

American Medical Student Association

1998–99  
National Initiative on  
Teenage Pregnancy

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**American Medical Student Association  
1998-1999 National Initiative  
February 7-14, 1999**

## **Teenage Pregnancy**

**W**elcome to the 1998-1999 AMSA National Initiative on Teenage Pregnancy. We have developed this handbook as a resource for you to start projects on this important issue at your school and in your community. This handbook contains background information and statistics on teenage pregnancy, federal assistance programs for these young mothers, project ideas, contact information, clinical electives and much more.

The week of February 7-14, 1999, has been designated National Initiative Week. During this week, AMSA chapters across the country will implement Mentorship Day and highlight other projects in the school and community focusing on teenage pregnancy. Your region's Associate Trustee and your Trustees-at-Large are here to help you plan and implement your projects. Join us and more than 20,000 of your fellow AMSA members as we work to prevent unwanted pregnancies and help pregnant teens.

This handbook—as well as additional information on clinical electives and relevant legislation—will be posted on the AMSA web site at <http://www.amsa.org>. We'll also be sending out periodic e-mail updates and reminders to each local chapter's National Initiative Coordinator. Please contact Philip Chang at [amsastal@www.amsa.org](mailto:amsastal@www.amsa.org) if you are a coordinator or would like to be subscribed to the National Initiative listserve.

If you have any problems, questions or suggestions, please contact either Phil or Rob by voice mail or e-mail. On behalf of the National Initiative Committee, we look forward to a truly national, collaborative effort!

Warmest regards,  
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The members of the National Initiative Committee have been helpful with advice and information that has gone into this handbook. Special thanks to Karin Lee for many hours of discussion that led to the Mentorship Day idea, and Deborah Goldberg for information on the CO-OP program.

I'd also like to thank the previous Trustee-at-Large, Ilana Addis, for suggesting this topic over a year ago. She has always felt very strongly about this issue and is currently training as an OB/GYN. I pray that these efforts will fulfill the vision she had in mind.

And finally, thanks to you, the local AMSA member who holds this handbook. Without you, this project will not happen. May we make a difference in the health of our communities!

— *Philip Chang*

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## What is the National Initiative?

AMSA's National Initiative is chosen by the Association's entire membership and serves to focus the efforts of local chapters and regional and national leadership on a single issue. Formerly known as the National Project, past efforts have addressed such issues as domestic violence, childhood immunizations, medical ethics, health care for the homeless and adolescent smoking. The National Project was renamed the National Initiative this year to better describe the variety of projects that local chapters can implement related to the topic. This year's topic, Teenage Pregnancy, aims to involve and educate AMSA members about the challenges faced by teenage mothers, the issues at the societal level, and the programs at the local, state and national level that are targeted at pregnant teens.

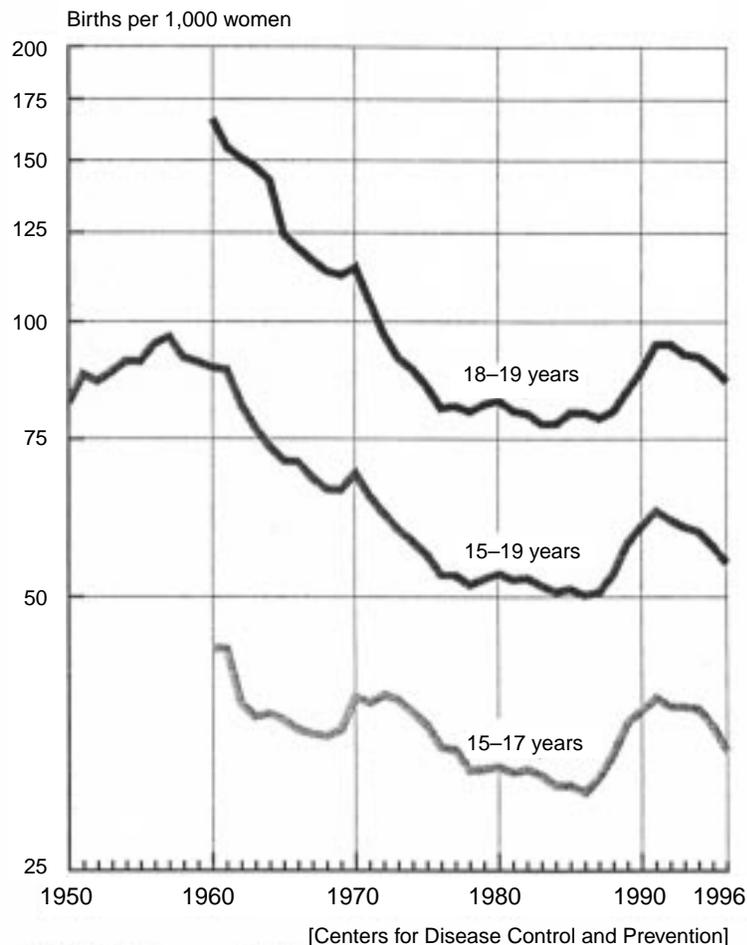
## INTRODUCTION

According to reports released by the Department of Health and Human Services in 1998, teen birth rates across the United States decreased by 12% between 1991 and 1996.<sup>1(p1)</sup> Unlike previous years, in which a decrease in the birth rate was accompanied by an increase in the abortion rate, preliminary reports indicate that the abortion rate also decreased between 1991 and 1996.<sup>1(p2)</sup> These combined figures point to an extremely welcome decrease in the pregnancy rate among teenagers.

This news comes as a relief to policy makers and social activists who noted a worrisome increase in the teen pregnancy rate during the 1980s. According to experts, there are two probable reasons for the recent decrease in the teen birth rate. First, the number of teens engaged in sexual activity leveled off in the early 1990s after a marked increase during the 1980s. Second, condom use increased in the early 1990s.<sup>1(p5)</sup>

Remarkably, even at its highest point in the 1980s, the birth rate in teens was considerably lower than in the 1950s and 1960s.<sup>1(p1)</sup> (See figure 1 below.) So why have policy makers become so interested in teen pregnancy during the past couple of decades?

Figure 1. Birth rates for teenagers by age:  
United States, 1950-96



The first reason is the dramatic increase in out-of-wedlock teen births. Although the rate of teen births has decreased since the 1950s, the percent of teen births which occurred outside of marriage increased from 15% in 1960 to 75% in 1995.<sup>2(p153)</sup> However, this trend of increasing out-of-wedlock childbirth is not limited to teenaged women. In fact, teenagers accounted for only 30% of out-of-wedlock births in 1995, whereas women in their 20s accounted for 54% of out-of-wedlock births.<sup>3</sup>

The second reason for increasing concern about teen births is the link between teen births and welfare. According to a report by the Alan Guttmacher Institute,<sup>4</sup> 53% of welfare funding is spent on families in which at least the first child was born to a teenager. Statistics like this have been repeatedly cited as justification for increased governmental spending and political involvement in reducing teen pregnancy.

## **TEEN PREGNANCY & BIRTH STATISTICS IN THE UNITED STATES**

### **National Statistics**

Approximately *one million* teens aged 15–19 years become pregnant each year in the United States. This translates to 40% of females becoming pregnant before they reach the age of 20 (*Newsweek*, May 11, 1998: 40). About half of the teenagers who become pregnant give birth each year.<sup>1(p1)</sup> Approximately 40% of pregnant teens have abortions.<sup>5(pp993-994)</sup> The majority of births occur to women aged 18–19. For example, in 1996 the birth rate of teens aged 18-19 years (86.5 per 1000) was more than double the birth rate for teens aged 15–17 (38.7 per 1000). Relatively few pregnancies occurred to teens under the age of 15 (1.2 per 1000 in 1996).<sup>1(p2)</sup>

### **Race and Cultural Statistics**

Birth and pregnancy rates vary greatly across racial lines in the United States. Black teenagers were at the greatest risk for teen pregnancy in 1991. However, between 1991 and 1996, the birth rate for Black teens aged 15–19 decreased by a greater percentage than for any other race (21% compared to an overall decrease of 12%).<sup>1(p3)</sup> This dramatic decrease has helped to narrow the disparity between birth rates for black and white teenagers. Nevertheless, the birth rate in 1996 for Black teens aged 15–19 was 91.7 births per 1000, compared to 50.1 births per 1000 for white teens.<sup>1(pp3,9)</sup> Hispanic teenagers now have the highest rates of teen pregnancy at 105.5 per 1000 teens aged 15-19.<sup>1(p9)</sup> (See Figure 2 below.)

### **State Statistics**

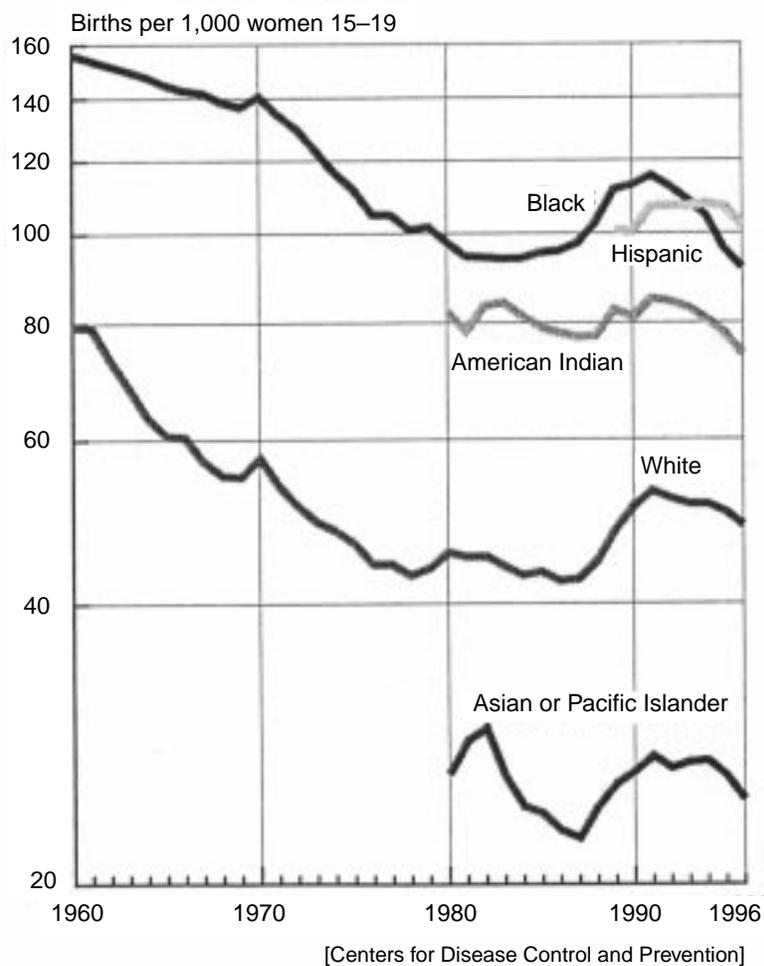
Birth rates also vary significantly by state. In 1995, rates ranged from a low of 28.6% in Vermont to a high of 105.5% in Washington, D.C.<sup>1(p3)</sup> Some of the variation in birth rates across the states can be accounted for by the variation in Hispanic and Black populations. Because the birth rates for Black teenagers and Hispanic teenagers are approximately double that of non-Hispanic white teenagers, states with higher populations of Black and Hispanic teenagers should be expected to have a higher overall birth rate.<sup>1(pp3-5)</sup>

The recent decrease in birth rates across the country was distributed somewhat evenly across the states. The birth rates in all states and the District of Columbia decreased between 1991 and 1995. (In five states, the decrease was not statistically significant.) Vermont showed the greatest percent decrease (27.1%) in teen birth rate between 1991 and 1995.<sup>1(p8)</sup>

## Worldwide Statistics

Even with decreases in the birth rate over the past several decades, the birth rate to teenagers in the United States is considerably higher than in most other industrialized countries. The birth rate to teenagers in the United States is twice that of Great Britain; more than four times that of Sweden and Spain; seven times that of Denmark and the Netherlands; and 15 times greater than the birth rate in Japan.<sup>6</sup> However, teenage sexual activity in the United States and these other countries does not vary significantly. There are several possible explanations for the higher birth rate in the United States. In the United States, society identifies teenage sexuality, not just teen pregnancy, as a social problem. According to one article, this negative focus on teen sexuality causes adolescents to feel greater embarrassment about obtaining contraceptives.<sup>7(p569)</sup> Other reasons for the higher teen pregnancy rate in the United States are less access to contraceptives and health care for adolescents and a larger poverty class.<sup>5(p997),7(p569)</sup>

Figure 2. Birth rates for teenagers 15–19 years by race and Hispanic origin: United States, 1960–96.



## **RISK FACTORS FOR TEEN PREGNANCY**

### **Environmental Risk Factors**

Research on teenage pregnancy risk factors indicates that there are a variety of environmental factors that are strongly correlated to increased rates of teen pregnancy. For example, there is a strong correlation between teen pregnancy and the neighborhood in which the teens live. Teens who live in neighborhoods with high levels of poverty, low levels of education and high residential turnover are at higher risk for teen pregnancy.<sup>2(p153), 8(pp11-14)</sup>

Family is also a strong indicator of the likelihood of teen pregnancy. Typically, teens who come from poor, less educated, single-parent families are at a greater risk for pregnancy.<sup>2(p153),8(pp11-14)</sup> Teens whose mother or sister gave birth as a teen are also more likely to become pregnant during their teenage years. According to a study which used data from the British National Child Development Survey, daughters of women who gave birth as teenagers are nearly twice as likely as daughters of older mothers to give birth as a teen.<sup>9</sup> Research also indicates that females whose families provide less support and supervision are more likely to become pregnant as teenagers.<sup>8(pp11-14)</sup>

### **Individual Risk Factors**

Several individual risk factors may affect whether a teen becomes pregnant. Outwardly, apparent risk factors include poor performance in school, aggressive behavior, engaging in other risky behavior (including using drugs and alcohol), dating at a young age, dating older partners, and not being well-liked by peers. Teens who experience puberty at an early age, males with high levels of testosterone and adolescents who have experienced sexual abuse or pressure are also at greater risk of early childbearing.<sup>8(pp11-14)</sup>

There are also several attitudinal factors that increase the likelihood of a teen becoming pregnant. Females who have permissive attitudes toward premarital sex, have negative attitudes toward using contraceptives, and either want to have a child or are ambivalent about having a child during adolescence are more likely to become pregnant as teenagers. An adolescent female may be ambivalent about becoming pregnant if she has a low expectation for her future, feels unable to control her life or feels isolated.<sup>7(pp562-567),8(pp11-14)</sup> A study of urban adolescent males indicates that males involved with pregnancy are more likely to believe that causing pregnancy is a sign of manhood.<sup>10</sup>

Many of these individual and environmental risk factors may be tied into experiences of poverty. The environment that poverty creates, the lack of resources and support, and the resulting perceptions of limited educational and financial opportunities may reduce the perceived cost of teen pregnancy and motherhood for adolescent females. Having a child may be perceived as the only way to bring meaning into the adolescent's life.<sup>2(p153)</sup>

### **Societal Changes and Out-of-Wedlock Pregnancy**

A combination of factors puts teenagers at greater risk of out-of-wedlock birth as compared with several decades ago. First, the average ages of menarche and spermarche have decreased. Secondly, people have first intercourse at a lower average age than in previous decades.<sup>8(p3)</sup> Finally, because of the loss of low-skill, high-paying manufacturing jobs in the United States, the average age of school completion and marriage have increased dramatically, especially for the middle class.<sup>2(p153),8(p3)</sup> This creates a wider time gap in which people are sexually active outside of marriage and are subsequently more likely to have multiple partners, to become

infected with STDs and to become pregnant before getting married.<sup>8(p3)</sup> Because of the changing economic structure and the demand for more educated workers in the United States, adolescents are much less likely to give birth in the context of marriage and financial stability.<sup>2(pp153-154)</sup>

## **TEENAGE SEXUAL PRACTICES**

According to the 1995 National Survey of Family and Growth, approximately 50% of teens aged 15–19 years have had sexual intercourse.<sup>11</sup> Although condom use and contraceptive use in general among teenagers has increased over the past few decades, fewer than half of all males aged 15–19 used condoms consistently in 1995 (in 100% of all acts of sexual intercourse during the year).<sup>12</sup>

Still, the most recent statistics indicated that 86% of teenage pregnancies are unintended.<sup>8(p6)</sup> There are several reasons that a teen may become pregnant unintentionally. One reason is lack of knowledge about topics such as the mechanics of pregnancy and use of contraceptives. Other teens are knowledgeable but choose to take sexual risks. Reasons a teenager would engage in risk-taking behavior include a sense of invulnerability, a perceived high cost (unwanted side effects) of contraceptives, a perceived high benefit of sex, and/or a limited consideration of future effects. Obstacles to protected sex, such as limited access to contraceptives and health care, may increase the likelihood that teenagers will engage in sexual risk-taking behavior.<sup>2(p154),7(pp562-566)</sup>

## **CONSEQUENCES OF TEEN PREGNANCY**

Determining the consequences of teen pregnancy on the lives of teenagers is complicated because of the difficulty in distinguishing between preexisting conditions and those that are a result of the early pregnancy. For example, greater dependence on welfare is often associated with teen pregnancy. However, since poor adolescents are at high risk for teen pregnancy, poverty may be a preexisting condition rather than an effect of the pregnancy.

Nevertheless, studies indicate that adolescents who become pregnant are at risk for several negative consequences. Those consequences include reduced educational achievement, reduced earnings potential, poorer mental health and psychological functioning, lower marital stability, larger families, and greater health risks.<sup>2(p155),8(p7), 13(p344)</sup> The children of teen mothers are at greater risk for low birth weight, infant mortality, delays in cognitive development, behavioral problems, and child abuse.<sup>2(p158),13(pp344-347)</sup>

Except for the very young (<15 years old), adolescents do not have physiological characteristics that increase the risk of negative consequences due to pregnancy. Instead, the negative effects of early pregnancy are attributed to socioeconomic factors and the behaviors of adolescents. Because teen mothers typically have lower incomes than older mothers, the teen and her child are subject to the limitations of living in poverty.<sup>13(p347)</sup> Thus, they may have less adequate housing, poor nutrition, and less access to medical care. In terms of behavior, adolescents tend to seek less prenatal care and less postnatal care for themselves and their children, and to eat less nutritionally.<sup>2(pp155-158),13(p350)</sup>

## INTERVENTION PROGRAMS

### Prevention Programs

Because of widespread social concern over teen pregnancy, especially during the 1980s and 1990s, numerous prevention programs have been implemented throughout the United States. However, there is considerable disagreement over which approach is most effective. Conservative and religious groups argue for an abstinence-only approach, while more liberal groups, such as Planned Parenthood, emphasize comprehensive sexuality education, including information about contraceptives and STDs (*New York Times*, May 1, 1998:A17). Unfortunately, most programs that have been implemented in the United States have not had a well-developed evaluation component.

In 1997, under the direction of the National Campaign to Prevent Teen Pregnancy, Douglas Kirby, Ph.D., director of research for ETR Associates, conducted a review of various teen pregnancy prevention programs across the country. Kirby evaluated five different types of prevention programs: 1) education programs; 2) contraception distribution programs; 3) programs designed to improve parent-child communication about sexual topics; 4) multiple component programs; and 5) youth development programs.

Of the *education programs*, Kirby concluded that programs that combined information about abstinence with comprehensive education about sexuality and HIV/STD infection seemed to be most effective at reducing sexual risk-taking behavior. He did not find any conclusive evidence that programs that only taught abstinence were effective in reducing teen pregnancy. Furthermore, neither comprehensive sexual education programs nor *contraceptive distribution programs* showed an increase in any measure of sexual activity, as some people feared they would. According to Kirby, *programs designed to improve parent-child education* showed short-term improvement in communication, but showed no evidence of changes in sexual behavior.<sup>8(pp45-48)</sup> However, results of the National Longitudinal Study on Adolescent Health suggested that greater time spent in parent-child activities reduced the likelihood of the child becoming a teen parent.<sup>14</sup> According to Kirby, *multi-component programs*, which included a range of community and media activities, showed promise for decreasing teen pregnancy rates when the programs were maintained for long periods of time. Kirby also evaluated *youth development programs*, which focused on building self-esteem and learning life-skills. Although these programs normally did not focus on sexuality, the evaluations suggested that these programs might be effective at decreasing teen pregnancy rates.<sup>8(p48)</sup>

### Interventions for Teen Parents

Several programs have been implemented throughout the country to improve the outcomes for teen parents. These programs provide a wide range of services, including educational programs, job training, child care and transportation. Unfortunately many of these programs have not increased the rate of employment or decreased dependency on welfare. The reason for the ineffectiveness of these programs may be that the young parents, which the programs target, are multiply disadvantaged. Not only do they face the demands of raising a child at a young age, but the teen parents also often live in poverty and have very low levels of education. The low level of education especially increases the difficulty of succeeding with job training or obtaining higher education. These intervention programs do not typically focus on the children of teen parents, so it is unclear whether these programs positively or negatively affect the outcomes for children.<sup>2(p162)</sup>

## **POLICY AND LEGISLATION**

### **Review of Federal Policy Regarding Family Planning**

In the 1960s, several research reports suggested that people in lower socioeconomic classes had a higher rate of unwanted childbearing. Because of these reports, many policy makers and governmental officials became concerned with the inequality of access to family planning services. Subsequently, several laws were enacted in the 1960s and 1970s to provide government support for family planning programs.

In 1965, federal funds were made available for family planning through the Office of Economic Opportunity. In 1967, Title IV-A of the Social Security Act was amended to require states to provide family planning services to women receiving welfare assistance. Finally in 1970, Title X of the Public Health Services Act was signed into law. This law created a comprehensive federal program dedicated to providing confidential family planning services to anyone who needed them, including adolescents. Title X funding is the only federal funding that is dedicated solely to family planning services. In 1972, Title XIX of the Social Security Act (the Medicaid statute) was amended to require all state Medicaid programs to include family planning services. Currently, 46% of public funding for contraceptive services is provided through Medicaid.<sup>16</sup>

### **Parental Consent and Notification Laws**

In the 1980s and 1990s, Congress made several major attempts to place restrictions on family planning services to adolescents. In 1983, Congress passed the “squeal rule” regulation, which required Title X-funded clinics to mail a notification to parents when their child visited a family planning clinic. Two federal appeal court judges barred enforcement of this law, and the law was eventually repealed. In 1996, Representative Ernest Istook (R-OK) offered an amendment requiring minors to have written parental consent before receiving services at Title X-funded clinics. After heated debate, a substitute amendment was passed, which required Title X grantees to certify that they encourage family participation in services for minors. In 1997, the U.S. House of Representatives narrowly rejected an amendment to Title X-funding legislation, which would have required Title X-funded clinics to notify parents prior to dispensing contraceptives to minors.<sup>16</sup>

Currently, states are left with the role of regulating teens’ autonomy in seeking contraceptives and reproductive health services. As of May 1997, 23 states and the District of Columbia have explicit laws that authorize minors to consent to receive contraceptives. Laws in 27 states explicitly authorize pregnant minors to consent to prenatal care and delivery services. The District of Columbia and all states except Texas authorize minors to consent to receive treatment for STDs. In 1997, Texas passed a law that prohibits using state funds to distribute prescription drugs, including birth control and STD medication, to minors without the consent of their parents. A state court judge ruled the law to be unconstitutional, but the decision is being appealed at the direction of Governor George Bush.<sup>17</sup>

Laws governing a minors’ right to consent to abortion tend to be more restrictive. In 30 states, some type of parental involvement is required for an adolescent to obtain an abortion. In 15 of those states, the adolescent must have the permission of at least one parent. In the other 15 states, the adolescent need only notify at least one parent of the abortion.<sup>17</sup> Many of these states include a judicial override clause, which allows teens to receive permission from a judge in lieu

of their parents. Ultimately, parental and notification laws may have little effect on the lives on teens, because several studies indicate that many teens, especially younger teens, voluntarily consult with their parents regardless of notification laws.<sup>18</sup>

### **Welfare Reform Law of 1996**

In August of 1996, the United States Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, also known as the welfare reform law of 1996. Because so many lawmakers have made the connection between teen pregnancy and higher spending on welfare, the welfare reform law included several items that addressed teen pregnancy and out-of-wedlock pregnancy. These items include limitations on welfare benefits, a mandate to reduce teen pregnancy, a focus on strengthening statutory rape laws, funding for abstinence-only education, and an “illegitimacy bonus” for states that decrease out-of-wedlock births.

There are several provisions of the bill that regulate welfare benefits and will impact young parents. These provisions are summarized as follows:

- (a) entitlement to cash welfare benefits is abolished;
- (b) families can receive benefits for no longer than five years over their lifetimes (shorter at state discretion, longer if states use their own funds);
- (c) recipients are required to work 20–30 hours per week after two years of TANF [Temporary Assistance to Needy Families] receipt;
- (d) minor mothers are required to live with a parent or legal guardian and to stay in school; and
- (e) mothers are required to identify the fathers of their children and to cooperate with child support enforcement.<sup>2(p162)</sup>

Exactly how these provisions will affect teen mothers and their children remains to be seen. There are several studies that indicate that the new law will make young parents’ lives more difficult. For example, many teen mothers receive welfare for at least ten years,<sup>15</sup> so the new time limits will be challenging. Furthermore, several recent reports suggest that co-residence of grandmothers and teen mothers leads to “higher mother-grandmother conflict and poorer child functioning.”<sup>2(p161)</sup>

Another provision of the welfare reform law directly addressed teen pregnancy. Section 905(a) of the welfare reform law mandated that “not later than January 1, 1997, the Secretary of Health and Human Services shall establish and implement a strategy for 1) preventing out-of-wedlock teenage pregnancies, and 2) assuring that at least 25% of the communities in the United States have teenage pregnancy prevention programs in place.”<sup>19</sup> Unfortunately, Congress allocated no funding with which to accomplish these tasks. In January 1997, Secretary of Health and Human Services Donna Shalala responded to these instructions by suggesting a stronger focus on abstinence be added to existing programs and asserting that prevention programs already exist in at least 30% of communities in the United States.<sup>20</sup>

In an effort to further reduce teen pregnancies, Congress also created the Justice Department Program on Statutory Rape through the welfare reform law. The program has three parts: 1) to “study the linkage between statutory rape and teenage pregnancy”; 2) to “educate state and local criminal law enforcement officials on the prevention and prosecution of statu-

tory rape”; and 3) to “ensure that the Department of Justice’s Violence Against Women initiative addresses the issue of statutory rape.”<sup>19</sup> This provision is part of nationwide trend of tougher statutory rape laws (*The New Republic*, October 20, 1997:12).

The other strategies in the welfare reform law focus on all out-of-wedlock pregnancies, not just teen pregnancies. One piece of Congress’s effort is funding abstinence education for all unmarried people in the United States. According to the welfare reform law, \$50 million is appropriated for each fiscal year from 1998 to 2002 for abstinence education. These moneys will be allocated to the states and the District of Columbia through maternal and child health block grants. The states are required to match every \$4 of federal funding with \$3 of state funding. Therefore, the total funding allotted to abstinence education is \$87.5 million dollars per year for each of the next five years.<sup>20</sup> All 50 states and the District of Columbia have applied for these funds. The welfare reform law includes no evaluation component of its abstinence education programs. Fortunately, 43 states have included some form of evaluation component in their program applications.<sup>21</sup>

The scientific grounds for this initiative are shaky at best. Currently, there are no conclusive studies that indicate that abstinence-only education is an effective method of preventing out-of-wedlock pregnancies (see Prevention Programs above). Statistics also suggest that promoting abstinence among unmarried people may be a difficult task. According to the 1995 National Survey of Family Growth, 82% of women aged 15–44 in the United States had sexual intercourse before they were married.<sup>11</sup>

The fourth measure in the welfare reform law directed at reducing out-of wedlock pregnancies is an “illegitimacy bonus” for states. According to the welfare reform law, \$20 million will be awarded to the five states that show the greatest decrease in all out-of-wedlock births and, simultaneously, reduce their abortion rate below the 1995 rate. The bonus will be awarded to five states per year for four years beginning in fiscal year 1999. The welfare reform law does not explicitly state how birth and abortion rates will be tabulated. Currently, the method of calculating abortion rates varies greatly by state. In fact, five states do not calculate their abortion rate at all.<sup>20</sup> Determining a standard method of calculating the abortion rates for all states may be problematic.

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## Choose Your Own Adventure!!

Teenage pregnancy is an ongoing problem in today's society, but not due to a lack of attention. In fact it seems that everyone has an idea about how to "solve" the problem of teenage pregnancy, yet not much has changed. While small strides have been made in reducing the number of teenage pregnancies, the amount of money spent on prevention programs is disproportionate to the outcome. There are many possible reasons for this, such as the wrong populations are getting the wrong information, or teenagers are just not getting any information at all. *However, as a society, we cannot respond to this by throwing up our hands and giving up.* Rather we need to figure out what will work.

For AMSA's Teenage Pregnancy Initiative, we have selected several approaches to this issue and we hope each chapter can find the most effective means of preventing teenage pregnancy in its community. Since there are many different options, we decided that the "Choose Your Own Adventure" format would lend itself nicely to our projects (and if you are not familiar with this format, you must have blocked out your childhood altogether). Just follow along and you should find the project that is right for your community. Of course, like most of us did when we were kids, you can read all the possibilities and do as many of them as you like, but we hope that this format makes choosing a project a little easier.

### I. Assessing your community's needs and resources

First and foremost, you need to target your community. Most teenage pregnancy statistics show that low socioeconomic status is a good predictor of the groups that are at higher risk, although all teens can benefit from sexuality education. The Alan Guttmacher Institute <<http://www.agi-usa.org>> keeps state-by-state statistics broken down by race and age, so that is a starting point. However, it may be beneficial to ask the local school board, department of health and local clinics, as well, in order to get more specific demographics.

The next step is to identify what type of intervention is needed (i.e., sexuality education, making contraception more available, etc.). This involves contacting your local school board to find out what type of sexuality education is offered in the schools. Also, if possible, try to talk to some teenagers about what they think about their sexuality education and what more they would like to know.

However, even good education can only go so far and then you need to see if adequate services are available to the teens who have slipped through the cracks. In order to do this, call around to local clinics or hospitals and find out what services they offer, as well as any local, state or federal agencies that may serve a role along the way (WIC, etc.). Finding out whether or not these clinics offer prenatal care, contraceptive counseling and abortion to teenagers is important in assessing the resources that are available. Another really good way to get this information is to go to the clinics themselves and ask to be shown exactly what process a teenager would go through if she came to that clinic.

Once you have gathered this information, it is important to find out how easily accessible it is to teenagers who may be afraid to ask adults for help. This may be difficult to assess, but find out if the clinics advertise in a "teen friendly" manner, and since location is always important, find out if the clinic is in a neighborhood or school where teens could easily go, or if it is only accessible by car. Once you have done all of this background research, you should have an idea of your communities strengths and weaknesses.

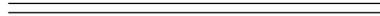
PRE-COITUS (non-pregnant child)    —> —> —>    POST-COITUS/PRE-NATAL (pregnant)    —> —> —>    POST-NATAL (mother with child)



Sexuality Education



Social Services  
Education  
Prenatal Care  
Abortion Services



## II. Choosing a Project

Now that you have a good idea about what your community resources are like for pregnant teens, it is time to pick a specific project for your chapter. Since there are so many approaches to dealing with teen pregnancy, we are going to try to give suggestions and guidelines for some of the most popular and effective projects in existence. Most projects are designed to either prevent teenagers from getting pregnant, through education and self-esteem workshops, or to help pregnant teenagers keep their life on track and prevent second pregnancies until they are more equipped, financially and mentally, to have a family. Now your adventure in preventing teenage pregnancy can begin....

- ◆ If your community is seriously lacking in the sexuality education department, go to *Education* (p. 13)
- ◆ If the education and resources are out there, but not reaching the teenagers, they may as well not be there. To build a bridge between the resources and the teens, go to *Spread the Word* (p. 15)
- ◆ If you would like to start a program to match medical students with pregnant teens (good for chapters that do not have time to do the educational programs, but have a few members who are dedicated and willing to take on a big responsibility), go to *Follow-Up* (p. 16)
- ◆ And last, but certainly not least, is our Teen Mentoring program, which we would like EVERY chapter to participate in during Teenage Pregnancy Focus Week (Feb.7-14,1999). Go to p. 17 for information on our *National Initiative*.

## Education

If your chapter is small or has a lot of other projects going on, then it is best to try to get involved with some of the organizations that are already well established. There are several organizations that offer education programs targeting teenagers. You should check your community to see if any of these are available.

For example, **Planned Parenthood** <<http://www.plannedparenthood.org>> has affiliates all over the country and many of these rely on volunteer educators to go out and teach people about sexuality issues. Also, several **Boys and Girls Clubs** provide education using the *Talking to Teens about Tough Issues* curriculum (a list of these clubs and a description of the curriculum can be found at <[http://www.childrennow.org/toughissues/Talk\\_Open.html](http://www.childrennow.org/toughissues/Talk_Open.html)>. If no programs are in existence in your community, then you can try to do some of the programs below, but it may take a little more people power than the community-based programs.

If your chapter has a fairly large group of people interested in participating in various education programs, there are several existing curricula that can be tailored to your specific needs. The ones listed here have been developed by national AMSA or AMSA chapters. Materials are available at minimal cost from the AMSA Resource Center at (703) 620-6600, ext. 217.

- 1) **STATS (Students Teaching AIDS to Students)**. This program was started by AMSA in 1988 and is designed to train medical students to become HIV/AIDS educators. Medical students go into their communities and teach adolescent and pre-adolescent populations the facts about HIV and how to prevent infection.
- 2) **CO-OP (Contraceptive Options Education Project)**. This program was started by medical students at the University of Pittsburgh and focuses on explaining, clearly and accurately, the various methods of birth control (including abstinence). This program is especially good if you are working with college-age teenagers.
- 3) **Teen Health Issues**. This program was started by the AMSA chapter at Louisiana State University School of Medicine in Shreveport and is designed to empower teens to make wise decisions about their sexuality by teaching skills to negotiate safer sex.

There are also lots of other programs that may be useful:

- The **U.S. Department of Health and Human Services** funds several programs, many of which emphasize abstinence in an attempt to delay the onset of sexual intercourse. These may be good programs for younger populations. To learn more about these programs check out the Web site at <<http://aspe.os.dhhs.gov/hsp/teen/examples.htm>>.
- Another good source is the **Coalition for Positive Sexuality** <[www.positive.org/cps](http://www.positive.org/cps)> which is a grassroots organization that has published a booklet entitled *Just*

*Say Yes!* They pass this booklet out to high school students and have gotten a lot of good feedback from teens. According to CPS, this booklet is “pro-safe sex, pro-teen, pro-choice, pro-queer and pro-woman” and it is available in Spanish! This would be a good teaching tool if you are working with teenagers who are already sexually active.

- There are also many programs that have been specifically designed to reach out to young men. **The Urban Institute** <<http://www.urban.org/family/invmale.html>> has compiled a description of many of the most successful programs and information about publications and program curricula.
- Finally, if you are interested in starting your own program from scratch, check out the **National Campaign to Prevent Teenage Pregnancy** <<http://www.teenpregnancy.org/SumEdu.html>> for information about the characteristics of programs that work.

You may want to pick and choose from what we have presented and design a unique program for the teenagers in your community. You could even make a series using several of the various programs and offer it to various groups. As you can see, there is an enormous amount of information out there, it is just a matter of getting it to the right people!

## Spread the Word

If the education and resources are out there, but they are not reaching the teenagers, they may as well not be there. If this seems to be the case, start a campaign to inform teenagers of the re-sources available to them. This type of a project does not need many people, so it is good for a small chapter to do, and actually it is a good idea for ALL chapters to do.

If the various clinics have fliers they give out, offer to distribute them to various teen groups. Put them up in public places where teenagers are likely to see them or go to schools as kids are arriving or leaving and ask them to distribute the fliers to their friends.

If there are no pre-made fliers, make your own. Be sure that the language is teen-friendly and make sure you know what services the clinics offer before you include them in your flier. A good alternative to a flier is a laminated, wallet-sized card that teenagers can easily carry around. It should include local clinics and phone numbers as well as hotlines (HIV/AIDS hotlines, or STD hotlines). This may be more inconspicuous and therefore more appealing to teens. Here is an example:

Front:

**Local Clinics**  
Gaithersburg Nichols Center  
19650 Clubhouse Road, Suite 104  
Gaithersburg, MD 20879  
(301) 208-1300  
Silver Spring Center  
1400 Spring St., Suite 450  
Silver Spring, MD 20910  
(301) 608-3448

Back:

**Helpful Numbers**  
Planned Parenthood: 1-800-230-PLAN  
National AIDS hotlines:  
English: 1-800-342-AIDS  
Spanish: 1-800-344-SIDA  
Deaf and Hearing-Impaired  
People (TDD/TTY):  
1-800-243-7889  
National STD Hotline: 1-800-227-8922

## Follow-Up

Since most of the programs we have discussed so far have dealt with prevention of pregnancy, we are now going to talk about programs that are designed to help teenagers who are already pregnant.

Several medical schools have programs that pair up a medical student with pregnant teenagers. Programs differ as far as length of commitment and degree of involvement are concerned, but they all have the same idea in mind. These programs can be set up through various clinics, possibly even an adolescent health clinic at your school or the local health department.

The medical student accompanies the pregnant teenager to her doctor's appointments and tries to help educate the patient about proper nutrition, etc. They try to help the patient understand what is happening to her body, and in general they just try to be supportive. Not only does this program benefit the teenager, it also teaches medical student some of the day-to-day struggles of a pregnant teenager. The students should also try to be present for the delivery and then follow along with the patient for the first few months of postnatal care. Obviously this is a long-term involvement, and it may need to be tailored to fit people's schedules, but it is a great project that every chapter can have people participate in.

## National Mentorship Day –1999 National Initiative

The week of February 7–14, 1999, will be the official AMSA National Initiative Week coinciding with Teenage Pregnancy Focus Week. We would like to get all of the AMSA chapters to participate in a **National Mentorship Day** during this week. This project was designed by the Medical College of Virginia and can be tailored to your school's specific needs or desires.

The goal of the project is to set positive role models for teens at risk of becoming pregnant. The program can be done with middle school or high school students depending on what your chapter feels is more feasible.

- Utilizing local agencies, such as Area Health Education Centers (AHECs) or school-based clinics, get the names of about 50 young women (of course, you can also design your program to include young men) who have either had children or are considered to be at risk of becoming pregnant.
- Send letters to these women to invite them to your program (since it involves missing a day of school, it is probably a good idea to clear this with the local school board, and you may want to have a faculty advisor do this).
- The women should be instructed to meet at your school in the morning. Start the day with breakfast and an introduction to mentoring, and explain what their schedule for the day will be like.
- Pair up a medical student with each young woman, if possible, and then divide into groups of five or six (teenagers). These groups will stay together for the remainder of the day.
- The day will consist of several “rotations” that are up to each chapter to design. Here are some suggestions:
  - Give a tour of the school and the hospital
  - Go to the places that would be of interest to teenagers, e.g., a newborn nursery, NICU, the cafeteria, etc.
  - Set up “stations” with various women doctors, so that the young women can get a first-hand glimpse of these women doctors at work.
  - Another rotation could be a STATS program or some other program to talk to these women about their values and goals, and how choosing to have or not have sex can affect these choices.
- Of course each group will stop to have lunch at some point and then continue with the rotations.
- Once all the groups are done, you wind up with a debriefing of the day and get the women to fill out an evaluation form.

Here are some additional pointers:

- ◆ Recreational therapists or occupational therapists who work in psychiatry departments have a lot of resources on self-esteem and could be scheduled as one of your “rotations.”
- ◆ Plan for 50 young women and keep a waiting list. The week of the program, call and confirm with the young women; that way, if people back out you can fill those slots with people on the waiting list.
- ◆ Create a policy for what to do if one of the girls gets sick (this has been a problem at chapters that have done this program).
- ◆ Contact women’s organizations and alumni organizations to try to get money for food.
- ◆ Although this program has been done before with young women, it would be just as easy to do with young men as well, if your chapter would prefer to include men.

## Clinical Electives

- 1) **Medical Students for Choice** has a Reproductive Health Internship for first- and second-year medical students from the U.S. and Canada. The program accepts approximately 55 students and pays a stipend of \$1,000 for the four-week course. They also offer unpaid clinical electives for third- and fourth-year students. Contact Karen Haggarty for more information on this program. Phone: (510) 540-1195; Web site: <http://www.ms4c.org>
  
- 2) There are many schools that offer electives for students relevant to teenage pregnancy issues. All schools offer general obstetrics and gynecology electives, as well as family medicine electives. The following electives are unique and more specific to teen pregnancy issues. This list was compiled primarily by information found on the World Wide Web, as well as information from individual medical schools. There are certainly more programs out there, so if your school or a school you are interested in is not listed, you should look into it on your own. Also, most schools have specific policies regarding visiting students, so if you are interested in any of these electives you should call or write to the schools to find out more information.

School	Elective(s)
University of California, Irvine 1-800-542-7337 <a href="http://www.com.uci.edu/~schreine/Elective_Handbook">http://www.com.uci.edu/~schreine/Elective_Handbook</a>	OB/GYN 645A: Family Planning and Office Gynecology
University of California, L.A. (310) 825-8020 <a href="http://www.medsch.ucla.edu/sao/elec9899.htm">http://www.medsch.ucla.edu/sao/elec9899.htm</a>	PE 250.03: Adolescent Health Care PE 350.01: Young Adult Medicine PE 350.04: Adolescent Medicine FP 251.01: The Free Clinic Experience
University of California, San Diego (619) 534-8503 <a href="http://cybermed.ucsd.edu/Catalog/clnel.html">http://cybermed.ucsd.edu/Catalog/clnel.html</a>	Peds 432: Clinical Experiences in Adolescent Medicine
Loma Linda University (909) 558-4472 <a href="http://www.llu.edu/llu/medicine/bulletin/smb3toc.html">http://www.llu.edu/llu/medicine/bulletin/smb3toc.html</a>	FMDN 894: Adolescent Pregnancy: Social and Medical Aspects
University of Colorado (303) 315-4354 <a href="http://www.uchsc.edu/sm/sm/extern/extca.htm">http://www.uchsc.edu/sm/sm/extern/extca.htm</a>	PED 8020: Adolescent Medicine at Children's Hospital (includes participation in CAMP—Colorado Adolescent Maternity Program)

School	Elective(s)
Georgetown University (202) 687-1004 <a href="http://www.dml.georgetown.edu/schmed/curriculum/fourth/electives/index.html">http://www.dml.georgetown.edu/schmed/curriculum/fourth/electives/index.html</a>	OB/GYN 4270-526: Breastfeeding, Maternal and Child Health and Reproductive Health OB/GYN 4270-520: Natural Methods of Child Spacing in Developing Countries
Howard University (202) 806-6270	Peds 906-235: Adolescent Medicine Peds 966-420: Adolescent Medicine Ob/Gyn 904-905: Family Planning Ob/Gyn 904-908: Human Sexuality
University of South Florida (813) 974-2068 <a href="http://www.med.usf.edu/MD/MANUAL/toc.htm">http://www.med.usf.edu/MD/MANUAL/toc.htm</a>	Peds MEL 8586: Adolescent Pediatrics
Mercer University (912) 633-1063 <a href="http://musm.mercer.edu/musm/departments.htm">http://musm.mercer.edu/musm/departments.htm</a>	Dept. of Community Science: Introduction to Public Health
Morehouse School of Medicine (404) 752-1652 <a href="http://www.msm.edu/">http://www.msm.edu/</a>	Community Health/Public Medicine CHPM818: The Public Health Elective
University of Hawaii (808) 956-8300 <a href="http://medworld.biomed.hawaii.edu/tocontents.html">http://medworld.biomed.hawaii.edu/tocontents.html</a>	Peds: Adolescent Medicine
Chicago Medical School (847) 578-3215 <a href="http://www.finchcms.edu/cms/medschool.html#depts">http://www.finchcms.edu/cms/medschool.html#depts</a>	FM 821: Women's Health Care in a Primary Care Setting FM 801: Community Medicine Peds: Adolescent Medicine
University of Chicago, Pritzker (773) 702-1939 (773) 702-2598 (fax)	Adolescent Medicine Family Planning
University of Iowa (319) 335-8053 <a href="http://www.medadmin.uiowa.edu/admin/osac/osac.htm">http://www.medadmin.uiowa.edu/admin/osac/osac.htm</a>	Dept. of Preventative Medicine 063:998 Using Community Services in Primary Care Practice
University of Louisville (502) 852-6183	Introduction to Adolescent Medicine

School	Elective(s)
Louisiana State University, New Orleans (504) 568-4874 <a href="http://www.medschool.lsumc.edu/academics/fourth/">http://www.medschool.lsumc.edu/academics/fourth/</a>	FMMD 435I: Adolescent Medicine
Tulane University (504) 584-1984 <a href="http://www.mcl.tulane.edu/departments/StudentAffairs/IVS.htm">http://www.mcl.tulane.edu/departments/StudentAffairs/IVS.htm</a>	Community Medicine: Preventative Medicine and Public Health
Johns Hopkins University (410) 955-3080 <a href="http://infonet.welch.jhu.edu/education/course_desc/som_elecbk/contents.html">http://infonet.welch.jhu.edu/education/course_desc/som_elecbk/contents.html</a>	Peds: Adolescent Medicine Research opportunities: <ul style="list-style-type: none"> <li>• Adolescent Medicine (iron-deficiency and anemia, contraception, school-based clinics and health/sexuality education)</li> <li>• Adolescent Medicine (STD and HIV infection; factors affecting condom use by adolescents; parenting styles and relation to adolescent behaviors; health education)</li> <li>• Adolescent Medicine (teen parenting, contraceptive behaviors, evaluation of teaching regarding male reproductive health)</li> <li>• Iatrogenic and financial costs of providing health care; health-care delivery systems; adolescent pregnancy</li> </ul>
Boston University (617) 638-4160	PEDS: Adolescent Medicine OB/GYN: Substance Abuse in Pregnancy
Harvard Medical School (617) 432-1515 <a href="http://www.harvard.edu/academics/catalogs/medical/electivesindex.html">http://www.harvard.edu/academics/catalogs/medical/electivesindex.html</a>	PD701M.7 Adolescent Medicine Pediatrics in a Neighborhood Health Center ME552M.3: Women's Health Elective PD528M.3: Primary Care OB516M.23 Women's and Children's Health
Dartmouth Medical School (603) 650-1509 <a href="http://www.dartmouth.edu/dms/studnt_life/main_elect.html">http://www.dartmouth.edu/dms/studnt_life/main_elect.html</a>	OBY 502: Family Planning
New Jersey Medical School (973) 972-4640	FMED 9030: Health Disparities in Minorities FMED 9080: Family Medicine in the Community PEDS 9063: Adolescent Medicine
University of New Mexico (505) 272-3414	PEDS: Adolescent Medicine

School	Elective(s)
<p>Albert Einstein (212) 430-2102/2104 <a href="http://www.aecom.yu.edu/registrar/elect.htm">http://www.aecom.yu.edu/registrar/elect.htm</a></p>	<p>FM6: Women's Health FM7: Adolescent Health Care in a Family and Community Setting OBGYN H703: Nutritional Influence on Pregnancy PEDS N519: Adolescent Ambulatory Care</p>
<p>Columbia University (212) 305-3806 <a href="http://cpmcnet.columbia.edu/dept/ps/electives/">http://cpmcnet.columbia.edu/dept/ps/electives/</a></p>	<p>OB01P: Family Planning and Reproductive Health OB41H: Ambulatory Gynecology and Family Planning PE02P: Adolescent Medicine PE50L: Adolescent/Young Adult Health</p>
<p>New York University (212) 423-6777</p>	<p>OB/GYN: Program for Senior Student Elective in Family Planning (Program director: Alexander Coman, M.D., (212) 423-6796/7) PEDS: Adolescent Medicine (Program director: Peter A. Masella, M.D., (212) 423-6228)</p>
<p>University of Rochester (716) 275-4541 <a href="http://www.urmc.rochester.edu/smded/4YrElectives/">http://www.urmc.rochester.edu/smded/4YrElectives/</a></p>	<p>ClinicalElective PEDS 615: Adolescent Medicine</p>
<p>SUNY, Brooklyn (718) 270-1875</p>	<p>PEDS 4426: Adolescent Medicine PEDS 4446: HIV/AIDS and Adolescence</p>
<p>Duke University (919) 684-2498 <a href="http://www2.mc.duke.edu/depts/som/descript.html">http://www2.mc.duke.edu/depts/som/descript.html</a></p>	<p>CFM-258C: Legal Issues in Medicine PED-243C Adolescent Medicine</p>
<p>University of Oklahoma (405) 271-2129 <a href="http://medicine.ouhsc.edu/education/courfset.htm">http://medicine.ouhsc.edu/education/courfset.htm</a></p>	<p>PEDI 9461: Adolescent Medicine</p>
<p>Hahnemann University (215) 762-3541 <a href="http://www.auhs.edu/medschool/curricula/index.html">http://www.auhs.edu/medschool/curricula/index.html</a></p>	<p>OB/GYN: Family Planning</p>
<p>University of Pittsburgh (412) 648-8935 <a href="http://www.dean-med.pitt.edu/redbook/MainTableOfContents">http://www.dean-med.pitt.edu/redbook/MainTableOfContents</a>.</p>	<p>OB/GYN 5490 E: Women's Health PEDS 5550 D: Adolescent Medicine</p>
<p>Brown University (410) 863-2293 <a href="http://biomed.brown.edu/Medicine_Programs/ClinicalElectives/indexa.html">http://biomed.brown.edu/Medicine_Programs/ClinicalElectives/indexa.html</a></p>	<p>496: Reproductive Health Initiative 553: College Student Health</p>

School	Elective(s)
University of Tennessee, Memphis (901) 448-5506	FME1-3012/F: Senior Clerkship-Junior Internship in Family Medicine Community-Based Clinics FME1-4020/F: Public Health Elective OBG1-4030/F: Clinical Elective in Pediatric and Adolescent Gyn. PED1-4040/F: Community Pediatrics
Baylor College of Medicine (713) 798-4600 <a href="http://www.bcm.tmc.edu/osa/osa-electives_2.html">http://www.bcm.tmc.edu/osa/osa-electives_2.html</a>	Comm. Med. 420-509: STDs: Diagnosis, Therapy, and Epidemiology PEDS 520-444: Alienated Youth: Interview Techniques for Adolescents
University of Texas-Galveston <a href="http://snapper.utmb.edu/utmb/department.htm">http://snapper.utmb.edu/utmb/department.htm</a>	OBGU-4001: Family Planning
University of Texas-Houston (713) 500-5160 <a href="http://www.uthscsa.edu/som/toc.htm">http://www.uthscsa.edu/som/toc.htm</a>	OBGY 4004: Primary Care Preceptorship in Ob & Gyn OBGY 4027: Community Outreach Elective PED 4010: Adolescent Medicine
Marshall University (304) 696-7229 <a href="http://meb.marshall.edu/4thyear/index.htm">http://meb.marshall.edu/4thyear/index.htm</a>	FCH 860: Community Medicine PED 814: Adolescent Medicine
University of Wisconsin (608) 263-4923 <a href="http://www.biostat.wisc.edu/infolink/educ/academics/3-4acad.html">http://www.biostat.wisc.edu/infolink/educ/academics/3-4acad.html</a>	PEDS 940: Adolescent Medicine
Medical College of Wisconsin (414) 456-8733	PEDS dL115: Adolescent Medicine
University of Toronto (416) 978-2717 <a href="http://utl1.library.utoronto.ca/www/medicine/depts.htm">http://utl1.library.utoronto.ca/www/medicine/depts.htm</a>	Fam/Comm. Med 32-93-D4-018: Bay/Women's Health Centre PEDS: Adolescent Medicine
University of Ottawa <a href="http://www.uottawa.ca/academic/med/electives/">http://www.uottawa.ca/academic/med/electives/</a> PEDS: Adolescent Medicine	PEDS: Teen Health Centre PEDS: Clinical Experience at the Teen Health Centre
McGill University (514) 398-8358/3516 <a href="http://www.med.mcgill.ca/undmededuca/">http://www.med.mcgill.ca/undmededuca/</a>	PEDS: Adolescent Medicine

- 3) **The American Medical Women's Association** has a list of schools that have electives in reproductive medicine based on their model curriculum. AMWA will match students with the various programs based on when the student wants to take an elective and which electives have openings. Students who attend the medical schools offering the elective have priority, but there are usually extra slots for other interested students. For more information on this, call AMWA at (703) 838-0500, ext. 3315, or go to their Web site: <http://www.amwa-doc.org>

If your school does not offer any type of reproductive health electives and you are interested in changing this, AMWA together with Medical Students for Choice has a booklet designed to help medical students improve their schools' reproductive health curriculum. AMSA has several copies of this booklet which we will distribute at the COC. However, if you do not get a copy and you are interested, you can get one by calling AMWA at (703) 838-0500 or MSFC at (510) 540-1195.

# Resources

## **American Medical Women's Association**

Web site: <http://www.amwa-doc.org>  
More information on page 24.

## **Planned Parenthood**

Web site: <http://www.plannedparenthood.org>  
Planned Parenthood is an excellent resource for brochures and educational material. However, each affiliate varies as far as the resources they offer, but it is still good to get in touch with them. Hotline: 1-800-230-PLAN

## **Medical Students for Choice**

Web site: <http://www.ms4c.org>  
This is a national organization designed to support pro-choice medical students.

## **American College Health Association**

Web site: <http://www.acha.org>  
This organization targets college students and is a good source for very informative brochures. Since the majority of teenage pregnancies occur in women who are ages 18-19, it may be wise to target local college groups, and the ACHA is a good resource for these programs.

## **The Campaign to Prevent Teen Pregnancy**

Web site: <http://www.teenpregnancy.org>  
This is a national organization which formed in response to President Clinton's challenge to reduce the number of teenage pregnancies.

## **The Coalition for Positive Sexuality**

Web site: <http://www.positive.org>  
This is a grassroots organization based in Chicago. They have written a booklet called *Just Say Yes!* which they pass out to high school students.

## **Children Now**

Web site: [http://www.childrennow.org/toughissues/Talk\\_Open.html](http://www.childrennow.org/toughissues/Talk_Open.html)

## **The Urban Institute**

Web site: <http://www.urban.org/family/invmale.html>  
This is a good source for programs aimed at reaching young men.

## **National AIDS Hotlines**

English: 1-800-342-AIDS  
Spanish: 1-800-344-SIDA  
Deaf and Hearing-Impaired People (TDD/TTY): 1-800-243-7889.

## **National STD Hotline**

1-800-227-8922