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.

Program	**Description**	**Cost per year**		
		Existing		**Proposed**
		Local Govern-ment	Other	
Beating the Odds (MACAA & Region Ten)	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)	$30,700	$15,300	
Beating the Odds	City expansion (1 FT MACAA, 1 PT Region Ten; 40 children @ Johnson, Burnley-Moran, Greenbrier, Venable)			$46,700
Beating the Odds	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)			$52,000
Camp Horizon (MACAA)	City at present (1 FT; 60 children)	$38,000	-0-	
Camp Horizon	County expansion (1 FT, travel $3750; 40 students @ Burley, Sutherland, Walton, Henley)			$30,000
Reach (FOCUS)	City and County at present (3 PT; 35 Children, 40 Parents, 20 others throughout city and county)	$67,700	$12,500	
Reach	County expansion (1 FT, 2 PT; 25 children @ 4 middle schools; travel, work experience costs, enrichment/travel experiences)			$75,000
Teensight (FOCUS)	County and city at present (3 PT, 58 teen moms @ 6 city and county high schools; travel, materials, and supplies)	$34,000	-0-	
Teensight	City and County expansion; 3 PT, 58 more teen moms)			$51,600
Young Guys of Distinction (MACAA & Teensight)	City and County at present (1 FT; 35 children at Walker, Buford, Westhaven)	-0-	$32,000	
Young Guys of Distinction	City and County Expansion (2 FT; 70 children at 3 County middle schools and 3 City elementary schools)			$64,000
Total Costs of Existing Programs		$170,400	$59,800	
Total Costs of Both Existing Programs and Proposed Expansions		$230,200		$319,300
Grand Total		$549,500		

FT = Full-time position; PT = Part-time position

Proposed expansion of programs

Table 1: Costs of current teen pregnancy/STD prevention programs and proposed expansions

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

	Cost per year		**Estimated Benefits per year**	
	Existing	**Proposed**	**Conservative**	**Realistic**
Total Costs and Benefits of Existing Programs	$230,200		$420,900	$855,900
Total Costs and Benefits of Proposed Expansions (for which benefits can be estimated)		$319,300	$439,300	$910,400
Grand Total Costs and Benefits of Existing Programs and Proposed Expansions (for which benefits can be estimated)	$549,500		$860,200	$1,766,300

Table 2: Total costs and estimated benefits of current teen pregnancy/STD prevention programs and proposed expansions

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.

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 <u>not</u> 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 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 .95 x .95 x .95 x .95 x .95 x $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, (.175 - .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 (.350 - .02) x $37,000 x .774 x 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 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 <u>teens who are sexually active</u>, 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.

<u>Pregnant teens</u> 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:

<u>Teen parents</u> 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 <u>all our youth</u> *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.

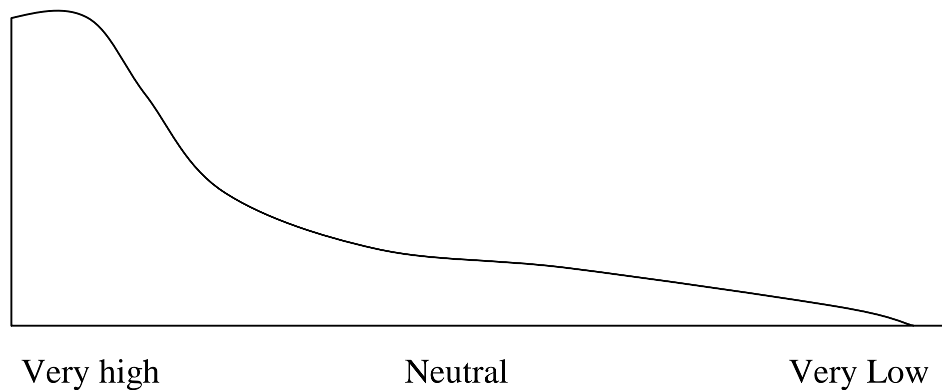

Figure 4. Graph representing hypothetical distribution of local teens' motivation to avoid becoming a teen parent

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

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
Dyan Aretakis, FNP/MSN – Nurse; Teen Health Center, University of Virginia
Cri Kars-Marshall, Ph.D. – Medical Sociologist; Council on Adolescent Pregnancy (CAPP)
Steven Stern, Ph.D. – Economist; Department of Economics, University of Virginia
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,[31] 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.

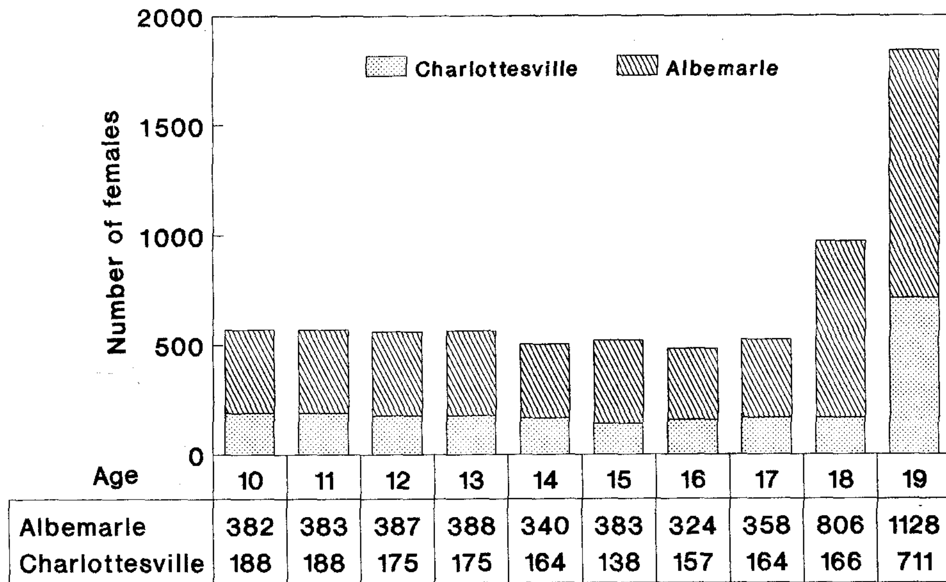
A Mission Statement was adopted by the Work Group early in the process to direct the community focus of the Strategic Plan:

> 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.).

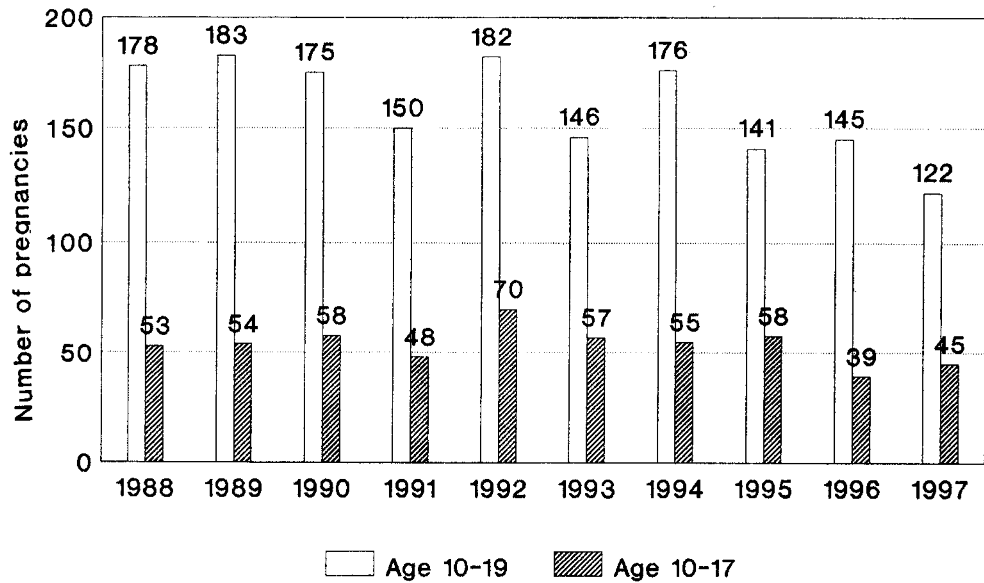


Age	10	11	12	13	14	15	16	17	18	19
Albemarle	382	383	387	388	340	383	324	358	806	1128
Charlottesville	188	188	175	175	164	138	157	164	166	711

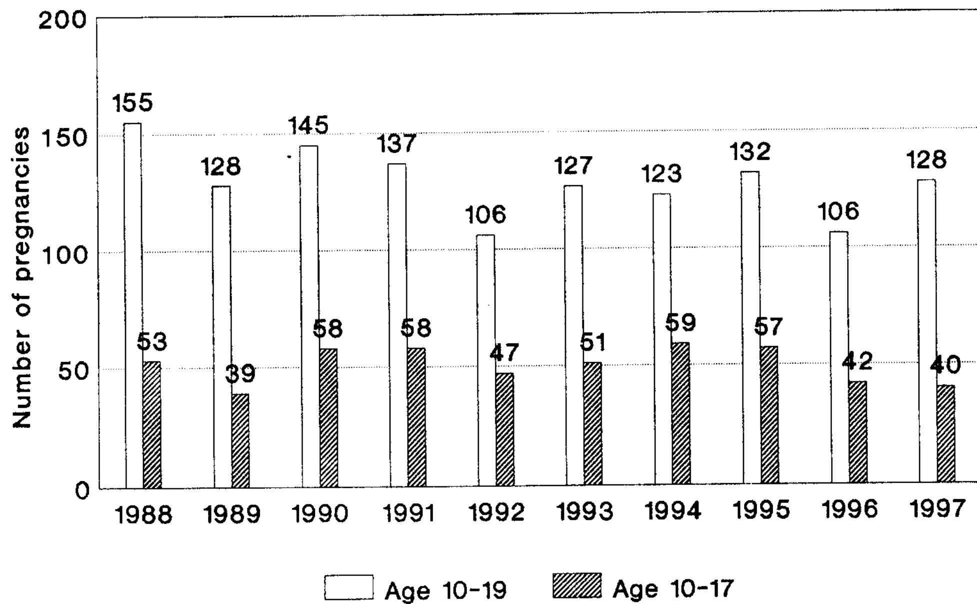
In Charlottesville and Albemarle County notable variation exists among the numbers of teens at 10-17 years of age and those at 18 and at 19 years. This occurs because 18- and 19–year-olds move into the area to attend the University of Virginia and Piedmont Virginia Community College, swelling the census 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



Charlottesville



Albemarle County

APPENDIX D. Number of pregnancies among girls aged 10-19 and 10-17 years, Charlottesville and Albemarle County, by year, 1988-1997

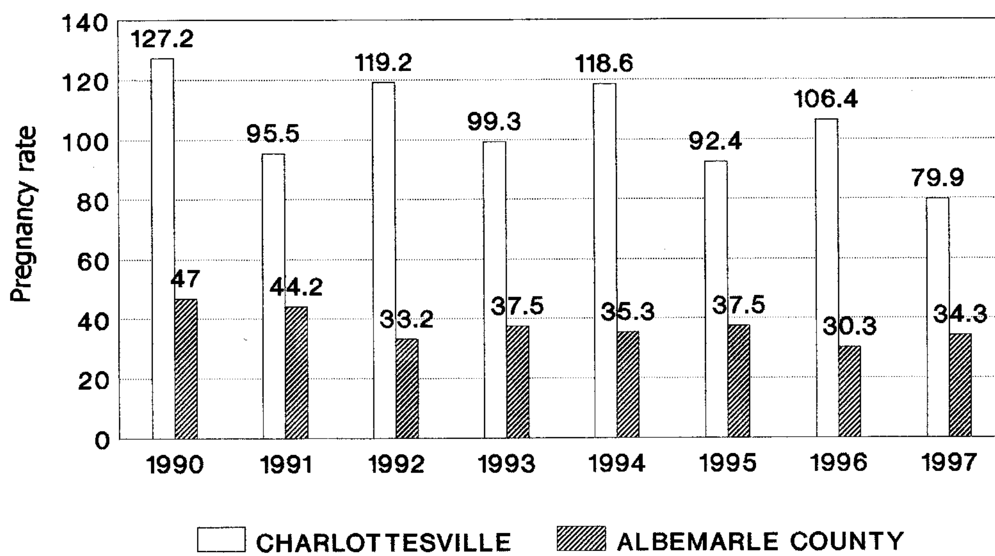
For many purposes, even more important than the **number** of teen pregnancies is the **rate** of teen pregnancies. A pregnancy rate takes into account the size of a specific population which is "at risk" of pregnancy (e.g. all teen females from 10-19, or all Charlottesville teen females aged 15-19), 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).

$$\frac{\text{Number of pregnancies to teen females in a population}}{\text{Number of teen females in the same population}} \times 1000 = \textbf{teen pregnancy rate}$$

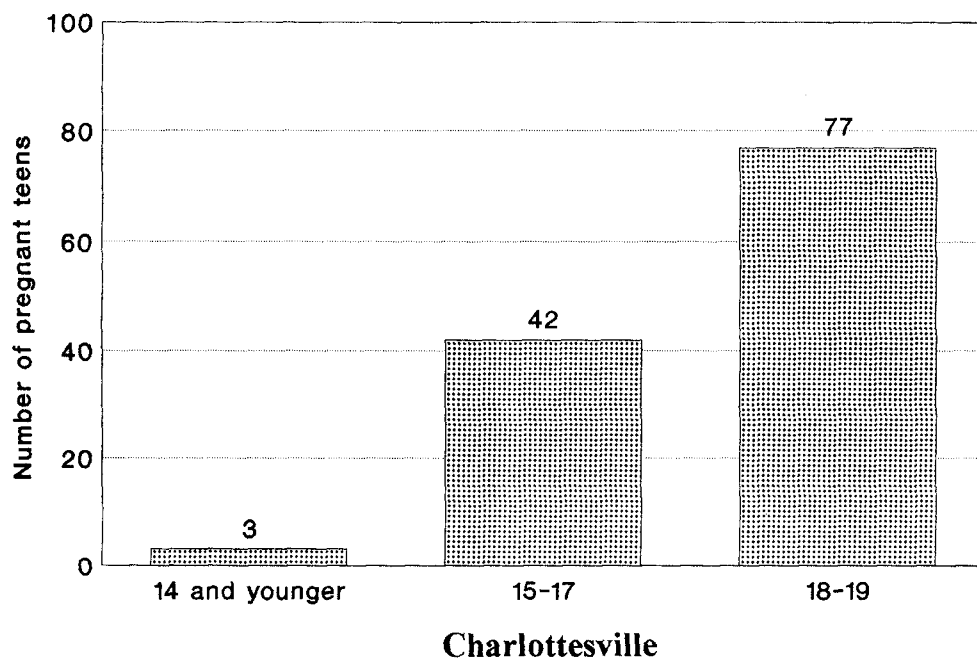
For example, in 1990 for the entire state of Virginia, the pregnancy rate for teens aged 15-19 was 90.4.

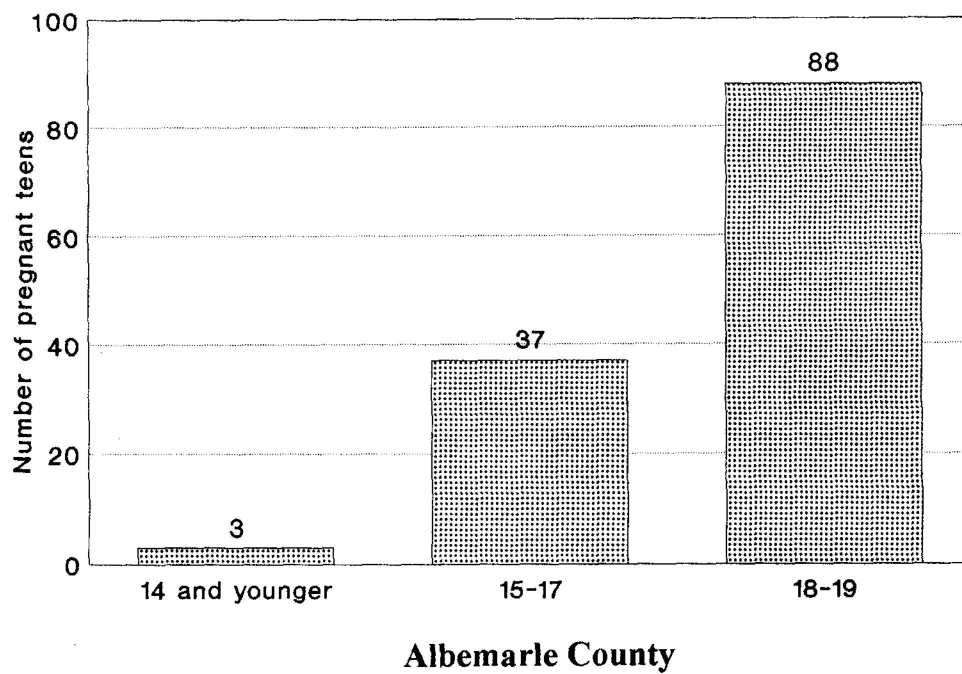
$$\frac{\text{No. of pregnancies to Va females aged 15-19} = 19{,}236}{\text{Number of Virginia females aged 15-19} = 212{,}892} \times 1000 = 90.4$$

APPENDIX E. Calculating teen pregnancy rates

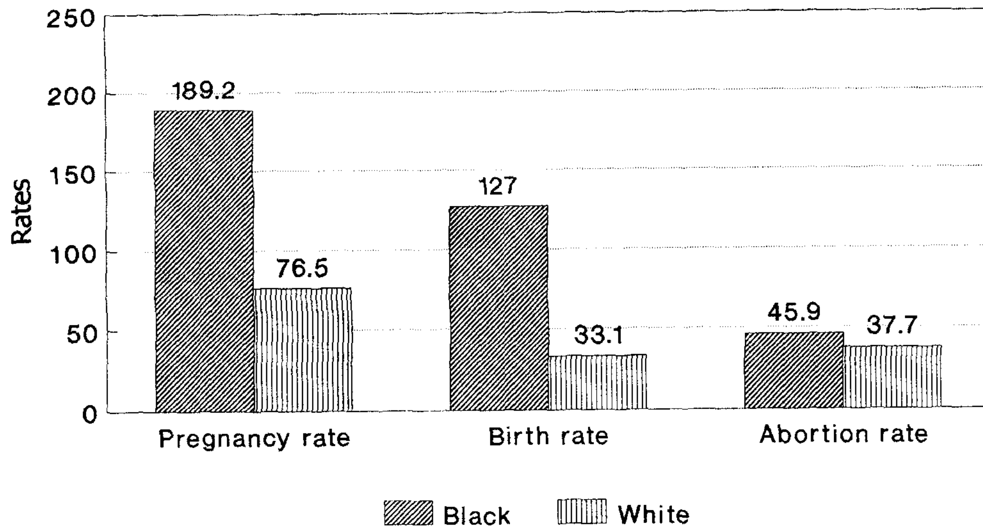


APPENDIX F. Pregnancy rates (per 1000) for girls age 15-19, Charlottesville and Albemarle County, by year, 1990-1997

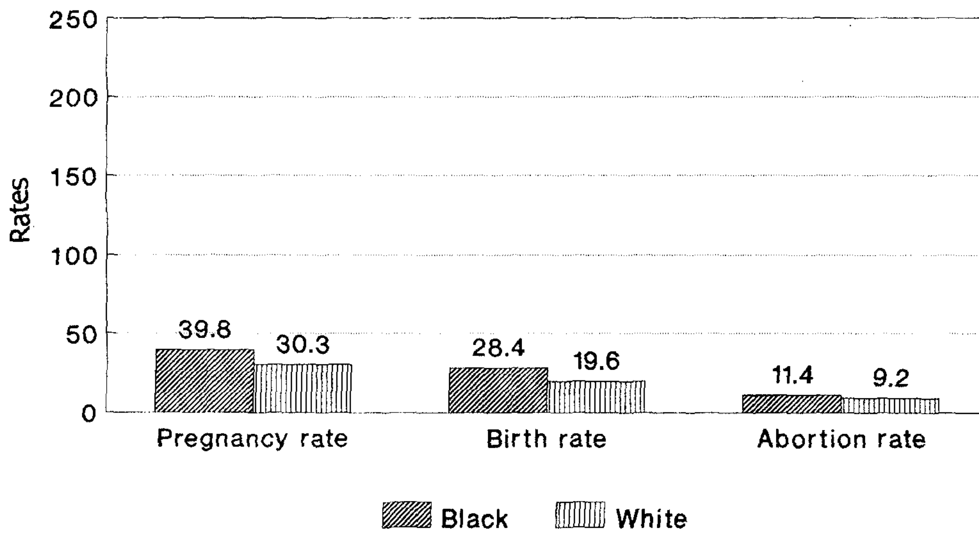




APPENDIX G. Number of teen pregnancies by age group, Charlottesville and Albemarle County, 1997

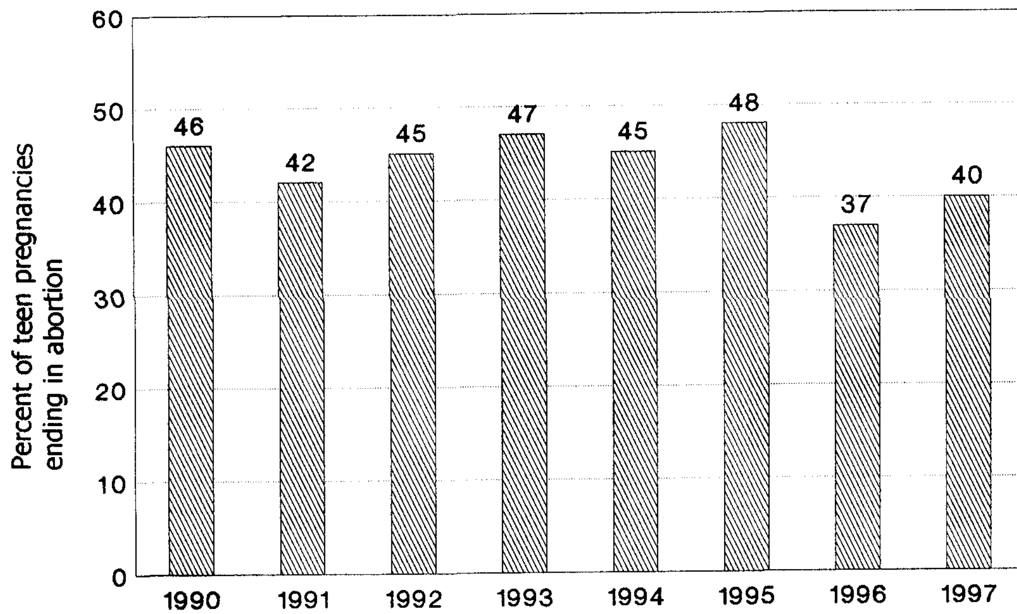


Charlottesville

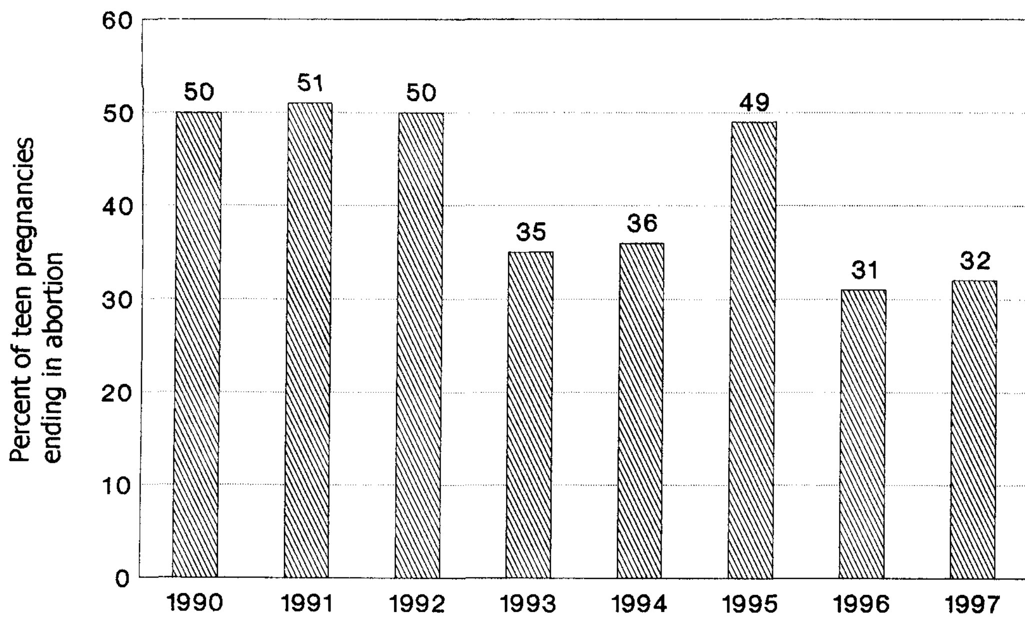


Albemarle County

APPENDIX H. Pregnancy, birth, and abortion rates (per 1000) for females aged 15-19, by race, Charlottesville and Albemarle County, 1996

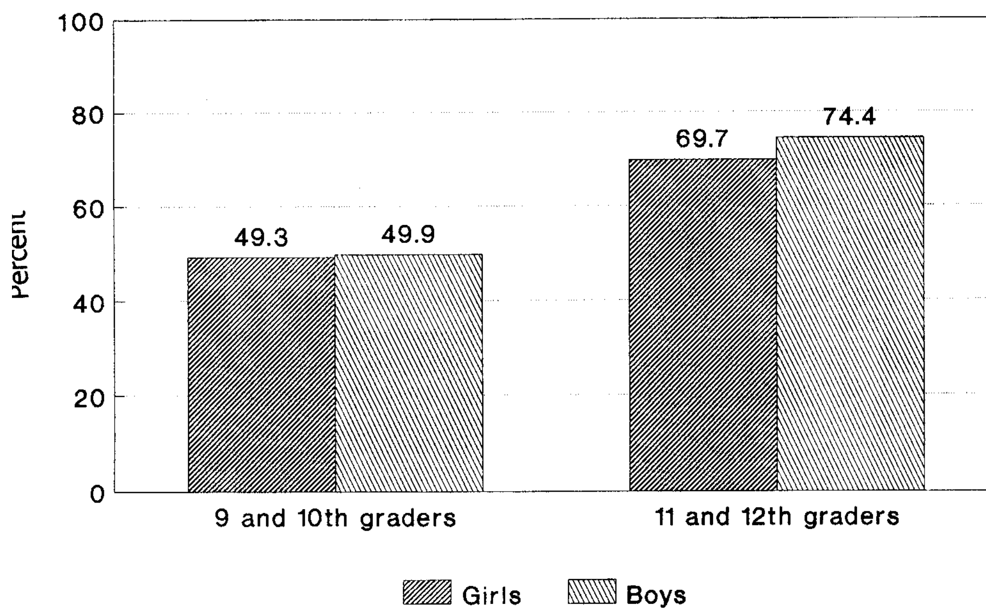


Charlottesville



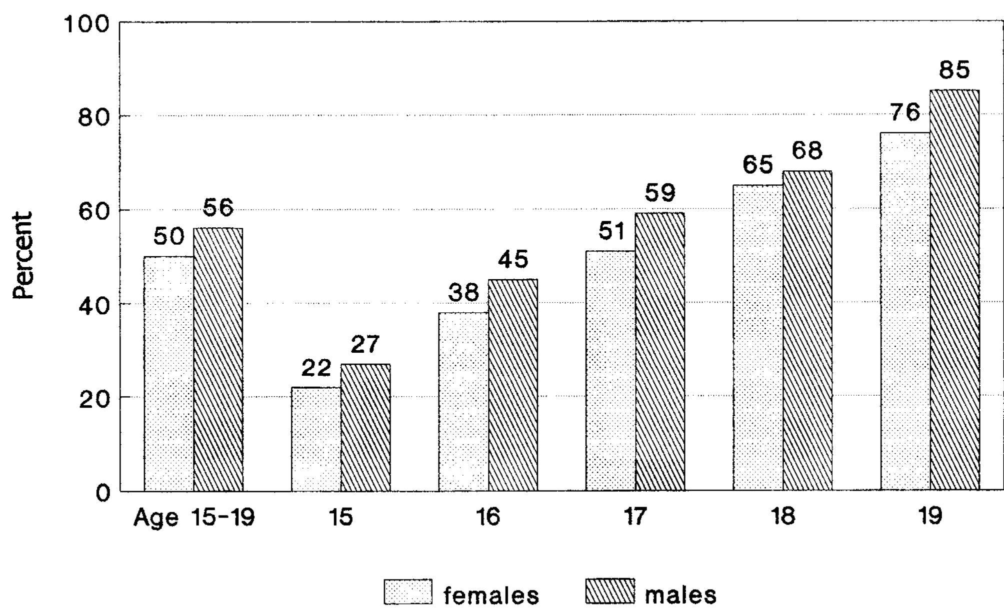
Albemarle County

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 (Elizabeths) 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 41were 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, syphlis 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 +.5 x 0.167)/2 = 0.0468 and a more realistic rate of (0.01+.5 x .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 pregnacy/ STD prevention.