately funded school-based health and social services clinic which also dispenses contraceptives.

The Connecticut Governor's budget for fiscal year 86-87 included $225,000 to expand already existent school-based clinics. These funds will finance three new clinics, two in urban areas and one in a rural community.

Wisconsin authorized $1 million for teen pregnancy prevention and services programs, including school-based clinics. These are just a few examples of programs being initiated or continued by states and localities throughout the United States.

Evaluation. Are the clinics effective in curtailing the adolescent pregnancy rate? And if so, can their success be measured? According to the Rev. Marilyn Ericksen of Planned Parenthood Affiliates of California, which supported legislation to create three clinics in Southern California, the programs are usually evaluated by establishing a data base in the clinic to catalogue changes in the pregnancy rate, number of students sexually active, number of visits per clinic and for what services, etc. These statistics are collected for two to three years and then compared with a control school in a similar area without a clinic. The data is then analyzed to determine if any change in health conditions, sexual attitudes or behaviors has occurred.

Evaluation of the oldest clinic, the St. Paul Adolescent Health Service Project, established in Minnesota in 1971, showed overall effectiveness in reducing unintended births, keeping adolescent mothers in school, and reducing the number of unintended second pregnancies.

In addition, John Hopkins University completed a two-year study of clinics, which concluded that students served waited seven months longer to have sex than did their counterparts in a demographically similar school without access to a clinic. The study further concluded that the pregnancy rate at the school with a clinic fell by 30 percent while the school offering only traditional classroom health education programs experienced a 50 percent increase.

Supporters of the school-based clinics feel that recent and projected growth in the number of clinics and in the number of students who use them indicate they have been successful in addressing not only family planning needs, but also overall medical care needs for teens, who are considered one of the most underserved populations in America.

Outlook for the Future. The verdict is still out on school-based clinics; both sides of the dispute raise important questions. Undoubtedly, we have seen only a small fraction of a long and continuing battle over the moral and ethical questions raised by these clinics.

U.S. Surgeon General Everett Koop recently said that public health education in the schools is needed to inform students about the danger of AIDS (Acquired Immune Deficiency Syndrome), a sexually transmitted disease. This may open new doors and challenge traditional assumptions about the role sex education plays in our public schools, and it will have important implications for school-based clinics.

Ms Spangler and Ms Albert are policy analysts with the Council's Western Office.

Next year, more than a million teenage girls will become pregnant, giving the United States the third highest adolescent pregnancy rate in the developed world.

December 1987

For Immediate Release

Contact: Beth Fouhy
Mia Day
202/347-5700

NEW PUBLICATION HIGHLIGHTS SCHOOL-BASED CLINIC POLICY INITIATIVES

(Washington, DC) -- In 1986, the state of Oregon proposed a $25 million initiative that would provide funds for the development of 11 comprehensive school-based health clinics, bringing to 16 the number of school-based clinics in that state. Sponsored jointly by the state's Departments of Human Resources and Education, the bill would also earmark funding for the prevention of school dropout, teenage pregnancy, and adolescent drug/alcohol abuse. This bill represents just one of the many state actions highlighted in **School-Based Clinic Policy Initiatives Around the Country: 1986**, recently released by the Support Center for School-Based Clinics, a project of the Center for Population Options.

Policy Initiatives Around the Country is a unique resource that offers an overview and description of school-based clinic-specific policy developments which occured at the federal and state level. Designed to assist policymakers and school-based clinic advocates in formulating plans and actions, the information provided, obtained through a national survey, represents the most complete and accurate compilation of its kind available.

More than 35 initiatives addressing school-based clinics were acted upon in 1986, including 15 bills, 14 task force recommendations, and at least seven executive branch actions. (In comparison, in 1985 there were only 13 such initiatives.) A brief description of each action is provided as well as a summary chart of activities. Drafts of actual legislation and a sample state health department "request for proposal" are also offered.

School-Based Clinic Policy Initiatives Around the Country: 1986 is available for $3 (plus 15% postage and handling) from: CPO Publications Dept., 1012 14th Street, NW, Suite 1200, Washington, DC 20005.

The Support Center for School-Based Clinics is a project of the Center for Population Options, a national organization dedicated to the prevention of unintended teenage pregnancy. CPO's Support Center provides individual technical assistance, regional training, public policy analysis, an annual conference, and publishes a quarterly newsletter.

"Sex Education is now more than ever important."

The Surgeon General,
Anchorage Daily News
March 2, 1988

WASHINGTON -- Surgeon General C. Everett Koop told a White House panel Tuesday he is concerned abut the spread of the AIDS virus among teenagers and expressed outrage at suggestions the disease cannot be spread through heterosexual intercourse.

Reiterating his call for sex education programs beginning at the elementary levels, Koop said, "I think it is quite possible to raise a generation of adolescents down the road that would be far less sexually active than the present one.

He emphasized that such programs should involve parents and incorporate moral and social values along with anatomical studies.

Although only a relative handful of the more than 50,000 AIDS cases reported so far involve teenagers, Koop said little information is available on the extent to which the virus may be lying dormant among that group.

Because of the long incubation period of the disease -- five years or more -- Koop said he is reluctant to rule out an outbreak of AIDS cases in young heterosexual adults who contracted the virus as teenagers.

Are You Interested?

For more information contact:
Barbara Krygier, R.N.
(SERRC)
586-6806
For information on:
The Alaska Adolescent Family Life Project

A Project of
South East Regional Resource Center (SERRC)

Using the curriculum
Values & Choices
Search Institute
Minneapolis, MN

Search Institute is a not-for-profit organization with 28 years of experience in research and program development for youth and their families

Funded by a grant from
Office of Adolescent Pregnancy Program
U.S. Dept. of Health & Human Services
February 1988

Alaska Adolescent
Family Life Project

Values & Choices

A Guide for Teen Sex Education

South East Regional Resource Center
(SERRC)
210 Ferry Way, Suite 200
Juneau, Alaska 99801
(907) 586-6806

7th & 8th Grade Teens are. . .

Prime

Time

In 1983, 1.3 million teenagers became pregnant. Most of them neither wanted a child, nor expected that pregnancy would ever happen to them.

Alaska Teen (15-19) pregnancy rate is 13% higher than the national average and for Alaskan native teens 70%. More than 600 Alaskan girls high-school aged and younger will have babies this year.

Adults of both liberal and conservative learnings believe that parents should take part in their own children's sex education, but research shows t[illegible] few do. Students in their late teens report learning about sex mostly from their friends, and mostly between the ages of 10 and 13. This age group needs help from adults in understanding issues related to sexuality and in making positive life choices.

Parents want to be involved. In a recent national survey, 80 percent of parents said they needed help in educating their children about sex.

The goal of the Alaska Adolescent Family Life Project is to prevent teen pregnancy by:

1. Teaching parents to become the main educators of their children's sex education.

2. Teach parents and children about the consequences of early sexual activity.

The curriculum chosen to accomplish these objectives is Values & Choices.

Values and Choices is a new program in human sexuality developed by experienced educators and piloted and tested nationally. Designed for 7th and 8th grade students, the course has four important features:

1. Instruction founded on seven basic human values.

Classroom discussion and activities help students focus attention on seven basic values, which are applied to behavior in general as well as to specifically sex-related behavior. The values are:

- •Equality
- •Promise-Keeping
- •Honesty
- •Self-Control
- •Respect
- •Social Justice
- •Responsibility

The course shows that these values are essential to the growth and maintenance of all positive human relationships.

2. Lively and informative videotaped segments.

Stimulating informative video segments illustrate the concepts being discussed. Some include interviews with teen parents who talk about their experiences. These interviews were taped in various parts of the U.S. and reflect a variety of ethnic and economic backgrounds.

3. A fifteen-lesson curriculum with extensive teaching helps.

1. Starting Out! (Self Esteem)
2. What's Really Important? (Seven Basic Values)
3. Changes (Puberty)
4. More Changes (Feelings of Attraction)
5. Equal though Different (Sexism & Stereotypes)
6. Making Choices (Decision Making)
7. Going Out? (Dating)
8. Saying NO
9. Pregnancy & Birth
10. Planning for the Future
11. Teenage Pregnancy (The Reality)
12. Teenage Pregnancy (The Choices)
13. Taking Chances (Sexually Transmitted Disease AIDS)
14. The Power of Touch
15. Moving On!

4. Three Parallel Sessions for Parents

A parallel three-session program for parents in which parents preview the classroom videotapes and are introduced to the activities planned for their children's in-class instruction. Parent participation is an extremely valuable part of the course. However, lack of parent attendance does not prevent students' participation in the class.

SOUTHEAST REGIONAL RESOURCE CENTER

ALASKA ADOLESCENT FAMILY LIFE PROJECT

Southeast Regional Resource Center was awarded the Adolescent Pregnancy Prevention Grant from the Office of Adolescent Pregnancy, US Department of Health and Human Services in November, 1987. The project manager of the program is a nurse with a strong background in sexually transmitted diseases, AIDS, and Pediatric nursing. A total of 165 seventh and eighth grade adolescents participated in the human sexuality class, *Values and Choices* during the Spring of 1988. The students were from the Southeast communities of Haines, Juneau, and Ketchikan. The goal of the program is to encourage the postponement of premarital sexual activity among adolescents through three objectives:

1. To help parents become effective in transmitting factual information, values and attitudes about sex and sexual activity to their children.
2. To increase adolescent awareness of the responsibilities of sexuality and the dangers of early sexual activity.
3. To provide life-planning counseling for adolescent females who have been identified as high risk for early sexual activity.

Values and Choices is designed specifically for seventh and eighth graders. The course runs for three weeks on a daily basis or it can be adapted to be used on a once a week schedule as was done in some Southeast communities. *Values and Choices* includes the following units:

1. Starting Out (Self Esteem)
2. What's Really Important? (Seven Basic Values)
3. Changes (Puberty)
4. More Changes (Feelings of Attraction)
5. Equal though Different (Sexism & Stereotypes)
6. Making Choices (Decision Making)
7. Going Out?(Dating)
8. Saying NO
9. Pregnancy & Birth
10. Planning for the Future
11. Teenage Pregnancy (the Reality)
12. Teenage Pregnancy (the Choices)
13. Taking Chances (Sexually Transmitted Diseases)
14. The Power of Touch
15. Moving On

There are three parallel sessions in which parents preview classroom videos and activities followed with discussions and activities. Parent participation is an extremely valuable part of the course. However, lack of parent attendance does not prevent student's participation.

Pre and posttests were administered to measure the effectiveness of the program in the areas of knowledge, parent communication and attitudes toward sex. Based on the evaluation results, the course was effective in increasing students knowledge of human sexuality issues; changing student's attitudes towards teen pregnancy; and increasing parent communication on sexually related topics.

Values and Choices is successful in accomplishing the goals which the curriculum's designers set for themselves. It increases knowledge concerning human reproduction and the effects of teenage pregnancy; it increases support for a number of values which are consistent with preventing the premature initiation of sexual intercourse; it has strong impact on awareness of sexually transmitted diseases; it influences the intention to engage in teenage intercourse; and it does all this without carrying the "Say No" message to the point where it has negative impact on the overall attitude toward sexuality. Not only is the curriculum effective but responses from parents and teachers show that it was well liked in Southeast this past year.

Response to comment: "Sex Education Should Be Taught At Home"

Statistics reveal that most kids watch 7 hours of TV per day. If a child is watching just four hours per day, they are viewing 9,000 scenes that are sex related per year. Are you as a parent having 9,000 conversations per year to counteract the misinformation they are receiving by way of the TV?

Research also shows that kids who make better decisions regarding sexuality (postponement of sexual activity) have good communication with their parents.

Response to comment: "If you teach them about sex they will go out and do it"

Research shows that it is not what kids learn about sex that make them go out and do it, but it is the lack of information and the unanswered questions that cause experimentation. (from Sol Gorden, sex educator)

12 AND 13 YEAR OLD KID'S ANONYMOUS QUESTIONS BEFORE THE COURSE

How old are most kids when they first have sex?

Do girls get as worked up as boys about sex?

How do you insert a tampon, and in what hole do you put it in? They won't fit in my vagina!

Do they really make swirly colored condoms and different colored ones?

Why are we doing this? Why not start it in high school?

Why do we have to do this?

I think this is gross. Why do boys always want to lick out girls and they want girls to give them head?

I don't get how you know when you're going to have your period. If you mark it on the calendar can you tell?

What are breasts made of?

What is the age that is right to get laid? Is it wrong to have sex before 18?

Why do we have to say if we have screwed a girl/boy? Because it's none of your business.

What is the teenage percent of sexual intercourse?

What is masterbating?

Do you have kids - where and how did you first have sex?

How big can a penis get?

If I am pressured to kiss a person should I?

Will a girl get pregnant if she is standing up during intercourse?

What's a blow job?

What is the white fluid that comes from your vagina that is not your period or egg?

What makes babies get kidney problems? Is it the parent's fault?

Medical Consequences of Early Sex & Multiple Partners Among Teens

1. AIDS has been diagnosed in 200 U.S. teenagers. Little information is available on the extent to which the virus may be lying dormant among sexually active teenagers.

2. Genital warts are transmitted predominantly through sexual contact; often affect young women & contain an agent which belongs to a group of oncogenic (cancer causing) viruses (p. 500, Holmes STD.) Basically this means that of the 40 wart viruses identified, 5 are found in the genital tract, 2 of which are cancer causing.

3. Quotes from Holmes: *Sexually Transmitted Diseases*
   A. A history of veneral disease was equally common among teenaged serial monogamists(single partners) and sexual adventurers (multiple partners).
   B. The anatomy and physiology of the adolescent's cervix make it especially susceptible to gonococcal and chlamydial infection. Cervical ectopy, which exposes columnar epithelium(a type of cell directly to the male's ejaculate and urethral discharge, may increase the adolescent female's likelihood of acquisition of gonococcal infection in any single coital (sexual intercourse) episode. The same is true for chlamydia
   C. Infants of adolescent mothers probably suffer some 10,000 cases of chlamydia pneumonia annually.
   D. Carcinoma of the cervix is linked with early age of first intercours and multiple sex partners.

4. Abstinence is the only 100% effective method for the prevention of STD's and pregnancy. It is a positive choice for many adolescents that health-care practitioners should reinforce and encourage. Health care providers must continue to encourage adolescents to think carefully about their values on sexual activity and to help those who have chosen not to be sexually active. (Journal of Community Health Nursing, Vol. 4, N#4, 1987.)

SEVENTH GRADE KIDS ANNONYMOUS QUESTIONS FROM ALASKA'S ADOLESCENT HUMAN SEXUALITY COURSE

Questions are copied just as kids wrote them, with no corrections in spelling or grammar.

Questions related to pregnancy:

Can a girl get pregnant if they stop having sex before the ejaculation?
If a baby is born dead, can the mother nurse another baby if the baby's mother's milk is not good?
How do you know if you can get a girl pregant?
If a male ejaculates into a girls anus will she get pregnet?
I think I'm pregnant
If you have sex, but you've never had your period, can you get pregnant? *(This question was asked a total of 3 times)*
Does a women feel different when she is pregnet
If you want to have more than 2 kids at the same time, do you have sex that many times? If so how does a lady have the room?
How can a pregnant women give birth to quadrupulets? would she have to have sex 4 times? How would she have enough room for them to grow inside her?
What if a woman doesnt want to have a baby but is scared to have an abortion. What would happen if she kept the baby in the vagina?
If a man ejaculates before sex can the lady still get pregnet.
How can douche increse risk of pregnancy?
If they don't have the father in with the delivery, than why do they have Lumonz classes?

Questions on masturbation:

Can you get an STD *(sexually transmitted disease)* by masturbating
How do girls masterbate
Can jacking off hurt you
What Does "Jacking off" mean
Why do people master Bade

Questions on condoms:

Are condomes 100% safe? If you use a rubber, and use it right, will you not get pregnet?
How so you get your tubes tied?
If you're "fixed" and you have sex, can you get the lady pregnet: if the guy is "fixed"
How do boys no what size of rubbers to use?

If a boy uses a rubber, and the sperm leaks out of the rubber is that very common?
Whats the difference beetween a lubericated and a non-Lubericated rubber?
If you used a rubber semicid or a sponge or diaphram or somethibng, are you 100% safe?
What is a diaphram?
Is there a kind of rubber for girls
Do girls use condems
How can you get a condom if you are scared to but them or go to the Health clinic
Are you going ot show us a rubber, birth control pill and or other birth control uses?
What if the rubber slips off into the vigina w. .le having sex? can you get it out.
If I used a rubber would I still catch the diseases?

AIDS questions:
Ive seen show were guy's are in love with guys one always seems to have aids, why?
Can a man get aids if he ejaculates then drinks his own semen?
How can you get aids when you are in love with the same sex?
To prevent Aids can you use type of things that prevent pregnancys (beside condoms)
What happens if you have AIDS and your wearing a condom and if gets a tiny hole and a few sperm escape?
How long is it going to be before there is a cure for Aids
Can you get Aids from french kissing

Question concerning homosexulaity:
How does a girl and girl have sex!
How do lesbeons have sex
Do male homosexuals have a smaller penis? And do lesbians have smaller breasts?
What is a Bisexual and a trisexual?
Why are there homosexual's

Questions regarding menstruation:
What if I have my period in class and I'm not wearing a pad
What is a period?
I heard if you start to use a tampon at ayoung age you won't function right, is it true?

Questions regarding relationships:

Is it normal to like your best friends brother?

One of my best friends is dating a boy Nobody approves of. He both smokes and drinks. She has a very strong need to be loved. I feel she might so anything for him. Should I get involved?

If I like someone, how do I let him/her know without seeming stupid?

If I like a girl realy bad, but I don't know if she like me, how do I find out?

What do you do if some one talks to you about someone else and the person who they are talking about talks to you about the person who was talking about them in not so good of a way

What do I do if someone I'm Really Really in love with, likes me just a little, and he keeps trying to get me jeleous. When I was at the dance he kept slow dancing under my nose. So I started crying and he saw me and asked me 2 dance at the last dance. What Do I Do?

Personal questions for the teacher:

Have you had sex? Was it fun?

Have you ever tried a vibrator?

Are you or your husband "fixed"?

What did you think of the letter in the Newspaper?

Hy how is you doing?

Do you have any kids?

Have you given your husband a blow job? Did he like it? Did you?

Do you get embarressed talking about sex and is it O.K. to get embarressed about it?

When did you first have sex, where, how old, why?

Are you Gay!

Are you seually Active?

Do you use a vibrator?

Is it hard for you not to express your feelings while teaching this class?

Do you like this job and why did you get this job

Questions on body changes:

Would the lady that has biger breast give more milk than the lady that has smaller breast.

If a girl has small breasts does that mean that she is slim and girls with Big Breasts fater

How so you know if you can sperm?

How does puberdy have afect on macherity

What do I do if my friends kid me about my breast size?
What should I do about people teasing me about having no Breast?
When your voice begins to Yodel, how much more longer untill you voice changes?
How come your hair still grows when your dead
What is pubic hair
Why do blondes ten to have pubic hair blond
When girls shave their underarms do you save up or down
Is it OK to cut or shave you pubic hairs?
When you have an erection why does it get hard because there is no bone there is there
What hapens to girls when they get hornys like when a boy gets an erection
Guys get erections when they see girls in a way what happens to girls in this position
When a boy is turned on his penis get's hard. When a girl get's turned on do her niples get hard?
Boys get erections when they get horny - what happens to girls
I always have this slimy sticky stuff in my underware. Am I normal? What is it?
Do breasts have milk all the time and if men suck on them does milk come out.
Does the girl that has smaller breast give the same a mount of milk than a girl that has biger Breast.
Why do Men like Women with big Breast, and Big thies?
What is a penis made of?
How old should you be to ware a tampon?

Questions on sexually transmitted diseases (STD):
What else can you use besides the condom to not catch STD/AIDS
Crabs?
What is herpes? *(Asked a total of four times)*
Can you get herpes from oral sex

MISCELLLANEOUS
Why do girls give boys blowjobs?
What is eating out a girl
Exactly what is oral sex? *(Asked a total of 5 times)*
How do you French Kiss
Can you get sick or what could happen if you french but not for a long time
What are blow jobs?
What and where is the rectal area?

What is ment by sex up the butt
What if butt f-------(you know what) or making love through the butt
What's the difference about having sex standing up or laying down
When the penus goes into the lady, does it hurt?
What would happen if the penis is put to far into the vagina
What would happen if a lady got her things cut and the man didn't know she did and had sexual intercourse? Would she become pregnant
Does it feel good when a boy ejaculates inside you? and does it hurt the first time if it is present
How old do you have to be to have sex?
Why do people like sex so much? and it makes them feel so good
What should I do if my girlfriend asks me to have sexual intercourse with her.
How many times can a man ejaculate at one time.
What are douches good for?
How do you have sex if the boy is bigger than the girl or the girl is bigger than the boy.
When a penis enters your vagina doe it hurt?
When you have sexual intercourse do you move the penis up and down in the vigina
If you were parlyzed from the neck down would you still be able to have sex.
Do Elders have sexual intercourse?
What is the cut off for having sexual intercourse for elders
How come some people like to make love alot
How did sex start! Ibet the government made the virus so in the future the population would be equal.
Why do people have sex before they are married?
Why do people not use birth control when they don't want babies?
How did the teenage pregnancy start so much. I mean when did the percent go up.
What percent of teen mothers go on to have a good life?
Why do kids are age have sex?
Why is sex so important to bays!
You aren't answereing my questions!
How can a Guy get raped
If you had sex with your sister what would happen with the baby?
What so you so if someone like your brother has made you feel uncomfortable?
What is an orge?

Is it wrong for girls to use a dildo?
Why do they call sex entercrose? Please answer
Can you have kid when you are older than 45 whats the age limit
Why are we doing this
Why are we having this class

Verbatim Responses From Students

This class is very valuable for teens that are learning about sex. We learned about almost everything we wanted to know and found out more of what we didn't know much about. In the future I think that boys definitely need to be in this class. They are the ones who need to learn the most about sex and the choices that they will make in their lifetimes. Boys really don't know much about these things but they pretend that they do. They really need to know the facts. Thank You.

I think that the Values & Choices class was good. Not to brag or anything but my family is very open so I already knew just about everything that was discussed. But I suppose that the material we went over was the stuff we should have gone over. Most of all I think that there should be boys in this class. Maybe for the first half of the "season" like, they should have their own class. But then the last half of the year, they can have their class with us. Well, later.

I think this is a very good class for 8th graders to take. I think they should have a separate class for boys and sometimes the boys and girls could get together and tell each other how they feel about sex so they could try to understand each others point of view.

I think this class should keep going on next year! It should be boys and girls. Because guys get the wrong idea sometimes and think that what she wants is sex!!! In this class the best things to me were the videos you showed us on the VHS!

I think the Values & Choices class would be good enough for next year too. They should have one for boys. I think they should have it twice a week but shorter. It was a great class & I learned a lot from this class.

I think that the Values & Choices class has taught me a lot. I probably would have taken a wrong turn if I hadn't taken this class. It might have saved my health. It was well worth our time. I have benefited from this. I know why & what about human sexuality. Now I know that I'm not the only one. Everyone else is going through the same thing. Thanks!

I think that the Values & Choices class was really good. It was a very good idea and should continue. I think they should have a guys class too, but with an only guys and an only girls. Guys shouldn't be left out from everything we've learned. Thats not right. Values & Choices has taught me alot & I'm sure it's taught everyone else alot too. Thank you for having it.

Values & Choices was a good class, and I think they should have this class next year with boys, so that boys know what to expect when they have sex, and that sex can be fun when your ready for it, and when your not ready for it, it can be a problem. I learned lots of things about this class, and some of the movies were really good. Thank you for having me in here.

I like being able to talk about stuff when it was necessary and need to be able to discuss our problems with each other. It was quite interesting. I would have put the group in a more convenient spot and every day of the week instead of just one. Things that I learned that I can use later in life would be all the stuff in the movies and what you taught us.

The class was very interesting. The discussions were neat because alot of people gave their opinions and reallu opened up. I've learned to show more respect for myself, stand up to

boys by saying no, holding off sex until I get older and many other things. I think you should keep it up.

I really enjoyed this class, it taught me to watch myself around guys and how to deal with heavy situations. I wouldn't really want to change anything except for some of the attitudes some of the other girls had in the class.

What I liked about this class is that it really lets you feel open. I guess I already knew this - but it helps you make hard choices, like teen pregnancy and what you'd do in a bad situation.

I liked this class. I learned alot and it helped me build my self confidence.

I liked it because we get to watch movies. I would change the class to have guys in the class because they deal with this stuff too. The thing that we learned will help us say NO to things we don't want to do.

Well, first I liked the gettin- out of P.E. and second we learned about how you can get diseases and tell if you can get rid of the diseases. But I like this course alot and the only thing I would change is put boys in the class.

During this human sexuality class I learned alot about birth. In my other Sex Ed. classes they didn't talk about that so I thought it was good. I think there should be more role playing because I'm sure that would help kids in years to come. This class will give me knowledge on STD's and pregnancy and I will use it in the future. I think that this was a good class and it should be continued.

I liked the part about the diagrams of the opposite sex because I really didn't know where things were at. I wouldn't change a thing about the course, things that will help me in the future were the values. I think it is a great class.

I liked what was being taught and I learned alot. At the beginning it was really boring. I think on the first part you should push it faster and not make it so long. About Aides and the other diseases, that was really interesting and go on that topic more.

I liked the Values because they are important. I would make the part about STD's longer and more understandable so people know more about it. The decision making part will help m make lots of decisions.

I like the whole class because it taught me alot about what is going on in our bodie know my dangers now so I will be careful of what I do.

I liked the class because it was fun and helped others understand alot of thir feel are uncool. I probably would have tried to put a little more on AIDS in the pr it's such a serious problem. Maybe peer pressure too.

The class was excellent and I especially like the films because they s thinking about for a long time. I would change the part where your always values because after a while we got tired of hearing about them and start

part was I think the very best thing thats going to help me in the future.

I liked it. It taught me things I didn't know. I also think this is a good time to teach kids these things. The anonymous question box was good.

I liked learning about human sexuality because it will help me make some decisions about how to deal with sex.

I think the things that will help me in the future are about STD's because I will know what to avoid.

I liked the part about geting diseases because I felt I needed to know about it so it would give me another reason not to have sexual intercourse. Everything that was taught to me will help me in the future.

I liked the movies because they were easier to understand.

I I enjoyed learning about diseases because I had many questions about AID's. I would have the boys and girls separated. I learned about the genital organs and about pregnancies. It will help me to know what's going on inside me.

I liked the class because I learned some important things that I will need to know in the time to come. I would change some of the forms that we filled out because they were personal and the teacher didn't need to know. Also at the beginning of class we were told that no one would see the test we were taking. This did not happen.

I liked the whole unit because it taught me alot I didn't know. I also liked how you were straight forward about that. That made me realize that if I had any questions I could ask you without being harssed. I'm glad you came down because what you told me will make me more aware of the consequences.

Well, I liked it when you answered questions in the box because some people were too embarrased to ask it out loud. I wouldn't change anything.

I really liked the whole course. My friends and I talk about sex & stuff, and alot of the things they said were not true. My mom also liked the class because she got to go to those meetings and she said she liked talking about things that girls should talk about. Because we hardly ever talked about sex, only the stuff we heard about on the NEWS about AIDS.

I liked the amonymous questions.

I really enjoyed this class, it was very interesting and I learned alot of things that will help me in the future. I really think you should extend this unit on to next year. Everybody needs to know this kind of stuff.

I thought that this unit was extremly helpful in any sexual decisions we might have in the future. You really opened my eyes on the sexual decisions that have to be made and the consequences that go along with them.

I liked the part about AIDS, I really learned alot. I also liked the movie with the black lady, it was more realistic, she realiy showed why you shouldn't have a baby so young. I certainly won'tI

I think the course was good because it brought forward what many of us didn't know and didn't have the courage to ask about. I think this should go on in schools all over the world to inform kids and adults about some of the risks there are by having sex. The parent involvement was OK and a good idea because the parents got to ask their own questions and find out what the kids were learning. It was especially nice to have such kind. funny and caring teachers like Mrs. Salness and yourself. I hope courses like these continue to aware our nations people & children alike.

I think you should come back next year so I can learn more. I would probably get into nore detail next year. The anonymous questions really helped, so did the homework and the movies. Changes in puberty and not misjudging anyone will help me out for the future with all the diseases now occuring. Thanks so much for teaching us.

I relly appreciate your coming to our class to help us understand some sensitive subjects, that otherwise we wouldn't have talked about. I thought you did a good job of presenting the facts to us, clearly and honestly. I especially enjoyed the videos. I didn't get a chance to write any but I think that the anonymous questions really helped us to know that we were not the only ones with those types of personal question

I liked this class because I learned lots of things about sex through the videos. The thing I didn't like was that the boys and girls are together and that makes me more uncomfortable about asking sexual questions. But I enjoyed writing anonymous questions.

I liked the videos, because you can learn alot more by watching or knowing it happens to other people and not just yourself. I would change the homework and the video just a little bit because almost all the situations are happening to girls and not boys. I learned about AIDS and veneral diseases and how they can be passed on from one person to the next.

I really enjoyed your human sexuality course. I liked the birth. Everyone thought it was gross but I didn't. I think birth is a beautiful part of life. I'm glad that I know about STD's because it's a very important topic. It's a risk to your own life. You handled the topics at our level so we could understand.

I liked the homework with my parents because it's nice to talk with them. I would make more male situations in the video's. I learned a lot about AIDs and sexually transmitted diseases. I now know how to stop muself from taking drugs or having sex.

This class is very important. It helped me make some choices and helped me understand. I think all the units and videos were acceptable to teaching this class. The videos helped me visualize the situations and made the class more interesting. I think there should be a little more talk about AIDs because that is our main social concern right now and I think it needs to talked about more. Thank you for helping me and our class.

THE FOLLOWING DOCUMENT HAS NOT BEEN FILMED BUT IS AVAILABLE IN THE ORIGINAL FILE

Alaska Adolescent Family Life Project

Parent Manual

South East Regional Resource Center (SERRC)
218 Front Street, Juneau, Alaska 99801
(907) 586-6806

THE FOLLOWING DOCUMENT HAS NOT BEEN FILMED BUT IS AVAILABLE IN THE ORIGINAL FILE

HUMAN SEXUALITY

Barbara Kuyquir RN
Bartlett Memorial Hospital
Head Nurse 586 2611 Ext 220
Home 463-5356

Values & Choices

Teacher's Manual