
The School/Community Sexual Risk Reduction Program for Teens

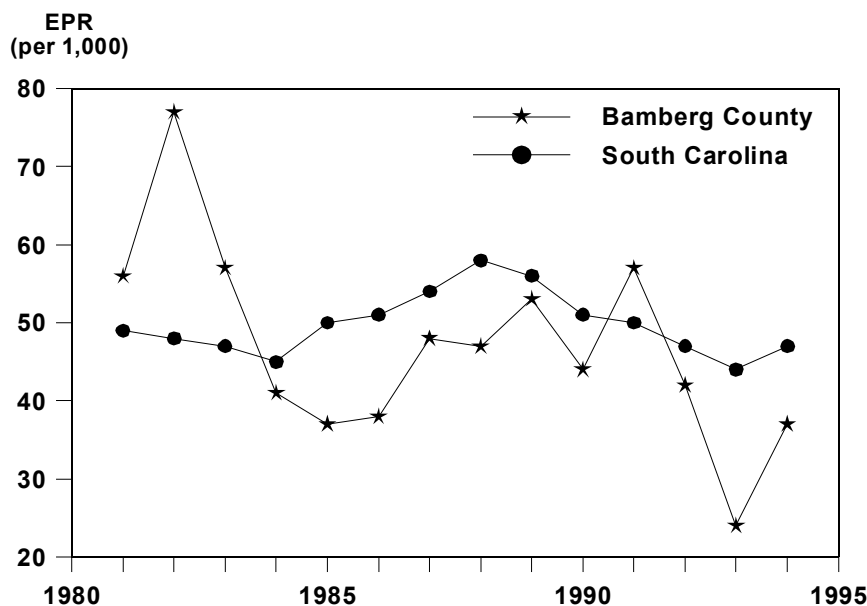
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This paper describes a teen pregnancy reduction program that, unlike many other such attempts, has demonstrated an actual reduction in teen pregnancies. This program, the School/Community Sexual Risk Reduction Program for Teens, used a community-wide approach and multiple interventions. It was described in detail in an article in the *Journal of the American Medical Association*, published June 26, 1987. That article outlined the following results from the program (see Figure 1):

- ❖ In the 2nd year, the estimated pregnancy rate for girls between 14 and 17 years old dropped from 66.9 per 1,000 to 24.0.
- ❖ In the 3rd year, the estimated pregnancy rate was 25.0 per 1,000; in the 4th year it fell to 22.5.

An external evaluation of the program credited this 50% reduction in teen pregnancies to the program's focus on multiple interventions in the target community.

Figure 1. Estimated pregnancy rates for females, aged 14–17, in Bamberg County and South Carolina, 1981–1994



Source: SC DHEC Office of Vital Records and Public Health Statistics.

Methods

The School/Community Sexual Risk Reduction Program for Teens began in October 1982 in Bamberg County, South Carolina. The county's population is rural, agricultural, poor, and undereducated. According to the 1980 census, 58% of the residents are Black; 42% are White. Before 1982, the county ranked among the top 20% in estimated pregnancy rate for girls between 14 and 17 years old.

This project used a community-based model that recognizes the many factors which contribute to public health problems—whether that problem is high blood pressure, AIDS, infant mortality, or teen pregnancy. Because there are multiple causes, the model predicts that long-term improvements will require community-wide recognition of the problem and a number of “high dosage” interventions directed at the entire community.

Many factors contribute to the problem of teen pregnancy. These factors are complex, interrelated, and not easily remedied. Among these factors are the following:

- ❖ Peer pressures and peers' view about sexual activity, prevention, and contraception
- ❖ Parental activities and behaviors concerning communication and sexual decisions
- ❖ Family relationships
- ❖ Single parent families
- ❖ Latchkey children
- ❖ Cultural and religious beliefs
- ❖ Sexual relationship and role models in the media
- ❖ Lack of self-confidence, self-esteem, and responsibility and lack of decision-making, problem-solving, and assertiveness skills
- ❖ Perceptions of susceptibility and seriousness of sexual involvement
- ❖ Availability of educational and counseling services
- ❖ Lack of sexuality education
- ❖ Engagement in other risky behaviors such as drug or alcohol use
- ❖ Attitudes of medical and clinical personnel
- ❖ Socioeconomic status
- ❖ Availability of medical and health services

Teenage girls play a primary role in the problem and its solution. However, there are also important roles played by the men or boys who impregnate them and by parents, teachers, religious advisors, medical providers, businesses and industries, and taxpayers. The problem is complex. To believe a “magic pill” or a “plea for more self control” will solve it is naive and simplistic. The community-based intervention model offers promise because it involves many groups, agencies, and stakeholders and is flexible enough to connect the interests, resources, and energies of everyone in the community.

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Objectives and strategies

The project's outcome objective was to reduce unintended pregnancies among never-married teens and preteens. The primary behavioral objective was to support and promote abstinence and postponement of sexual intercourse. The secondary behavioral objective was to promote effective contraception among those teens who are sexually active. To achieve these objectives, multiple educational programs were directed at all members of the community. Educational programs aimed to help people

- ❖ recognize that early sexual intercourse and pregnancy creates problems that do not enhance the quality of life
- ❖ understand growth and developmental changes of children, adolescents, and adults
- ❖ improve skills in assertiveness, communication, problem-solving, and decision-making to help youth resist peer, societal, and cultural pressures
- ❖ improve teens' self-esteem and aspirations
- ❖ understand and acquire skills regarding reproduction, contraception, and pregnancy prevention

Target groups for these educational programs included the following:

- ❖ **Teachers and community agency professionals.** These adults benefit from formal instruction, graduate education, and other intensive educational forums designed to help them educate and guide youth.
- ❖ **Parents.** Short courses, offered in a structure that ensures participation, can improve parenting skills. Religious organizations may have the greatest opportunity to reach this group.
- ❖ **Children and adolescents.** This group needs planned, organized, and sequential sexuality education, taught by academically prepared teachers, from kindergarten through high school.
- ❖ **Teen peer leaders.** These teens work within schools and community organizations to influence their peers and younger children through organized outreach programs.
- ❖ **Youth at high risk of pregnancy.** These teens are targeted with special programs and one-to-one interventions.

Community-based activities are a vital part of the school/community model. While school activities are important, the community, through its homes, churches, and civic organizations plays an equally compelling role. The goals of community-based interventions are to nurture community ownership of the problem; to foster understanding of the universal need for planned activities to solve the problem; to inform family, community, and business people about the available services and resources of the project; and to recruit clients and target audiences for the project's services. These community interventions involve the me-

dia, parents, religious organizations, health and human service organizations, and other community groups and activities.

Religious organizations have been particularly important in reducing sexual risk. Many churches and clergy promote strengthening families and improving adolescent health. Many believe the church has a pivotal role in teaching parents to become the primary sexuality educators of their children. Medical and public health professionals also play an important role in education about family planning and in referral to reproductive health services. Human and social services organizations also provide a variety of related services and are a critical component of a community-based prevention effort.

The School/Community project also stressed public outreach through local newspaper and radio stations and took advantage of opportunities to promote the program's messages by speaking to civic groups and holding public events. The goal was to saturate the community with pregnancy-prevention messages and raise awareness.

Conclusions

In years 2 through 4 after the implementation of the School/Community Program, the estimated pregnancy rate in the target county showed a remarkable sustained decline, a decline not observed in comparison counties. The model targeted the entire community and recruited parents, teachers, clergy, civic and social service organizations, youth, and others.

This model can be used in other places where unintended adolescent pregnancy is a social and public health concern. We recommend that efforts to adapt this program include three ingredients:

- ❖ Adequate funding to recruit professional staff and to allow enough time to implement and fine-tune a program
- ❖ A receptive intervention population made more responsive by appropriate information dissemination strategies
- ❖ Involvement of the entire community

Policy options

In my work, I have found the following options to be important ones for communities interested in preventing teen pregnancies to consider:

- ❖ Teen pregnancy is a complex sociocultural problem, and communities must recognize and accept responsibility for solving the problem.
- ❖ Local officials, community leaders and, especially, schools must make a public commitment to preventing teen pregnancy.
- ❖ Unintended pregnancies are a community public health problem. Effective solutions require multiple interventions directed at children, adolescents, parents, teachers, agency professionals, health care providers, business and industry, community leaders, and others.

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- ❖ Sexuality education in schools, from kindergarten through high school, should be sequential, age appropriate, and comprehensive. Graduate coursework and continuing education should be required for all sexuality education teachers.
- ❖ Programs and services that enhance life options, employment, job placement, crisis intervention, and case management are directly related to efforts to prevent teen pregnancy.
- ❖ Availability and access to educational programs, counseling, and services for contraception, pregnancy testing, adoption, and abortion should be provided by physicians, other health care providers, clergy, and other community organizations.
- ❖ Broad-based community interventions require adequate funding (estimated at \$150,000 a year) to employ professional staff to develop collaborative arrangements, orchestrate, and implement program components.
- ❖ Solving complex social problems takes time. Measurable changes in knowledge, attitudes, behaviors, and health status will take 3 to 5 years.
- ❖ Colleges and universities are valuable resources and partners to community programs. They can provide graduate and continuing education for teachers, technical assistance in community organization and planning, and assistance in designing evaluation methods to assess process, implementation, and health status outcomes.



The School/Community Sexual Risk Reduction Program for Teens was a cooperative effort involving the Bamberg School Districts #1 and #2, Hampton County School Districts #1 and #2, and the Department of Health Promotion and Education, School of Public Health, University of South Carolina. The project was supported by the Office of Adolescent Pregnancy Programs, U.S. Public Health Service, DHHS, and the South Carolina Health and Human Services Finance Commission. This program is now in the 3rd year of a 4-year replication initiative in three Kansas communities, funded by the Kansas Health Foundation.

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