A COMMUNITY STRATEGIC PLAN

FOR PREVENTING

TEEN PREGNANCIES AND

SEXUALLY TRANSMITTED DISEASES

Prepared by the
Strategic Planning Work Group
Of the
Task Force on Teen Pregnancy Prevention

Charlottesville and Albemarle County, Virginia

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MISSION STATEMENT

To guide the development of a community strategic plan for preventing teen pregnancies and sexually transmitted diseases, the Strategic Planning Work Group of the Task Force on Teen Pregnancy Prevention adopted the following mission statement:

All teens are entitled to opportunities to fulfill their potentials. An adolescence characterized by respect, good health, avenues for learning, and hope for the future provides such opportunities. Pregnancies and sexually transmitted diseases during adolescence rob youth of these opportunities.

Our mission is to prevent adolescent pregnancies and sexually transmitted diseases through a comprehensive, community-wide, collaborative effort that promotes abstinence, self-respect, constructive life options, and responsible decision-making about sexuality.

LIST OF ABBREVIATIONS

<table>
<thead>
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<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>CAPP</td>
<td>Council on Adolescent Pregnancy Prevention</td>
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<td>CACY</td>
<td>Charlottesville/Albemarle Children and Youth Commission</td>
</tr>
<tr>
<td>CCF</td>
<td>Charlottesville/Albemarle Commission on Children and Families</td>
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<td>CYFS</td>
<td>Children, Youth, and Family Services</td>
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<td>FLE</td>
<td>Family Life Education</td>
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<td>MACAA</td>
<td>Monticello Area Community Action Agency</td>
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<td>SARA</td>
<td>Sexual Assault Resource Agency</td>
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EXECUTIVE SUMMARY

Teen pregnancies, particularly those that result in teen parenthood, extract a high price -- from the adolescents themselves, their babies, and society. In addition to the personal costs, conservative economic estimates place the financial cost to taxpayers for each teen birth at $37,000 over the lifetime of the mother and child.

Although local teen pregnancy rates have shown a modest drop during the 1990s, paralleling a national trend, American teen pregnancy and teen birth rates remain by far the highest in the industrialized world. In 1995 the birth rate for girls aged 15-19 was 54.7 in the United States overall, 45.4 for Virginia, 58.5 in Charlottesville, and 19.7 in Albemarle County. In France, as a comparison, the teen birth rate that year was 7. In addition, national statistics show that 3 million American teens each year are diagnosed with sexually transmitted diseases (STDs) that cost our nation huge amounts more to diagnose and treat.

The analysis and proposals in this document are the product of the Strategic Planning Work Group, created in direct response to the May 30, 1997 town meeting on "Partners in Teen Pregnancy and STD Prevention" sponsored by a consortium of local organizations. This strategic plan presents the Work Group’s review of approaches that have been demonstrated in other communities to reduce the rates of teen pregnancies and STDs. In this document the Work Group concludes that Charlottesville and Albemarle County can and should strengthen efforts to decrease teen pregnancy and STDs, and that investing in these tested prevention programs can be cost effective. It advances some 50 specific recommendations for meeting current needs, proposes which local groups could assume responsibility for implementing each recommendation, and includes a summary “Action Agenda”.

Because no single factor marks those most at-risk for teen pregnancy or STDs, the most successful prevention efforts address the teen as a whole person, including social, emotional, intellectual, biological, and individual aspects. National research indicates that the most effective prevention programs include youth development, volunteer service, and skills-training components. Less comprehensive efforts, however, can also have an effect on teen pregnancy/STD prevention; the plan suggests steps that should be taken by families, schools, community organizations, health care providers, religious organizations, and the business community.

Local prevention programs are supported through a combination of public, private, and not-for-profit funding sources. Currently, prevention programs in Charlottesville and Albemarle County that directly address teen pregnancy and STD prevention cost approximately $230,200 annually. These prevention
programs are highly cost-effective; conservative estimates suggest that each dollar spent on teen pregnancy prevention returns nearly 2 to 4 times its value to the community. This report consequently recommends expanding the budget for teen pregnancy and STD prevention programming to approximately $550,000 per year.

The success of local programming for the prevention of teen pregnancies and STDs has been restricted by limited financial resources, by reluctance to initiate potentially controversial programs, and by the absence of a community vision that articulates priorities in the fight against teen pregnancies and STDs. This strategic plan offers nine highest priority recommendations for improving the Charlottesville/Albemarle community’s prevention efforts:

- Build on proven interventions by expanding good local programs and initiating programs shown to be effective in other localities.
- Focus on each adolescent as a whole person by offering programming that addresses social, emotional, intellectual, individual, and biological aspects.
- Improve communication about sexuality and reproductive health by encouraging adults and the media to provide clear, constructive, consistent support of the prevention message.
- Increase spending on prevention programs by public, private, and not-for-profit sectors, recognizing the cost-effectiveness of such efforts.
- Coordinate community prevention efforts by funding a professional, who will also assist with special events, information dissemination, program evaluation, and grant applications.
- Strengthen parents’ ability to communicate with their children of all ages about developmental issues and to articulate their own values about sexuality by offering support and educational opportunities for parents.
- Expand existing highly effective programs to provide a seamless continuum of services for youth of all ages in our community.
- Improve the implementation of Family Life Education curricula in schools by, among other things, adding skills building and enhancing teacher training.
- Expect health care providers to play a more active role in educating youth and parents about reproductive health and prevention of teen pregnancy and STDs.

This plan acknowledges that deep-seated differences in values and beliefs will preclude consensus on some issues. To succeed, we must seek common ground on which to build effective teen pregnancy and STD prevention efforts in our community. We must treat our differences with respect, encouraging and supporting all groups to develop prevention programs consonant with their beliefs. We must strive for unity of principle while respecting the diversity of means.
CHAPTER I.  INTRODUCTION

I. A. Purpose of this strategic plan

The Charlottesville/Albemarle County community\(^1\) has long been concerned about pregnancies and sexually transmitted diseases (STDs) among our adolescents,\(^2\) despite the virtual absence of public policy on the issue. During the last 40 or 50 years, residents have increasingly perceived teen pregnancies with misgivings, in large part because the personal, social, and economic costs have grown. The teen pregnancy rate today is about the same as in the 1950s, but now a much smaller percentage of teens get married when they get pregnant. Single-parenting teens too often drop out of school, qualify only for low-paying jobs, and not infrequently, end up on welfare. Moreover, since the 1950s, the abortion rate among teens has increased, and, with the spread of AIDS since the 1980’s, alarm about STDs among teens has grown.

Parents' apprehensions about teen pregnancy and STDs have been paralleled by disquiet expressed by many sectors of the society: schools, local civic and youth-serving organizations, health care providers, religious groups, the media, etc. The concern, however, has been manifest in only a handful of local programs that reach only a small proportion of the youth who need them; the following chapters will discuss these efforts. With a few laudable exceptions, our community's ventures into teen pregnancy/STD prevention programs that have demonstrable impacts have been limited by inadequate funding and/or paralyzed by fear of controversy.

Both of these problems -- the inability to find resources to sustain needed programs and the unwillingness to initiate a program that may provoke challenges from some sector of the community -- are linked to a third problem: the absence of a common community vision that articulates what we will do about teen pregnancies and STDs, and what our priorities are.

The strategic plan outlined in the following pages attempts to fill this gap in our community vision. It is intended:

(a) to raise awareness about the need to deal more effectively with teen pregnancies and sexually transmitted diseases in our community;

\(^{1}\) The City of Charlottesville in central Virginia has an estimated population of 38,100, of whom teens aged 15-19 comprise 6%. By race, 74% of the population is white, 23% black, and 1% Hispanic. The average family income is $40,050. Albemarle County, 750 largely rural square mile surrounding Charlottesville, has a population of 80,200; 8% are 15-19. By race, 84% is white, 11% black 2% Hispanic. Family income averages $50,442.

\(^{2}\) In this document we will use the terms “adolescents”, “teens”, and “youth” interchangeably, all referring to boys and girls age 10 through 19 unless more narrowly defined.
(b) to provide a broad perspective that helps coordination of efforts and cooperation among agencies;

(c) to review the strengths and weaknesses of our current efforts;

(d) to advance specific recommendations for meeting current needs, and to suggest priorities;

(e) to propose institutional responsibilities for implementing, or for monitoring the implementation of, the proposed tasks; and

(f) to stimulate discussion that may lead to new policies and programs in the public, nonprofit, and private sectors.

This report contains hundreds of implicit and explicit ideas for improving our community’s teen pregnancy prevention efforts. From among the many ideas, some fifty specific recommendations emerged using three criteria:

- the probability that the program/activity/policy will have an effect in reducing teen pregnancy and STD rates in our community, based on reliable evaluations of experience elsewhere;
- the cost, in terms of money, people, and time; and
- the cultural and political acceptability in our community at this time: is the activity consonant with overall community values?

Because local teen pregnancy rates have shown a modest drop during the 1990’s paralleling a national trend (see I.C.1., below), there is a risk that we as a community will relax our efforts to deal with the problem. Such complacency would be ill-advised. American teen pregnancy and teen birth rates are by far the highest in the industrialized world; the small recent declines do not change this picture. Moreover, every year in Charlottesville and Albemarle County unintended teen pregnancies number in the hundreds; each represents personal anguish and social costs that might have been avoided. We have a continuing responsibility to devote to this issue the attention it deserves.

I. B. Background

The need for strategic planning for teen pregnancy and STD prevention in our area has been evident for some time. In the 1990’s alone, three major efforts were
launched to identify overall needs in the Charlottesville/Albemarle community and to develop projects and programs in the context of the “big picture”.

During 1993-1994, the Charlottesville/Albemarle Children and Youth (CACY) Commission – now merged with the local Community Policy Management Team (CPMT) and given expanded responsibility as the Commission on Children and Families (CCF) -- convened a series of forums and working groups with over 50 local citizens to develop a "Community Action Plan." The plan, presented to the community at a March 1995 “Roundtable Discussion,” identified three top-priority issues: character education in elementary schools, greater parent involvement in teen pregnancy prevention, and focussed programs aimed at small groups of high-risk children aged 8-11. Though working groups met to deal with all three issues, only the third topic led to tangible results. The group developed and obtained initial funding for the "Beating the Odds" program at the Monticello Area Community Action Agency (MACAA), currently serving 63 children in the city and county (described in Chapter IV.C. and Appendix L).

In 1995, a needs assessment report by the Council on Adolescent Pregnancy Prevention (CAPP) reviewed strengths and weaknesses in local teen pregnancy/STD prevention activities. One of CAPP’s conclusions was that teen pregnancy/STD efforts would continue to be fragmented and inadequate until a systematic strategic plan was developed by the community. Without such a plan, scarce resources were unlikely to be allocated optimally.

On May 30, 1997 a town meeting on “Partners in Teen Pregnancy and STD Prevention” was sponsored by a consortium of local organizations (see Appendix B). The 60 concerned citizens who participated reviewed the community's present approach to teen pregnancy prevention and suggested the next steps for concerted effort. Participants urged that four topics be addressed immediately: parents’ communication with their children about sexuality and other subjects (echoing a theme from the 1995 Roundtable Discussion); after-school activities for teens; expansion of existing teen pregnancy prevention projects into more schools; and strategic planning. A working group was established to deal with each issue.

The strategic plan presented in this document was created in direct response to the Town Meeting consensus recommendation. The Strategic Planning Work Group began meeting in the summer of 1997, and over the next two years a small group collected data, reviewed literature, and drafted sections of the Plan. These drafts were then critically reviewed by a larger group more representative of the community’s diversity. The Strategic Planning Working Group’s membership and its operations are detailed in Appendices A and B.
I. C. The need to prevent teen pregnancy and sexually transmitted diseases

I. C. 1. The statistical picture: Teen pregnancies

Approximately 4 in 10 girls in the United States become pregnant at least once before turning 20 years old (National Campaign to Prevent Teen Pregnancy, 1997b, p. 3).

A million teenage girls in America got pregnant in 1997. Of that number, our share was 128 girls in Albemarle County and 122 in Charlottesville (Virginia Center for Health Statistics, 1998). Over the past ten years, local figures on teen pregnancies have varied somewhat; Appendix D graphs the data for all teens (i.e., age 10-19) and for teens age 10-17.

The meaning of these numbers is easier to understand when translated into rates representing the number of pregnancies per thousand teen girls (see Appendix E for steps in calculating a rate). Rates can be compared among different groups or to show changes over time.

For example, Figure 1 shows that the pregnancy rate for girls aged 15-19 in Albemarle County is lower than the rate for all teen girls in the state of Virginia,

![Figure 1: Pregnancy rates for girls 15-19 in 1995, Albemarle County, Charlottesville, Virginia, and USA](image)

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3 Appendix C shows, for each age, the total number of girls between ages 10 and 19 for both Charlottesville and Albemarle in 1990 – the most recent census year. The total is about 7000, and the number of boys in this age group is roughly the same.

4 A pregnancy rate requires reliable data for both the number of pregnancies in a particular group in a given year (the numerator), and also the total number of females in that group in that year (the denominator). Only in census years – once every ten years in the USA (1970, 1980, 1990, etc.) – is the denominator highly reliable. Between censuses, we must rely on estimates that become less trustworthy as the decade progresses.
and the pregnancy rate for Charlottesville teen girls is higher than the state average. Focussing on 15-19 year old girls, who are responsible for 98% of teen pregnancies, both the city and county rates show a modest and irregular drop over the past eight years (see Appendix F) that parallels a state and national trend.

Though the overall numbers and rates help describe the situation, they tend to obscure the fact that each teen pregnancy is unique. So, of course, are the impacts on the teens and their families. The age at which a teen pregnancy occurs, for example, can make a tremendous difference. In both the city and the county, three of the pregnancies in 1997 were to girls aged 14 or below – still in junior high – but most of the pregnancies were to 18 and 19 year olds, some in college (see Appendix G). A small proportion of the girls were married (18% in Albemarle, 11% in Charlottesville); most were not.

There are also differences in teen pregnancy rates by race, which may be primarily a function of the overall socio-economic disparity in our community between blacks and whites. As Appendix H shows, in Charlottesville the 1996 pregnancy rate for black teens aged 15-19 was more than twice that of white teens, and the birth rate of black teens was nearly four times higher. In Albemarle County these differences are considerably less apparent, and the rates for both black and white teens far lower.

Figure 2 shows the outcome of the teen pregnancies in 1997. Most now result in live births, and nearly all teen mothers choose to keep their children rather than

![Figure 2: Outcome of teen pregnancies, 1997, Charlottesville and Albemarle](image-url)
place them for adoption. Until 1995 the majority of adolescent pregnancies ended in abortions and miscarriages. The change in the proportion of teen pregnancies that end in abortion over the last eight years is shown in Appendix I.

Teen birth rates, rather than teen pregnancy rates, have in recent years become preferred by many authorities as a useful way to measure adolescent reproductive health and behavior. This is mainly because data on teen births are far more reliable (some teen pregnancies, particularly those ending in an early miscarriage, are unreported), and because a birth is more likely than a pregnancy to be a life-changing event for a teen.

The current pattern of teen birth rates, shown in Figure 3, is similar to that of teen pregnancy rates – except that the Charlottesville rate is greater than the national rate. For teens age 15-19 in 1996, the birth rate in Charlottesville is nearly three times that of Albemarle County, and about 30% higher than the state. To provide a sense of perspective, Figure 3 includes the comparable teen birth rate for France: it is about a third that of Albemarle County.

The birth rate among American teenagers aged 15-19, after increasing sharply in the 1980’s, declined consistently between 1991 and 1996 a total of 12.4%; the rate in Virginia during the same period dropped 15% (Ventura et al., 1998). Local birth rates, analyzed by the Strategic Planning Work Group for this report, have fluctuated over the same six-year period because of our relatively small population. When these normal variations are smoothed out with a regression line, the results reveal that birth rates for 15-19-year-old teens in our community declined at an even faster rate from 1991 to 1997. In Charlottesville, the drop in the teen birth rate was 21%; in Albemarle County, 24%.

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5 Data are not available to indicate the proportion of teen births that led to adoption in our community, but nationally in 1988 only one percent of babies born to never-married African American women and three percent of babies born to never-married white women were placed for adoption (Bachrach 1992).

6 Teen birthrates are on average nearly six times lower in France, Germany, and the Netherlands than in the U.S. Rates of STDs, including HIV/AIDS, are four to seven times lower than in the U.S., and adolescents in these countries become sexually active later than American teens (Berne and Huberman, 1999, p. 7). One expert (Huberman 1999) suggests that the reasons are because in Europe:
(a) Sexual health and responsibility are public health issues, not religious issues; emphasis is on ethical behavior of individuals, rather than church doctrine or collective force;
(b) Sexuality education is not necessarily a course, but is often integrated throughout school subjects, through all grades. The focus is on giving complete and accurate information. Sexuality education promotes the values of respect, responsibility, and committed relationships.
(c) National health insurance gives sexually active youth free and convenient access to contraception and emergency contraception.
(d) Young people generally believe that it is “stupid and irresponsible” to engage in sex without protection.

There is, of course, variation in teen pregnancy and STD rates among the full range of European countries. Until we better understand they cause of the differences, we must be cautious in using Europe as a model.
A look at all 150 teens who gave birth in 1990 in Charlottesville and Albemarle County revealed that 29 gave birth to their second child and 8 gave birth to their third or fourth child (Kars-Marshall and Marshall, 1992). These figures show that one in four (24.7%) already had at least one birth. Since the number of live births and the number of abortions for teens were about the same in that year, probably another quarter had been pregnant but ended the pregnancy with an abortion. This suggests that roughly half the teens in our community who get pregnant have already been pregnant once before.

Data on teen sexuality – knowledge, attitudes, or behavior -- are not available for our community, an absence that makes it much more difficult to identify local needs and to tailor our own solutions for preventing pregnancy and STDs. As a proxy, we can look at studies of the state and national levels to suggest the situation in the Charlottesville/Albemarle community. One important item of information, for example, is that the average age of puberty for American girls is now under 13, and the average age of marriage is 26.

Though parents may not wish to believe it, roughly half the teens in high school have had sexual intercourse. In a 1992 study of public-school students in Virginia, half of all ninth and tenth graders -- both boys and girls -- reported already having had sexual intercourse (Department of Education, 1992). Among

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7 Data on a small group of local teens and young adults has recently been collected but not yet fully analyzed for two studies through the UVA Department of Psychology (Whitten 1999; Whitten and Mitchell, in press).

8 Charlottesville and Albemarle County schools participated in the survey, but chose not to ask the questions about sexual activity.
eleventh and twelfth graders, 70% of the females and 74% of the males reported having had sexual intercourse (see Appendix J).

Roughly the same pattern was revealed in a national survey in 1995 (Moore et al. 1998; see Appendix K). More than half of 15- to 19-year-old males and females said they were sexually experienced. Two-thirds of the teenage women used a condom the first time they had intercourse; they were more likely to do so if their partner was the same age or younger. Overall, fewer than half the sexually active teenage men used a condom every time they had sex; between the ages of 16 and 19, the level of consistent use drops from 70% to 36%.

This research also found that the probability that a sexually active young woman had given birth increased steadily from 3% of 15-year-olds to 28% among those aged 19. At each age, girls who did not use a contraceptive method at first intercourse were about twice as likely to give birth as those who used a method.

In contrast, the probability that a sexually experienced male between ages 15 and 17 will have impregnated their partner is approximately 4%. In fact, of all the men responsible for the pregnancies of women under 18, only one-quarter are also under 18. This gender difference mainly applies to pregnancy rates (as opposed to rates of sexual activity) and reflects a tendency for females who become pregnant to do so as a result of intercourse with an older male. For most teenage females, their first sexual partner is either the same age or within one to two years in age. But, for those teenage females who not only have intercourse but also become pregnant, 60% have a partner who is three or more years older. A smaller percentage (21%) of unmarried mothers between ages 15 and 17 were impregnated by males who were more than 5 years older (i.e. meeting statutory rape definitions in many states).

Another recent major study, with a nationwide sample of more than 16,000 high school students, indicates that the proportion of teens (grades 9 through 12) engaging in sex, after rising in the 1970’s and 80’s, dropped from 54.1% in 1991 to 48.4% in 1997 (Centers for Disease Control and Prevention 1998). The proportion of 1997 students who had had sexual intercourse ranged from 38% of ninth graders to 61% of twelfth graders.

The same research shows that among sexually active high school students in 1997, nearly 57% had used a condom the last time they had intercourse – compared to about 46% in 1991. Moreover, during the same period, the number of teens reporting that they had had four or more sexual partners over their lifetime decreased from nearly 19% to 16%; most had no more than one partner in the past year.
Though at least one third of the teen population does not use condoms or other contraceptives the first time they have intercourse, use of contraception by teens has increased in the past eight years. Indeed, the Vice President for Research of the Alan Guttmacher Institute links this trend to the drop in teen pregnancy:

About 20 percent of the decrease since the late 1980’s is due to decreased sexual activity and 80 percent…is because of more effective contraceptive practice. (Jacqueline Darroch, quoted in Havemann, 1999)

Of particular interest is use of DepoProvera, reported in national research and by local health care providers as increasingly popular with sexually active adolescent girls.

Risky sexual behavior, in addition to being linked with pregnancy and STDs, also appears to be associated with a wide range of other adolescent problem behaviors including delinquency, alcohol and drug use, and academic difficulties (Jessor and Jessor 1977; Donovan and Jessor 1985).

I. C. 2. The statistical picture: Sexually transmitted diseases

We know less about STDs among teens – particularly among local teens – than about teen pregnancy. National statistics show, however, that 3 million American teens become infected each year with an STD – three times more than the number who get pregnant. Teens are at particular risk of STDs because of their low rate of condom use and because the physiology of the adolescent woman’s cervix makes it more susceptible to some of the STDs.

Two very common viral STDs – genital herpes and genital warts – are not routinely reportable, nor is there an easy screening test available. Thus reliable data on their prevalence, particularly among teens, is not available. The cause of genital warts is the human papilloma virus or HPV. Cell changes detected in a cervical pap smear, though not a diagnostic certainty, strongly suggest the disease. Locally, the Teen Health Center reports that over 20% of their female patients have abnormal pap smears with changes that may be caused by HPV.

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9 “Risky sexual behavior” includes sexual intercourse without a condom or other contraceptive, with multiple partners, or while drunk or high on drugs.

10 Note, however, that (a) both partners can get an STD but only half of them can get pregnant, and (b) many STDs are undiagnosed and/or underreported – perhaps as many as are reported, while data on the number of pregnancies is generally pretty good except for those that end in early miscarriages.

11 Personal communication from Dyan Aretakis, UVA Teen Health Center, 1999.
studies based on pap smears have estimated that half of sexually active young women are infected.

For both genital herpes and genital warts, treatment can be given to deal with the immediate problem but it cannot remove the virus from the body. Infected people can have painful herpes outbreaks for the rest of their lives. Herpes and warts can be spread even if the person does not have any symptoms.

Two bacterial STDs – chlamydia and gonorhea -- are more commonly known and more reliably reported because of the availability of simple, commonly used screening tests. Untreated infections can lead to pelvic inflammatory disease and permanent scarring, which can impair fertility in men or, more commonly, women. As with viral STDs, both these bacterial infections may be silent, causing few or no symptoms (particularly among women). A national study of 3,200 sexually active girls aged 12-19 found that more than 24% of the girls making their first clinic visit were infected with chlamydia (Burstein et al. 1998).

In Virginia in 1997-1998, 46% of the reported chlamydia cases and 32% of the gonorrhea cases were adolescents aged 10-19. In the Charlottesville/Albemarle area, because UVA students increase the ratio of adolescents, teens represent an even greater proportion of the cases: 50-54% for chlamydia and 37-42% for gonorrhea. Moreover, in this area, the prevalence is increasing. From 1997 to 1998, the reported chlamydia case rate in adolescents increased from 7 per 1,000 to 9.3 per 1000; the reported adolescent gonorrhea case rate rose from 2.4 per 1000 to 4.5 per 1,000.12

Syphilis tends to be diagnosed in older groups, with only 11% of the Virginia cases reported in 1997 under age 19. As with gonorrhea, reported cases of syphilis declined significantly during the 1990’s; none has been reported among local teens in recent years.

The most feared STD today is the human immunodeficiency virus/autoimmune deficiency syndrome (HIV/AIDS). Although at a national level reported cases have decreased in recent years, AIDS is nevertheless more of a risk to teens than it was a decade ago because the pool of infected partners has increased (Vobejda 1998). Though half of HIV infections in this country occur among people under 25 years of age, no teens in Charlottesville or Albemarle County have been reported to the Thomas Jefferson Health Department with HIV or AIDS. However, there is very little local testing among teens, and a positive test would be attributed to the location of the screening. It is assumed that some local teens are becoming infected but they are not being identified until they are in their twenties.13 The delay between acquiring the infection and having either symptoms

12 Personal communication from Linda Vasquez and Bob Parker, Thomas Jefferson Health Department, 1999.
13 Personal communication from Dr. Susan McLeod, Thomas Jefferson Health Department, 1999.
or other cause to be tested makes it likely that many teen cases of HIV go undetected.

Teens’ ignorance about STDs and unrealistically low appraisal of their risk of STDs are impressive. Though we have no local studies to pinpoint problems and help develop education strategies, national research probably reflects the local situation. In one of the most recent investigations,

the majority of 15- to 17-year-olds surveyed seriously underestimated the occurrence of STDs other than HIV/AIDS and the chance for acquiring them. Fewer than half knew that herpes and HPV cannot be cured or that gonorrhea and chlamydia can be. Only one-third of those who were sexually active thought they were at risk of acquiring an STD, and fewer than that had been screened for infection. (Stepp, 1999).

Improving knowledge and altering risk perception, however, will not be enough to reduce teen risk-taking behavior. Current HIV/AIDS prevention models are drawing heavily on behavior change theories that take into account community norms, fear and anxiety, interpersonal skills, locus of control, and other factors.

Many sexually active teen girls have accepted the message that they should protect themselves from pregnancy, so they use the pill or Depo-Provera for contraception. But, despite their fear of AIDS and the admonitions of health clinic staff, the girls do not think consistently about the need for abstinence or condoms for STD prevention. Most STDs are silent, especially in women, so they can be passed on and do permanent damage without being recognized unless screening is built in as part of a routine exam. Such exams are important elements of the services provided to adolescent females by local clinics, and are now recommended for sexually active teens every 6 months (Burstein et al. 1998).

How many – and more importantly, which -- of the 14,000 boys and girls ages 10-19 in Charlottesville and Albemarle County are “at risk” of getting pregnant or contracting an STD? Some experts argue that the whole adolescent and pre-adolescent population is theoretically at risk, since there is virtually no certainty that any individual teen will avoid an STD or unwanted pregnancy before age 20. Other experts propose ways to define the “at risk” population, noting that -- based on past experience – there is tremendous variation in the probabilities that various subgroups of the 14,000 teens will get pregnant or contract an STD (see Chapter 2., Section A.).

14 Personal communication from Dr. Susan McLeod, Thomas Jefferson Health Department, 1999.
The national data showing fewer teen pregnancies in the past few years and a decline in teen births, coupled with the surveys indicating that sexually active teens are more inclined in recent years to use condoms and have fewer partners, point to encouraging changes in risk behavior. Though the precise causes of these recent trends are uncertain, national experts tentatively attribute the changes to (a) the growing barrage of messages from schools, community groups, churches, and families urging teens to delay sex and protect themselves against AIDS, (b) teens’ fear of getting sick and dying from AIDS, (c) greater accessibility to condoms and other contraceptives, (d) successful efforts to strengthen teens' decision-making and refusal skills, and (e) social, cultural, and economic trends that have led to the broad general decline in a range of youth problem behaviors nationally (e.g. criminal behavior, drug use, etc.).

I. C. 3. The human situation

Whether out of compassion for the people often put at insurmountable disadvantage because a teen gets pregnant or contracts a STD, or out of a dispassionate dollars-and-cents calculation, there are compelling reasons for our community to devote fiscal and human resources to preventing the problems.

Each unintended pregnancy forces upon the young woman – often with little support from her partner, her family, or others she can trust – a decision between the option of abortion or carrying the pregnancy to term. If the outcome of the pregnancy is a birth, another choice must be made by the mother: to keep the baby or place it for adoption.

In the roughly 60% of local teen pregnancies that end in a birth (see Figure 2), there are likely to be physical, social, psychological, and economic effects on the infant, the teen mother and the father, and the parents of the teen mother -- as well as economic impacts on the larger community. Most teen mothers or fathers have had no training to take care of an infant; it is frequently the baby’s maternal grandparent(s) who becomes the primary care giver. Often a teen, especially if she is a single mother, will drop out of school and/or quit a job after the birth of their child. Neither the mother nor the father may know how to obtain maternal and child health care, daycare for the baby, welfare or child support, continuing education, or a job consistent with newly changed circumstances. Fathers may be unaware of their legal and financial responsibilities for the child.

Although the consensus of the research community is not settled on the total impact of adolescent parenting (Hoffman 1998), some effects seem pretty certain.
Studies (summarized in Hayes 1987) suggest that teen mothers\textsuperscript{15} have higher rates of birth complications; higher school dropout rates with lower education attainment or greater delays in completing school; poorer jobs, with lower incomes and lower occupational prestige; increased chances of welfare dependency; greater chances of single parenthood and marital instability. Not surprisingly, teen parents are significantly less likely to function well as parents than are older parents.

For children born to teen mothers, research indicates that they are more likely to show deficits in social, emotional, and cognitive functioning that can be seen years after their birth. They have more chance of suffering child abuse and neglect; a greater risk of long-term health and developmental problems; poorer adaptation to school and poorer intellectual achievement, with a higher chance to be a school dropout and have troubles with police; and a tendency to become teen parents themselves.

The economic burden of caring for a child – in whatever ways the costs may be shared by the teen mother, the father, the parent(s) of the teen mother, or society in general -- represents money that could be going for other purposes. Estimating the costs of teenage pregnancies is not an exact science, and a range of estimates for the costs of teen pregnancy exists. However, even choosing from the lower cost projections yields an estimated annual cost for the nation as a whole of $6.9 billion to taxpayers from lost tax revenues, increased spending on public assistance, health care for children, foster care, and the criminal justice system. Recent evidence suggests that these financial estimates may underestimate the problem by overlooking effects on the young offspring of teen parents (Maynard, 1996). The $6.9 billion figure is the estimated cost to taxpayers for first births to teenagers under 18, compared to first births if they had waited until age 21. If the estimated costs to society (including the costs to the teens and their families, not just the tax dollars) are calculated, the figure swells to $15 billion.

The economic costs of STDs are roughly of the same magnitude, according to Helene Gayle, director of the Centers for Disease Control’s program for HIV, STD and tuberculosis prevention:

STDs, not including HIV, cost about $8 billion annually to diagnose and treat – largely preventable expenses (cited in Stepp, 1999).

No direct data exist on the local economic costs of teen pregnancies, though it is possible to estimate our share of the national cost. The $6.9 billion cost was based on a total of 185,000 teen births, or a cost in today’s taxpayer dollars of $37,000

\textsuperscript{15} Compared to teen women who postponed parenthood until after age 20.
for each birth over the lifetime of the mother and child. For 82 teen births in Albemarle County in 1997, then, the costs to taxpayers (not including the costs to the teen or her parents) would be $3 million; for the 69 teen births in Charlottesville, $2.5 million. In other words, the community would save $5.5 million by having these 151 teens delay giving birth until at least age 21.

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16 Data are not available to adjust this figure on the basis of whether a child is kept by the teen parent(s) or given for adoption.
II. A. Roots of teen pregnancy/STD problems: Risk factors

Recent research has aimed at a better understanding of the variables linked with teen pregnancy, giving us some idea of which teens might have a higher risk of getting pregnant. The clearest finding to emerge from our review of the research is that teen pregnancy is not the result of any single problem. There appear to be three general categories of factors that increase the risks for teen pregnancy (Kirby 1997):

(a) Biological factors such as higher levels of testosterone in males that influence sexual behavior, and earlier age of puberty for males and females (Allen et al., 1997).

(b) Social/environmental factors such as poverty, parental unemployment, family marital disruption, parental lack of education, family history of teenage parenthood, poor childrearing practices, and being a sexual abuse victim.

(c) Individual factors such as drug and alcohol use, poor educational performance and low educational expectations, low general expectations for the future, an external locus of control, aggressiveness, and lack of religious affiliation (Vincent et al., 1987; Koo et al., 1994).

Although these general risk factors have been linked to teenage pregnancy, in each case the documented relationship is a very slight one.

In addition, researchers have identified more specific predictors of risky sexual activity. These include a teenager’s beliefs and values about sexual behavior, pregnancy, and childbearing; the teen’s perception of the beliefs and values of others in the community; and her/his own specific plans/goals regarding sexual behavior. In brief, those who see risky sexual behavior and pregnancy as completely unacceptable have a lower risk of becoming pregnant than those who are less disturbed by these possible outcomes.

We draw two main conclusions from the national research.

First, there is no single factor that “marks” those most at-risk for teen pregnancy, in part because so many adolescents are at substantial risk. Given that 25% of female adolescents become pregnant before reaching age 18 (Alan Guttmacher Institute, 1994), a far higher percentage are likely to be putting themselves at risk of pregnancy and avoiding it only through luck.
Second, most of the risk factors listed above support the proposition that the risk of teen pregnancy is highest for those teens living in unsupportive environments who are struggling to adapt to the expectations our society holds of adolescents in areas such as academic success, avoiding delinquency, etc. Although pregnancy rates for adolescent females are high enough that one could reasonably argue that all teens are “at-risk,” we will use the term “high-risk” to refer to teens who face a combination of the risk factors listed at the outset of this section (e.g. poor educational performance, family history of teenage parenthood, high levels of drug or alcohol use).

Conversely, adolescents who are thriving in their communities and have enough support that they can envision continuing to thrive as adults, appear best situated to avoid teen pregnancy. In this respect, the succinct summary of the research literature by Marion Wright Edelman, President of the Children’s Defense Fund, appears quite germane: “The best contraceptive is a future you believe in.”

II. B. Findings from program evaluations

Virtually all operating programs that target teen pregnancy make at least some claim that theirs is an effective approach to prevention. To sort among these claims we reviewed programs that have been rigorously and objectively evaluated, meaning programs that have: a) utilized both program groups and well-matched comparison or control groups; b) looked at actual changes in sexual behavior or in pregnancy rates; and c) had their results subjected to peer review by scientists who have no vested interest in the programs. We used this approach because we wanted to identify programs that would stand up to careful scrutiny, regardless of how much enthusiasm they may have aroused among their proponents.

The programs demonstrating the strongest evidence of effectiveness are described below, presented in descending order of efficacy:

✓ **Youth Development/Volunteer Service Programs** - These programs get teens involved in volunteer community service and link this service to helping teens cope with specific challenges of adolescence: education, career exploration, decision-making skills, resisting peer pressure, and coping with family problems. Volunteer service appears to work by giving teens a vision of themselves as potentially competent, contributing adult members of their communities, while engaging them in positive interactions with adults and peers. There are two large-scale evaluations in the literature, each with a different program, both with strong findings of reductions in pregnancy rates among participating youths (averaging as high as 50% reductions in one program; see Allen et al., 1997). Further, there is evidence that even preschool
programs that increase children’s capacities to cope with educational and social demands of childhood (without ever addressing sexuality) may have the effect of reducing pregnancy rates ten years later in adolescence (Kirby 1997).

✓ **Sex and HIV/AIDS Education Programs combined with skills training** - Programs that link education about the dangers of risky sexual behavior (particularly those that focus on HIV/AIDS risk) and are combined with social skills-training programs, have shown some evidence of reduction of teen pregnancy rates and risky sexual behavior. Social skills-training programs typically focus on topics such as assertiveness training and effective decision-making and use techniques such as role-playing to allow teens to practice skills they are learning. Many such programs have been evaluated to date with some showing signs of efficacy and others not. Somewhat better results have been obtained with HIV/AIDS education programs than with basic sex education programs in this context (perhaps because fear of contracting a potentially fatal illness is a more powerful motivator than fear of pregnancy)(Kirby 1997).

In view of these findings, it is not surprising that Family Life Education (FLE) evaluations around the country often do not reveal an impact on teen pregnancy or adolescent risk behavior. Most traditional FLE curricula still consist almost solely of “Sex and HIV/AIDS Education Programs” without skills training.

✓ **Multi-Component Programs** - These programs combine disparate elements such as community mobilization, media campaigns, installation of condom vending machines, peer educational programs and classroom instruction. At least one community that has adopted this approach reports significant decreases in pregnancy rates relative to surrounding communities, a result that other communities are now working to replicate (Koo et al., 1994; Vincent et al., 1987).

Two popular approaches for preventing teen pregnancy and/or STDs show only weak or equivocal evidence of effectiveness:

- **Improved Access to Contraception (e.g., school-based clinics providing contraceptives)** - Although early research suggested that improving access to contraceptives, *by itself*, was a quite promising approach to reducing teen pregnancy, more rigorous recent research has been far less likely to find positive effects.

- **Curriculum-based Sex Education Programs in Isolation** - These have generally been quite thoroughly and rigorously evaluated and have consistently found to neither reduce pregnancy rates nor to decrease (or increase) adolescent sexual
behavior. It appears that simply presenting information to adolescents, without helping young people cope with the challenges of adolescence (e.g., decision-making, finding a role for themselves in the community, etc.) has little impact, positive or negative, on teens’ behavior.

It should be noted that abstinence-only programs, though extensively publicized, have yet to be rigorously evaluated. However, unlike some of the other approaches above, abstinence-only approaches are new enough that this lack of positive data may merely reflect the fact that good research is difficult and time consuming; possibly abstinence-based approaches have not yet received sufficient scrutiny to allow conclusions about them to be drawn. Thus, while these approaches have not demonstrated that they are effective, neither has evidence accrued to allow one to draw the conclusion that they are not effective.

The evaluations in recent years help us understand not only what is likely to occur as a program intervenes on the life of a teenager, but what is not likely to occur. In particular, the results indicate that teaching students about sex and safe-sex practices does not result in an increase in promiscuity, as some critics feared.

Several conclusions can be drawn from the review of program evaluation literature. After years of program development, the list of successful approaches to preventing pregnancy is sobering in its brevity but nevertheless offers a basis for optimism. Although most teen pregnancy prevention programs have fallen short of expectations, some of the programs have reduced pregnancy rates by 50% under real-world conditions.

The principles embodied in successful programs seem to coalesce around the idea of focusing on the adolescent as a whole person. Successful programs help adolescents develop as social and emotional beings. Somewhat surprisingly, they may or may not even concentrate on sexuality, but they all focus on helping the overall process of adolescent development with approaches ranging from teaching decision-making skills to encouraging youth involvement in their community through volunteer service. Such programs, recent research suggests, have an ameliorating effect not just on teen pregnancies, but on a number of other adolescent problems including violence and drug use.
CHAPTER III: OVERARCHING ISSUES AND RECOMMENDATIONS

Proposals for dealing more effectively with teen pregnancy and STDs can be divided into those that tend to be particularly relevant for a “sector” (families, schools, etc.), and those that transcend a single sector. In this chapter, we discuss the transcending, “overarching”, issues and recommendations for teen pregnancy/STD prevention, grouped in two categories: (a) those that set the tone in the community, and (b) those that guide the mix of programs in the community. Because the recommendations in this chapter tend towards general guidelines rather than specific actions, in some instances we do not assign responsibility for implementing them.

III. A. Setting the Tone

1. Community values: Though we are a community of diverse values, certain core beliefs – honesty, for example -- are held in common. Shared values – reaffirmed by parents, schools, religions, etc. – are part of the social glue that allows us to live and work together in relative harmony. In a positive way, a broadly similar system of beliefs provides a society common goals and visions. Conversely, by inducing shame, guilt and/or social sanctions, the framework of values discourages inappropriate behavior that may threaten the smooth functioning of the family and other social units.

Some values, though widely held, enjoy only rare or inconsistent public affirmation, a situation that reduces their influence on behavior. For example, there is probably widespread consensus in our community that teens tend to be poorly equipped with the skills necessary for parenting. Most of us probably also share the sentiment expressed in the mission statement for this strategic plan (see page iii):

All teens are entitled to opportunities to fulfill their potentials. An adolescence characterized by respect, good health, avenues for learning, and hope for the future provides such opportunities. Pregnancies and

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17 In July 1993 the Albemarle County School Board adopted a set of core values to be used as part of a code of behavior, since updated; the list includes: respect for authority, cooperation, courage, fairness, honesty/integrity, industry, justice, loyalty, patience/self-control, patriotism, respect for others, responsibility, self-respect/esteem, virtue (Keyser 1998). The Charlottesville elementary schools and Walker Upper Elementary School have been developing a character education program that focuses on selected “words of the month” such as trustworthiness and perseverance. The schools involve the community, businesses, teachers and students in making these words – and the concepts they represent – a more integral part of their lives. Henley Middle School in the County recently reported a drop in disciplinary problems after adopting a character education program that emphasizes trustworthiness, respect, responsibility, fairness, caring and citizenship (Nonte 1999). The state recently mandated character education for all schools.
sexually transmitted diseases during adolescence rob youth of these opportunities.

Nevertheless, these important community values are not forcefully and consistently stated, and thus their impact on adolescents’ behavior is diminished. The timidity and ambivalence with which our community expresses the value that “Teen girls should not get pregnant; boys should not get girls pregnant; and neither should get STDs” are doubtless perceived by teens themselves.

Recently an expert team examined the reasons teen pregnancy and STD rates in France, Germany, and the Netherlands are significantly lower than those in the USA. The team’s report notes, among many other things, that governments in these countries support massive, consistent, and long-term public education campaigns which use television, radio, billboards, discos, pharmacies, and doctors (Berne and Huberman, 1999).

**Recommendation:** Communicate clearly and directly to youth that as a community it is our strong, unambiguous value that adolescents should not get pregnant or contract STDs. Conduct public awareness/social marketing campaigns to reestablish and then maintain this value in a prominent position. Involve teens in both composing the messages and disseminating them.

**Responsibility:** CAPP, together with Planned Parenthood of the Blue Ridge and the Commission on Children and Families, should jointly be asked to plan and coordinate the initial media campaign. City and county school systems could participate, as could the religious community.

2. **Public policy:** Neither of the local governments has articulated community goals for teen pregnancy/STD reduction. Public policy can encourage and guide deliberate programmatic (and budgetary) changes. The absence of any such policy regarding pregnancy/STD prevention is in itself a de facto policy implying an acceptance of the current situation and a reluctance to encourage schools and public youth-serving agencies take even the most timid steps.

**Recommendation:** Both local governments should express, in public policy and budget allocations, their commitments to reducing the levels of teen pregnancies and STDs. Two ways to express such a policy would be for both the city and the county to endorse this Community Strategic Plan and to increase fiscal and personnel resources for implementing the Plan’s recommendations.
Responsibility: On the county side, this recommendation would be implemented by the Albemarle County Board of Supervisors, perhaps at the suggestion of the County Executive’s Office. For Charlottesville, the endorsement would come from the City Council at the suggestion of the City Manager’s Office.

Recommendation: The Commission for Children and Families (CCF) should establish a “Study Group on Teen Pregnancy/STD Prevention” to help guide the implementation of recommendations in this Strategic Plan. In the future, the CCF should identify teen pregnancy/STD prevention as a “priority issue” for its work.

3. Barriers to communication: American culture embraces conflicting views and attitudes toward sexual behavior, and the underlying inconsistency impedes discussion about, and responsible behavior regarding, risk of pregnancy and STDs. The Institute of Medicine (1995, p. 188, 194), in a cross-cultural comparison of views on sexuality, concluded that the United States is:

a country that has left its Victorian, perhaps puritanical, past far behind but is not comfortable with present day sexual practices; and [has] a popular culture that, paradoxically, glorifies sexual expression – especially illicit romantic sex between perfectly formed, unmarried young people – but cannot accompany this fascination with plentiful messages of health promotion and disease prevention, including the use of contraceptives to avoid unintended pregnancy. (p. 194)

As Rhode (1993-94, p. 657) has said so bluntly about America:

Few if any societies exhibit a more perverse combination of permissiveness and prudishness in the treatment of sexual issues.

This reluctance – prudishness – makes it difficult to disseminate clear, accurate information about contraception, which in turn doubtless limits contraceptive use.

In Charlottesville and Albemarle County, as in other American communities, most people find it difficult to speak candidly about teen sexuality, including teen pregnancy and STD prevention. The constraint is spawned by any of a number of issues: simple embarrassment about the perceived indelicacy of the topics; ignorance of the subject matter; awkwardness about how to initiate a discussion; apprehension that initiating a discussion about adolescent reproductive health will lead to repercussions from
outsiders; the (mistaken) belief that talking about teen sexual behavior somehow encourages it.

For many, it is even more difficult to talk about STDs than pregnancy prevention. STD information is complicated to master even for adults, and youth are often constrained by social stigma. In a discussion with a group of young people in Northern Virginia, no one they knew, including their parents, wanted to talk about genital warts and other so-called “skanky” diseases (Stepp, 1999).

It is not coincidental that industrialized countries with the lowest teen pregnancy rates (e.g. France, Germany, and the Netherlands) also have the least inhibited communication about teen sexuality and pregnancy/STD prevention. In these nations, unlike the USA, open, honest and consistent communication about sexuality occurs between adults and teens through schools, families, and health providers, and has not resulted in earlier sexual activity (Berne and Huberman 1999). The role of the media in creating an atmosphere of open communication cannot be overemphasized:

The media [in Germany, France and the Netherlands] provided a startling demonstration of how a nation might address unintended pregnancy and sexually transmitted infections as public health issues. Massive, government-supported social marketing campaigns seek to normalize condom use. Explicit television commercials, billboards and posters are everywhere. Slogans proclaim “Safe sex or no sex” and “Got your keys? Got your cash? Got your condom?” The media campaigns present a positive view of sexuality, so long as it is safe. (Brick 1999).

In our discussions with community members as we prepared to write this strategic planning document, many spoke about their reluctance to talk in everyday contexts about teen pregnancy and STD prevention. This recurrent theme was voiced by parents (who said they were inhibited about talking with their children because of embarrassment and inadequacy), teachers – even some FLE teachers (who expressed hesitancy to talk about reproductive health and pregnancy prevention because of fear of recrimination by parents or supervisors), religious leaders (unwilling to risk offending segments of their congregations), and leaders in youth-serving agencies (fearing repercussions from outraged parents).

**Recommendation:** Adults in our community should develop greater knowledge, skills, and confidence for communicating constructively with teens and pre-teens about reproductive health and sexuality. More specific recommendations on this issue are included in the next chapter.
**Recommendation:** Establish a teen pregnancy/STD prevention speakers’ bureau, with specialists who can talk about the range of relevant issues. Actively seek to arrange for lecture/discussions in local civic, school, religious, etc. organizations.

**Responsibility:** CAPP should be asked to administer the speakers’ bureau, with assistance from the Teen Health Center, Martha Jefferson Hospital, United Way, and Planned Parenthood of the Blue Ridge.

### III. B. Adjusting the Mix of Programs

4. **Balancing** (a) core broad-based programs aimed at youth with unspecified risks of teen pregnancy/STDs, and (b) special programs targeted for high-risk youth:

Limited resources force a community to make hard choices about the kinds of public-service programs that can be supported, and about who receives such services. Some argue that, since all teens are theoretically at risk of pregnancy and STDs, a community has the responsibility to provide prevention programs for everyone. This can be done through efforts aimed at virtually all teens (e.g., FLE; training to improve parent-child communication; community-wide media campaigns), as well as smaller programs intended for youth of indeterminate risk who are served by the provider organization (e.g., programs offered through religious communities or scouts).

Others contend that the greater need is to fund programs designed for adolescents with a higher-than-average chance of getting pregnant or contracting an STD (e.g. Beating the Odds, Camp Horizon, Steppin’ Up, and Reach, described in Appendix L). Not only do such narrower efforts concentrate resources where the need is presumably greatest, but – in terms of teen births averted – programs directed at this audience are cost effective (see Chapter V).

At this time we simply do not know the distribution of risk among our community’s teens, and no research-based guidelines exist to suggest the ideal distribution of resources in a community.

**Recommendation:** Pursue both broad-based efforts and programs focussed on high-risk youth simultaneously. When appropriate, our community’s decisions about selecting new programs should be based on enlightened

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18 “High-risk” to refer to teens who face a combination of risk factors such as poor educational performance, family history of teenage parenthood, high levels of drug or alcohol use (see Chapters I.C.1 and II.A.).
opportunism – that is, if funding is made available for a proven program of either kind, it should not be rejected.

**Recommendation:** Determine the proportion of Charlottesville/Albemarle youth who can be considered at “high risk” of a teen pregnancy or STD, and the proportion of “low risk”.

**Responsibility:** This empirical problem is likely to be answered in research currently underway by Steven Stern and Michael Brien at UVA

5. **Building programs on others’ lessons:** Communities all over America -- and in other countries -- are exploring ways to tackle teen pregnancy and teen STD problems. A bewildering array of programs, projects, messages, and tactics has been developed. Many of these efforts, including some of the most popular, are untested and based more on ideological hopes and beliefs than proven efficacy. On occasion, residents in our community have – with some success -- vigorously opposed proposed pregnancy/STD prevention programs or elements of programs, and advocated others – all with little reliable data to support their claims.

Only in the last five years have reliable and objective evaluations begun to be available; we can now design our own teen pregnancy/STD prevention strategies based on the tested experience of others. Programs of proven effectiveness have widely varying natures, but they tend to share one or more common themes: emphasis on responsible behavior (including abstinence), building self-esteem, skill training to resist peer pressure, encouraging an interest in planning for the future, and building teens’ community involvement.

**Recommendation:** Ensure that the designs of new teen pregnancy/STD prevention efforts, or modifications of existing efforts, build on the results of reliable evaluation research.

6. **Leaving room for innovation:** Notwithstanding recommendation #5, above, research has yet to provide definitive answers about how to best reduce teen pregnancy and STDs. The community should encourage diversity of ideas and new approaches; experimentation has value when it is accompanied by reliable evaluation.

**Recommendation:** Encourage new experimental programs or projects in small controlled settings and with well-designed evaluation.
7. **No magic bullets; the cumulative effect of diverse efforts:** Reviewing the results of program evaluations can be discouraging in that no single approach eliminates teen pregnancy and STDs. We need to encourage various types of programs to meet the many-sided needs of our teenagers. In a community that shares the aim of reducing teen pregnancy and unsafe sexual activity, all participants who debate tactics for achieving the common goal need to be flexible and open-minded.

Local governments cannot fund all needed teen pregnancy/STD prevention activities. Private and non-profit organizations can supplement public sector resources, particularly for innovative projects. By promoting all activities that have a reasonable chance of helping with teen pregnancy/STD prevention, the community increases the cumulative effect.

**Recommendation:** Support diverse programs for teen pregnancy/STD prevention, recognizing that no single approach will be appropriate or effective in all settings. In general, target public funds to support teen pregnancy/STD prevention strategies and programs that have been shown to work. Use funds from the private sector and nonprofit organizations to both proven programs and creative, untested approaches that have well-planned evaluation components.

8. **Continuum of services:** Few at-risk boys and girls have access to programs directly related to teen pregnancy prevention. For example, Beating the Odds (described in Appendix L), a successful local program for 8- to 11-year-olds, handles only 70 city and county children from an available pool of hundreds. Thus a program may be effective for youth who receive the services, while the overall effect on area teen pregnancy rates is small.

Moreover, a child who “graduates” from an age-based program may not find entry into another appropriate program as he or she grows older. Our community is far from providing a seamless “continuum of services” to ensure that all at-risk youth have access over time to teen pregnancy and STD prevention programs. Missing (with a few exceptions) is direct pregnancy/STD prevention programming for boys, for example, and programming for anyone in those neighborhoods not served presently by the MACAA and Teensight programs.

Significantly more funding is needed than currently available to achieve the goal of a continuum, and to meet the needs of both high-risk youth and the much larger number of teens and pre-teens at normal risk.
**Recommendation:** Ensure that all adolescents – including, but not restricted to, high risk children – have access to a continuum of services for pregnancy and STD prevention. The programs in this continuum need not be provided only by youth-serving community agencies, but also by schools, religious groups, and health care providers.

**Recommendation:** In primary prevention programs consistently include an aim to gradually move participating youth toward programs that are NOT specifically teen pregnancy prevention efforts – toward volunteer activities, for example, or sports, which are less expensive.

9. **Focus on each adolescent as a whole person:** Evaluation research indicates that teen pregnancy has been lowered the most where programs are designed to deal simultaneously with a range of adolescent needs. The greatest impact on high-risk teens occurs when the interventions involve parents and other family members, help with school work, provide sports, boost self confidence, monitor physical health, offer after-school activities, and provide reproductive health information and services. Such efforts are labor-intensive and expensive. But they work.

In addition, teen pregnancy/STD prevention programs aimed at the whole adolescent, in a well-rounded intensive way, have benefits in addition to reducing pregnancy/STD rates. In the absence of a single multi-faceted program with integrated activities (dealing with support for schoolwork, health care, sports, job training, etc.), many of the same advantages would likely occur if teens were involved simultaneously in several extra-curricular activities. For example, Teens Give, a program of volunteer service for adolescents identified through the court system (described in Appendix L), shows results in better performance in school and lower rates of trouble with the law. ArtReach at FOCUS and the Music Resource Center (described in Appendix L) both aim at strengthening self-esteem of high-risk youth through self-expression. Though the impacts on participants in these two local programs – and of participants in organized sports, or other local youth activities -- has not yet been assessed, it is probable that we would see positive effects on a range of risk behaviors.

**Recommendation:** In considering the desired balance of youth-serving programs in our community, recognize the value of broad-spectrum efforts aimed at the adolescent as a whole person, as well as narrower programs that focus on a particular problem.
10. **Focus on boys vs. girls**: How should limited resources for teen pregnancy prevention programs be allocated between girls and boys? On the one hand, programs for girls are important because girls incur the major costs of pregnancy (other than the babies themselves) and have the most incentive to change behavior. On the other hand, since there are a somewhat smaller number of boys responsible for most of the teen pregnancies, a program effective at identifying such boys and changing their behavior would have large effects. Moreover, both males and females contract STDs.

At present, it has not been demonstrated whether programs aimed either at boys or at girls are more effective in reducing teen pregnancies and STDs. It is apparent, though, that efforts directed at boys are less common, despite several promising new approaches. For example, MACAA and Teensight at FOCUS have recently launched “Young Guys of Distinction”, a primary pregnancy prevention program for 10 to 15-year-old boys in Charlottesville. And a component of Teensight at FOCUS’ Reach program currently involves 13 boys aged 12-18. At a national level, “Wise Guys”, a program promoting abstinence and sexual responsibility for 10-19-year-old young men, has been selected as a “Best Practice Model” by North Carolina’s Adolescent Pregnancy Prevention Coalition.

**Recommendation**: Evaluate potential programs in terms of their effect on teen pregnancy rates without any special regard to the gender of those receiving services.
CHAPTER IV: ISSUES AND RECOMMENDATIONS BY SECTOR

IV. A. Families

Families -- especially parents -- are children's first and best teachers about love, values, and sex, and research confirms that parents and family are important influences on teens' sexual behavior and pregnancy risk (Miller 1998). Parent/child connectedness (i.e., support, closeness, warmth) is related to lower adolescent pregnancy risk. So, too, are parental attitudes and values disapproving of adolescent sexual intercourse and (in most studies) parental supervision/regulation. On the other hand, abused children are at high risk for teen pregnancy and other problems.

Studies linking direct parent/child communication with teen pregnancy risk, however, are inconclusive, though the willingness and ability of parents to talk knowledgeably with their children increases the probability that the children will make informed and responsible decisions.

Parents can positively influence (though never absolutely determine) whether adolescents have sex, use contraceptives, contract STDs, or become pregnant. The success in risk reduction depends on, among other things, adults having fundamental parenting skills and knowledge, including the ability to listen constructively, to articulate their own values, to maintain communication with teachers and others who have contact with their children, and to serve as role models. Parents also need to be able to strengthen children's self-esteem, confidence, and refusal skills, and to use examples from real life (e.g., TV news) to stimulate constructive discussions about responsible behavior.

To help train and support parents for these responsibilities, a range of community organizations -- churches, schools, civic/neighborhood groups, health-care centers, etc. -- would ideally offer courses and workshops that strengthen knowledge and skills, and establish networks of adults that provide needed encouragement and guidance. Parents/responsible adults would be actively involved in school curriculum decisions and knowledgeable about the content of FLE courses; they would also participate in parent-teacher conferences and other opportunities to learn about their child by seeing him/her through others' eyes.

No studies reveal how Charlottesville/Albemarle parents, in particular, deal with their children regarding pregnancy/STD risk reduction. However, if we are like other communities where survey research has been conducted, some parents are deeply involved in helping their children learn appropriate values, knowledge, and behavior regarding sexuality. The majority of parents, though, report that they have little meaningful communication with their adolescent children; they feel
insecure about their abilities to educate their children about sex and reproductive health, because of embarrassment, lack of skills to meet their children at an appropriate level, and uncertainty about relevant age-appropriate information. Often parents of sexually active teens lack basic knowledge about available contraceptive options, including their safety, effectiveness, cost, and accessibility; their grasp of STDs is rarely more proficient.

The social institutions in our community are not well designed to strengthen parents' capability to influence their children's risk of adolescent pregnancy or STDs. Indeed, all three previous town meetings during the 1990s to discuss teen pregnancy identified “parent-child communication” as a key issue for community attention. The fact that no special steps have been taken to deal with the problem attests to its difficulty.

In schools, according to our discussions with teachers, counselors, and parents, parent-teacher conferences are poorly attended, especially as children get older, and the weakest parent-teacher links are with parents of high-risk kids. The location and timing of Parent-Teacher Organization (PTO) sessions are often awkward for working and single parents, and the sessions ordinarily avoid sensitive topics such as the adults' role in teen pregnancy prevention. Few parents voice policy preferences for libraries or FLE classes. A laudable example of a school’s effort to increase parental involvement is Burnley-Moran Elementary School’s program of sending buses into the Westhaven public housing area to help parents attend PTO sessions.

Our discussions with local health care providers suggest that, with few exceptions, this sector of our community also does less than it could to help parents. Family physicians have limited time and interest – and not always the expertise -- to focus on parent-child interaction, especially regarding sexuality and reproductive health. The Teen Health Center, the Health Department, and Planned Parenthood of the Blue Ridge, though prepared to discuss teen pregnancy with individual parents or groups (e.g., PTO's; parents at churches), report that they are rarely asked to do so. Pamphlets and booklets are available to help improve parent/child communication, but miss large segments of the appropriate audiences.

Only a handful of local churches devote attention to teen sexuality and pregnancy prevention, and even these churches provide little guidance or support to parents (see section E, below).

Several community agencies offer help to parents. Children, Youth and Family Services (CYFS) gives individual family counseling to families in crisis. Parents Anonymous, affiliated with CYFS, is a support group for and by parents with a special mission to prevent abuse and neglect. MACAA provides some parent
education classes. Teensight at FOCUS helps teen parents learn parenting skills. Planned Parenthood of the Blue Ridge offers parent group workshops on talking with one’s children about sexuality issues.

**Recommendation:** Parents should assume greater responsibility for the sexual behavior of their children.

**Responsibility:** Parents themselves should implement this recommendation, but the probability of increasing parental responsibility might be increased through a community public awareness/social marketing campaign – ideally a continuous effort rather than a one-shot event. Such a campaign might be implemented by collaboration between the media and youth-serving agencies (e.g., CAPP, CCF, CYFS, Division on Health Promotion of the TJ Health Department).

**Recommendation:** Strengthen parents’ ability to communicate with their children of all ages about developmental issues, including responsible sexual behavior, and to articulate their own values.

**Responsibility:** To ensure that parents have adequate factual sexual information, skill-training methods, and parent-child communication skills, it will be necessary to enlist the support of schools, churches, civic organizations, youth-serving agencies, parenting support groups, health care professionals, the media, etc. To encourage and coordinate this community-wide effort, Planned Parenthood of the Blue Ridge might be asked to take the lead, perhaps in conjunction with Children, Youth, and Family Services, the UVA Department of Pediatrics, and the UVA School of Nursing.

One mechanism to help implement this recommendation would be to train adults to work with parents as peer educators. Responsibility for putting such a peer education program into place might be given to parents’ support groups that already exist.
IV. B. Schools

Public schools in the city and county educate roughly 16,000 students; private schools enroll an additional 4,000. Though the Charlottesville and Albemarle County public school divisions are separate and distinct, there are elements in common.

Schools’ main direct effort to deal with teen pregnancy and STD is through a curriculum called Family Life Education (FLE). Currently, both public school divisions teach FLE from kindergarten through tenth grade. Students in middle and high schools (though not in grades eleven or twelve) are exposed to FLE from 10 to 15 hours per year. In some FLE classes, however, science replaces the sexuality education component, especially when a teacher is less than comfortable with the topic.

Contrary to widespread belief, only a small proportion of the subject matter of FLE deals with sexuality. In ninth and tenth grades, for example, from roughly 50% to 90% of the short FLE module is devoted to such issues as household budgeting, family violence, breastfeeding, and parenting. In discussions with teens to develop this strategic plan, many reported that the modest age-appropriate information on sexuality and reproductive health is boring. Little effort is made in local schools to integrate FLE issues into other classroom topics (e.g. biology, English). More importantly, FLE curricula do not supplement didactic teaching with substantial efforts to enhance adolescents’ life skills by, for example, engaging them in role plays, decision-making practice, or values clarification exercises. Yet it is only when these supplemental activities are included that FLE courses have been shown to have measurable effects on teen pregnancy prevention (Kirby, 1997).

Various community agencies (e.g. the Health Department, Teen Health Center, Sexual Assault Resource Agency (SARA)) have been approved as resources, and staff from these agencies occasionally play a role in FLE courses. FLE curricula and the list of resources are reviewed irregularly; for all new FLE resources, School Board approval is needed. In neither school division are refresher courses for FLE teachers a regular feature, and supervision is reported to be minimal. Despite the limitations, teachers who handle FLE inform us that they are generally satisfied with the curriculum, class activities, and assignments.

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19Family Life Education is the process of acquiring information and forming attitudes, beliefs and values about identity, relationships and intimacy. It encompasses sexual development, reproductive health, interpersonal relationships, affection, intimacy, body image, and gender roles. FLE addresses, among other things, the biological, socio-cultural, and psychological dimensions of sexuality, including the skills to communicate effectively and make responsible decisions.
School officials acknowledge the importance of preparing students for the real world through teaching FLE. The primary demands on the school systems, however, are to reach the state-mandated Standards of Learning (SOL’s) and to maintain accreditation. This allows little time for FLE – none, say local school officials, in the 11th and 12th grades -- since FLE is not part of the SOL requirements. Moreover, there is reluctance to devote greater time or effort on the FLE curricula at a time when researchers have only just begun to publish reliable evaluations of FLE at a national level (no local assessments have been attempted; see Chapter II). Most school officials see FLE as a potentially volatile topic, and to avoid a public outcry prefer to quietly and unaggressively continue present activities.

In both Charlottesville and Albemarle County schools, following state guidelines when FLE was mandated, parents who do not wish their children to be exposed to FLE opt out of the program by sending a letter to the school.21

Local private schools vary in the degree to which they have developed FLE courses and teen pregnancy/STD prevention classes. This diversity ranges from no formal mention of prevention issues (at Tandem Friends School), to planned but not yet fully implemented FLE teaching units for K-through-12 grades (at St. Anne’s Belfield).

The expense for providing FLE is modest. In the whole Albemarle public school system – kindergarten through tenth grade – we calculate the annual cost of FLE staff time to be $59,000.22 In the Charlottesville system, the cost of staff time is $39,600.23

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20 In this context it is interesting to note that public support for FLE has been underestimated in communities across the USA. Surveys in North Carolina, for example, found over 90% of parents wanted schools to provide sexuality education and 85% said schools should work closely with health clinics (Huberman 1995). In Oregon 79% of parents surveyed either strongly favored or somewhat favored requiring sex education to be taught by schools (Oregon Action Agenda 1997).

21 Until May 1999, parents in Albemarle County who wished their children to be enrolled in FLE had to opt in to the program. This was accomplished by the school sending letters describing the FLE curriculum to parents of all children, then processing the returned letter giving permission. Since 96 per cent of the parents wanted their children in the County FLE classes, this procedure created a sizable administrative workload for County teachers that was largely eliminated with an opt-out approach. We commend the County school board for its decision to move to the “opt-out” parental permission mechanism.

22 For the Albemarle County high schools, we assume that 18 weeks (90 hours) per year are spent on health, of which 15 hours (one sixth of the time) is devoted to FLE. Three full-time and three half-time teachers (a total of 6.5 full time) are assigned to the health classes; their average full-time salary is $36,000. The cost of the FLE component is therefore about $39,000 (1/6 x 6.5 x $36,000). The middle schools’ FLE costs of $20,016 are calculated in the same way: 9 weeks (45 hours) spent on health, of which 12.5 hours is on FLE; four half-time (i.e. two full time) teachers, with average salary of $36,000. In elementary schools, the FLE unit on puberty for one or two hours in the fifth grade implies only trivial costs.

23 In Charlottesville High School, 2.5 full-time health and physical education teachers teach health for 36 weeks per year; five weeks are spent on FLE. At an average salary of $35,200, 0.347% is $12,214. In city
Though we do not know the precise effects of FLE, if it succeeds in averting three teen births each year it will have paid for itself (assuming conservatively that each teen birth costs taxpayers $37,000, not including the costs to the teen or her parents; see chapter I.C.3., pages 13-14 and Chapter V, page 50).

In addition to FLE, local schools contribute significantly to teen pregnancy/STD prevention in other direct and indirect ways:

- School counseling professionals are available in most schools, though often on a part-time basis, to help students with personal, as well as academic, problems. In the county, responding to the recognition that schools are being overwhelmed by all they are being asked to do to help families under pressure, a new Family Support Program is placing trained, experienced social workers in all 15 elementary schools where they can respond directly to the needs of parents and children.

- Most schools have some kind of health care provider, ranging from uncertified health clinicians to certified registered nurses, working on a part- or full-time basis. These specialists can help with reproductive health problems or refer students to appropriate professionals.

- “Character education” provides a consistent set of expectations that students respond to, and allows teachers to incorporate the value education into their lessons as they see fit. As of the last state legislative session, all schools in Virginia are required to include Character Education in their curricula. Several schools in our community already do so (see footnote 17 on page 19 for examples).

- A number of schools in the city and the county collaborate on small-scale teen pregnancy prevention programs, concentrating on high-risk youth, implemented by community organizations (MACAA and Teensight at FOCUS; see Table 1 in Chapter V, page 51).

- Extra-curricular sports and interest groups occupy students after classroom hours, encouraging involvement in constructive activities, helping to build decision-making skills, and boosting self-confidence.

It becomes clear that schools play an important role in preparing youth to avoid pregnancy and STDs. An examination of the research literature, however, also makes it apparent that in other American communities schools are making greater efforts than ours to introduce programs shown to lead to reductions in youth risk behavior.

middle schools, twelve full-time science and two health teachers teach health for a 36-week period; FLE takes two weeks. At an average salary of $35,200, 0.778 implies an FLE cost of $27,386.
• Our local schools do not yet have peer education programs, using selected and trained teens to provide other students with accurate information about pregnancy and STD prevention. Lessons might be learned from peer education being used elsewhere in the community: The AIDS Services Group (ASG) has developed a peer education program focusing on HIV awareness, recruiting and training students from St. Anne’s Belfield; SARA has implemented the VIVA peer education program; and UVA’s Madison House has experimented with this technique.

• Systematic efforts to introduce youth volunteer programs have, until now, been tried only in one of the local private schools. Monticello High School, working with United Way, is moving toward the establishment of a volunteer program for students.

• Neither public school division has school-based health centers (i.e. fixed clinics on school grounds that provide primary health care services to students) or even school-linked health centers (i.e. clinics not on school grounds with special relationships to the pupils from one or more schools). Though there is not convincing evidence that they prevent teen pregnancy, such clinics have the potential to make important contributions to children’s health. Problems might arise, however, in how schools would balance students’ confidentiality with parents’ right to know what is going on in schools.

Public and private schools in Charlottesville and Albemarle County can clearly do more to provide students with information and skills that are likely to reduce teen pregnancy/STD at-risk behavior, both for students at ordinary risk of teen pregnancy and those at high risk.

Recommendation: Provide comprehensive FLE in both public school divisions and all local private schools, in all grades, using regularly updated FLE curricula which incorporate techniques and resources that have been demonstrated to actually lead to reductions in teen pregnancy/STD risk behavior. These include curricula that provide skill building activities (such as assertiveness and decision-making skills) in the context of providing basic, factual, age-appropriate information about human sexuality.

✓ Ensure there is a working locus of responsibility and advocacy for FLE in each public school division, that FLE is taught and not replaced by other topics (even science), and that teachers who are uncomfortable talking about sexuality and contraceptive topics are not asked to teach
those topics. School Boards and school administrators need to demonstrate strong support for FLE.

- Within the constraints of demands imposed by the SOLs and accreditation, increase the number of hours children are exposed to FLE, whether through schools or in other community programs, and extend FLE to the eleventh and twelfth grades.

- Periodically review and up-date the content, class activities, and teaching methods of the FLE curriculum. Resources should be examined annually to keep up with the constantly changing tools and approaches to conveying information. Teachers should be trusted to use their professional judgement for determining classroom resources within the boundaries of guidelines set by the school administration.

- Provide ongoing refresher training for teachers. Local agencies could assist school divisions by suggesting speakers and organizing an annual training. Part of such refresher training should provide teachers with new resource materials about FLE topics and teaching methods.

- Evaluate -- in all grades -- the quantity, content, and quality of individual FLE teaching. This assessment should observe the variety of teaching methods, involvement of students in role-playing, content of skills training, etc. Efforts to introduce new innovative approaches that supplement (not replace) proven approaches should be rewarded. Peer coaching among teachers, together with supervision, can help to ensure teachers are comfortable teaching these topics.

- Involve parents more in the schooling -- including FLE -- of children at all ages. Parental input should be sought in designing FLE curricula and in selecting the reading, audio-visual, and other resources. FLE teachers should incorporate joint parent-child homework assignments to allow parents to be more involved and to communicate with their children about sexual issues.

**Responsibility:** Though responsibility for the execution of these recommendations ranges from the localities’ School Boards to teachers and parents, the School Health Advisory Boards of the city and the county might be asked to encourage and monitor their implementation.
**Recommendation:** Continue to provide students with access to trusted professionals (psychologists, counselors, etc.) who are knowledgeable about reproductive health issues.

**Recommendation:** Consider introducing student peer-education programs designed to counter misinformation about sexuality among students.

**Responsibility:** The School Health Advisory Boards should be asked to consider assuming responsibility for overseeing these two recommendations, perhaps with technical backstopping from Planned Parenthood of the Blue Ridge.

**Recommendation:** Schools should continue to work throughout the year with professionals from approved community resources (including the Health Department, Teen Health Center, Planned Parenthood of the Blue Ridge, SARA, etc.) who can assist and support teachers and other staff in providing accurate and up-to-date information.

- Maintain and strengthen the Thomas Jefferson Health Department’s longstanding relationship with schools to provide accurate information, and familiarize all students with its services.

- Investigate the possibility of establishing school-based or school-linked health clinics in middle and high schools to allow students easy access to much needed services by trained health professionals. Technical assistance for feasibility studies might be provided by the Thomas Jefferson Health Department or the Teen Health Center, perhaps in conjunction with the UVA Department of Pediatrics and/or the UVA School of Nursing.

- Extend the expansion into the schools of local pregnancy prevention programs, such MACAA’s Beating the Odds and Teensight at FOCUS’s Reach, which aim specifically at high-risk students.

- Seek collaboration with community organizations to create youth volunteer programs linked with schools.

**Responsibility:** The School Health Advisory Board, possibly in collaboration with the TJ Health Department, should be asked to consider assuming responsibility for overseeing these recommendations.
IV. C. Community Organizations

A number of organizations in the community are either directly or indirectly involved with preventing teenage pregnancy and STDs, and an even larger number have the potential, not yet fully utilized, to be involved. The organizations directly involved are MACAA through its Beating the Odds, Camp Horizon, and Steppin’ Up programs; and FOCUS through its Teensight and Reach programs. The MACAA and Reach programs are designed for small numbers of high-risk youth and aimed at primary prevention, that is, the main goal is pregnancy/STD prevention. Teensight provides teen mothers with the skills and support system to stay in school, get and keep a job, and strengthen parenting abilities; a secondary aim is to help these adolescents avoid a subsequent pregnancy. There is strong evidence that Camp Horizon and Teensight are very effective, based on participants’ comparatively few pregnancies. The other programs are too new to evaluate yet.

Planned Parenthood of the Blue Ridge provides technical support for these community teen pregnancy/STD prevention programs, as it does for FLE in public and private schools and for some church-based teen sexuality training programs. For selected components of the programs’ curricula, Planned Parenthood makes specialists available to talk with youth (or their parents), and offers audio-visual and other supplementary educational material (e.g. model curricula, books, pamphlets, posters, “Baby Think It Over” dolls) from its open library of resources. A community educator is available to lead workshops and professional training for groups.

The Council on Adolescent Pregnancy Prevention (CAPP) does not provide direct services to teens, except for distributing a “Teen Help Card” (listing telephone numbers of community services) and a flyer describing local family planning services for teens, and paying for needy teens’ taxi fare to family planning clinic appointments. CAPP’s primary function is as a support network and information clearinghouse for local professionals and others interested in pregnancy prevention; it also works to strengthen community policies and programs regarding teen pregnancy/STD prevention, and organizes an annual public awareness campaign.

There are also a number of related youth-serving organizations either that affect the risk behavior that leads to teen pregnancy (e.g., Teens Give) or that have underutilized potential to affect such behavior (e.g., Boys and Girls Club, Girl Scouts, Piedmont Family YMCA). For the most part, the programs with untapped

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24 All the organizations mentioned in this chapter are described more fully in Appendix L. “Reach” is more formally The Teensight Reality\Check program.
potential have a captive audience of children of the relevant ages and backgrounds, and an established teen pregnancy prevention program developed by the national office of the organization. Many of the local organizations do not implement the available national model, either because of different local priorities or concern about the sensitive nature of the subject.

Discussions about coordination among existing programs, and even possible consolidation, have recently been stimulated as our community teen prevention programs sought local funding. While there is obvious value in coordination, in this situation the expectations for increased efficiency may have been overrated. The two main community-based pregnancy prevention efforts (i.e. the MACAA and Teensight at FOCUS programs) have communicated and coordinated much more in the last few years than ever before. But because both programs are so small and deliberately focus on quite different populations of youth, the increased coordination did not appear to lead to any significant gain in program efficiency.

A current proposal for city, county, and United Way funding of community-based teen pregnancy/STD prevention programs would provide a lump sum of money that MACAA and Teensight at FOCUS would decide how to allocate. Such an arrangement would demand an improbably level of cooperation by historically independent agencies, essentially demanding that they operate as a single entity. The two agencies, in the interest of promoting peaceful relations, would agree to compromises on funding that have little to do with optimal allocations. Optimal allocation requires hard choices that competing agencies are usually not in a position to jointly make. The proposed allocation rule also takes the public, as it is represented by local governing bodies, out of the process of allocating public funds. A much better process would have the local governments making decisions with significant input from other interested parties including the agencies running the programs and the public.

Youth volunteer programs, current evaluation research suggests, appear to be among the most effective ways to reduce the risk behavior that leads to teen pregnancy (and many other adolescent problems). There is hope that, in our community, by encouraging far more youth to be involved in volunteer activities and providing them with the opportunities to do so, we can have a significant impact on a high proportion of youth at relatively low cost. Teens Give estimates that initial monetary costs for such a venture would be $100,000.

Presently, United Way is making significant progress in expanding youth volunteer activities by encouraging agencies which might use youth volunteers, serving as a community broker for volunteer activities, and exploring opportunities in local high schools. Their Service Learning project with Monticello High School will be continued after a successful first year pilot,
Youth volunteer programs require adult intervention to a) supervise the youth, b) create volunteer activities, and c) help youth reflect on the value of the activities. In the long run, some of these activities might be performed by high school students themselves in a model similar to Madison House (which operates for college students). But a Madison House for high school youth will not happen without significant resources, and unless adult volunteer coordinators accept the idea of sharing administrative tasks with teenage volunteers – much as Martha Jefferson Hospital does with the Reach program. That change requires many confidence-building steps along the lines developed by staff at successful youth volunteer agencies such as Teens Give and the Miller School's volunteer program. Both programs, relying on adult supervision of the high school students, have built a reputation of providing reliable youth volunteers. Despite significant startup costs, this approach seems very promising given the history of success by groups such as Teens Give and the national research showing large and statistically significant effects of such programs.

Recommendation: Establish a long-term goal in Charlottesville and Albemarle County to expand the two existing teen pregnancy prevention programs for high risk youth throughout the city and the county.

Responsibility: City and county governments should take immediate steps to plan this expansion, and to provide – perhaps aided by additional support from United Way, local foundations, and private donors-- the increased funding that will be needed. Perhaps the Commission on Children and Families could be asked to guide the effort to expand services of the existing programs.

Recommendation: Establish a long-term goal in Charlottesville and Albemarle County to increase the number of youth involved in meaningful volunteer activities.

Responsibility: The ad hoc Task Force on Volunteerism, together with United Way, could be asked to coordinate efforts (a) to seek funding, (b) to identify organizations willing to accept volunteers (e.g., UVA service fraternities), and (c) to help place teens.

Recommendation: Encourage youth-serving organizations such as the Boys'...
and Girls' Club, the Boy Scouts and Girl Scouts, 4-H Clubs, and the city/county Department of Parks and Recreation, to become more involved in teen pregnancy prevention, using, where possible, programs available from national headquarters.

**Responsibility:** The Council on Adolescent Pregnancy Prevention (CAPP) might be asked to provide the stimulus for this effort.

**Recommendation:** Continue to look for feasible ways to evaluate and improve teen pregnancy prevention programs using both local and national data. This need is discussed in greater detail with specific recommendations in Chapter V.

**IV. D. Health Care Services**

During adolescence the greatest risks for morbidity and mortality are behavioral, ranging from the risky consequences of driving while using drugs and alcohol to engaging in unprotected sex. Health care for teens needs to be continuous and preventive, aimed at modifying behavior. Instead, in large part because of money and time constraints within the system, health care tends instead to be -- as it is for adults -- episodic and curative. One result of the inadequate focus on preventive care for adolescents is that teens delay seeking family planning services for an average of 18 months from their sexual debut (first intercourse). Consequently when teens do seek contraceptives, they are often already pregnant. A parallel problem is that sexually transmitted diseases among teens are often identified so late that they require emergency room treatment and/or hospitalization.

Most physicians have little training about adolescent reproductive health. The specialized health-care clinicians who work with children and adolescents, whether in private practice providing comprehensive care or in public clinical settings offering episodic treatment, are well positioned to provide not just curative care but anticipatory guidance (e.g., about prevention of pregnancy and STDs) to their young patients and their parents. To help clinicians refocus their attention on preventive health services for adolescents, guidelines developed by the American Medical Association include recommendations for:

- an annual preventive services visit from the ages of 11 to 21 at which time biomedical and psychosocial aspects of health are addressed;
- a complete physical examination at least three times during these years (with annual pap smears for sexually active adolescent females);
- an established office policy regarding confidential care for teens that is clear to both adolescent and parent(s);
• health guidance annually regarding responsible sexual behaviors, including abstinence, together with the availability of condoms and birth control methods.

This ideal situation has yet to be widely implemented, and we rarely see parents guided by their child’s health-care provider deal with sexuality issues in an environment of clarity, respect, and honesty. It is not surprising that evaluation research shows little or no beneficial effect on pregnancy or STD prevention from an adolescent’s random and brief encounter with a health care professional, though two studies show an increase in contraceptive use (Kirby 1997).

The Charlottesville/Albemarle community has several hundred medical professionals who have the opportunity to provide local youth with health-care services to reduce the risk of early sexual activity, pregnancy, and STDs. These include physicians (pediatricians, family practitioners, obstetricians/gynecologists, others), pediatric and family nurse practitioners, and certified nurse midwives.

In addition to private practices, the area is fortunate to have four specialized clinics to which teens can turn for reproductive health care. All provide contraceptive counseling (including information about abstinence and methods available at drug stores), pregnancy testing, pregnancy counseling (options for prenatal care, abortions, and adoptions) and referral if appropriate, Pap smears and breast exams, and STD testing and treatment for both males and females. Contraceptives available at all four clinics include condoms, birth control pills, Depo-provera (three-month injection), Norplant (five-year implant under the skin; not available at the UVA Student Health Center), and emergency contraception (the morning-after pill).

• **Thomas Jefferson District Health Department** (1138 Rose Hill Drive, Charlottesville), covering Charlottesville, Albemarle, Fluvanna, Greene, Louisa, and Nelson Counties, is part of the state-tax-supported health system. Fees are on a sliding scale based on ability to pay; a pregnancy test is $11.00, contraceptives are $1.00, and exams are free.

• **Planned Parenthood of the Blue Ridge** (1928 Arlington Blvd., Charlottesville) is a non-profit organization offering professional reproductive health-care educational (see previous section) and clinical services. A pregnancy test costs $15.00, with costs of other services on a sliding scale depending on income.

• **The Teen Health Center** (1400 W. Main Street, Charlottesville) is a specialized clinic of The Woman's Place at the University of Virginia. Fees are on a sliding scale based on ability to pay, with a maximum of $70.00 plus lab tests.
• **Elson Student Health Center at The University of Virginia** (corner of Jefferson Park Avenue and Brandon Avenue, Charlottesville) serves only UVA students (no partners). Costs for clients are included in the student health fee paid each semester, though lab and prescription costs are extra.

In addition to these sources of reproductive health care, there are a number of agencies that provide teens with education, counseling, and referral to specialized medical care. These include the Department of Pediatrics and the Department of Obstetrics and Gynecology at the University of Virginia Health System, the Charlottesville Center for Reproductive and Sexual Health, and the Charlottesville Pregnancy Center. This latter agency, supported by 40 evangelical churches, provides free pregnancy testing, advice on abstinence-only teen pregnancy prevention programs, relationship counseling, and information on options as part of its anti-abortion mission.

Significantly, staff at the four clinical facilities report that their reproductive health services are underutilized by teens. This observation is confirmed by a rough comparison of the number of female teens in the community – approximately 4,300 in the 15-19 year-old group (see Appendix C) – with the number of females in that age group who visit one of the clinics at least once – estimated very approximately at fewer than 1000. Further, national data show that only about half of sexually active high school students used a condom or other contraceptive the last time they had sexual intercourse, and far fewer sexually active teens have tests for STDs (see Chapter I.C.2).

A small survey of the local youth-serving health-care providers, conducted in preparation for writing this strategic plan, suggests that all discuss information about sexuality, but that the range of topics and depth of detail was limited by the (often brief) time made available. All clinicians reported that the youths’ confidentiality was respected in these discussions. Few of the clinicians had (or took advantage of) an opportunity to talk with parents about teens’ reproductive health issues.

Optimally, local health-care providers would see more teens and would spend more time with them; their attention would shift from primarily “problem” visits on rare occasions to regular sessions where preventive care became the chief concern. One local physician noted that the community, and more importantly the managed care companies, did not see the value of preventive health-care visits during adolescence. Only a few health care professionals currently talk to teens about community values regarding early sexual activity and/or parenthood, or – for sexually active teens – fully discuss contraceptive options. Emergency contraception,\(^{26}\) though legal for over twenty years, remains relatively unknown among sexually active adolescents – as well as adults.

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\(^{26}\) Emergency contraceptives are methods of preventing pregnancy after unprotected intercourse. The most common are the “morning-after pills”, consisting of a larger dose of ordinary oral contraceptive pills (usually two 4-pill doses taken 12 hours apart) within 72 hours after sexual intercourse. Even more
Clearly not all local health-care professionals are trained adequately to provide the wide range of educational, counseling, and medical services required to meet the needs of today’s adolescent clients – and to work constructively with the teens’ parents. Local professional organizations of health care providers – where possible using guidelines prepared by national groups – should offer training and support.

Regrettably, the economic status of a teen affects the type and quality of health care services that are accessible. Though reproductive health care is widely available and affordable at the clinics identified above, for the poor it is hard to obtain comprehensive care with one provider with whom a young person can develop a relationship. Private practices only see teens with insurance, including Medicaid. Given the long-term societal costs of unwanted teen pregnancies and STDs, greater efforts should be made to ensure that all youth have access to high-quality reproductive health care.

**Recommendation:** Parents should
(a) take their children for yearly comprehensive preventive health-care checkups which include reproductive health;
(b) require their children’s health-care professionals to cover reproductive health care (including preventive care); and
(c) know what kind of messages their children are being given (or not given) by health-care professionals.

**Responsibility:** These are parents’ responsibilities.

**Recommendation:** Health-care professionals, following at least the A.M.A. guidelines, should promote positive messages about sexual development throughout the lifespan of their patients. Age-appropriate sexual information should be part of normal anticipatory guidance in health-care visits from birth through adolescence. The “preventive” part of a teenager’s health-care visits should include attention to history, risk behaviors, and guidance. Abstinence and contraceptive methods -- including emergency contraception – should be discussed, as well as risk-taking for STDs.

**Responsibility:** The UVA Teen Health Center could be asked to assume this responsibility, perhaps working through local health care professional societies.

effective is a copper-T IUD inserted up to five days following unprotected intercourse. It is not certain how emergency contraception works, but it makes the lining of the uterus inhospitable to pregnancy.
**Recommendation:** Health-care professionals must stay current about the adolescent issues of pregnancy, prevention, STDs, birth control methods, abstinence counseling, and availability of abortion services. They should also be current in their knowledge about the laws affecting adolescent health care, child abuse and reporting, parental notification and judicial bypass for abortion, and confidentiality.

**Responsibility:** Planned Parenthood of the Blue Ridge might be requested to provide up-to-date information to health-care providers in the community who work with adolescents, perhaps in collaboration with local medical professional societies.

**Recommendation:** Adolescents should be screened more frequently for STDs.

**Responsibility:** Health care providers and parents should be asked to carry out this proposal.

**Recommendation:** Training opportunities in adolescent health care must be strengthened and supported for medical students, residents, and nursing students.

**Responsibility:** The UVA Medical Center and Martha Jefferson Hospital, together with their affiliates, could be asked to focus on these training efforts.

**Recommendation:** Local health-care professionals should increase their efforts to provide educational outreach regarding adolescent reproductive health issues.

**Responsibility:** Local health care providers, in addition to making individual efforts to talk to schools and civic organizations, should volunteer to be included in the Speakers’ Bureau to be organized by CAPP.

### IV. E. Religious Communities

Religious communities stand out as the only grassroots social organizations that serve individuals and families from cradle to grave. People choose faith communities based on deep and fundamental beliefs, and religious leaders can have immense power to influence followers. Edicts carry weight with congregation members and, sometimes, within the larger community.
Despite this potential, our informal survey for this strategic plan suggests that most local congregations are not actively participating in teen pregnancy prevention efforts, or in the provision of rigorously evaluated sexuality education. In the Charlottesville/Albemarle community, networking and resource-sharing events sponsored by CAPP in the past several years to reach and educate religious community leaders have been sparsely attended, though those attending have responded positively.\(^{27}\)

At the national level, many mainstream religious denominations have developed, and make available to individual congregations, sexuality education curricula. Locally, about five churches implement such denominational sexuality education programs. A non-scientific telephone survey of leaders in 25 of the larger religious communities in our area asked how the church/synagogue addresses youth sexuality education/teen pregnancy prevention. The responses fell into five general categories:

1. No programming directly related to sexuality education or teen pregnancy prevention (most are in this category);
2. Abstinence-only programs (e.g., “True Love Waits”) that promote only chastity to prevent pregnancy and transmission of STDs;
3. Comprehensive sexuality education programs that are abstinence-based but include information about contraception, STD prevention, and a skills-building component;
4. Religious education specifically developed for a religious community’s middle and high school population, a curriculum which integrates sexuality education, volunteer work, and a “rite of passage” ceremony (e.g. an Episcopal Church-developed program called “Journey to Adulthood”);
5. Mission and outreach programs provided to the larger community. These include Emmaus with Child, the Charlottesville Pregnancy Center, and the Elizabeth Project. These programs tend to focus on providing support for young pregnant women who choose to carry their pregnancies to term. Support might include housing, prenatal care, and information about adoption placement.

Implementation of sexuality education programs appears dependent on pastoral and congregational consensus, education, and volunteer support (most church school teachers are volunteers). This last condition implies that religious

\(^{27}\)For example, CAPP organized several breakfast meetings for community religious leaders to discuss the needs and possibilities for teen pregnancy prevention programs through local church and synagogue youth organizations. CAPP offered to arrange for specialists who would help set up or strengthen such programs, and to provide educational materials. Fewer than a dozen local religious leaders attended the breakfasts, and none took advantage of CAPP’s offers.
communities may also be constrained by teachers’ discomfort with sexuality issues and lack of teacher training and resources.

Because religious communities serve members throughout the lifespan, most provide a rite of passage for youth who choose to participate. These rites of passage include bar/bat mitzvah, confirmation, youth baptism, a “True Love Waits” chastity pledge ceremony, or a program like “Journey to Adulthood” that spans fifth through twelfth grades and is implemented in several Protestant denominations. These rites of passage present a natural opportunity for youth sexuality education; some churches provide sexuality education within the context of these larger programs.

Although a few local faith communities are implementing some noteworthy and comprehensive programs that include elements believed to prevent premature sexual activity (e.g. volunteer work; developing and practicing new behavioral skills), most religious communities are not taking full advantage of their unique position in the larger community.

**Recommendation:** Leaders of religious communities should speak out about sexuality issues, including teen pregnancy/STD prevention, in a way consonant with denominational and congregational beliefs. A congregation may not always agree with its leader, but messages conveyed from the “pulpit” carry weight within the community and model sexuality discussions for congregants. If needed, religious community leaders should educate themselves first to educate their communities.

**Recommendation:** Religious communities, in accordance with their denominational and congregational beliefs, should provide sexuality education to children, youth, adults, and families through their existing religious education programs. Since most religious communities profess commitment to support children and families, parents should be encouraged and taught how to address and discuss sexuality with their children. To implement this recommendation, religious communities may need information about effective programs and training opportunities for leaders, teachers, and parents.

**Recommendation:** Religious communities should address teen pregnancy/STD prevention within mission and outreach efforts, and augment the teen pregnancy/STD prevention efforts of local community agencies.
Responsibility: The primary responsibility for implementing all three of these recommendations rests with the individual religious communities. Perhaps the local Interfaith Alliance, Council of Churches, or Alliance of Interfaith Ministries might be asked to provide support and encouragement toward this goal. The Council on Adolescent Pregnancy Prevention (CAPP) and Planned Parenthood of the Blue Ridge could be asked to provide technical assistance for educational programs.

IV. F. Business Community

Local business plays an important role in the provision of health and human services in the Charlottesville/Albemarle area. In addition to making direct financial and in-kind contributions to local community organizations, many firms free employees for volunteer help with public-sector and nonprofit groups (assisting in the delivery of services; participating on working committees; serving on governing boards; etc.). The private sector also gives direct financial support to the local United Way, which in turn funds community teen pregnancy prevention programs.

In addition to fulfilling a general civic responsibility, employers recognize that it is in their best financial interests to support efforts to prevent teen pregnancies and STDs. First, with a local unemployment rate hovering around 1%, many businesses have difficulty finding good workers. Young people who become pregnant and drop out of school are unlikely to have the education, skills, work ethic, stable home life, etc., that defines a productive employee. Second, if employees’ teenage children have babies who demand time and attention from the new grandparents, job productivity can be affected. And third, the overall economic costs of teen pregnancy and STDs, estimated conservatively at over $5 million each year just in Charlottesville and Albemarle County (see section I.C.3.), is reflected in the tax burden for businesses as well as individuals.

The potential for greater business participation in teen pregnancy/STD activities is great, through more active involvement with ongoing community programs, more liberal direct funding, and more imaginative in-house programs. The March of Dimes, for instance, has available for businesses a “workplace education” program focussing on teen pregnancy prevention (including a module on “parenting your teen”). This program would be a valuable “on the job” resource for local employees. More businesses could participate in the United Way “Day of Caring,” as way of showing residents how easy it is to spend a little time with a community agency and the difference their involvement could make. Businesses with a special link with adolescents – hair stylists, clothing stores, music stores –
have a unique opportunity to distribute educational material about teen pregnancy/STD prevention.

**Recommendation:** Businesses should strengthen efforts to provide a “family-friendly” environment that encourages parents to be involved in their children’s lives. Employee seminars and workshops (on such general topics as parent-child communication, and on such specific issues as STD/pregnancy prevention for teens) should be made available. Employees should be given some flexibility with work schedules so they can deal with family issues that may be related to teen pregnancy.

**Recommendation:** Businesses should continue and step up efforts to encourage their employees to participate as volunteers in community youth programs, including those that help prevent pregnancy and STDs among teens.

**Responsibility:** The Charlottesville-Albemarle Chamber of Commerce, in collaboration with United Way, could be asked to educate member businesses about how to introduce more “family-friendly” policies and programs, and should help link interested businesses with the necessary technical resources (e.g. experts on teen pregnancy prevention to speak with employees).

**Recommendation:** More businesses should consider establishing a link with a school or community youth program – particularly a youth volunteer program -- giving corporate support through the provision of adult mentors, help with transportation, and funding. Businesses with some special marketing ties to adolescents should offer to help distribute educational materials about teen pregnancy/STD prevention.

**Responsibility:** Perhaps United Way, working in conjunction with the Chamber of Commerce, the CCF, and/or CAPP, could identify specific ways for businesses to assist community organizations, and could help the businesses take advantage of such opportunities.

In gathering information for this Strategic Plan, we were told that some businesses shy away from direct financial support of teen pregnancy/STD prevention activities because the controversial nature of some programs might alienate customers. This protestation ignores the many noncontroversial interventions – youth volunteer programs, for example, or mentoring programs – which recent research suggests are among the most effective in preventing teen pregnancy and STDs.
**Recommendation:** A few carefully chosen, locally owned businesses should be asked to contribute funds (possibly in addition to other kinds of support) for one or more teen pregnancy/STD prevention efforts from a list of active community programs.

**Responsibility:** The Council on Adolescent Pregnancy Prevention (CAPP) might be asked to approach a few businesses that have displayed community responsibility (e.g. ACAC, Lakeland Tours, Bodo’s, Crutchfield, and some local banks).
CHAPTER V: FINANCIAL AND ADMINISTRATIVE SUPPORT

We begin this chapter by examining present and proposed costs of our direct community teen pregnancy prevention programs. To help put the expenses in perspective, we also estimate the programs’ financial benefits in terms of averting births. The chapter concludes with a discussion of the need for a coordinator for the various teen pregnancy/STD prevention efforts, and for a Steering Committee.

V. A. Economic costs of current and proposed programs

Table 1 (on the next page) summarizes the economic costs of the community’s programs that have had significant direct effects on teen pregnancy/STD prevention.28 These programs, also discussed in Chapter IV.C. (page 37), consist of Beating the Odds, Camp Horizon, Reach, Teensight at FOCUS, and Young Guys of Distinction.29

The unshaded rows in Table 1 represent the current five programs, whose total annual cost is $230,200. Of this, $170,400 comes from city and county public funds, and $59,800 from foundations and private-sector sources.

The proposed extensions of teen pregnancy/STD prevention programs, as suggested by the agencies, are indicated by the shaded rows in Table 1. In brief, they consist of expansions of the current activities into additional city and county youth populations of high-risk children, and total an additional $319,300. For example, Beating the Odds presently exists in four neighborhoods (identified in the table) at a cost of $46,000 per year. To expand Beating the Odds into the rest of the city elementary schools would cost $46,700 more per year, and to expand it into four more elementary schools in the county, another $52,000.

V. B. Economic benefits of current and proposed programs

Direct teen pregnancy and STD prevention programs in our community now consume $230,000 per year, and this Strategic Plan proposes increasing the amount to about half a million dollars. Is it worth the money?

28 We have deliberately not included in this table the youth programs – such as the Boys and Girls Club, Boy Scouts, or 4-H Club – that may have indirect effects on teen pregnancy prevention. Nor have we included FLE, estimated to cost $98,600 per year in the city and county (see Chapter IV.B., page 32), because we can not estimate its economic effects.

29 The costs of Steppin’ Up, a small program at MACAA, are represented in the figures for Beating the Odds and Camp Horizon.
## Table 1: Costs of current teen pregnancy/STD prevention programs and proposed expansions

<table>
<thead>
<tr>
<th>Program</th>
<th>Description</th>
<th>Existing Cost per year</th>
<th>Proposed Cost per year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Beating the Odds</strong></td>
<td>City and County at present (1 FT MACAA, 1 PT Region Ten; 63 children @ Garrett Sq/Clark, Jackson-Via/Blue Ridge Commons, Yancey/Esmont, Greer/Whitewood Village)</td>
<td>$30,700</td>
<td>$15,300</td>
</tr>
<tr>
<td><strong>Beating the Odds</strong></td>
<td>City expansion (1 FT MACAA, 1 PT Region Ten; 40 children @ Johnson, Burnley-Moran, Greenbrier, Venable)</td>
<td></td>
<td>$46,700</td>
</tr>
<tr>
<td><strong>Beating the Odds</strong></td>
<td>County expansion (1 FT MACAA, 1 PT Region Ten, Travel: $7,500 includes students and staff, assumes in school programs during school hours; 40 children @ Scottsville, Cale, Red Hill, Agnor-Hurt)</td>
<td></td>
<td>$52,000</td>
</tr>
<tr>
<td><strong>Camp Horizon</strong> (MACAA)</td>
<td>City at present (1 FT; 60 children)</td>
<td>$38,000</td>
<td>-0-</td>
</tr>
<tr>
<td><strong>Camp Horizon</strong> (MACAA)</td>
<td>County expansion (1 FT, travel $3750; 40 students @ Burley, Sutherland, Walton, Henley)</td>
<td></td>
<td>$30,000</td>
</tr>
<tr>
<td><strong>Reach</strong> (FOCUS)</td>
<td>City and County at present (3 PT; 35 Children, 40 Parents, 20 others throughout city and county)</td>
<td>$67,700</td>
<td>$12,500</td>
</tr>
<tr>
<td><strong>Reach</strong></td>
<td>County expansion (1 FT, 2 PT; 25 children @ 4 middle schools; travel, work experience costs, enrichment/travel experiences)</td>
<td></td>
<td>$75,000</td>
</tr>
<tr>
<td><strong>Teensight</strong> (FOCUS)</td>
<td>County and city at present (3 PT, 58 teen moms @ 6 city and county high schools; travel, materials, and supplies)</td>
<td>$34,000</td>
<td>-0-</td>
</tr>
<tr>
<td><strong>Teensight</strong></td>
<td>City and County expansion; 3 PT, 58 more teen moms</td>
<td></td>
<td>$51,600</td>
</tr>
<tr>
<td><strong>Young Guys of Distinction</strong> (MACAA &amp; Teensight)**</td>
<td>City and County at present (1 FT; 35 children at Walker, Buford, Westhaven)</td>
<td>-0-</td>
<td>$32,000</td>
</tr>
<tr>
<td><strong>Young Guys of Distinction</strong></td>
<td>City and County Expansion (2 FT; 70 children at 3 County middle schools and 3 City elementary schools)</td>
<td></td>
<td>$64,000</td>
</tr>
<tr>
<td><strong>Total Costs of Existing Programs</strong></td>
<td></td>
<td>$170,400</td>
<td>$59,800</td>
</tr>
<tr>
<td><strong>Total Costs of Both Existing Programs and Proposed Expansions</strong></td>
<td></td>
<td>$230,200</td>
<td>$319,300</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td></td>
<td></td>
<td>$549,500</td>
</tr>
</tbody>
</table>

*FT = Full-time position; PT = Part-time position*  
*Proposed expansion of programs*
In short, the answer is a resounding yes. The analysis below shows that the measurable economic benefits of the current direct teen pregnancy prevention programs in our community, though the estimates are rough, can be calculated conservatively at almost twice the costs of the programs. A more realistic estimate yields benefits almost four times the programs’ costs (see Table 2). It should be emphasized that these figures represent the financial benefits only of preventing teen pregnancy; they do not take into account the likely sizable benefits in preventing STDs, or the other collateral beneficial effects of the programs (for example, volunteer-service programs have as large an effect on school dropout rates as they do on teen pregnancy rates). Nor does this calculation include the benefits to the mother or child – only to society.

Our method of calculating a program’s economic benefits consists of first identifying the impact of the program in terms of averting teen pregnancies, and then assigning an economic value to that impact (ignoring, for this analysis, other impacts).

To measure a program’s success, if any, in averting teen births, we compare (a) the pregnancy rate of teens in a program with (b) the pregnancy rate of comparable teens not in the program. In the following paragraphs we illustrate our approach with respect to Camp Horizon. Full details of our assumptions in assessing each of the other programs listed in Table 1 appear in Appendix M.

<table>
<thead>
<tr>
<th></th>
<th>Cost per year</th>
<th>Estimated Benefits per year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Existing</td>
<td>Proposed</td>
</tr>
<tr>
<td>Total Costs and Benefits of Existing Programs</td>
<td>$230,200</td>
<td>$420,900</td>
</tr>
<tr>
<td>Total Costs and Benefits of Proposed Expansions (for which benefits can be estimated)</td>
<td>$319,300</td>
<td>$439,300</td>
</tr>
<tr>
<td>Grand Total Costs and Benefits of Existing Programs and Proposed Expansions (for which benefits can be estimated)</td>
<td>$549,500</td>
<td>$860,200</td>
</tr>
</tbody>
</table>

Table 2: Total costs and estimated benefits of current teen pregnancy/STD prevention programs and proposed expansions
From data provided by the program, we know that, at most, 3% of Camp Horizon participants become pregnant by the age at which they should finish high school. On average, two-thirds of pregnancies lead to births in Charlottesville. So we estimate that 2% of Camp Horizon participants give birth by the age at which they should finish high school.

For the birth rate of comparable high-risk teens not in the program, we have to rely on estimates since there is no data. For our estimate, we simply use the birth rates for girls in Charlottesville as an extremely conservative estimate of the rate for high-risk girls, and, for a more realistic estimate, we double the Charlottesville rate.

The annual teen birth rate for all 10- to 14-year-old girls in Charlottesville is 2 (per thousand) and for 15- to 17-year-old girls it is 60.3 (per thousand). A 12-year-old Camp Horizon participant would have had a .998 chance (1-.002) of not giving birth between ages 12 and 13, another .998 chance between ages 13 and 14, another .998 chance between ages 14 and 15, a .9397 chance between ages 15 and 16, another .9397 chance between ages 16 and 17, and another .9397 chance between ages 17 and 18. The chance of not giving birth by age 18 is the product of these probabilities: .998 x .998 x .998 x .9397 x .9397 = .825. This implies that a 12-year-old Camp Horizon participant would have had a 17.5% chance (1 -.825) of giving birth had she not participated in Camp Horizon. On the other hand, she has a 2% chance given that she did participate. Thus, the effect of the program on birth rates is 17.5% - 2% = 15.5%.

The estimated cost of a birth in today’s dollars over the lifetime of the mother and child is $37,000 (see Chapter I.C.3., page 13). Some of the costs of the birth occur immediately; others take years to occur. The costs that occur in years after the birth need to be discounted. The idea is that a dollar in a year from now is not worth as much as a dollar today because we could take a dollar today, put it in a bank and have more than a dollar in a year from now. Similarly a cost in the future is not as expensive as the same cost today.

Typically, we deal with this by discounting future costs to put all costs in terms of costs today. If we add up these discounted costs over time, then the total discounted cost of a birth is estimated to be $37,000. We also need to discount costs even more because they occur in years after program costs; the goal is to put all costs and benefits in terms of dollars at the time of the program.

Next, we need to adjust for program participation over many years. We make the most conservative assumption that, once in a program, the child participates as long as possible. Thus we divide benefits by the number of years of program participation to get savings per new child participating. We conservatively
discount birth costs by five years using a 5% annual discount rate. Thus, a birth at age 17 costing $37,000 is worth only \(0.95 \times 0.95 \times 0.95 \times 0.95 \times 0.95 \times 37,000 = 28,630\). This implies that the conservative estimate of the cost savings for one Camp Horizon participant is the difference in birth probabilities, \((0.175 - 0.02)\), times the cost of a birth, $37,000, times the discount factor, 0.774, divided by 2 years of participation = $2219. Since there are 60 participants per year, the total cost savings is $133,167. If we use the more reasonable estimates of high-risk birth rates, the total cost savings becomes \((0.350 - 0.02) \times 37,000 \times 0.774 \times 60 / 2 = \$283,516\).

We performed similar calculations for Camp Horizon expansions by adjusting program size. We assumed that the proposed expansion of Camp Horizon will result in benefits proportional to its size. This leads to a conservative estimate of added benefits of $88,800 and more realistic benefits of $189,000.

Note that the total conservatively estimated benefits to the programs included in Table 2 are about 15% of the total teen pregnancy public costs ($5.5 million) discussed in Chapter I.C.3. Our conservative estimates suggest that complete expansion, including Teens Give, would reduce teen pregnancy rates by about one-quarter. This is a reasonable expectation given these programs’ success at targeting high-risk youth and dramatically changing their behavior.

In any case, it is clear that Camp Horizon, Teensight, and Teens Give are very worthwhile programs. Even ignoring benefits to the participants in the program, the programs more than pay for themselves in terms of reduced costs to society associated with lower pregnancy rates. If the newer programs (Beating the Odds, Reach, Young Guys of Distinction) have similar results, they will also be cost effective.\(^{30}\)

Given this analysis, it is clearly cost-effective to devote more funding to programs aimed at directly preventing teen pregnancies.

**Recommendation:** Base the amount of public-sector money spent on teen pregnancy and STD prevention efforts on (a) the public-sector costs of teen pregnancies and STDs and (b) the benefits of preventing these pregnancies and STDs. Recognize that good teen pregnancy/STD prevention programs are highly cost-effective, and expect the public sector, the private sector, and the not-for-profit sector to contribute more to the solution of this problem.

\(^{30}\) Based on the information available at this time, we are not able to measure the benefits of two planned programs: the Teensight at FOCUS job training program (at a proposed cost of $109,600) or the City’s Youth Service Learning Center (at a proposed cost of $100,000).
The programs listed in Table 1 were able to count on funding only for their initial two or three years of their operation. Even as the new staff launched their programs, the directors had to spend time seeking future support to maintain the activities. The absence of assured long-term funding for community teen pregnancy/STD programs hinders staffing, weakens planning, increases time spent in grant-writing (at the expense of programmatic effort), and lowers morale.

**Recommendation:** Where possible, funding sources should commit themselves to supporting programs for at least a five-year period, contingent upon satisfactory progress reports.

V. C. Administrative support and overall program coordination

In our community, there is currently no systematic coordination for the various activities intended to provide information or services for teen pregnancy and STD prevention. Program administrators may occasionally discuss activities at CAPP meetings, or through informal networks, or – as is now required for United Way funding – when preparing grant requests. But there are few opportunities for all the players in the public, private, and not-for-profit sectors to identify and deal with gaps and overlaps in the whole community’s teen pregnancy and STD prevention strategy. In the present highly decentralized situation, where limited funding can create a competitive rather than a cooperative atmosphere among agencies, there is often poor communication about the submission of funding requests – and no identified specialist outside the agencies to stimulate and assist in proposal writing.

A centralized teen pregnancy/STD prevention coordinator (or coordinating body), whose tasks and limited authority have been ratified by local governments and program administrators, is currently an essential element in the prevention programs of many communities. A teen pregnancy/STD prevention coordinator can:

1. serve as a clearinghouse for information about funding possibilities, training opportunities, lessons from other communities, etc.;
2. act as an advocate for unserved or underserved youth, helping to design programs and obtain funds for them;
3. stimulate and guide special events (e.g., public awareness/social marketing campaigns, outside speakers, panel discussions, forums);
(4) work as the primary local advocate for teen pregnancy/STD prevention in the community, speaking to local government bodies, civic organizations, funding agencies, etc.;

(5) help, as appropriate, with program evaluations;

(6) function as the liaison with state and national teen pregnancy/STD prevention agencies;

(7) prepare annual reports on our community’s progress in addressing teen pregnancy and STDs; and.

(8) prepare funding requests to support the initiation of new and the maintenance of existing pregnancy/STD prevention programs.

In communities where a Coordinator’s office has legitimacy and impact within the community (e.g. Mecklenburg County, NC; Roanoke, VA; Atlanta, GA), it is visibly linked with a prestigious local institution that plays a major role in health care and/or youth services (e.g. a large hospital or local government service agency). The host institution provides office space, administrative support and supervision, and administers some of the grants for teen pregnancy/STD activities (e.g. public awareness/social marketing campaigns; a professional sexuality education specialist to work with youth and parents’ groups).

Regarding coordinators role in the preparation of funding requests, recent experience at the Task Force on Teen Pregnancy Prevention (the group of which our Strategic Planning Work Group is a part) may be instructive. The Task Force recently hired a consultant to seek funding for maintenance and expansion of the programs by Teensight at FOCUS and MACAA. Using about $13,000 in seed money from the state’s Partners in Prevention program, during the year ending September 1998 the consultant helped the Task Force write 16 grant applications for a total of $520,000. The result was that less that 15% of the requested program funding was granted: Teensight received a $5,000 grant from an outside source (the Seay Foundation) and a larger amount ($65,000) from the local Perry Foundation. MACAA received no funds.

Two problems were evident as this effort progressed:

(a) It was difficult to divide the needs for new programs into innovative, discrete packages that fell under the modest limits ($5,000) of most of the appropriate funding agencies.
(b) Most foundations were not interested in providing funds for the maintenance of small existing programs.
The Task Force also looked into seeking funds for large research-oriented projects, but learned that our needs did not meet the current criteria of most funding agencies (e.g., emphasis on abstinence programs to the exclusion of other approaches; preference for projects in economically depressed cities).

The experience suggests, among other things, that it is unlikely for outside foundations to provide a significant proportion of support for our local needs, and that outside fundraising requires long-term help from an experienced person. A coordinator can provide the long-term grant-writing services. Our own community, however—primarily the local city and county governments, through their taxpayers—must make a financial commitment to reducing teen pregnancy with or without a coordinator.

To the argument that the dollars for maintaining such a coordination post could be better spent on front-line programs for teens, some experienced specialists reply that a good community coordinator provides overall benefits (in terms of program impact and new program support) that far outweigh his or her costs.

**Recommendation:** Jointly, in Charlottesville and Albemarle County, create a position of “Teen Pregnancy/STD Prevention Coordinator,” with the job description based on the tasks listed above. Support the position for the first three years with funds from private-sector sources. Evaluate the position for usefulness and cost-effectiveness after two years, with the understanding that funding responsibility for a demonstrably beneficial position would shift to local governments from year four.

**Responsibility:** Local foundations and/or private donors could be asked to fund the Coordinator position for the initial three years. Recruitment for the post could be handled by Task Force on Teen Pregnancy Prevention, in conjunction with (if the next two recommendations are accepted) Martha Jefferson Hospital and the Steering Committee.

**Recommendation:** Request Martha Jefferson Hospital to provide office space, administrative support, and supervision for the new position of Teen Pregnancy/STD Prevention Coordinator.

The position of Coordinator can be strengthened with backup and guidance from a group of informed residents who are actively involved in teen pregnancy/STD prevention in the community. Constituted as a “Citizens’ Advisory Committee” or “Steering Committee,” the group can be given authority by local governments and agencies to support and advise the Coordinator and to assist him/her with tasks.
The group should be representative of the range of constituencies for which teen pregnancy/STD prevention is an issue in the community (including adolescents themselves), and include leaders in ongoing prevention efforts. To give the committee standing in the community, and to provide administrative/secretarial support, it should be constituted and supervised by a city-county youth-serving agency.

**Recommendation:** Immediately establish a permanent teen pregnancy/STD prevention advisory and support group composed of community leaders in the field. This Steering Committee should be responsible for assisting the Teen Pregnancy/STD Prevention Coordinator or, if the Coordinator position is not filled, responsible for performing some of the tasks proposed (above) for the Coordinator.

**Responsibility:** The Commission on Children and Families (CCF) could be asked to establish a new “Study Group” that could serve as the proposed Teen Pregnancy/STD Prevention Steering Committee. Until then, the existing Task Force on Teen Pregnancy Prevention (responsible for this Strategic Plan) could perform the necessary advisory and support functions.
CHAPTER VI: EVALUATING LOCAL EFFORTS

Measuring objectively the success of teen pregnancy/STD prevention programs helps policymakers and program staff make decisions

- to continue or discontinue a program;
- to improve its practices and procedures, perhaps by adding or dropping specific program strategies and techniques;
- to institute similar programs elsewhere;
- to allocate resources among competing programs; and
- to accept or reject a program approach or theory (Weiss 1972:16).

The keys to doing good evaluations of local programs are (a) to build in data collection as an integral part of the program, and (b) to match the size, scope, and nature of the evaluation research to the characteristics of the program being evaluated. Matching the evaluation to the programmatic effort is tricky: extensive, rigorous, and systematic program outcome research can be tremendously valuable, but also logistically demanding and extremely expensive – in some cases more than the cost of actually running the program. Such an intensive effort is appropriate only in those unusual cases in which a completely new programmatic approach has been developed, implemented, tentatively evaluated, and has achieved sufficient national attention to permit independent funding of evaluation efforts. A major evaluation is simply not appropriate or feasible – primarily because of the cost -- for most small local programs.

Indeed, if an agency or organization in our community adopts a program (or element of a program) that has been rigorously and objectively evaluated elsewhere, there is little need to replicate the entire assessment. Rather, an appropriate goal, at least initially, would be to ensure that the local implementation accurately reflects the tested model.

In the past year or two, our local governments, together with United Way, have articulated policies reflecting a new seriousness being given to assessment issues. Until recently, public service programs in our community (including those addressing teen pregnancy/STD prevention) received only the most cursory evaluation – often little more than the earnest assurance of the program administrator that all was going well. Now local governments and United Way jointly are reviewing past evaluation reports from grant recipients to determine how reliably progress can be measured, revising questions on progress reports to better measure outcomes, and developing a new program evaluation model.

To help determine how to match an evaluation exercise with the local teen pregnancy/STD prevention effort it examines – and to increase the probability that
comparable programs collect comparable data -- funding and administrative agencies should consider three distinct but not mutually exclusive categories of data:

- **Description of the client population**: Responsible teen pregnancy prevention programs continuously collect at least rudimentary data on the people they actually (not ideally) serve. This information helps ensure that (a) program administrators know if they are reaching their intended audience, and (b) the program can be coordinated with other service providers to fill gaps and avoid overlaps. At the least, records are kept on each client/participant’s age, gender, race/ethnicity, and residence location; depending on need and feasibility, more detailed information is sometimes gathered on whether the teen is sexually active, contraceptive history, pregnancy history, socio-economic status, etc. Ideally, all community programs would cooperate to identify the client variables to be described, with the result that standardized data would be made available for each program – without violating confidentiality.

- **Process evaluation**: Process data are collected to help determine how closely a program is operating in accord with its objectives. To do this, records are kept on what the program actually does, in terms, for example, of the number of each type of services provided, by whom, and the numbers of youth (or others) served or exposed to the intervention. Some process evaluations also include money and time expenditures (per client, for example, or per teacher trained), producing a measure of the cost-effectiveness of the project. These data, when compared with the intended input, support decisions about program continuation or modification.

- **Outcome evaluation**: To determine whether a teen pregnancy/STD prevention effort is having its intended impact, one measures, before and after the intervention(s), a parameter the program aimed to change. These hoped-for “outcomes” could include: greater awareness or knowledge about something (e.g., the disadvantages of early parenthood, or how contraceptives work), modified attitudes (e.g., more respect for abstinence), better skills to make and enforce responsible decision-making (e.g., how to say “no”), or alterations in behavior (e.g., delayed age at first sexual intercourse, or greater use of effective contraceptives for sexually active adolescents). Ultimately, of course, the programs – if successful – should result in reductions in teen pregnancy and/or STD rates.

Some programs – particularly those intended to enhance the development of the whole person -- have incidental benefits other than those related to pregnancy and STD prevention. To the degree those impacts can be anticipated, data should be collected on those outcomes as well.
In addition to (or sometimes instead of) measuring the selected outcome variable(s) before and after the program intervention, some programs evaluate their impact by comparing the outcomes of those who participate in the program against a matched group of individuals who do NOT participate. If the program is effective, there should be a significant difference in the two groups. It should be noted that using a comparison group effectively can be difficult because of problems inherent in identifying accurately matched groups.

Because some adults in our community object to “personal” questions being asked of youth, it is sometimes impossible for evaluators to get reliable data to show whether a teen pregnancy/STD prevention program has had an impact on sexual behavior or pregnancy histories; this is true particularly for broadly-targeted, school-based programs. Though no outcome evaluation of our local FLE curricula has yet been attempted (and thus no objections voiced to any questions), decisions were made in Charlottesville and Albemarle County, for reasons that had nothing to do with science, to omit questions on sexual activity from the 1992 Virginia Youth Risk Survey.

**Recommendation:** All local teen pregnancy/STD prevention efforts – whether aimed at adolescents themselves, pre-teens, parents, or the whole community – should be periodically evaluated and the results used to improve the program (and/or the overall mix of programs in the community). The type and extent of the evaluation should be based on available resources (e.g., funds, personnel time and skills) and the degree to which the local effort reflects other programs that have been reliably evaluated.

**Responsibility:** Every director/manager/head of a local teen pregnancy/STD prevention program should collect continuous data that can be used for evaluations – and then use it.

**Recommendation:** The current United Way/local government review and upgrading of program evaluation models and procedures should establish an overall strategy for program evaluation ensuring that comparable programs collect comparable data. These new guidelines should be followed for all evaluation activities for teen pregnancy/STD prevention programs in the community.

**Responsibility:** The United Way Program Review and Funding Committee could be asked to work with the Commission on Children and Families to standardize program evaluations, and provide a list of evaluation specialists who would volunteer to help.
Recommendation: All local agencies that provide funds for teen pregnancy/STD prevention programs should (a) insist that the provision of program support obligates the program leader to undertake some degree of program evaluation, and (b) include, in the funding grant, enough money for a cost-effective program evaluation.

Responsibility: All local funding agencies (e.g. local governments, foundations, United Way and other agencies) should be asked to follow this recommendation.

Recommendation: The community should work with the Thomas Jefferson Health Department and the state Department of Education to improve the quality of baseline data about teen sexual behavior and STDs.

Responsibility: In line with the CCF’s interest in improving data concerning youth in our community, the CCF could be asked to spearhead this effort.

Other (non-evaluation) Research: Research other than evaluation of programs in progress can be of tremendous value in helping a community identify needs and define programs that meet those needs. We in the Charlottesville-Albemarle area have virtually no reliable information about our teens’ attitudes and values, their hopes and preferences, and their knowledge and behavior regarding sex and reproductive health. No data exist on local parents’ knowledge and attitudes about their children’s sexuality or their ability to talk with children about such issues. We know little about the ability and willingness of local youth-serving professionals – health care workers, religious leaders, education specialists, etc. – to help our children avoid pregnancies and STDs. This dearth of data is in sharp contrast to a comparable university community, Chapel Hill, North Carolina, where a rich database helps planners to identify priority problems and design appropriate programs.

If such research is done through schools it does, of course, place additional demands on the time of both teachers and students, but there are significant benefits. For example, by identifying children’s (or parents’) areas of ignorance or misinformation, communities can tailor educational programs to local needs. Training teachers and upgrading courses for FLE can also be more effective, and public awareness campaigns can target local needs when appropriate data are available. Local and state decision-makers for schools in North Carolina, for example, were better able to represent their constituents’ wishes when opinion
polls revealed that 90% of parents throughout the state wanted schools to provide sexuality education.

**Recommendation:** Research relating to our understanding of local teen pregnancy and STD issues should be encouraged. Charlottesville and Albemarle County local governments and school boards should actively solicit UVA and PVCC to undertake appropriate research (particularly in the social sciences), and should make schools and other public agencies more accessible for such research.

**Responsibility:** While city and county governments and school boards have the ultimate responsibility for implementing this recommendation, the CCF might be asked to serve as the prime advocate for it.

**Recommendation:** UVA and PVCC should create incentives to reward faculty for undertaking research that contributes to the local community and helps reduce the town-gown gap.

**Recommendation:** Local foundations should earmark money to support UVA or PVCC faculty and students to do research on issues related to local teen pregnancy/STD prevention.
VII. CONCLUSIONS

In several ways, our review of the teen pregnancy/STD situation in Charlottesville and Albemarle County offers encouragement. The rates of teen pregnancies and teen births in both the city and county show modest declines in the past eight years, and the rates in Albemarle County are significantly below the state and national averages. Clinical services for teens seeking reproductive health care – including contraceptives – are very good. Both city and county public school systems have Family Life Education courses that reach nearly all students. The community boasts a few good pregnancy prevention programs aimed at small groups of high-risk children; some of these programs have recently expanded. We should also be encouraged to know that local teen pregnancy and STD rates can be lowered further, as our review of the research literature shows, and the examples of European countries should give us hope.

Often, though, the picture painted in these pages is disturbing. In 1997 – a fairly typical year – 250 Charlottesville and Albemarle County teens got pregnant. Of these, 90 ended with induced abortions and 151 in live births. Albemarle County’s teen birth rate is approximately three times greater than that of western European countries, and the Charlottesville rate is three times higher than the county’s. Most sexually active teens do not take advantage of local clinical services. Only about 15% of pregnant teen girls are married, and more than 80% of teen pregnancies are unintended. Every year about 1 in 4 sexually experienced teens acquires an STD, three times the number of teens who get pregnant. The teen pregnancy prevention programs in our community simply do not have the resources to deal with the needs of ordinary adolescent boys and girls, much less the needs of all high-risk children. A number of youth-serving organizations with access to many children avoid direct involvement in pregnancy or STD prevention.

For some readers, the most unpleasant element in this document may be the observation that many teens in the community – our children – are sexually active. We know they have had sexual intercourse because the youth themselves tell us, in national and statewide surveys, and because their statements are confirmed by the patterns of reported abortions, miscarriages, and births among girls aged 10-19.

The positive side of this disclosure is that most youth before age 17 are NOT sexually active; 8 in 10 girls and 7 in 10 boys are virgins at age 15. This fact suggests one of the most important strategic goals for our community teen pregnancy and STD prevention effort:

For teens who are not sexually active, we must provide clear support for their decision to remain abstinent, along with the knowledge and
skills needed to maintain this stance. For those not yet sexually active, and for all younger teens, this should be the main pursuit of pregnancy prevention efforts.

Of 15-19 year-olds, however, more than half of both males and females are sexually active, a proportion that rises to three-quarters of 18- and 19-year olds.

For **teens who are sexually active**, we must ensure that they have worthwhile life options, help them recognize that a pregnancy or STD may interfere with personal goals, and provide access to information and reproductive health services so they have the means to avoid STDs and unintended pregnancies.

The 250 teens each year who get pregnant constitute a third group that deserves special attention. Whether the pregnant teen (with or without her mate) decides for abortion, adoption, or parenthood, she may feel that just when she is the most vulnerable, she has the least access to a network of caring and counseling.

**Pregnant teens** need special support to make the appropriate decision about the outcome of the pregnancy, to continue in school, to comply with prenatal health care guidelines, to prepare for parenting an infant, and to deal with other decisions in a life complicated by the pregnancy.

Though this document deals with pregnancy and STD prevention, it is likely to be parenthood, more than pregnancy, which provokes the most critical life changes. For this reason a fourth category of teens deserves attention:

**Teen parents** should be provided support and counseling that increases the probability that they will be good parents and decreases the probability that the role of parenthood will shut off other possibilities for personal growth.

Each of the four strategic goals proposed above focuses on a subgroup of the adolescent population; a fifth needs to be added. This last strategic goal encompasses all teens – indeed, all pre-teens as well. It builds on the recognition that (a) all children will, as part of normal healthy development at some later point in life, become sexually active, and (b) whenever that point comes, many are unprepared and unprotected against STDs and pregnancy.

We should **equip all our youth before** their first sexual experience with the capacity to make responsible decisions about reproductive health.
and behavior, and provide them with age-appropriate knowledge and skills to avoid STDs and unintended pregnancies.

These five broad strategic goals provide a comprehensive vision for teen pregnancy/STD prevention in our community.

As we seek realistic strategies for reaching these goals, it is important to remind ourselves that tremendous variation exists within the population of adolescents. Of particular relevance for this discussion, teens differ in their motivation to avoid becoming a parent while still a teen. It is interesting to imagine a continuum of this motivation, along which any adolescent could be placed.

At one end would be a teen who has a powerful, paramount, desire to keep from giving birth and becoming a parent. She or he is likely to be abstaining from sex, or, if sexually active, using effective contraceptives, and in the event of an unintended pregnancy, would consider an abortion.

At the other extreme would be an adolescent who wants to get pregnant (or cause a pregnancy) and become a parent. Many teens exist in a world that offers little hope: hope of a worthwhile education, for example, or a satisfying job, a stable and loving family, affordable housing and health care. Without hope, teen parenthood is not seen as an obstacle to achieving future goals, as it is among more advantaged adolescents. Instead, for many youth with few other life options, pregnancy appears a realistic way to satisfy basic needs for recognition, status, nurturance, respect, prestige, and independence.

If we could somehow measure each teen in our community, we could distribute the entire population of local youth along this continuum according to his or her

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**Figure 4**. Graph representing hypothetical distribution of local teens’ motivation to avoid becoming a teen parent

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motivation to avoid giving birth and become a parent while still a teen. An entirely hypothetical distribution, based on speculation, is suggested in Figure 4. Most teens in the Charlottesville/Albemarle area would probably cluster at the “very high motivation to avoid” pole, according to the observations of members of the Strategic Planning Work Group who deal every day with local youth. But some (how many? who?) would be in the middle of the scale, with weak or ambivalent motivation, somewhat indifferent to – or in denial of -- the risk of teen pregnancy or parenthood. Yet other adolescents (is this a small but growing number? a declining number?) would fall at the “very low motivation to avoid” end, representing their wish to become teen parents.

The conjectural distribution in Figure 4, by illustrating that teens’ motivation to avoid becoming a parent varies, suggests that prevention strategies must also vary.

For planning community efforts to prevent pregnancies and STDs, the strategic implications for youth who want to be a parent are obvious. In addition to whatever other more short-term interventions are proposed, in the parts of Charlottesville and Albemarle County where hope is elusive among teens, we should be working more intensively on systemic community changes through job training and decent-paying jobs, insuring safe and affordable housing, etc. Improving the socio-economic context in which teens make decisions about risk is difficult, expensive, and controversial. But without adjustments in the underlying situation, community teen pregnancy prevention programs – at least for less advantaged youth -- cannot be expected to have their optimal effect.

Simultaneously, many immediate things can be done to modify teens’ attitudes, beliefs, knowledge, and behavior in ways shown to reduce teen pregnancy and STD rates.

In previous chapters we proposed roughly fifty specific recommendations (see Chapter I.A. for the selection criteria). From among those proposals, nine priority recommendations have been selected on the basis of their cost-effectiveness. In addition, a new recommendation is offered after consideration of community consensus on the topic of teen pregnancy/STD prevention.

- **Build on proven interventions**: Ensure that the design of new teen pregnancy/STD prevention efforts, as well as the continuation or modification of existing efforts, takes advantage of the results of reliable evaluation research.

- **Focus on each adolescent as a whole person**: Recognize the value of broad-spectrum efforts, with interventions that involve parents and other family members, help with school work, provide sports, boost self-confidence,
monitor physical health, offer after-school activities, and provide reproductive health information and services. In addition to reducing pregnancy and STD rates, such a well-rounded approach has other benefits for teens.

- **Normalize and increase communication about sexuality and reproductive health, including teen pregnancy and STD prevention:** Inspire adults in our community to develop greater knowledge, skills, and confidence for communicating constructively with teens and pre-teens – and each other – about reproductive health and sexuality. Encourage the media to provide consistent and long-term public education campaigns about teen pregnancy/STD prevention, and establish and maintain a bureau of speakers to talk knowledgeably with local groups about the topic.

- **Spend more on teen pregnancy/STD prevention:** To a greater degree, base the amount of public-sector money spent on teen pregnancy and STD prevention efforts on the public-sector costs of teen pregnancies and STDs. Our community should recognize the cost-effectiveness of good teen pregnancy-STD prevention programs, and expect the public sector, the private sector, and the not-for-profit sector to contribute more to the solution of this problem.

- **Provide coordination for community teen pregnancy/STD prevention efforts:** The community should recruit a professional to coordinate the various teen pregnancy/STD prevention efforts, to serve as a clearing house for information, to stimulate special events, to help with program evaluation, and to assist in the drafting of grant applications. The position, filled at least half-time, should be initially funded for a minimum three year period.

- **Strengthen parents’ ability to communicate with their children** of all ages about developmental issues, including responsible sexual behavior, and to articulate their own values. Although formal programs may assist in this process, the primary responsibility here lies with the parents.

- **Expand existing highly effective programs that prevent teen pregnancy and STDs to provide a seamless “continuum of services”**; Charlottesville and Albemarle County have already begun to implement effective programs that reduce pregnancies and STDs, and should now establish a long-term goal of expanding these programs so that all eligible youth have access to them.

For high-risk youth, Teensight at FOCUS, Reach, and Camp Horizon appear highly effective, yet serve only a small fraction of those likely to benefit.

For more typical youth (who are also at substantial risk of pregnancy and contracting STDs), volunteer community service programs have shown
striking effects in reducing pregnancy rates (along with other problem behaviors) in national evaluations, yet also serve only a small fraction of those local youth who are likely to benefit.

Expansion of these programs is not only likely to be effective, but also cost effective, bringing a rapid return on our community’s initial financial investment as well as numerous long-term social benefits.

- Improve the implementation of Family Life Education in schools: Simply offering fact-based FLE, however controversial, is not enough to reduce pregnancy rates. But enhancing this education with skill-building activities (such as assertiveness and decision-making skills) in the context of providing basic factual and age-appropriate information has been shown to be effective in preventing pregnancies. This broadened approach, together with improved teacher training, should be the basis for FLE education in local schools.

- Expect health care providers to play a more active role in educating youth – and their parents – about reproductive health and pregnancy/STD prevention: Health care professionals should promote positive messages about sexual development throughout the lifespan of their patients. Age-appropriate sexual information should be part of normal anticipatory guidance in health care visits from birth through adolescence.

This strategic plan begins by observing that teen pregnancies, particularly those that result in teen parenthood, extract a high price – to the adolescents themselves, their babies, and society. So, too, do sexually transmitted diseases among adolescents have high costs. The document goes on to review strategies that have been demonstrated, through objective evaluations in other communities, to reduce the rates of teen pregnancies and STDs.

Further, this plan argues that we in Charlottesville and Albemarle County can – should -- strengthen efforts to deal with teen pregnancy and STDs, and that investing in these tested prevention programs can be cost effective.

But agreeing on a common vision – on this (or any) strategic plan – is not an easy first step. A review of the lessons learned from recent program evaluations around the country (Philliber and Namerow 1995, p. 3) points out that in some communities, work on teen pregnancy has become a virtual battleground, where adults argue over program approaches and even question each other’s morality. As a result, programs to prevent teen pregnancy have often been selected because they make adults comfortable rather than because they are effective.
Conversely, programs of demonstrated effectiveness have been rejected because small
groups have opposed them on moral or religious grounds.

For any community to effect change, some degree of consensus is required about both the
problems and their solutions (Kotloff et al., 1995, p. 6). We can probably reach
consensus that adolescence is a time for education and growing up, not for pregnancy and
childbearing (National Campaign to Prevent Teen Pregnancy, 1997a).

But it may be more difficult to find agreement in our community for this document’s
definition of the problems and, even more formidable, to reach consensus in favor of the
solutions proposed in this strategic plan. In the past few years this inability to find
unanimity has derailed proposals for teen pregnancy programs here as elsewhere, a
problem well summarized in the title of a thoughtful publication by the National
Campaign to Prevent Teen Pregnancy (1998): “While the adults are arguing, the teens
are getting pregnant.”

One way through these differences is for all sides to embrace a new ethic of “unity of
purpose, diversity of means” (National Campaign to Prevent Teen Pregnancy, 1997b, p.
14):

This perspective stresses the importance of reducing teen pregnancy and STDs,
but allows each group to take action in its own arena and in its own way without
opposition. It also tacitly recognizes that America is an increasingly diverse
country requiring respect and tolerance for differing points of view.

We will never reach 100% agreement on what to do about teen pregnancies and STDs,
and we should not expect to. There will always be people who insist that community
leaders are moving too fast or too slow, or that the proposed actions are
counterproductive or even immoral.

But the lack of total concurrence must not be allowed to paralyze the community’s ability
to take meaningful steps. In this regard Tillamook County, Oregon, provides an
instructive model. The essence of their approach was to take action in an atmosphere of
tolerance, with all sides “agreeing to disagree” (National Campaign to Prevent Teen
Pregnancy, 1997a, p. 2):

When in 1990 state data showed that this rural county of 23,000 citizens had one
of the highest teen pregnancy rates in the state, the county health department
proposed creating a school-based clinic that would provide contraception,
provoking intense community conflict. The proposal was defeated by the school
board, but the community agreed that something had to be done. They decided the
only consensus they needed was that the teen pregnancy rate must drop. Various
segments of the community developed intensive initiatives – ranging from creating new church-based abstinence education programs, to improving access to family planning clinics, to expanding YWCA programs for girls – and agreed not to fight each other’s efforts. By 1994, the county teen pregnancy rate had dropped by 70 percent, becoming the lowest in the state.

Those of us in Charlottesville and Albemarle County who are concerned about our teen pregnancy and STD rates may not believe it is realistic here to aspire to a 70% reduction in four years. But we can, working with planners and program developers, seek to avoid simplistic solutions, to implement programs with the greatest evidence for success, and give attention to the broad array of risk factors that reduce motivation to avoid pregnancy (e.g., poverty, lack of opportunity)(Kirby 1997). Even more important, we can agree not to fight each other’s efforts. In the public sector particularly, we can agree to include “opt out” mechanisms that allow teens (and their parents) to not be subjected to any programs they find objectionable on the basis of religion or conscience.

So, for a final recommendation:

✔ Seek common ground on which to build effective teen pregnancy/STD prevention efforts in the community, but recognize that deep-seated differences in values and beliefs will preclude consensus on some issues. Treat these differences with respect, while encouraging and supporting the groups who espouse them to develop prevention programs consonant with their beliefs. Strive for unity of principle (i.e. the importance of reducing teen pregnancies and STDs) while respecting diversity of means.

This strategic plan represents a modest, mainstream approach to teen pregnancy and STD prevention. Surely a community with the wealth of resources that Charlottesville and Albemarle County enjoys can find the will to implement it.
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APPENDIX A: STRATEGIC PLANNING WORK GROUP MEMBERS

Institutional affiliations are shown only to identify the individual members of the Strategic Planning Work Group, and are not meant to imply institutional endorsement of this document.

SMALL WORK GROUP

John F. (Jack) Marshall, Ph.D. (Chair) – Applied Anthropologist; Council on Adolescent Pregnancy Prevention (CAPP)
Joseph Allen, Ph.D. – Psychologist; Department of Psychology, University of Virginia
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Mary Sullivan, M.Ed. – Family Life Education Consultant; Council on Adolescent Pregnancy Prevention (CAPP)

LARGE WORK GROUP
Debra Abbott – Educational Programs Director, MACAA; Director, Beating the Odds, Camp Horizon, Project Discovery, Young Guys of Distinction
Saphira Baker – Director, Charlottesville/Albemarle Commission on Children and the Family
Maureen Burkhill – Associate Director, Teensight at FOCUS; CAPP
Betsy Collins – Childbirth Education Coordinator, Martha Jefferson Hospital; Chair, CAPP
Bonnie Drumm – parent; community activist
Kate Gaston – Principal Associate, JUST Solutions, Evaluation and Planning
Tonya Grinde – The Women’s Place, University of Virginia Health System
Allen Hughes – Comdial Corporation; United Way Program Review and Funding Committee
Carol Grace Hurst – CYFS Runaway Program
Susan McLeod, M.D. – Director, Thomas Jefferson Health Department
Alicia Lugo – Director, Teensight at FOCUS
Helen Marek – Albemarle County Department of Social Services
Diantha McKeel – Albemarle County School Board; The Women’s Place, UVA Health System
Rhonda Miles – Upward Bound Program at University of Virginia
Ray R. Mishler – Vice President, Development and Community Relations, Martha Jefferson Hospital
Melody Jane Moore – United Way, Thomas Jefferson Area
Warrick Palmer – Coordinator, Young Guys of Distinction at MACAA
Kathy Parker – Past Executive Director, Planned Parenthood of the Blue Ridge
Linda Peacock – Assistant City Manager, City of Charlottesville
Sally Thomas – Albemarle County Board of Supervisors
Cathy Smith Train – President, United Way, Thomas Jefferson Area
Juan Diego Wade – Albemarle County Planning Department
Mick Watson – Coordinator, Teensight JTPA and Reach Boy’s Program
Rosanne Welker – Community Education Public Affairs Liason, Planned Parenthood of the Blue Ridge
Roxanne White – Assistant County Executive, County of Albemarle
Elizabeth K. Williams, M.D. – Pediatric Associates
APPENDIX B: THE STRATEGIC PLANNING PROCESS

The strategic plan in this document has been produced in direct response to a consensus recommendation made at a May 30, 1997, town meeting on "Partners in Teen Pregnancy and STD Prevention." The public meeting, sponsored by a consortium of organizations, was convened to review the community's present approach to teen pregnancy prevention and to suggest the next steps for concerted effort. Participants urged that four topics be addressed immediately: parents' communication with their children about sexuality and other subjects (repeating the theme from the 1995 Roundtable Discussion); after-school activities for teens; expansion into more public schools of existing teen pregnancy prevention projects; and strategic planning. A working group was established to deal with each issue.

The Strategic Planning Work Group began meeting in the summer of 1997, and adopted a two-tier approach, a result of the difficulty finding more than a few volunteers who could spend much time on the plan. The initial research, the preliminary preparation of documents, and the rewriting of drafts was undertaken by the "small group." This group consisted of six community members who were in some way professionally involved with teen pregnancy/STD prevention and who were willing to devote considerable time to the exercise. The small group averaged about two meetings per month over the year, in addition to research and writing by individual members. The drafts were critically reviewed by the "big group," which represented a broader spectrum of the community including knowledgeable citizens who had less time to spend on the effort; this group met about seven times. The members of both groups are listed in Appendix A.

A Mission Statement was adopted by the Work Group early in the process to direct the community focus of the Strategic Plan:

All teens are entitled to opportunities to fulfill their potentials. An adolescence characterized by respect, good health, avenues for learning, and hope for the future provides such opportunities. Pregnancies and sexually transmitted diseases during adolescence rob youth of these opportunities.

Our mission is to prevent adolescent pregnancies and sexually transmitted diseases through a comprehensive, community-wide, collaborative effort.

31 The organizations were The Albemarle Department of Social Services; Charlottesville Department of Social Services; Council on Adolescent Pregnancy Prevention (CAPP); Martha Jefferson Hospital; Thomas Jefferson Health Department; Teen Pregnancy Steering Committee of the CACY Commission; The Woman's Place; UVA Teen Health Center
that promotes abstinence, self-respect, constructive life options, and responsible decision-making about sexuality.

To avoid reinventing the wheel, the small group initially sought to identify and build on ideas from other communities' strategic plans. Despite networking through national teen pregnancy organizations and working through the internet, few appropriate community-level strategic plans for teen pregnancy/STD prevention could be found. An early meeting of the Big Group, however, was devoted to discussion with the Teen Pregnancy Prevention Coordinator in Roanoke, who was instrumental in the development of her city's strategic plan. The group devoted a great deal of attention to reviewing the literature assessing the impact of programs tried elsewhere (see section I.C.).
In Charlottesville and Albemarle County notable variation exists among the numbers of teens at 10-17 years of age and those at 18 and at 19 years. This occurs because 18- and 19–year-olds move into the area to attend the University of Virginia and Piedmont Virginia Community College, swelling the census figures. Because many of the older teens are college students living away from home, and because many of the younger teens are physiologically and behaviorally distinct from older teens, for many purposes it is useful to examine teen pregnancy data in three age groups: 10-14, 15-17, and 18-19.

**APPENDIX C.** Teen female population by age, Charlottesville and Albemarle County, by age, 1990*

*Special printout of the 1990 Census data for CAPP, by the UVA Academic Computer Center, 1993*
APPENDIX D. Number of pregnancies among girls aged 10-19 and 10-17 years, Charlottesville and Albemarle County, by year, 1988-1997
For many purposes, even more important than the number of teen pregnancies is the rate of teen pregnancies. A pregnancy rate takes into account the size of a specific population which is “at risk” of pregnancy (e.g. all teen females from 10-19, or all Charlottesville teen females aged 15-19), and indicates how many pregnancies occur per thousand females. This allows direct comparisons among groups of females (e.g. American teens and French teens), or among the same group at different times (e.g. Charlottesville teens in 1990 and in 1997).

\[
\text{Number of pregnancies to teen females in a population = \frac{\text{No. of pregnancies to Va females aged 15-19}}{\text{Number of Virginia females aged 15-19}}} \times 1000 = \text{teen pregnancy rate}
\]

For example, in 1990 for the entire state of Virginia, the pregnancy rate for teens aged 15-19 was 90.4.

\[
\text{No. of pregnancies to Va females aged 15-19 = 19,236} \times 1000 = 90.4
\]

APPENDIX E. Calculating teen pregnancy rates
APPENDIX F. Pregnancy rates (per 1000) for girls age 15-19, Charlottesville and Albemarle County, by year, 1990-1997
APPENDIX  G. Number of teen pregnancies by age group, Charlottesville and Albemarle County, 1997
APPENDIX H. Pregnancy, birth, and abortion rates (per 1000) for females aged 15-19, by race, Charlottesville and Albemarle County, 1996
APPENDIX I. Percentage of teen pregnancies ending in abortion, Charlottesville and Albemarle County, by year, 1990-1997
APPENDIX J. Percentage of public high school students in Virginia who have had sexual intercourse, 1992*

* Department of Education, 1992
APPENDIX K. Percentage of students nationally who have had sexual intercourse, by age, 1995*

* Moore et al., 1998
APPENDIX L: Summary descriptions of local programs, projects, and organizations involved in teen pregnancy and/or STD prevention

This appendix lists alphabetically and briefly describes the local organizations and agencies directly and indirectly involved in preventing teen pregnancy and/or treating sexually transmitted diseases. Because programming changes over time to meet the perceived needs of the target populations, and because the number of teens seeking or willing to participate in services varies, the descriptions below are necessarily more general than specific at points.

For a more comprehensive list covering over 300 local agencies that provide social, health, or other services to children and youth, we recommend the Guide to Youth Services for the Charlottesville/Albemarle Community, 1999-2000. This 107-page document was published in May 1999 jointly by the Charlottesville/Albemarle Commission on Children and Families (CCF) and the Information & Referral Center of the United Way, Thomas Jefferson Area.

AIDS/HIV Services Group of Charlottesville
700 Harris Street, Charlottesville, VA 22903
804-979-7714
The ASG provides condoms, dental dams, and lubricants as part of the safe sex kits distributed through their outreach programs. The ASG Education Department offers a peer education program called HIT SQUAD (HIV Intervention for Teens) that trains high school students to teach the facts about HIV/AIDS in any classroom, such as History or English. The ASG outreach workers are trained to work with all at-risk populations and use various educational models to encourage behavioral change, such as (1) multiple sessions that encompass information about STDs and sexual negotiation and communication skills; (2) one-on-one prevention case management in a series of meetings that focus on the individual’s behaviors and potential risk-reduction. Annually, ASG serves approximately 90 case clients and reaches approximately 12,000 people through education and outreach programs. These programs are funded by the Virginia Department of Health and fundraising efforts. Evaluation tools are designed by ASG staff with the support of the Virginia Commonwealth University Survey and Research Lab and the University of Virginia Evaluation Department.

ARC of the Piedmont—Infant Development Project
509 Park Street, Charlottesville, VA 22902
804-977-4002
The Infant Development Project (part of the Growing Healthy Families Collaborative) provides home visits to infants (birth through three years) who are at risk of developmental disabilities. As part of this services, ARC works with mothers to help create a stimulating environment for their children. The Project also counsels mothers of infants at risk of disabilities to postpone subsequent pregnancies. ARC does not keep statistics on teen mothers served. Serves the City of Charlottesville, as well as the counties of Albemarle, Green, Fluvanna, Louisa, and Nelson.

Boys and Girls Clubs
Smith Recreation Center, Cherry Avenue, Charlottesville VA 22902
804-977-2001 (Harold Young and Dave Hilyard)
The Boys and Girls Clubs offer recreational, instructional, and social activities for boys and girls aged 6-18. A series of programs begun in November of 1998 specifically address the risks of drug and alcohol abuse as well as teen pregnancy. Groups form 3-4 times per year with 12-15 participants each. Smart Moves, for 13-15 year olds, and Smart Start, for 10-12 year olds, run 1-2
hour weekly sessions for 13 weeks; Smart Kids, for 6-9 year olds, runs for 6 weeks; Smart Parents helps parents of 13-15 year olds recognize indicators of risky behavior. The programs are too new to have completed evaluation.

**Boy Scouts of America, Stonewall Jackson Area Council**  
801 Hopeman Parkway, P.O. Box 813, Waynesboro, VA 22980  
540-943-6675  
Offers a program for which youth and adults are intended to develop character, citizenship, mental and physical fitness, and are reinforced through advancement, activities, and outdoor programs. Provides no specific teen pregnancy/STD prevention education or services.

**Charter Behavioral Health System of Charlottesville**  
2101 Arlington Blvd., Charlottesville, VA 22903  
804-977-1120  
800-552-2208  
Provides short- and long-term residential care for teens with psychiatric or substance abuse issues. Only local hospital that provides separate adolescent programming, specifically designed for 11-18 year olds. Number of teens served varies.

**Charlottesville Free Clinic**  
1138 Rose Hill Drive, Charlottesville, VA 22903  
804-296-5525  
Volunteer health professionals provide free primary, acute mental health and follow-up services to people without health insurance who do not qualify for free care at other sites. Teen clients seeking reproductive health care are referred to the Teen Health Center.

**Charlottesville Pregnancy Center**  
320 West Main Street, Charlottesville, VA 22903  
804-979-8888  
Counseling programs are available to provide women with information about pregnancy and pregnancy alternatives. Abortion is discouraged, and abstinence is the only approved pregnancy/STD prevention method for unmarried teens. The Center serves approximately 100 clients per month, seeing each client an average of three visits. Evaluation is informal. Funding is provided through local churches, small grants, and private donations. The Center's educational component uses a program that combines methods and ideas from a number of national abstinence-only education programs.

**Children, Youth, and Family Services**  
116 West Jefferson Street, Charlottesville, VA 22902  
804-296-4118  
Promotes the healthy growth of children and the positive development of family relationships by providing a continuum of services from prevention to mediation. Services include individual and family counseling, parent education, respite care, and the Runaway Emergency Shelter program for all income levels in the locality.

**Community Attention**  
907 East Jefferson Street, Charlottesville, VA 22902  
804-970-3577  
All Community Attention programs counsel and/or educate teens on pregnancy issues in either individual or group formats. Community Attention works with other local agencies--such as the Teen Health Center, Teen Pregnancy Prevention, PAT, SARA, TEENSIGHT--to educate and
advise clients on such issues. Provides a teen volunteer service program, Teens GIVE, that serves up 40 youths per day in spring, summer, and fall sessions. Similar programs have been shown effective in reducing teen pregnancy. Community Attention programs served approximately 420 teens in FY 1998.

Council for Adolescent Pregnancy Prevention (CAPP)
Contact: Mary Sullivan
804-974-6390
P.O. Box 3092, Charlottesville, VA 22903
CAPP’s primary function is as a support network and information clearinghouse for local professionals and others interested in pregnancy prevention; it also works to strengthen community policies and programs regarding teen pregnancy/STD prevention, issues a monthly newsletter, and organizes an annual public awareness campaign. CAPP does not provide direct services to teens, except for distributing a “Teen Help Card” (listing telephone numbers of community services) and a flyer describing local family planning services for teens, and paying for needy teens’ taxi fare to family planning clinic appointments.

Elizabeth Project
Contact: Leslie Harris
804-980-3164
Biblically based project pairs young pregnant women (Marys) with supportive Christian women (Elisabeths) for 12-week sessions discussing prenatal, childbirth, and child-rearing issues. The Project is a pregnancy intervention program that seeks to enable adolescents to give birth to healthy babies through education and encouragement. The goal is to help each Mary realize her influences on her baby’s development, to help her gain confidence to make healthy decisions and choices. The Project seeks to collaborate with the adolescent community services and health care providers. Evaluation is informal. Serves approximately 8-24 young women each year, depending on enrollment. Sponsored and administered through the Virginia Council of Churches.

FOCUS
1508 Grady Avenue, Charlottesville, VA 22903
804-295-8336
Funding for the following three programs administered through FOCUS derives from a combination of local funds and outside grants.

Teensight is a small program aimed at in-school pregnant and parenting teens. It forces the participants to deal with the reality of parenting, thus encouraging them to avoid another pregnancy. The program also assists each participant in caring for her child, finishing school, and becoming a good mother. Employability skills training is also offered. TEENSIGHT operates in all local high schools and served 67 teens through the 1997-98 school year. It costs approximately $10,000 per year. Evaluation suggests that it is effective reducing pregnancy rates and increasing education completion rates for participants; in the years 1990-1998, TEENSIGHT enrolled 757 teens with a repeat pregnancy rate ranging from only 1.5-10%, as compared to the national average of 40%.

Reach: this component of the Teensight project, begun in July 1996, uses an innovative peer advocacy and parental involvement program to prevent at-risk teen girls in Charlottesville and Albemarle County from becoming pregnant. Martha Jefferson Hospital was the initial founder and supporter. Focusing primarily on middle and high school girls, the program uses pregnant and parenting teens as advocates and adults as mentors; works with community agencies to create a network of services and resources;
includes life skills and sexuality education for both participants and advocates; targets at-risk boys for parallel services and activities with adult male role models; emphasizes parental involvement and parent education; place each participant in a volunteer position with MJHospital. A strong emphasis on evaluation and case studies helps to establish better use of community resources. Home visits, tutors, transportation assistance, and support groups for the mothers of participants are also available.

**JTPA (Job Training Partnership Act):** This component of the TEENSIGHT project assists with education and employment for economically disadvantaged youths and adults. It serves youths aged 15-21 in Planning District 10, and serves youths and adults in Planning District 9. JTPA provides long-term training, pre-employment maturity skills, job development and placement assistance, counseling, and financial assistance with tuition, child care, transportation, books, material, and supplies. Since 1989, 660 individuals have been enrolled in Teensight JTPA, with 81% entering employment after graduation.

**Garnett Day Treatment Center**
1 Garnett Center Drive, Charlottesville, VA  22901  
804-977-3425  
Psychiatric day treatment center for youth offering counseling on an individual basis, in a group setting, and to families; also offering supplemental educational and emergency services.

**Girl Scouts of the USA, Virginia Skyline Council**
Contact: Mary Inge, Field Director  
804-286-5156  
1707 Allied Lane, Charlottesville, VA  22903  
Committed to helping girls 5 to 17 years develop their fullest potential and become responsible, resourceful women. The Girl Scouts have a national program to deal with teen pregnancy prevention; it is not implemented locally.

**Monticello Area Community Action Agency (MACAA)**
1025 Park Street, Charlottesville, VA 22902  
804-295-3171  
Funding for the following three programs administered through MACAA derives from a combination of local funds and outside grants.

**Beating the Odds** is a small program that provides services to children aged 8-11. Local schools select the children served, 16 children in the city of Charlottesville and 16 children in the county of Albemarle. Two sites in each jurisdiction provide space for sessions. The program helps the children develop resilience skills, long-term goals and strategies to deal with peer pressure and conflict. For those children identified as having been sexually abused, a Region 10 counselor provides more intensive services. In addition, approximately 40 students from previous years’ programs receive follow-up services. The program costs approximately $50,000 per year. The program is too new to have completed evaluation.

**Camp Horizon** is a primary pregnancy prevention program that provides services similar to those described for Beating the Odds for 100 girls aged 11-14 who live in the city of Charlottesville. Participants are chosen with help from the schools, parents, and self-referral. The program cost $38,000 per year. The **Steppin’ Up** component trains Camp Horizon graduates to become peer leaders. Training topics include mediation skills and
sexuality education. Evaluation suggests that this program has a significant effect on the pregnancy rate of its participants.

**Young Guys of Distinction** is a male companion program to Camp Horizon. Serving 30 young men aged 12-15 living in the city of Charlottesville, the curriculum stress issues of academic achievement, responsibility, and success in home and school. Mentors serve as role models. The program costs $30,000. The program is too new to have completed evaluation.

**March of Dimes**
1160 Pepsi Place, Suite 114-A, Charlottesville, VA 22901
804-973-3463
Non-profit charitable organization providing services, education, and research related to [preventing] birth defects.

**Piedmont Family YMCA**
Contact: Bob Vanderspiegel, Executive Director
442 Westfield Road, Charlottesville, VA 22901
804-974-9622
Aimed at putting Christian principles into practice through programs that build healthy spirit, mind, and body. Includes recreation, fitness and character building, child care, youth leadership and youth sports. No specific activities aimed at teen pregnancy/STD prevention.

**Planned Parenthood of the Blue Ridge, Inc. (PPBR)**
1928 Arlington Blvd., Suite 100, Charlottesville, VA 22903
804-296-2330
PPBR, a non-profit agency, offers confidential, respectful, and affordable reproductive health care on a sliding scale. Services include routine gynecological care; family planning and contraceptives; pregnancy testing and counseling; referrals for prenatal care, adoption and abortion services; STD/HIV testing and treatment; patient counseling and education to reduce risk behaviors. The Education Department provides professional training for family life education teachers, counselors, health care, and other professionals. Workshops on sexuality issues are also offered to teens, school or church groups, and parents. The Resource Center offers videos, books, and research packets on sexuality issues. PPBR also provides advocacy for reproductive rights. The PPBR clinic served approximately 33 teens under the age of 18 and 147 young women aged 18-19 in 1998. The PPBR education department served approximately 1,980 clients in 1998. Funding is secured through patient services, fundraising, private donations, and education fees.

**Project LINK**
300 West Main Street, 2nd Floor, Charlottesville, VA 22902
804-972-1760
Project LINK serves women and children affected by chemical dependency. Through home visits, resource counselors provide information, referrals, transportation, and emotional support. Programs are tailored to meet each client’s needs. When enough teens are clients, support and educational groups are formed. Serves approximately 10-15 pregnant and parenting teens per year.
Region Ten Community Services Board
800 Preston Ave., Charlottesville, VA 22903
804-972-1800
Regional agency responsible, within Planning District 10, for planning, developing, funding, and operating mental health, mental retardation, and substance abuse services in the community.

Runaway Emergency Shelter (Children, Youth, and Family Services)
804-977-4260
Provides shelter and informal educational material (video tapes, pamphlets, etc.) for teens in need. Number of teens served per year was not available.

Sexual Assault Resource Agency (SARA)
P. O. Box 6705, Charlottesville, VA 22906
804-295-7273
SARA supports survivors of sexual assault and seeks to prevent harassment, assault, and incest. Services include individual counseling, sexual assault prevention programs for elementary schools through college, self-defense classes, outreach, legal advocacy, and a volunteer-staffed hotline. In addition, SARA has collaborated with the Shelter for Help in Emergency (SHE) to create a peer education group called Voices for Interpersonal Violence (VIVA). VIVA provides a teen-driven forum for awareness, discussion and education regarding sexual violence and harassment, and for encouraging healthy relationships. SARA served approximately 11,025 people through educational programming in fiscal year 1997-98. SARA served 357 primary victims, of which 41 were under the age of 18, in fiscal year 1997-98.

Teen Health Center/UVA
1400 West Main Street, Charlottesville, VA 22903
804-982-0090
The Teen Health Center offers routine adolescent health care for teens aged 12-20, seeing approximately 300 patients per month. Services include routine checkups, acute medical problem care, routine gynecological care, immunizations, pregnancy testing and counseling, prenatal and postpartum care, family planning and contraceptives, STD/HIV testing and treatment, patient counseling and education to reduce risk behaviors. Community outreach offers group education for health care professionals, teens, school or church groups, and parents. The Center will begin training ten teens as peer health and wellness educators, including sexuality issues and pregnancy prevention.

Thomas Jefferson Health Department
1138 Rose Hill Drive, Charlottesville, VA 22093
804-972-6237 (Family Planning)
804-972-6217 (STDs/HIV)
The TJ Health Department (or District) provides basic health care services to the community. For adolescents, the Department offers immunization, family planning and contraceptives, pregnancy testing and counseling, STD/HIV testing and treatment, partner notification for gonorrhea, syphilis and HIV, confidential and/or anonymous HIV testing, individual counseling and education to reduce risk behaviors, and educational programs to groups including schools. For pregnant adolescents and teen mothers, the Health Department provides nutrition counseling and supplemental foods (WIC program). In addition, assessment, referral and case management services are offered as part of the Growing Healthy Families initiative.
APPENDIX M: Calculating the economic benefits of current and proposed teen pregnancy prevention programs

Chapter V.B. describes our methods for calculating the economic benefits of the births averted by Camp Horizon. The method of calculating the benefits of the other community teen pregnancy prevention programs follows the approach used for Camp Horizon, though the assumptions about the number of births averted, and other components of the calculation, must be adjusted. In this appendix we describe those adjustments.

For **Beating the Odds**, we assume its effect will be the same as Camp Horizon. Beating the Odds is too new to evaluate in the same way as Camp Horizon, but the two programs are similar in both structure and management. The three necessary adjustments occur because the average Beating the Odds participant is 10 years old, and participants can participate for 3 years. Thus there are two more years to give birth (at very low rates) and cost savings must be discounted two extra years. After making the necessary adjustments, the conservative estimate of benefits is $85.9 thousand, and the more realistic estimate is $180.0 thousand. We assume that the proposed expansion of Beating the Odds will result in benefits proportional to its size. This leads to added estimated conservative benefits of $109.2 thousand and more realistic benefits of $240.6 thousand.

For **Teensight**, the calculations change because the birth rate for participants changes to 1.0% and the average age of participants is 16 with two years of participation. After making the necessary adjustments, the conservative estimate of benefits is $114.2 thousand, and the more realistic estimate is $220.8 thousand. We assume that the proposed expansion of Teensight will result in benefits proportional to its size. This leads to added estimated conservative benefits of $114.2 thousand and more realistic benefits of $220.8 thousand.

The **Reach** program is hard to evaluate; we assume it is an average of a Teensight program and a Teens Give program (described below). Presently, this program is too new to evaluate in the same way as Camp Horizon. So our assumption is really just a guess. However, because it has a significant volunteer component (like Teens Give) and also has features similar to Teensight and the same management as Teensight, our assumption seems reasonable. The average age of participants is 14 years with three years of participation. This implies a teen conservative birth rate of participants of \( (0.01 + 0.5 \times 0.167)/2 = 0.0468 \) and a more realistic rate of \( (0.01 + 0.5 \times 0.335)/2 = 0.089 \). After making the necessary adjustments, the conservative estimate of benefits is $46.8 thousand, and the more realistic estimate is $95.8 thousand. We assume that the proposed expansion of Reach will result in
benefits proportional to its size. This leads to added estimated conservative benefits of $33.4 thousand and more realistic benefits of $68.4 thousand.

The **Young Guys of Distinction** program is modeled like Reach, so we make similar assumptions. After making the necessary adjustments, the conservative estimate of benefits is $46.8 thousand, and the more realistic estimate is $95.8 thousand. We assume that the proposed expansion of The Young Guys of Distinction program will result in benefits proportional to its size. This leads to added estimated conservative benefits of $93.6 thousand and more realistic benefits of $191.6 thousand.

**Teens Give** is very much like the programs described in [the earlier section]. Though there have been no formal studies of its effect on teen pregnancy, in other ways (e.g., school performance, criminal recidivism) it has performed very well. We can therefore assume it is like one of the national volunteer-oriented programs and reduces teen pregnancy by 50%. The average age of participants is 15. This implies, conservatively, a teen birth rate for participants of 59.3 (per thousand) and a more realistic rate of 117.0 (per thousand). After making the necessary adjustments, the conservative estimate of benefits is $341.0 thousand, and the more realistic estimate is $648.4 thousand. We assume that the proposed expansion of Teens Give will result in benefits proportional to its size. This leads to added estimated conservative benefits of $115.6 thousand and more realistic benefits of $219.8 thousand.
APPENDIX N: PRELIMINARY ACTION AGENDA

This Action Agenda is simply a reorganization of the recommendations in the body of the Strategic Plan, proposing who should do what with whom to reach the strategic goals. It is not intended to usurp organizations’ autonomy by assigning them work, but rather to begin a process of turning this plan into action. This Agenda is tentative; it can and should be revised as leaders of local agencies examine the Strategic Plan in terms of their own organizational goals, objectives, and capabilities.

Some activities - those requiring only administrative decisions, reallocation of existing resources, and/or political will -- could be initiated immediately. Others - those needing additional resources, organizational adjustments, or new leadership -- will necessarily be delayed until funding or infrastructure is in place. All proposed actions can be undertaken immediately unless otherwise noted.

**Teen Pregnancy/STD Prevention Steering Committee** is to be a new group composed of the existing Strategic Planning (Small) Work Group of the Task Force on Teen Pregnancy Prevention and/or a new Study Group of the Commission on Children and Families.

- Guide the effort to obtain support for the Strategic Plan from organizations and leaders in the Charlottesville/Albemarle community, and encourage implementation of the Plan’s recommendations.

- Prepare grant requests to fund (a) a part-time position of Teen Pregnancy/STD Prevention Coordinator, (b) social marketing campaigns, (c) educational materials to be used by schools, religious groups, business, civic groups, etc., (d) other activities proposed in this Strategic Plan. Assist local agencies in preparing grant requests to expand their programs or develop new ones.

- [If funds are available for the Coordinator position] Provide support and guidance to the Teen Pregnancy/STD Prevention Coordinator.

- Assess progress toward achieving the strategic goals. A year from the date of distribution of the Strategic Plan - in September 2000 - and again in September 2001, the Steering Committee should examine the degree to which the recommendations in this Strategic Plan have been implemented. Needs should be reassessed, priorities revised, and the Action Agenda updated.
Commission on Children and Families

- Create a “Work Group” to focus on teen pregnancy/STD prevention. Consider asking this Group to become, or be part of, the Teen Pregnancy/STD Prevention Steering Committee (see above) that will operationalize and guide the implementation of the recommendations in this Strategic Plan.

- Collaborate with other community organizations to design and implement public awareness/social marketing campaigns for teen pregnancy/STD prevention.

- Consider in the future establishing teen pregnancy/STD prevention as one of the organization’s “Priority Issues.” Serve as a focal point of leadership and advocacy for teen pregnancy/STD prevention activities in the community.

Parents

- Assume greater responsibility for the sexual behavior of one’s children.

- Strengthen the ability to communicate with children about developmental issues, including responsible sexual behavior, and to articulate one’s own values.

- Ensure that children receive yearly comprehensive preventive health-care checkups which include reproductive health.

Schools, School Boards, and School Health Advisory Boards (city and county)

- Re-examine and improve the Family Life Education (FLE) programs
  -- Ensure that there is a clear locus of responsibility and advocacy in each school system.
  -- Increase the number of hours children are exposed to FLE (whether through schools or in other community programs), and extend FLE to the eleventh and twelfth grades (within existing financial constraints and the demands created by state SOL accreditation requirements).
  -- Update the content and teaching methods for FLE, incorporating techniques and resources that have been demonstrated to actually lead to reductions in teen pregnancy/STD risk behavior; most importantly, include more skill-building exercises.
  -- Provide for refresher training and support for FLE teachers (in collaboration with specialists from local agencies).
-- Evaluate the quantity, content, and quality of individual FLE teaching; encourage peer coaching among FLE teaching.
-- Involve parents more in the schooling - including FLE - of children at all ages; build in parent-child homework assignments.

• Strengthen teen pregnancy/STD prevention efforts outside the FLE curriculum
  -- [if funds become available] Encourage the expansion into schools of existing pregnancy/STD programs aimed at high-risk students (e.g. MACAA’s Beating the Odds; Teensight at FOCUS’s Reach)
  -- Continue to provide students with access to trusted professionals (counselors, psychologists, health care professionals, etc.) who are knowledgeable about youth-related reproductive health issues.
  -- Consider introducing student peer-education programs designed to counter misinformation about sexuality among students; collaborate with local agencies for technical assistance and funding.
  -- Increase student involvement in volunteer programs.
  -- Facilitate students’ access to off-campus health-care clinics, and investigate the possibility of establishing school-based health clinics.
  -- Permit carefully selected social science research on teen pregnancy/STD prevention to be carried out within the student population.

Monticello Area Community Action Agency (MACAA)

• Continue current programs (i.e. Beating the Odds, Camp Horizon, and Steppin’ Up); in conjunction with the Teen Pregnancy/STD Prevention Steering Committee, seek funds to expand these programs.

Teensight at FOCUS

• Continue current programs (i.e. Teensight and Reach); in conjunction with the Teen Pregnancy/STD Prevention Steering Committee, seek funds to expand these programs.

Youth-Serving Organizations (Boys and Girls Club; Boy Scouts; Girl Scouts; YMCA; 4-H Club; etc.)

• Strengthen activities and programs that contribute to teen pregnancy/STD prevention; seek guidance from national organizational headquarters, and from local specialists.
Religious groups

- Address issues of teen pregnancy and STD prevention more explicitly, in accordance with denominational and congregational beliefs.
- Seek educational support from national church headquarters and from local specialists.

Regional employers

- Strengthen efforts to provide a “family-friendly” environment that encourages parents to be involved in children’s lives.
- Expand opportunities for employees to participate in volunteer youth programs.
- Consider establishing/expanding links with a school or community youth project (particularly volunteer programs), and work with the Charlottesville Area School Business Alliance.
- Help fund teen pregnancy/STD prevention efforts in the community; for businesses with a special link to teens, help provide information about pregnancy/STD prevention.

Local governments (i.e. City of Charlottesville and Albemarle County)

- Provide funding for
  (a) expansion into schools of existing pregnancy/STD programs aimed at high-risk students (e.g. MACAA’s Beating the Odds; Teensight at FOCUS’s Reach); and
  (b) new and expanded youth volunteer activities.
- If, at the end of the initial three-year trial period for the position of Teen Pregnancy/STD Prevention Coordinator, an evaluation suggests that the Coordinator has been cost-effective, assume responsibility for funding the position.

Community foundations and other local donors

- Provide funding for
  (a) the new part-time position of “Teen Pregnancy/STD Prevention Coordinator” for an initial three-year period;
(b) social marketing campaigns (e.g. to reaffirm community values discouraging teen pregnancy; to encourage parent-child communication);
(c) educational materials to be used by schools, religious groups, business, civic groups, etc.;
(d) local research that would contribute to teen pregnancy/STD prevention.

• Share with local governments responsibility for funding for the expansion of existing prevention programs for high-risk youth of MACAA, Region Ten, and FOCUS, both in and out of schools, and for new youth volunteer programs.

**Health care providers: General**

• Stay current about adolescent reproductive health issues, including relevant laws.

• When dealing with teens and pre-teens, follow the AMA guideline promoting age-specific messages about sexual development, and devote more attention to reproductive health during check-ups of youth. Ensure that teens know where to confidentially obtain reproductive health care information and services.

• Increase local educational outreach on adolescent reproductive health issues; volunteer to participate in the Speakers’ Bureau organized by CAPP.

• Test adolescents more frequently for STDs.

**Martha Jefferson Hospital**

• Continue to provide funding to direct teen pregnancy/STD prevention programs and the CAPP Transportation Fund.

• [If funds are available for the Coordinator position] Provide office space, supervision, and administrative support (not necessarily secretarial assistance) for the proposed Teen Pregnancy/STD Prevention Coordinator.

• [If funds are available for the Coordinator position] Administer grants for selected teen pregnancy/STD prevention activities, such as donations for sexuality education in the community.
Planned Parenthood of the Blue Ridge (PPBR)

- Continue to provide confidential reproductive health information and clinical services to teens and pre-teens; devote greater effort to informing local teens about the availability of services.

- Continue and expand the outreach program that provides educational specialists to local schools and organizations to speak about teen pregnancy/STD prevention; work with the proposed new CAPP Speakers’ Bureau.

- Renew the “Educating Children for Parenthood” program at Clark Elementary School or another school in Charlottesville; if evaluation shows it to be effective, offer to expand the program to other schools in the city and county.

- Continue to make available the PPBR Resource Center (with books, brochures, audiovisual materials, etc.) to teens and local groups.

- Collaborate with other community organizations to design and implement public awareness/social marketing campaigns for teen pregnancy/STD prevention.

Teen Health Center

- Continue to provide confidential reproductive health information and clinical services to teens and pre-teens; devote greater effort to informing local teens about the availability of services.

- Continue and expand the outreach program that provides educational specialists to local schools and organizations to speak about teen pregnancy/STD prevention; work with the CAPP Speakers’ Bureau.

Thomas Jefferson Health Department

- Continue to provide confidential reproductive health information and clinical services to teens and pre-teens; devote greater effort to informing local teens about the availability of services.

- Continue and expand the outreach program that provides educational specialists to local schools and organizations to speak about teen pregnancy/STD prevention; work with the CAPP Speakers’ Bureau.
**Council on Adolescent Pregnancy Prevention (CAPP)**

- Continue current activities that support teen pregnancy/STD prevention efforts in the community, including (a) the Transportation Fund (through a grant to CAPP from Martha Jefferson Hospital); (b) support to FLE teachers to attend training workshops and receive subscription to “Family Matters”; (c) annual production and distribution of the “Teen Help Card” and brochure describing local family planning services for teens; and (d) other support programs (e.g. speakers, seminars) and networking activities (e.g. monthly meetings, newsletters) to help local leaders exchange ideas and information.

- Provide encouragement and assistance to faith groups interested in developing teen pregnancy/STD prevention programs.

- Establish and maintain an active Speakers’ Bureau, arranging opportunities for local teen pregnancy/STD specialists to speak to community civic groups, parent and school organizations, faith communities, etc.

- Collaborate with other community organizations to design and implement public awareness/social marketing campaigns for teen pregnancy/STD prevention.

**United Way**

- Continue funding MACAA’s Beating the Odds and Teensight at FOCUS’s Reach; consider increasing funds to help the programs expand.

- Assist businesses in identifying opportunities for collaboration in youth volunteer programs and other activities that serve to help prevent teen pregnancies and STD (in conjunction with the Chamber of Commerce and CAPP).

- Take the lead in developing standardized data collection and evaluation strategies for community programs that serve youth.

**Local Media**

- Keep teen pregnancy and STD issues – both nationally and locally – in the public eye.

- Assist with local social marketing/public awareness campaigns regarding teen pregnancy/ STD prevention.