THE
NATIONAL
CAMPAIGN TO
PREVENT TEEN PREGNANCY

Progress Pending

How to Sustain and Extend Recent Reductions in Teen Pregnancy Rates

By Douglas Kirby, Ph.D., Karen Trocoli, MPH

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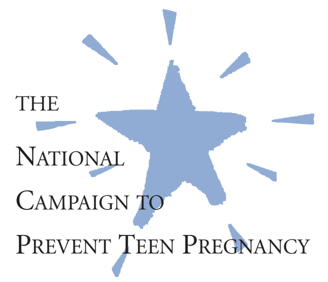

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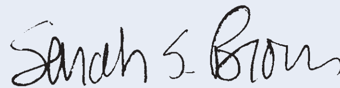
Introduction

The title of this publication — *Progress Pending* — suggests that this nation is on the verge of making significant strides in reducing the rates of too-early childbearing, but that we are in a holding pattern of sorts. Indeed, while recent headlines on the declining rates of teen pregnancy in the United States may lead some to believe this problem is solved, this is far from true. As a nation we still have the highest rate of teen pregnancy among industrialized nations and, when we look further inward — at various states, cities, or selected groups — it is easy to find instances where teen pregnancy and birth rates are stagnant or even increasing. Despite dramatic and encouraging declines nationwide in rates of teen pregnancy and births to teens, our work is far from done. We must take steps to sustain the progress we have made to date and work to extend our successes to areas where rates continue to be stubbornly high.

In order to better understand why progress is pending for some, the National Campaign to Prevent Teen Pregnancy and Covenant House (the largest privately-funded childcare agency in the United States providing shelter and services to homeless and runaway youth) convened a small invitational conference for teen pregnancy prevention leaders in June 2002. This roundtable provided a forum to discuss why there remain areas and groups with high rates; to share strategies that seem effective in reducing the incidence of too-early-childbearing; and to identify strategies for putting this information into practice. The participants raised many compelling points during the meeting that we believed were worth summarizing and sharing. To that end, we have used them to form the basis of the first chapter of this publication.

Chapter two presents a new paper by Douglas Kirby, Ph.D., *Effective Teen Pregnancy Prevention Programs: Do They Work for All?* Dr. Kirby, who authored the landmark report, *Emerging Answers* for the National Campaign, presented a session at the roundtable on what we know about the effectiveness of teen pregnancy prevention programs for various groups of teens. He has expanded on that presentation in the paper and offers a fascinating new perspective on this issue.

We are extremely grateful to the Charles Stewart Mott Foundation for providing the funding that made this work possible. Clearly it is important to remind people that, when it comes to teen pregnancy prevention, there is no time for complacency. We were thrilled to have the opportunity to convene an event with that message at its core. This roundtable enabled us to bring together a dynamic and devoted group of leaders, many of whom have first hand experience confronting the challenges of making progress in this field. We appreciate their time and candor and are glad to have the opportunity to share some of their insights with you through this publication.



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Chapter 1.
Progress Pending:
How to Sustain and Extend Recent Reductions in Teen Pregnancy Rates

By Karen Trocoli, MPH

The news regarding the United States' teen pregnancy and birth rates is encouraging. Since the early 1990s, these rates have been declining, reversing an earlier upward trend. Between 1991 and 2001, the birth rate for 15-19 year-old-girls fell 26% on the heels of four years of increases.[i] By 1997, the pregnancy rate of 15-19 year-old-girls dropped 21% from its all time high in 1990.[ii] These declines have been attributed both to less sex and to better contraceptive use among those teens who are sexually active.[iii]

Still, there is plenty of room for improvement in our teen pregnancy track record, both nationally and among certain groups of youth. Overall, four out of ten girls become pregnant at least once before age 20. That translates into more than 900,000 pregnancies a year and about half as many births among teens, giving the United States the highest teen pregnancy and birth rates of all industrialized nations.[iv] Meanwhile, certain populations of youth, defined by geography, race/ethnicity, poverty status, and other characteristics, have even higher rates.[v] For example:

- Teens who live in disadvantaged communities with high poverty rates are more likely to have sex, become pregnant, and give birth than teens who live in more affluent communities.[vi]
- Significant state disparities exist for teen birth rates. Thirteen states, all clustered in the South — almost one-quarter of the nation — have extremely high teen birth rates that rival the rates of nations such as Azerbaijan, Egypt, and Mexico.[vii]
- While the pregnancy and birth rates for African American and Hispanic teens aged 15 to 19 have declined substantially in recent years, they remain higher than for other groups. African American teens have the highest teen pregnancy rates and Hispanic teens have the highest teen birth rates in the United States.

It is clear that this nation is making great strides in reducing too-early-pregnancy and childbearing, but the success is neither even nor uniform. Too many teens are still becoming parents, often with burdensome consequences for themselves, their children, and society.

In order to better understand why "progress is pending" in too many communities, the National Campaign to Prevent Teen Pregnancy convened a small, invitational conference (a "roundtable") — in partnership with Covenant House and with funding from the Charles Stewart Mott Foundation — for teen pregnancy prevention leaders to explore why there remain areas and groups with high rates, to discuss strategies that appear effective in bringing high-rate areas more in line with national trends, and to consider what kinds of additional efforts are needed to sustain and extend the recent reductions the nation has experienced in teen pregnancy and birth rates.

Chapter one of this publication highlights some of the compelling points that emerged during the roundtable. It offers a set of observations that should be considered carefully by anyone working to reduce teen pregnancy, but particularly those focusing on groups of teens who are experiencing disproportionately high rates. This chapter is by no means a comprehensive report on "what works." Rather, it is an overview of some salient issues offered by those who work directly in communities with high rates of teen pregnancy, interspersed with additional information from other Campaign research, teens themselves, and other publications (including *Effective Teen Pregnancy Prevention Programs: Do They Work For All?* By

Douglas Kirby, Ph.D., which appears in its entirety as Chapter 2 of this publication.)

I. When it comes to declines in teen pregnancy rates, for many, the "glass is half empty."

Recent headlines on the declining rates of teen pregnancy in the United States may lead some to believe that this problem is solved and we can turn our attention to other issues. Overall the news *is* very good: the teen birth rate in 2001 reached its lowest level in 60 years.[viii] Some states — such as California, which saw its teen birth rate drop to its lowest level in decades between 1999 and 2000 — are reporting wonderful progress in reducing teen pregnancy rates. And a recent report from the Annie E. Casey Foundation lists 43 of the largest 55 U.S. cities as experiencing decreases between 1990-2000 in the percent of all births that were to teens.[ix]

While we can — and should — be proud of this progress, when we look beyond the headlines it becomes clear that this nation's work in reducing rates of teen pregnancy is far from done. Whether using a lens of geography or population groups, it is easy to find instances where teen pregnancy and birth rates are stagnant or even increasing. Despite impressive declines, the United States still has the highest teen birth rate among industrialized nations, as noted earlier. Examining trends among racial and ethnic groups reveals huge disparities in teen birth rates and in the pace of improvements over time. More specifically, while non-Hispanic whites, African Americans, Asian/Pacific Islanders, American Indians and Latinas all had decreases in birth rates among 15-19 year old girls between 1991-2001, Latinas' birth rates are three times the level of non-Hispanic whites.[x] And although every state in the nation reported decreases in birth rates for 15-19 year olds between 2000-2001, their results varied widely. New Hampshire had a teen birth rate of 21 per 1,000 compared to 68.5 per 1,000 in Texas. Also important to note is that even states with encouraging trends, such as California, have pockets without progress. Mirroring the national story, California's Latina teens have birth rates that are much higher than their non-Latina peers: California's 1999 birth rate for non-Hispanic white teens is 25.2, compared to 83.4 for Hispanic teens.[xi]

At the roundtable, two related questions surfaced: how can we better document these troubling trends; and what do we do with such data once we have it? Responses included the following.

Track Trends…If You Can: While national and state level data on teen birth rates are relatively current and accessible, local data are less likely to be as up-to-date or available. Some health departments and private organizations, such Child Trends, Inc. and the Annie E. Casey Foundation's Kids Count project, work hard to compile this information, but the data are not always comprehensive or collected uniformly across communities. Community leaders, advocates and policymakers should find out what kinds of data collection go on locally and see whether existing systems allow one to assess where teen birth rates are disproportionately high. If not, steps should be taken to improve such systems.

Several States are Using Innovative Strategies to Document Teen Pregnancy "Hot Spots": For example, the California Health Department (CHD) used geographical census information to map areas where there were a disproportionate number of teen births. Called "Hot Spots," these are the 25% of California zip codes that have the highest rate of births to 15-17 year olds.[xii] CHD published these findings and invited communities that were identified as hot spots to apply for funding to help reduce teen pregnancy. The New Mexico Teen Pregnancy Prevention Coalition (NMTPC) also undertook a similar project called the "Challenge 2005 Mapping Project." NMTPC and staff from the Department of Health's Office of Adolescent Pregnancy Prevention and Abstinence-Only Education Program agreed to a goal of reducing the teen birth rate in New Mexico by 20% by 2005. They realized that in order to do this, they needed a better understanding of how teens were faring county-by-county in

terms of dropout, birth, and poverty rates. This information is being collected on an ongoing basis and compiled into periodic reports. The information is then used to guide new program development that is responsive to the identified needs, resources and profiles of each community.

Consider Qualitative Measures of Teen Pregnancy Trends: To supplement the numbers, some have conducted focus groups of parents and young people to better understand what is going on in specific communities. For example, California's "Get Real About Teen Pregnancy" public education campaign conducted several focus groups (the full report is available www.letsgetreal.org/pdfs.voices.pdf), which yielded important context to the research and other interviews that were conducted as part of this project. One of the insights from this particular focus group work was that many African Americans expressed the belief that teen pregnancy had become normal and accepted in some communities, encouraging a repetitious cycle of too-early pregnancy and parenthood.

II. Answers are emerging about program effectiveness for various groups of teens

Researchers have been studying the effectiveness of various approaches to preventing teen pregnancy, and this growing body of research suggests that many are working. These findings have been detailed in the National Campaign to Prevent Teen Pregnancy's 2001 report, *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy*, authored by Douglas Kirby, PhD. This report provides information on specific approaches that appear effective, identifies key characteristics that effective programs have in common, and offers tips for replicating effective programs to increase the likelihood that they will succeed.

Yet even as *Emerging Answers* has answered many questions about what works in teen pregnancy prevention, it also has raised others. One of the most often heard from practitioners is: "Will these programs work in *my* community?" For instance, will these programs be as effective with Latina youth as they are for African American teens? Will they work as well with middle class suburban kids as with poor, inner city teens? To help answer these questions, Dr. Kirby reviewed the teen pregnancy prevention literature again in 2002 for the National Campaign to Prevent Teen Pregnancy, with an eye towards what the findings suggest about effectiveness for various groups of youth. His paper, which is chapter two of this volume, offers the following conclusions:

- Several teen pregnancy prevention programs have proven effective regardless of participants' race/ethnicity, gender, age/grade, prior sexual experience, or the income levels of their communities.
- Teen pregnancy prevention programs may be particularly effective with higher risk youth. Although it is difficult to measure the relative impact of each program with different groups, studies suggest that many are more effective with youth who initiate sex early, have unprotected sex, or who are teen parents. It is important to consider, however, that the majority of programs have been implemented and evaluated in low-income communities, which means there is simply more data available on their impact with poor youth.
- When determining which program to put in place, practitioners should, of course, carefully consider the characteristics of the youth they are trying to serve so they can select an intervention that will best match the young people's needs.

In addition to considering this interesting new research, practitioners also can learn about promising programs through anecdotal and other evidence. This is important to keep in mind because only a few teen pregnancy prevention interventions have been rigorously evaluated. Parents, community leaders, and those who run programs often have data and experiences that can enhance our understanding of what works in certain communities or with specific populations. Several

leaders provided important observations and context during the program panel at the roundtable.

- Pathways/Senderos Center, a project of Greater New Britain Teen Pregnancy Prevention Inc, is a neighborhood-based program that primarily targets low-income Latino youth and their families, many of whom come from homes that were started by teen parents. The program is based on the Children's Aid Society-Carrera Program, an intensive, long-term and comprehensive program that offers services ranging from family life and sex education to academic assessment and tutoring to involvement in arts and sports. Pathways/Senderos offers comprehensive services to prevent teen pregnancy and improve the well-being of youth generally. Since its launch in 1993, Pathways/Senderos has served as a neighborhood center for children and has sought to increase rates of high school graduation and decrease teen pregnancy rates. Fully 100% of youth in the program have graduated from high school, and half have gone on to college. There have been only two pregnancies.

- Covenant House is the largest privately funded non-profit childcare agency in the United States, providing shelter and support services to at-risk, homeless and runaway youth. Established in 1994, Covenant House Washington serves Wards 7 and 8 in Washington, DC, areas characterized by high rates of poverty, school dropout, substance abuse and low literacy. It comprises one fourth of the population of the city and contributes over half of all teen births. Among the myriad programs Covenant House Washington offers is the Peer-Supported Pregnancy Prevention Program (PSP3), a youth leadership program designed to help 10-14 year-olds confront teen pregnancy by providing them with empowering activities ranging from homework tutorials to career development.

- The Women's Association of Hmong and Lao's Teen Pregnancy Prevention Project (T3P), located in St. Paul, Minnesota, is a part of the MN ENABL (Education Now and Babies Later) project. ENABL encourages Hmong youth ages 12 -14 to delay sexual initiation. Many Hmong families are refugees, 65 % live below the poverty level, and only 31 % of Hmong students graduate from high school and/or continue on to higher education. Meanwhile, the birth rate among Asian females ages 15-19 is more than 3 times higher than their non-Hispanic white peers.[xiii] In an effort to reduce these rates, T3P educates Hmong youth about the risks of early sexual involvement, educates their parents about how to communicate better with their children about sex, and uses high school students as peer educators.

Although the three programs described above serve diverse populations, the roundtable discussion led to the identification of some common guiding principles. These include the following:

Commit to being there for the long term. Problem-plagued communities are used to seeing programs come and go and, for that reason, they often are reluctant to embrace new ones. In order to gain the trust and participation of the community, teen pregnancy prevention programs should pledge from the outset that they are committed to becoming integrated, permanent members of the community.

Involve parents in ways that work for them. All parents, no matter their backgrounds, ethnicity, or income level, want to see their children succeed. However, some parents may have difficulty participating in programs for various reasons, such as inconvenient meeting times or childcare problems. Programs need to consider strategies for accommodating teens' parents so they can become involved.

Teen pregnancy is just one of many problems for these communities. The neighborhoods these programs serve tend to be plagued by numerous problems ranging from poverty and violence to drug abuse. Teen pregnancy is often just one symptom of an overarching lack of hope and vision for a positive future, and a pervasive lack of good educational and social services and job opportunities. The services that community-based programs offer need to go beyond the mechanics

of teen pregnancy prevention and strive to provide youth with the motivation, skills and opportunities they need to take action so they do not become parents too soon. Several participants alluded to a simple observation by Marion Wright Edelman, founder of the Children's Defense Fund, that hope is a powerful contraceptive.

III. Consider the context in which youth are making decisions about sex and relationships.

Understanding why progress is pending in reducing teen pregnancy rates requires considering the various factors that influence young people's decisions regarding sex, love and relationships. Public opinion polling by the National Campaign to Prevent Teen Pregnancy has provided some general insights:[xiv]

- A "parent gap" exists when it comes to teens' decisions about sex. When asked who influences teens' decisions about sex the most, more adults cited teenagers' friends (30%) than any other source. Only 8% of teens, however, say friends are most influential.
- Nearly seven out of ten teens (69%) agree it would be easier for them to postpone sexual activity and avoid teen pregnancy if they were able to have more open, honest conversations about these topics with their parents. One of four teenage girls say their parents have discussed sex, love, and relationships with them "not nearly enough."
- Teens say morals, values and/or religious beliefs influence their decisions about sex more than parents, concerns about pregnancy and sexually transmitted diseases, friends, teacher and sex educators, or the media.
- The overwhelming majority of adults (88%) and teens (83%) wish the entertainment media more often presented the consequences of sex, including teen pregnancy.

Two organizations that participated in the roundtable have explored these issues further through focus group work with a variety of racial and ethnic groups. MEE Productions (Motivational Education Entertainment, Inc.) is a communications firm that provides research-based communications strategies for reaching and influencing urban populations. MEE specializes in public health issues, including reproductive health, and has published several reports, including *The MEE Report: Reaching the Hip-Hop Generation* (available at www.meeproductions.com), a detailed examination of sexuality issues and other elements of urban youth culture. Among the findings highlighted by MEE at the roundtable were the following:

- Three important factors greatly influence urban youth: peers, adults and the media.
- Peers are particularly important because, for many high-risk urban youth, they function as their family.
- Media has a large presence in the lives of urban youth because they spend so much time watching television, music videos and movies.
- Adults can have a tremendous impact on adolescents by spending time with them and engaging them in meaningful discussions.
- Many adults are unfamiliar with the shows and music these teens are consuming, making it difficult for them to combat any negative messages youth may be receiving.

As noted earlier, California's "Get Real About Teen Pregnancy" public education campaign conducted a study that included fourteen focus groups with Latino, African American, Thai, Filipino, Hmong, Cambodian/Khmer and Pacific Islander adults. The goal was to better understand how to create policies and programs that are effective with the state's diverse populations. The resulting publication, *Voices of California: A Multicultural Perspective on Teen Pregnancy* (www.letsgetreal.org/pdfs.voices.pdf), found some themes that cut across cultures and others that were more culture specific. For example, across all cultures:

- There is a belief that if young people have a sense of hope for the future and a clear sense of how to set and achieve goals, they are less likely to experience an unplanned pregnancy or to choose early parenting. They are also more likely to take steps to prevent pregnancy.

- The influence of parents or other important adults in a children's life is viewed as important in reducing the risk factors for early sexual involvement or teen pregnancy.

- Religion and spirituality play a factor in people's decisions and views about teenagers and sexuality.

Culturally specific findings included the following:

- For many African Americans, the issue of teen pregnancy has much less of a stigma than it did twenty years ago. In many of their communities, it has become a normal situation. Meanwhile, marriage has become less of an option because of changing values, norms and behaviors.

- In the Hmong and Lao community, early marriage is a tradition and teen pregnancy is a normal outcome of this practice. However, the economic and emotional demands of raising a family in the U.S. are bringing about a change in this view.

- Among Latinos, the level of acculturation influences teen pregnancy prevention issues, attitudes and behavior.

Finally, the roundtable included a panel of urban teens that worked with MEE productions. They offered several observations about these issues:

- Parents often make assumptions about what teens are doing rather than asking them directly.

- Boys and girls get different messages about becoming a teen parent. Girls hear that it will be their responsibility to raise the child; boys often hear that they will not be responsible for raising the child. In fact, some said boys are discouraged by the mother of the child from being involved and engaged.

- The best ways to get and keep teens engaged in teen pregnancy prevention programs is to give them something positive to work towards and help them build meaningful relationships with adults.

Collectively, these comments from adults and teens shed light on the powerful dynamics that influence decisions about sex and relationships. They underscore that, although some perspectives and beliefs are widely shared, others are unique to particular communities. This echoes the findings of Dr. Kirby's *Effective Teen Pregnancy Prevention Programs: Do They Work for All*, which concludes that, although many programs have been found to work across the board, practitioners must take into account the unique qualities of each community to ensure its specific needs are met.

IV. Good intentions are necessary but not sufficient

It is up to teen pregnancy prevention leaders — and other adults — to keep this message front and center: when it comes to sustaining and extending our progress in preventing teen pregnancy, there is no room for complacency. An important part of that message must be that even the best-intentioned programs can only be successful if they have sufficient funding, trained staff, and community support.

The issue of how to secure ample and consistent funding for teen pregnancy prevention programs arises frequently among practitioners and came up often at the roundtable. Many of the program representatives at the roundtable reported that this was a primary concern for them. Fortunately, several of them had been successful in this regard and reported new and innovative sources of support. For example, Pathways/Senderos has support from entities ranging from the Connecticut Department of Social Services Community Development Block Grant to the Work Force Investment Board

and its own bike-a-thon fundraiser. Covenant House Washington's PSP3 is supported by a strong public-private partnership that includes the Income Maintenance Administration, the Stewart Trust, and the Summit Fund of Washington. To guide programs in seeking such "non-traditional" sources of funding for teen pregnancy prevention, The National Campaign to Prevent Teen Pregnancy has issued two reports in its *Ready Resources* series: *Ready Resources I: Investing Welfare Funds in Teen Pregnancy Prevention*; and *Ready Resources II: Promising Partnerships Between Teen Pregnancy Prevention and the Workforce Investment Act*.

One related theme that emerged during the roundtable was the difficulties practitioners face convincing funders that prevention programs are a worthwhile investment. With state budget shortfalls and other financial worries dominating the news, convincing decisionmakers to devote money — or even to sustain current funding — for a problem that seems to be "solved" is particularly challenging. Furthermore many policymakers may not understand the connection between too-early childbearing and such related issues as school drop-out and welfare dependence, and may see those as competing concerns rather than related ones that can all be addressed and improved through investing in teen pregnancy prevention (see *Not Just Another Single Issue*, National Campaign to Prevent Teen Pregnancy 2002). With these concerns in mind, several suggestions were offered:

Programs should showcase their work. Teen pregnancy prevention programs should document and publicize the positive outcomes of their efforts whenever possible. This can be done numerous ways: through written materials such as annual reports or press releases announcing new partners or sharing encouraging results; community-based events such as health fairs or presentations at schools; and/or by initiating informational meetings with local foundations or others influential in the community.

Pitch Teen Pregnancy Prevention as a Worthwhile Investment. Prevention has always been a difficult concept to sell, since it is essentially working towards making something *not* happen. Prevention also usually requires a relatively long time to document success — it can often take two or more years to determine whether teen pregnancy or birth rates have declined, for example. The investment can also be expensive because many resources are required to help those most at risk for teen pregnancy and the host of social problems that are usually associated with it. The "pitch" is: preventing teen pregnancy is far cheaper than *not* preventing teen pregnancy. Indeed, about half of all mothers on welfare had their first child as a teenager, two-thirds of families begun by a young unmarried mother are poor, and teen parents and their children are less likely to graduate from high school.[xv]

U.S. taxpayers shoulder at least $7 billion annually in direct costs and lost tax revenues associated with teen pregnancy and childbearing.

Businesses need to get behind this issue. Reducing teen pregnancy will strengthen the future U.S. workforce. Today's economy requires a sophisticated and educated workforce. But too-early childbearing often short circuits the education process and prevents young men and women from preparing themselves for good jobs.[xvi] Clearly, this is not good for businesses. They have a vested interest in helping to prevent teen pregnancy and can do so by supporting community programs with funding or in-kind contributions, by speaking out publicly in support of such programs, by creating a workplace that helps the prevention cause (for example, offering teens internships) and other such leadership actions.

V. There is No Room for Complacency

As Sarah Brown, Executive Director of the National Campaign, and Sister Mary Rose

McGeady, President and CEO of Covenant House, wrote in the introduction to this publication, this sentiment was the core motivation for convening the roundtable in the first place. It was reiterated many times by the participants, and bears repeating here.

Some teen pregnancy prevention leaders are concerned that policymakers and others who hold the purse-strings that fund prevention efforts may take the improved national rates to mean that this problem is solved. While it is imperative that we underscore our progress and the good paybacks from our investments in prevention to date, we must give equal time to the message that there is no room for complacency. Why? A new group of young people becomes teenagers every year; too many teens are still becoming parents too soon; and we must do more to bring those areas where progress is pending more in line with encouraging national (and sometimes broad state) trends.

Teen birth rates have declined steadily since their peak in 1991. If teen birth rates had stayed at their 1991 level through 2001, the National Campaign estimates there would have been *nearly 800,000 additional babies born to teenagers.*

VI. There's more we can do to understand all this better and act on that understanding

The data and the anecdotal evidence both tell the same story: although we have made great strides in reducing teen pregnancy rates in the United States, not everyone is sharing in this progress. Not only are there huge disparities in the rates of too-early pregnancy and childbearing among various groups of teens, but even in those groups who *are* making progress in reducing rates, the pace of progress varies widely. Clearly we cannot rest on our laurels.

The more we understand about the factors that contribute to stubbornly high rates of teen pregnancy, the more adeptly we can address those factors. The good news is that there is already much useful information available from data collection, program evaluation, focus group research, conferences and roundtables, and the like. Practitioners, policymakers, researchers, and organizations at the national, state and local levels all can take steps to become familiar with this information, disseminate it further, and act on its implications. We also must work to identify areas where gaps in information exist and pursue opportunities for addressing them. Collectively we can be successful in sustaining and extending recent reduction in teen pregnancy rates ■

Endnotes

i Hamilton, B.E., Martin, J.A., Menacker, F., Park, M.M., Sutton, P.D., & Ventura, S.J. (2002). Births: Final Data for 2001. *National Vital Statistics Reports 51*(2).

ii Henshaw, S.K. (2001). *U.S. teenage pregnancy statistics with comparitive statistics for women aged 20-24*. New York: The Alan Guttmacher Institute.

iii Flanigan, C. (2001). *What's behind the good news: The decline in teen pregnancy rates during the 1990s*. Washington, DC: The National Campaign to Prevent Teen Pregnancy.

iv Flanigan, C. (2001). *What's behind the good news: The decline in teen pregnancy rates during the 1990s*. Washington, DC: The National Campaign to Prevent Teen Pregnancy.

v National Campaign to Prevent Teen Pregnancy. (1999). *The next challenge: Guarding against complacency*. Washington, DC: National Campaign to Prevent Teen Pregnancy.

vi Child Trends. (2002). *Ten reasons to keep the focus on teen childbearing*. Washington, DC: Author.

vii Child Trends. (2002). *Ten reasons to keep the focus on teen childbearing*. Washington, DC: Author.

viii Papillo, A.R., Franzetta, K., Manlove, J., Moore, K.A., Terry-Humen, E. & Ryan, S. (2002). *Facts at a glance*. Washington, DC: Child Trends.

ix The Annie E. Casey Foundation. (2003). *The Right Start Online* 2003. Retreived on January 29, 2003, from http://www.aecf.org/kidscount/rightstart2003

x Hamilton, B.E., Martin, J.A., Menacker, F., Park, M.M., Sutton, P.D., & Ventura, S.J. (2002). Births: Final Data for 2001. *National Vital Statistics Reports 51*(2).

xi Hamilton, B.E., Mathews, T.J., & Ventura, S.J. (2001). Births to Teenagers in the United States, 1940-2000. *National Vital Statistics Reports 49*(10).

xii Philliber Research Associates, SRI International Center for Education and Human Services, & Institute for Health Policy Studies at University of California, San Francisco. (2002). *Adolescents and their families in California's teen pregnancy hot spots*. Accord, NY: Philliber Research Associates.

xiii Hamilton, B.E., Mathews, T.J., & Ventura, S.J. (2001). Births to Teenagers in the United States, 1940-2000. *National Vital Statistics Reports 49*(10).

xiv National Campaign to Prevent Teen Pregnancy. (2002). *With one voice 2002: American's adults and teens sound off about teen pregnancy*. Washington, DC: Author.

xv National Campaign to Prevent Teen Pregnancy (2001). *Not just another single issue*. Washington, DC: Author.

xvi National Campaign to Prevent Teen Pregnancy (2001). *Not just another single issue*. Washington, DC: Author.

Chapter 2.
Effective Teen Pregnancy Prevention Programs:
Do They Work For All?

By Douglas Kirby Ph.D.

Despite encouraging progress over the past decade, the overall teen pregnancy rate in the United States remains high; and the rates in some communities and among some groups of youth are particularly high. This paper summarizes these differences and reviews multiple studies to assess whether pregnancy prevention programs are effective for all groups of youth and, especially, whether they are effective for higher risk groups. It also identifies particular programs that have been effective with different groups.

Teen Pregnancy, Childbearing, and Sexual Activity Among Different Groups

Although the U.S. teen pregnancy rate has declined during recent years, teen pregnancy remains a significant problem in this country. In 1997, the most recent year for which data are available, 9.4 percent of females aged 15-19 (or almost 900,000 teens) became pregnant (Ventura, et al., 2001). An estimated 78% of these teen pregnancies were unintended (Henshaw, 1998). In addition, close to 40 percent of girls in the United States became pregnant at least once before they reached age 20. (National Campaign to Prevent Teen Pregnancy, 1997).

Because any teen may have sex and fail to use contraception correctly and consistently, teens in all communities and in all groups become pregnant and give birth. Early and unintended pregnancy and childbearing are not limited to any particular communities or to any particular groups. Still, youth in some communities and in some groups are much more likely to have sex at an early age, to fail to use contraception correctly and consistently, and to become pregnant and give birth. For example, young people in disadvantaged communities are much more likely to become pregnant and give birth than youth in more advantaged communities. More specifically, multiple studies have demonstrated that communities with lower educational levels (Kirby, Coyle & Gould, 2001), fewer opportunities (Bickel et al., 1997), higher unemployment rates (Kirby, Coyle & Gould, 2001; Ku Sonenstein & Pleck 1993), lower income levels, (Brooks-Gunn et al., 1993; Hogan & Kitagawa, 1985; Kirby, Coyle & Gould, 2001; Mayer & Jencks, 1989) and other manifestations of disorganization (Billy, Brewster & Grady, 1994) have higher (and typically *much* higher) teen pregnancy or childbearing rates than do communities without these disadvantages.

In part because of differences in the opportunities and advantages their communities offer, specific racial/ethnic groups also often have different rates of unprotected sex, pregnancy and childbearing. For instance, the pregnancy rate in 1997 was 6.5% among non-Hispanic white teens ages 15-19, 17.0% among black teens and 14.9% among Hispanic teens (Ventura et al., 2001). Similarly, the birth rate in 2001 was 3.0% among non-Hispanic white teens, 7.3% among black teens and 9.2% among Hispanic teens (Martin JA, Park MM & Sutton PD, 2002). In short, African-American and Hispanic teenagers have much higher pregnancy and birth rates than non-Hispanic white teens. This has remained true even though the pregnancy and birth rates for African-Americans have declined substantially during the last decade.

The reason for the high rates of pregnancy among teenagers, and for even higher rates among blacks and Hispanics, is that they engage in unprotected sex that places them at risk of pregnancy. In 2001, 46% of all high school students had ever had sex

(Grunbaum, et al., 2002). These rates were much higher for blacks (61%), and slightly higher for Hispanics (48%), than for whites (43%). According to data collected in the 1995 National Survey of Family Growth, 85% of whites teens, 86% of African-American teens, and 74% of Hispanic teens used one or more methods of contraception during their last act of intercourse. In other words, African-American and Hispanic teens are more likely to become pregnant than non-Hispanic white teens, because a higher percentage of them have sex. When they do have sex, Hispanic youth are least likely to use any method of contraception.

Just as sexual activity and contraceptive use varies by race/ethnicity, they also vary by age. The older young people become, the more likely they are to have had sex and to use contraception if they do have sex. But because the increase in sexual activity outpaces the increase in contraceptive use, teens are more likely to become pregnant (or cause a pregnancy) as they get older. For example, the pregnancy rate is 1.2% for women 14 and under, 5.8% for 15-17 year olds, and 14.8% for 18 -19 year-olds (Henshaw, 2001). Sexual activity also varies by gender — male teens are more likely to have sex at an earlier age than female teens.

High rates of adolescent sexual activity, inconsistent and non-use of contraception, pregnancy, and childbearing among some groups, raise three important questions:

1. Is there reasonably good evidence that specific programs delay the initiation of sex, reduce the frequency of sex among those who have had sex, increase contraceptive use, and/or decrease pregnancy?
2. Are these programs effective with a wide variety of groups of youth or are they effective with only particular groups of youth? Are they effective with those groups of youth at highest risk for unprotected sex and pregnancy?
3. Are some of these programs more effective with some groups of youth than others, and if so, which ones?

The balance of this paper attempts to answer these questions.

Are Programs Effective?

There is now substantial evidence that four different types of programs can reduce sexual risk-taking among young people and, thereby, prevent teen pregnancy. These four groups of programs were systematically reviewed in *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy* (Kirby, 2001), published by the National Campaign to Prevent Teen Pregnancy, and are briefly summarized and updated here.

Sex and HIV Education Programs

The first group of programs includes sex and HIV education programs. These programs have evidence that they either delay sex, reduce the frequency of sex, reduce the number of sexual partners, increase condom use, or increase contraceptive use. These effects have been demonstrated for as long as one year (Jemmott, Jemmott & Fong, 1998; Kirby, Barth, Leland & Fetro, 1991; St. Lawrence et al., 1995; St. Lawrence et al., 2002; Stanton et al., 1996) and for even as long as 31 months (Coyle et. al., 2001). Positive behavioral effects have been observed in programs implemented in a variety of locations, including schools during regular school hours or during weekend hours, community health centers, community detention centers, shelters for runaway youths, and residential drug treatment programs.

Some of the evidence supporting these effects is based upon rigorous studies with randomized experimental designs (Coyle et. al., 2001; Jemmott, Jemmott & Fong, 1998; St. Lawrence et al., 1995). In addition, meta-analyses and reviews of multiple studies also provide positive evidence of impact (Jemmott & Jemmott, 2000; Kirby, 2001; Mullen, Ramiez, Strouse, Hedges & Sogolow, 2002). Importantly, researchers have identified some of the common characteristics of these effective programs that may contribute to their success (c.f., Jemmott & Jemmott, 2000; Kirby, 2001).

The curricula of the most effective sex education programs share ten common characteristics. These programs:

1. Focus on reducing one or more sexual behaviors that lead to unintended pregnancy or HIV/STD infection.
2. Are based on theoretical approaches that have been demonstrated to influence effectively other health-related behavior. These theories identified specific important sexual antecedents to be targeted.
3. Deliver and consistently reinforce a clear message about abstaining from sexual activity and/or using condoms or other forms of contraception. This appears to be one of the most important characteristics that distinguished effective from ineffective programs.
4. Provide basic, accurate information about the risks of teen sexual activity and about ways to avoid intercourse or methods of protection against pregnancy and STDs.
5. Include activities that address social pressures that influence sexual behavior.
6. Provide examples of and practice with communication, negotiation, and refusal skills.
7. Employ teaching methods designed to involve participants and have them personalize the information.
8. Incorporate behavioral goals, teaching methods, and materials that are appropriate to the age, sexual experience, and culture of the students.
9. Last a sufficient length of time (i.e., more than a few hours).
10. Select teachers or peer leaders who believe in the program and then provide them with adequate training.

Clinic Services

The second group of programs with evidence that they can reduce sexual risk-taking among teens includes clinic services. The research suggests that the counseling and instruction that takes place between a medical provider and a teen patient and the related materials and activities that can support and reinforce that counseling are key to the program's success. Four out of six studies reviewed found positive effects on behavior with brief, modest interventions. Typically these programs increased condom or other contraceptive use for three months to one year. All four of the effective interventions focused on sexual and contraceptive behavior, gave clear messages about abstinence and contraceptive use and included one-on-one consultation about the client's own behavior.

Service Learning Programs

The third group of interventions with evidence of success includes service learning programs. By definition, service learning programs include (1) voluntary or unpaid service in the community (e.g., tutoring, working as a teacher's aide, working in nursing or retirement homes, helping out in day care centers, or helping fix up parks and recreation areas); and (2) structured time for preparation and reflection before, during, and after service (e.g., group discussions, journal writing, or papers). Often the service is voluntary, but sometimes it is prearranged as part of a class. Oftentimes the service is linked to academic instruction in the classroom. Service learning programs have strong evidence that they reduce actual teen pregnancy rates. Four different studies, three of which evaluated programs in multiple locations, have consistently indicated that service learning reduces either sexual activity or teen pregnancy (Allen, Philliber, Herrling, & Kuperminc, 1997; Melchior, 1998; O'Donnell et al., 1999; O'Donnell et al., 2002; Philliber & Allen, 1992). The impact on pregnancy appears to last during the academic year in which youth are involved, but possibly not beyond.

Comprehensive Programs

The final group of programs includes the Children's Aid Society-Carrera Program. A very rigorous study of the CAS-Carrera program implemented in six different sites demonstrated that, among girls, it significantly delayed the onset of sex, increased the use of condoms and other effective methods of contraception, and reduced pregnancy rates (Philliber et al., 2002). However, the program did not reduce sexual risk-taking among boys. The CAS-Carrera Program, which is long-term, intensive, and expensive, includes the following components: (1) family life and sex education; (2) individual academic assessment, tutoring, help with homework, preparation for standardized exams, and assistance with college entrance; (3) a work-related intervention that includes a job club, stipends, individual bank accounts, employment, and career awareness; (4) self-expression through the arts; (5) sports activities; and (6) comprehensive health care, including mental health and reproductive health services and contraception. The program also gives a clear message about avoiding unprotected sex and early pregnancy. This is the first and only study to date that includes random assignment, multiple sites, and a large sample size that found a positive impact on sexual and contraceptive behavior and pregnancy, among girls for as long as three years.

The studies of these four groups of programs, as well as a few other studies demonstrate that programs can actually reduce sexual risk-taking and pregnancy among teens. Moreover, the diversity among them shows that there are multiple effective approaches.

Are Programs Effective With a Wide Variety of Groups of Youth and With Higher Risk Youth?

In addition to knowing that some programs are effective and can be effective in different settings, it is also important to know whether they are effective with a diversity of groups of young people or only with particular groups. After all, practitioners need to know whether an intervention that was found to be effective with one population of youth is likely to be effective with another. In addition, it is especially important to know whether programs are effective with groups at greater risk of pregnancy.

To help address these issues, Table 1 presents programs that have been found to be effective in different types of communities and with different groups of young people. Ideally such studies would systematically measure and present their findings according to a wide range of community characteristics, but this rarely happens. Most studies only report the income level of the community and the gender, race/ethnicity, and age of the youth in the sample; sometimes they provide separate results for sexually inexperienced and sexually experienced youth. Consequently, Table 1 is limited to those characteristics addressed in the studies.

The examples in Table 1 reveal that the programs identified as having evidence of success are effective across both mixed-income and low-income communities, and across all groups of youth determined by race/ethnicity, gender, age/grade, and prior sexual experience. As the table shows, a majority of the effective programs have been studied in low-income communities rather than in more middle class communities or communities with mixed family incomes. This does not mean that programs are not effective in more middle class or mixed income communities; in fact, at least six different types of programs have been found to be effective in mixed income communities. It simply means that people have implemented and evaluated more programs in low-income communities than in middle class or mixed income communities. The bottom line is that programs are effective in both low-income and middle class communities and the majority have proven effective in low-income communities.

The greatest number of effective programs has been found through evaluation studies involving mixed racial/ethnic groups in which no more than

80 percent of the sample is any single ethnic group. Moreover, these programs also have been found to be effective with each of the three largest ethnic groups (non-Hispanic whites, blacks, and Hispanics). The second greatest number of effective programs has been found to be effective with African American youth, reflecting the large number of programs that have been implemented and evaluated for black youth. Only a couple of programs have been implemented and evaluated for Hispanic youth (making quite clear the need for additional programs and research on programs serving Hispanic youth). Nevertheless, one program that was put in place for multiple ethnic groups was found to be effective for the Hispanic youth within the study. Moreover, other effective programs serving mixed groups of youth were found to be effective with samples that included many Hispanic youth (but not quite 80 percent). Thus, evidence indicates that one or more programs can be effective for all three of the largest ethnic groups.

Similarly, most effective programs were found to be effective in studies that included both males and females, although a few effective programs were designed for only males or only females, and a few programs were effective only for one gender. Programs also have been found to be effective with youth in middle school (typically aged 13 and under) and youth in high school (typically aged 14 and over). A slightly greater number of effective programs have focused on older youth, but this reflects, in part, the greater number of studies involving older youth.

Finally, effective programs have been identified using both sexually experienced and inexperienced youth. Some of these programs delayed the initiation of sex and, by definition, were effective with sexually inexperienced youth. Other programs were effective with sexually experienced youth by helping them return to abstinence. Finally, some of the programs increased contraceptive use, sometimes with youth who were sexually experienced before the program and sometimes with youth who initiated sex after the program.

In sum, effective programs have been found for all these different groups of youth. While there is a paucity of studies involving predominantly Hispanic youth, at least one program was found to be effective with this group, and other programs were effective with samples that included large numbers of Hispanic youth.

Of particular importance, these examples also demonstrate that effective programs have been identified for youth at higher risk of pregnancy — namely, those youth living in low-income communities, youth who are black or Hispanic, and those who are sexually experienced, sometimes at an early age.

Are Programs More Effective With Some Groups of Youth Than Others?

While the examples in Table 1 demonstrate that programs can be effective with different groups, they cannot determine the relative strength of each program with particular groups. This can only be done by implementing the same program with different groups of youth and analyzing whether it is more effective with one group than another. Demonstrating such "differential impact" requires especially strong evaluation designs (e.g., those with random assignment), larger sample sizes, and, of course, evidence of a behavioral impact among at least some groups of young people.

To date, only six studies have included a randomized experimental design, had a sample size of at least 200, measured impact on behavior, found a behavioral impact for at least 12 months, and assessed the relative impact of the program on different groups. These studies can provide evidence about the relative impact of different kinds of interventions.

The first of the programs, *Becoming a Responsible Teen*, delayed the initiation of sex, reduced the frequency of sex, reduced the number of sexual partners, increased condom use, and reduced the frequency of unprotected vaginal sex among the

study's participants — primarily black youth living in low-income areas (St. Lawrence, et al., 1995). Although the program was effective with many groups, an analysis of differential effects revealed that the curriculum was more effective at reducing the frequency of unprotected vaginal sex among males than among females. However, this gender effect may have been caused, in part, by much higher rates of unprotected sex at baseline among males than among females. The second and third of these programs, *Making a Difference* and *Making Proud Choices*, were evaluated in a single study (Jemmott, Jemmott & Fong, 1998). That study found that *Making a Difference* delayed the initiation of sex for three months and *Making Proud Choices* reduced the frequency of sex, increased condom use, and reduced the frequency of unprotected sex for a period of six to12 months. Again, these studies were done with low-income black youth. Analyses of differential effects revealed that *Making a Difference* was equally effective at encouraging abstinence for both sexually experienced and sexually inexperienced youth. By contrast, *Making Proud Choices* did have a differential effect on the frequency of unprotected sex between these two groups. It was not effective in significantly reducing the frequency of sex or the frequency of unprotected sex among those who were sexually inexperienced at baseline, but it was effective in reducing sex and unprotected sex among those who were sexually experienced at baseline. This may reflect the fact that relatively few of the sexually inexperienced youth initiated sex, creating a "ceiling effect."

The fourth program, the *Draw the Line* curriculum, delayed the initiation of sex and reduced the proportion of youth who had sex during the previous year, but only among males. (Coyle, et al, unpublished). Notably, the sample served was almost 60% Hispanic.

The fifth program, *Safer Choices*, increased condom use and reduced unprotected sex among youth over a 31-month period (Coyle et al, 2001). It had a positive impact across a variety of groups, regardless of their gender, ethnicity or sexual experience. However, it had a significantly greater impact on males than females on all four outcome measures related to condom use (use of condom at last sex, use of contraception at last sex, number of partners not protected by a condom, and frequency of sex without a condom). *Safer Choices* may have had a greater impact on Hispanics than any other ethnic group, especially in regard to delaying initiation of sex. Finally, *Safer Choices* appeared to have a greater impact on condom-related measures among higher risk youth who had unprotected sex prior to the intervention than among those youth who initiated sex after the intervention.

The sixth program, the *CAS-Carrera Program* described above, had very important long-term effects on sexual and contraceptive behavior and pregnancy, but only on females; there were no significant and positive behavioral effects on males. In part, the program helped female teens obtain health care services, including reproductive health care and long-term contraceptives. It is possible that the program may have reduced more barriers to contraceptive use for females than for males.

In addition to the six programs above, the differential impact of the *Teen Outreach Program* on pregnancy has been well studied (Allen & Philliber, 2001). This study did not employ an experimental design nor did it measure impact on pregnancy for a full year. However, it did include a very large sample size and the other studies of the *Teen Outreach Program* have provided strong evidence that it reduced teen pregnancy during the academic year in which students were involved. The analysis of differential effects revealed that the *Teen Outreach Program* was about equally effective with students regardless of their racial/ethnic group, gender or grade level. It was also effective in preventing pregnancy with students who were teenage parents and students who were not teenage parents, though it was more effective with the former. In other words, the *Teen Outreach Program* may have been even more effective with higher risk youth than lower risk youth.

The overall patterns of results from these seven studies are quite encouraging for several reasons. First, even these more carefully selected and more rigorous evaluations demonstrate that the impact of their respective programs is not generally limited to any single group defined by any of the characteristics of youth that were examined.

Second, they demonstrate that although programs are effective with both lower and higher risk youth, they are even more effective with higher risk youth (such as those youth who have engaged in unprotected sex at an early age (*Making Proud Choices* and *Safer Choices*) and those youth who were teen parents before the program (*Teen Outreach Program*).

Third, one study indicates that a particular program (*Safer Choices*) was especially effective at delaying sex among Hispanic youth — an important finding given that Hispanic youth are understudied and at higher risk of teen pregnancy.

In addition to these encouraging findings, the analyses of differential effects also suggest that programs that focus on increasing condom use are effective with males and females, but may be more effective with males. Similarly, programs such as the *CAS-Carrera* program, which removed barriers to long-term contraceptive use for females, may be more effective with females.

Conclusions

All of these studies — those that simply measured impact on particular groups of youth (summarized in Table 1) and the studies that measured differential impact of programs on different subgroups of youth — support several conclusions.

- First and most important, evaluations demonstrate that these programs are quite robust — several programs have been found to be effective regardless of the participants' race/ethnicity, their gender, their age/grade, their prior sexual experience, or the income level of their communities. This does not mean that any program can be used with any group — it remains important for practitioners to put programs in place that are appropriate to the characteristics of the youth they are trying to serve. However, regardless of the group of youth, there are some programs that have been found to be effective with selected groups of young people, and some
programs appear to effective with all of them.
- Second, programs may be especially effective with higher risk youth. Many programs have been found to be effective in low-income communities and with black youth who have higher rates of sexual activity. Even more important, analyses of differential effects reveal that some of these programs are more effective with youth who initiate sex early, have unprotected sex, or are already teen parents. This is an important finding for policy makers, because these youth are at greatest risk for poor outcomes and have the potential to greatly benefit from such interventions.

Table 1:
Examples of Programs that Have Been Found to Be Effective In Delaying Sex, Increasing Contraceptive Use, or Reducing Pregnancy By Community Income Level and Participants' Race/Ethnicity, Gender, Age/Grade, and Previous Sexual Experience[1]

	Sex and HIV Education Programs	Clinic Protocols	Service Learning Programs	CAS Carrera Programs
Community Income Levels				
Communities with Mixed Income	Draw the Line, Reducing the Risk, Safer Choices, Untitled (Klaus et al)	Untitled (Danielson et al)	Teen Outreach Program	
Low Income Communities	Postponing Sexual Involvement, Wise Guys, AIDS Prevention for Adolescents in School, Becoming a Responsible Teen, Be Proud Be Responsible, Making a Difference, Making Proud Choices, Healthy Oakland Teens, Untitled (Rotheram-Borus, et al)	ASSESS, Untitled (Orr, et al)	Reach for Health with Community Youth Service Learning	CAS Carrera programs
Race/Ethnicity				
Mixed Race/ Ethnicity	Draw the Line, Reducing the Risk, Safer Choices, Teen Talk, Untitled (Klaus et al), Wise Guys, AIDS Prevention for Adolescents in School, Get Real about AIDS, Healthy Oakland Teens, Untitled (Magura et al), Untitled (Rotheram-Borus, et al)	ASSESS, Untitled (Orr, et al)	Reach for Health with Community Youth Service Learning, Teen Outreach Program	CAS Carrera programs
Non-Hispanic White	Reducing the Risk, Safer Choices	Untitled (Danielson et al), Untitled (Winter et al)		
Black	Postponing Sexual Involvement, Safer Choices, Becoming a Responsible Teen, Be Proud Be Responsible, Making a Difference, Making Proud Choices			
Hispanic	Safer Choices			
Gender				
Mixed Gender	Reducing the Risk, Safer Choices, AIDS Prevention for Adolescents in School, Becoming a Responsible Teen, Be Proud Be Responsible, Making a Difference, Making Proud Choices, Get Real about AIDS, Healthy Oakland Teens, Untitled (Rotheram-Borus, et al)	ASSESS	Reach for Health with Community Youth Service Learning	

Table 1: Continued

	Sex and HIV Education Programs	Clinic Protocols	Service Learning Programs	CAS Carrera Programs
Male	Draw the Line, McMaster Teen Program, Safer Choices, Teen Talk, Wise Guys, Untitled (Magura et al)	Untitled (Danielson et al)		
Female	Reducing the Risk, Safer Choices, Untitled (Klaus et al)	Untitled (Orr, et al), Untitled (Winter et al)	Teen Outreach Program	CAS Carrera programs
Age/Grade				
11-13 years old/ grades 6-8	Draw the Line, McMaster Teen Program, Postponing Sexual Involvement, Wise Guys, Making a Difference, Making Proud Choices, Healthy Oakland Teens	ASSESS	Reach for Health with Community Youth Service Learning	
14-19 years old/ grades 9-12	Reducing the Risk, Safer Choices Teen Talk, Untitled (Klaus et al), AIDS Prevention for Adolescents in School, Becoming a Responsible Teen, Be Proud Be Responsible, Get Real about AIDS, Untitled (Magura et al), Untitled (Rotheram-Borus, et al)	ASSESS, Untitled (Orr, et al), Untitled (Winter et al)	Teen Outreach Program	CAS Carrera programs
Sexual Experience At Baseline				
Both Sexually Inexperienced and Experienced	Postponing Sexual Involvement, Reducing the Risk, Safer Choices, Wise Guys, AIDS Prevention for Adolescents in School, Becoming a Responsible Teen, Be Proud Be Responsible, Making a Difference, Making Proud Choices, Get Real about AIDS, Untitled (Magura et al), Untitled (Rotheram-Borus, et al)		Reach for Health with Community Youth Service Learning, Teen Outreach Program	CAS Carrera programs
Sexually Inexperienced	Draw the Line, Reducing the Risk, Safer Choices, Untitled (Klaus et al), Becoming a Responsible Teen, Making a Difference, Making Proud Choices, Healthy Oakland Teens		Reach for Health with Community Youth Service Learning	CAS Carrera programs
Sexually Experienced	Safer Choices, Teen Talk, Becoming a Responsible Teen, Making a Difference, Making Proud Choices	ASSESS, Untitled (Danielson et al), Untitled (Orr, et al), Untitled (Winter et al)		

References

Allen, J. P., & Philliber, S. P. (2001). Who benefits most from a broadly targeted prevention program?: Differential efficacy across populations in the Teen Outreach Program. *Journal of Community Psychology, 29*, 637-655.

Allen, J.P., Philliber, S.P., & Hoggson, N. (1990). School-based prevention of teen-age pregnancy and school dropout: Process evaluation of the national replication of the Teen Outreach Program. *American Journal of Community Psychology, 18*(4), 505-524.

Barth, R.P. (1996). *Reducing the Risk: Building Skills to Prevent Pregnancy, STD & HIV* (3rd ed.). Scotts Valley, CA: ETR Associates.

Boekeloo, B.O., Schamus, L.A., Simmens, S.J., Cheng, T.L., O-Connor, K., & D'Angelo, L.J. (1999). A STD/HIV prevention trial among adolescents in managed care. *Pediatrics 103*(1), 107-115.

Bickel, R., Weaver, S., Williams, T., & Lange, L. (1997). Opportunity, community, and teen pregnancy in an Appalachian state. *Journal of Educational Research, 90*(3), 175-181.

Billy, J.O.G., Brewster, K.L., & Grady, W.R. (1994). Contextual effects on the sexual behavior of adolescent women. *Journal of Marriage and the Family, 56*(2), 387-404.

Brooks-Gunn, J., Duncan, G.J., Klebanov, P.K., & Sealand, N. (1993). Do neighborhoods influence child and adolescent development? *American Journal of Sociology, 99*(2), 353-395.

Cornerstone Consulting Group, Inc. (2002). *Changing scenes: A curriculum of the Teen Outreach Program.* Houston, TX: Cornerstone Consulting Group, Inc.

Coyle, K.K., & Fetro, J.V. (1998). *Safer choices: Preventing HIV, other STD and pregnancy: Level 2.* Scotts Valley, CA: ETR Associates.

Coyle, K.K., Basen-Engquist, K.M., Kirby, D.B., Parcel, G.S., Banspach, S.W., Collins, J.L., et al. (2001). *Safer choices: Reducing teen pregnancy, HIV and STDs. Public Health Reports, 116*(Supplement 1), 82-93.

Coyle K., Marin, B., Gardner C., et al. (2003). *Draw the Line: Respect the Line: Setting limits to prevent HIV, STD and pregnancy, grade 7.* Scotts Valley, CA: ETR Associates.

Coyle, K., Kirby, D., Marin, B., Gomez, C., & Gregorich, S. *Draw the Line/Respect the Line: A randomized trial of a middle school intervention to reduce sexual risk behaviors.* Submitted for review.

Danielson, R., Marcy, S., Plunkett, A., Wiest, W., & Greenlick, M.R. (1990). Reproductive health counseling for young men: What does it do?. *Family Planning Perspectives, 22*(3), 115-121.

Ekstrand, M.L., Siegel, D., Nido, V., Faigeles, B., Cummings, G., Battle, R., et al. Peer-led AIDS prevention delays onset of sexual activity and changes peer norms among urban junior high school students. *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology.*

Fetro, J.V., Barth, R.B., & Coyle, K.K. (1998). *Safer choices: Preventing HIV, other STD and pregnancy: Level 1.* Scotts Valley, CA: ETR Associates.

Fisher, J.D. (1988). *Possible effects of reference group-based social influence on AIDS-risk behaviors and AIDS.* American Psychologist, 43, 914-920.

Grunbaum, J.A., Kann, L., Kinchen, S.A., Williams, B., Ross, J.G., Lowry, R., et al. (2002). Youth risk behavior surveillance — United States, 2001. *Morbidity and Mortality Monthly Report, 51*(No.SS-4), 48.

Henshaw, S.K. (1998). Unintended pregnancy in the United States. *Family Planning Perspectives, 30*(1), 24-29, 42.

Henshaw, S.K. (2001). *U.S. Teenage Pregnancy Statistics with Comparative Statistics for Women Aged 20-24*. New York: The Alan Guttmacher Institute.

Hogan, D.P., & Kitagawa, E.M. (1985). The impact of social status, family structure, and neighborhood on the fertility of Black adolescents. *American Journal of Sociology, 90*(4), 825-855.

Howard, M., Mitchel, M., & Pollard, B. (1990). *Postponing Sexual Involvement: An Educational Series for Young Teens*. Atlanta, GA: Grady Memorial Hospital.

Jemmott, L.S., Jemmott, J.B., III, & McCaffree, K.A. (1994). *Be Proud! Be Responsible!* New York: Select Media.

Jemmott, J.B., Jemmott, L.S., & Fong, G.T. (1998). Abstinence and safer sex: A randomized trial of HIV sexual risk-reduction interventions for young African-American adolescents. *Journal of the American Medical Association, 279*(19), 1529-1536.

Jemmott, L.S., & Jemmott, J.B. (1998). *Making proud choices: A safer sex approach to STD, teen pregnancy and HIV/AIDS prevention*. New York: Select Media.

Jemmott, J.B., & Jemmott, L.S. (2000). HIV risk reduction behavioral interventions with heterosexual adolescents. *AIDS, 14*(Supplement 2), 40-52.

Jemmott, L.S., & Jemmott, J.B. (1998). *Making a difference: An abstinence approach to STD, teen pregnancy and HIV/AIDS prevention*. New York: Select Media.

Kirby, D. (2001). *Emerging answers: Research findings on programs to reduce sexual risk-taking and teen pregnancy*. Washington, DC: National Campaign to Prevent Teen Pregnancy.

Kirby, D., Barth, R., Leland, N., & Fetro, J. (1991). Reducing the risk: A new curriculum to prevent sexual risk-taking. *Family Planning Perspectives, 23*(6), 253-263.

Kirby, D., Coyle, K., & Gould, J. (2001). Manifestations of poverty and birth rates among young teenagers in California ZIP codes. *Family Planning Perspectives, 33*(2), 63-69.

Klaus, H., Bryan, L.M., Bryant, M.L., et al. (1987). Fertility awareness/natural family planning for adolescents and their families: Report of a multisite pilot project. *International Journal of Adolescent Medicine and Health, 3*(2), 101-119.

Ku, L., Sonenstein, F.L., & Pleck, J.H. (1993). Neighborhood, family, and work: Influences on the premarital behaviors of adolescent males. *Social Forces, 72*(2), 479-503.

Magura, S., Kang, S., & Shapiro, J.L. (1994). Outcomes of intensive AIDS education for male adolescent drug users in jail. *Journal of Adolescent Health, 15*, 457-463.

Main, D.S., Iverson, D.C., McGloin, J., Banspach, S.W., Collins, K., Rugg, D., et al. (1994). Preventing HIV infection among adolescents: Evaluation of a school-based education program. *Preventing Medicine, 23*, 409-417.

Marin, B., Coyle, K., Gomez, C., et al. (2003). *Draw the Line, Respect the Line: Setting limits to prevent HIV, STD and pregnancy, grade 6*. Scotts Valley, CA: ETR Associates.

Marin, B., Coyle, K., Cummings, C., et al. (2003). *Draw the Line, Respect the Line: Setting limits to prevent HIV, STD and pregnancy, grade 8*. Scotts Valley, CA: ETR Associates.

Martin, J.A., Park, M.M., & Sutton, P.D. (2002). Births: Preliminary data for 2001. *National Vital Statistics Reports, 50*(10).

Mayer, S.E., & Jencks, C. (1989). Growing up in poor neighborhoods: How much does it matter? *Science, 243*(4897), 1441-1445.

Melchior, A. (1998). *National evaluation of Learn and Serve America school and community-based programs.* Waltham, MA: Center for Human Resources, Brandeis University.

Mullen, P.D., Ramirez, G., Strouse, D., Hedges, L.V., & Sogolow, E. (2002). Meta-analysis of the effects of behavioral HIV prevention interventions on the sexual risk behavior of sexually experienced adolescents in controlled studies in the United States. *Journal of Acquired Immune Deficiency Syndromes, 30*, 94-105.

National Campaign to Prevent Teen Pregnancy. (1997). *Whatever Happened to Childhood? The Problem of Teen Pregnancy in the United States.* Washington, DC: National Campaign to Prevent Teen Pregnancy.

O'Donnell, L., Stueve, A., Doval, A.S., et al. (1999). The effectiveness of the Reach for Health community youth service learning program in reducing early and unprotected sex among urban middle school students. *American Journal of Public Health, 89*(2), 176-181.

O'Donnell, L., Stueve, A., O'Donnel, C., Duran, R., Doval, A.S., Wilson, R.F., et al. (2002). Long-term reductions in sexual initiation and sexual activity among urban middle schoolers in the Reach for Health service learning program. *Journal of Adolescent Health, 31*, 93-100.

Orr, D.P., Langefeld, C.D., Katz, B.P., & Caine, V.A. (1996). Behavioral intervention to increase condom use among high-risk female adolescents. *Journal of Pediatrics, 128*(2), 288-295.

Philliber, S., & Allen, J.P. (1992). Life options and community service: Teen Outreach Program. In Miller, B.C., Card, J.J., Paikoff, R.L., & Peterson, J.L. (Eds.), *Preventing adolescent pregnancy.* Newbury Park, CA: Sage Publications.

Rotheram-Borus, M.J., Koopman, C., Haigners, C., & Davies, M. (1991). Reducing HIV sexual risk behaviors among runaway adolescents. *Journal of the American Medical Association, 266*(9), 1237-1241.

St. Lawrence, J.S. (1998). *Becoming a responsible teen: An HIV risk reduction intervention for African-American adolescents.* Scotts Valley, CA: ETR Associates.

St. Lawrence, J.S., Brasfield, T.L., Jefferson, K.W., Alleyne, E., O'Bannon, R.E., III, & Shirley, A. (1995). Cognitive-behavioral intervention to reduce African American adolescents' risk for HIV infection. *Journal of Consulting and Clinical Psychology, 63*(2), 221-237.

St. Lawrence, J.S., Crosby, R.A., Brasfield, T.L., & O'Bannon, R.E., III. (2002). Reducing STD and HIV risk behavior of substance-dependent adolescents: A randomized controlled trial. *Journal of Consulting and Clinical Psychology, 70*(4), 1010-1021.

Stanton, B.F., Li, X., Ricardo, I., Galbraith, J., Feigelman, S., & Kaljee, L. (1996). A randomized, controlled effectiveness trial of an AIDS prevention program for low-income African-American youths. *Archives of Pediatric Adolescent Medicine, 150*, 363-372.

Thomas, B., Mitchell, A., Devlin, M., Goldsmith, C., Singer, J., & Watters, D. (1992). Small group sex education at school: The McMaster teen program. In Miller, B., Card, J., Paikoff, R., & Peterson, J. (Eds.), *Preventing Adolescent Pregnancy* (pp.28-52). Newbury Park, CA: Sage Publications.

Ventura, S.J., Mosher, W.D., Curtin, S.C., & Abma, J.C. (2001) Trends in Pregnancy Rates for the United States, 1976-97: An update. *National vital statistics reports, 49*(4).

Walter, H.J., & Vaughn, R.D. (1993). AIDS risk reduction among a multi-ethnic sample of urban high school students. *Journal of the American Medical Association, 270*(6), 725-730.

Winter, L., & Breckenmaker, L.C. (1991). Tailoring family planning services to the special needs of adolescents. *Family Planning Perspectives, 23*(1), 24-30.

Note: All of these programs met the criteria for inclusion in *Emerging Answers* and had at least one positive significant behavioral impact. However, some of these programs have much stronger evidence than others that they actually change behavior. See *Emerging Answers* for a more information about which programs have the strongest evidence that they actually change behavior.

Criteria for coding: If 80% or more of the sample was a particular race or gender, then it was coded that race or gender. Otherwise it was coded mixed. If a program delayed the initiation of sex, then it was included in the sexually inexperienced category. If it presented separate and significant results for either sexually inexperienced or sexually experienced youth at baseline, then it was coded for the appropriate category. If had effects on both groups, it was also coded both.

Appendix A: Contact Information for Chapter One

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(916) 445-4171

www.dhs.cahwnet.gov

Charles Stewart Mott Foundation

Mott Foundation Building
503 S. Saginaw Street
Suite 1200
Flint, Michigan 48502-1851
(810) 238-5651

www.mott.org

Child Trends, Inc.

4301 Connecticut Avenue, NW
Suite 100
Washington, DC 20008
(202) 362-5580

www.childtrends.org

Children's Defense Fund

25 E St, NW
Washington, DC 20001
(202) 628-8787

www.childrensdefense.org

Covenant House Washington

7 New York Avenue, NE
Washington, DC 20002
(202) 610-9600

www.covenanthousedc.org

ENABL (Education First and Babies Later)

Project SIGHT
319 Division St.
Northfield MN 55057
(507) 664-0220

nco.northfield.mn.us/projectsight

Get Real About Teen Pregnancy

California Wellness Foundation
6320 Canoga Avenue
Suite 1700
Woodland Hills, CA 91367
(818) 593-6600

www.letsgetreal.org
www.tcwf.org

Kids Count Project

The Annie E. Casey Foundation
701 St. Paul St.
Baltimore, MD 21202
(410) 547-6600

www.aecf.org/kidscount

Motivational Educational Entertainment (MEE) Productions, Inc.

1608 20th Street, 2nd Floor
Washington, DC 20009
(202) 296-2601

www.meeproductions.com

New Mexico Department of Health

1190 S. St. Francis Dr.
P.O. Box 26110
Santa Fe, New Mexico 87502-6110
(505) 827-2613

www.health.state.nm.us

New Mexico Teen Pregnancy Coalition

P.O. Box 35997
Albuquerque, NM 87176-5997
(505) 254-8737
www.nmtpc.org

Pathways/Senderos Center

Greater New Britain Teen Pregnancy Prevention, Inc.
100 Arch Street
New Britain, CT 06051
(860) 229-2776

Teen Pregnancy Prevention Program (T3P)

The Women's Association of Hmong and Lao
506 Kenny Road
St. Paul, MN 55101
(651) 772-4788
www.wahlwomen.org

Appendix B: Contact Information for Chapter Two

Sex and HIV Education Programs

AIDS Prevention for Adolescents in School
Not published

Becoming a Responsible Teen
ETR Associates
4 Carbonero Way
Scotts Valley, CA 95066
(831) 438-4060

Be Proud Be Responsible
Select Media, Inc.
P.O. Box 1084
Harriman, NY 10926
(845) 774-2945

Draw the Line
ETR Associates
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Scotts Valley, CA 95066
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Get Real about AIDS
Comprehensive Health Education Foundation
22419 Pacific Highway S.
Seattle, WA 98198
(206) 824-2907

Healthy Oakland Teens
Not published

Making a Difference
Select Media, Inc.
P.O. Box 1084
Harriman, NY 10926
(845) 774-2945

Making Proud Choices
Select Media, Inc.
P.O. Box 1084
Harriman, NY 10926
(845) 774-2945

McMaster Teen Program
Not published

Postponing Sexual Involvement
Teen Services Program
Grady Memorial Hospital
80 Butler Street, SE
Atlanta, GA 30335
(404) 616-3513

Reducing the Risk
ETR Associates
4 Carbonero Way
Scotts Valley, CA 95066
(831) 438-4060

Safer Choices
ETR Associates
4 Carbonero Way
Scotts Valley, CA 95066
(831) 438-4060

Untitled (Klaus et al)
Not published

Untitled (Magura et al)
Not published

Untitled (Rotheram-Borus, et al)
Not published

Wise Guys

Family Life Council
301 E. Washington St.
Greensboro, NC 27401
(336) 333-6890

Clinic Protocols

Untitled (Orr, et al)

Not published

Untitled (Danielson et al)

Not published

Service Learning Programs

Reach for Health with Community Youth Service Learning

Education Development Center, Inc.
55 Chapel St.
Newton, MA 02458
(617) 969-7100

Teen Outreach Program

Cornerstone Consulting Group, Inc.
P.O. Box 710082
Houston, TX 77271-0082
(713) 627-2322

CAS Carrera Programs

Adolescent Sexuality Education Program
The Children's Aid Society
14-32 West 118th Street
New York, NY 10026
(212) 949-4800

Appendix C: Roundtable Agenda

Progress Pending: *How to Extend and Sustain Recent Reductions in Teen Pregnancy*

A Roundtable Sponsored by the National Campaign to Prevent Teen Pregnancy and Covenant House

The Loews L'Enfant Plaza Hotel, Washington, DC

June 6-7, 2002

Thursday, June 6, 2002

2:00 pm - 3:00 pm **REGISTRATION & REFRESHMENTS**

3:00 pm - 3:30 pm **WELCOME & OVERVIEW**

- **Karen Troccoli**, Director of State & Local Action, National Campaign to Prevent Teen Pregnancy
- **Isabel Sawhill**, President, National Campaign to Prevent Teen Pregnancy
- **Sister Mary Rose McGeady**, CEO, Covenant House
- **Sarah Brown**, Director, National Campaign to Prevent Teen Pregnancy

3:30 pm - 5:00 pm **SETTING THE STAGE: PROGRESS PENDING**

- **Elizabeth Terry-Humen**, Senior Research Analyst, Child Trends
- **Carolynn Michaels**, Chief, Community Challenge Grant Program, Office of Family Planning, California Department of Human Services
- **Kirsten Thomsen**, Executive Director, New Mexico Teen Pregnancy Coalition
- **Fern Johnson-Clarke**, Department of Health, State Center for Health Statistics, Washington, DC
- Moderator: **Leslie Kantor**, Vice President of Education, Planned Parenthood of New York City

5:00 pm - 5:30 pm **BREAK**

5:30 pm - 7:30 pm **DINNER: CONTEXTS OF URBAN YOUTH SEXUALITY**

- **Ivan Juzang**, Founder/President, MEE (Motivational Educational Entertainment) Productions, Inc.
- **Hector Sanchez-Flores**, Senior Research Associate, Institute for Health Policy Studies
- **Teens from MEE Productions' Community Action Team**
- Moderator: **Marisa Nightingale**, Director of Media Programs, National Campaign to Prevent Teen Pregnancy

Friday, June 7, 2002

8:30 am - 9:00 am **CONTINENTAL BREAKFAST**

9:00 am - 10:00 am **EMERGING ANSWERS**

- **Douglas Kirby**, Senior Research Scientist, ETR Associates
- Moderator: **Sarah Brown**

10:00 am - 10:15 am **BREAK**

10:15 am - 12:00 pm **EMERGING EXPERIENCES**

- **Vincent Gray**, Executive Director, Covenant House, Washington, DC
- **RoseAnne Bilodeau**, Executive Director, Pathways/Senderos Center, New Britain, CT
- **May Lee**, Women's Association of Hmong and Lao, St. Paul, MN
- Moderator: **Sharon Rodine**, Coordinator, HEART of OKC Project, Oklahoma City, OK

12:15 pm - 1:30 pm **LUNCH: PROGRESS PENDING - WHERE DO WE GO FROM HERE?**

- **Sarah Brown**
- **Sister Mary Rose McGeady**

The National Campaign gratefully acknowledges the Charles Stewart Mott Foundation for its generous financial support of this roundtable

Appendix D:
Roundtable Participant List

Progress Pending:
How to Extend and Sustain Recent Reductions in Teen Pregnancy

June 6-7, 2002

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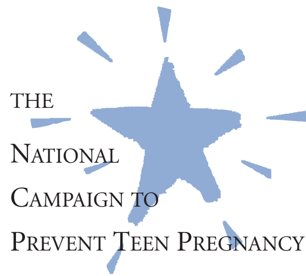

The National Campaign to Prevent Teen Pregnancy is a nonprofit, nonpartisan organization supported largely by private donations. The mission of the National Campaign is to improve the well-being of children, youth, and families by reducing teen pregnancy. The Campaign's goal is to reduce the teen pregnancy rate by one-third between 1996 and 2005.

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