

Healthy Generations

Volume 3, Issue 1
May 2002

Maternal & Child Health Program, School of Public Health at the University of Minnesota

Teen
Pregnancy

Inside this Issue

Healthy
Generations
Videoconference
Page 2

Beyond Disparities:
Nurturing Our
Young People
Page 5

NEWS
Minnesota's Teen
Pregnancy
Prevention Plan
Page 7

Aligning
Reproductive
Health Policies
with Reality
and Research
Page 9

What's Up?
back page

www.epi.umn.edu/mch



Health and Environmental Risks Associated with Early Childbearing

Wendy Hellerstedt, MPH, Ph.D.
Associate Professor
Division of Epidemiology
University of Minnesota

Adolescent mothers experience more pregnancy and delivery problems,^{1,2} and have less healthy babies than adult mothers.^{3,4} Most would agree that the health effects of teen childbearing – for mother and child – could be linked to the social conditions that precede pregnancy or be compounded by childbearing. While we understand short-term consequences, such as prenatal care access and infant outcomes, little is known about the long-term economic and social consequences of early parenting for girls. Research on men who father the infants of adolescents – some of whom may be adolescents themselves – is very limited. We do know that adolescent mothers – and adolescent fathers – are almost always partially educated and often depend entirely on adults or

social agencies for their economic welfare. The gap between reproductive maturation and social self-sufficiency is critical to why adolescent pregnancy and childbearing is defined as a "problem".

Another component of this "problem" is the prevalence and relevance of poverty. Early childbearing is concentrated among disadvantaged and impoverished youth. More than one-fourth of all adolescents in the U.S. are poor or near-poor. Approximately one-half of Black, Hispanic/Latino, and American Indian and one-third of Asian-American adolescents live in or near poverty. Many youth, especially those in poverty, may feel abandoned or isolated from mainstream society. In a money-driven society, how can impoverished youth develop a sense of future when they don't even fit in the present?

continued on page 2

Adolescent pregnancy and childbearing are health issues with profound social consequences. They are both intensely private concerns, yet they are the focus of relentless public discourse. Pregnancy and parenting among adolescents are considered by some to be measures of our nation's social ills. It is the social costs of adolescent pregnancy and childbearing, along with the medical or health consequences, upon which many researchers, policymakers, and educators focus their attention. It has been argued that the real risks of early childbearing are concentrated in the social dependence, rather than the biologic vulnerability, of the adolescent.

Adolescent childbearing is not uncommon in the U.S.: about 13% of all live births are to women younger than 20 years. There has been a considerable decline (20%) in teen birth rates between 1991-1999. In 1999, the birth rate was a record low (50 births/1000 among 15-19 year-olds). However, adolescent childbearing still remains a concern, as it is concentrated among the poorest and most disenfranchised youth. Characteristics of adolescents who become mothers are different from those of adolescents who get pregnant but do not have children and very distinct from the characteristics of adolescents who do not get pregnant. To understand the nature of early childbearing, and the characteristics of adolescent mothers, it is useful to recall that there are several steps that lead to childbearing including:

- o initiation of relevant sexual activity;
- o non-use, inconsistent or incorrect use of effective contraception; and
- o once pregnant, the decision to carry a pregnancy to term.

At each step, there are personal characteristics – and environmental and social conditions – that distinguish adolescent mothers from other adolescents. We hope to elucidate some of those distinguishing characteristics in this issue and in our subsequent videoconference on June 5, 2002.

We hope the articles in this issue stimulate discussion about social disparities and adolescent pregnancy, focusing on how we can nurture all young people with protective factors and how we can rebuild the agenda for teen pregnancy prevention to focus on reducing disparities among youth. Information on the fathers of infants born to adolescents will be presented at the videoconference. The authors of this issue and the presenters at the videoconference represent entities that have historically been close colleagues to the MCH Program faculty, staff, and students: Nancy Nelson, Executive Director of the Minnesota Organization on Adolescent Pregnancy, Prevention and Parenting (MOAPP); Michael Resnick, Director of the National Teen Pregnancy Prevention Research Center (PRC); Jennifer Oliphant, Outreach Coordinator at the PRC; and John Oswald, Director of the Center for Health Statistics, Minnesota Department of Health. The partnership among these individuals, and the organizations they represent, has facilitated several community-based research and education projects as well as provided a training ground for MCH students. Our invitation to these authors represents our recognition of their daily contributions to the well-being of youth through their professional work. We appreciate their generosity in sharing their insights with us.

–Wendy L. Hellerstedt, MPH, Ph.D.
–Erica Fishman, MSW, MPH

Healthy Generations Videoconference Adolescent Pregnancy and Parenting

June 5, 2002
1-3 p.m.

Blue Earth County
Voyager Room

410 S. 5th Street, Mankato

Chisago County

Lower Level, Rm 106

313 N. Main Street, Center City

Clay County

1st Fl., Family Services Center,

715 11th Street N., Moorhead

Crow Wing County

326 Laurel Street, Brainerd

Itasca County

Courthouse, Rm J135

123 NE 4th Street, Grand Rapids

Kandiyohi County

Room 2057, Health and Human

Services Building

2200 23rd Street NE, Willmar

Koochiching County

715 4th Street,

International Falls

Lyon County

Courthouse, Lower Level

607 W. Main Street, Marshall

Nobles County

Courthouse, Lower Level

315 18th Street, Worthington

Olmsted County

Room 2A/B

Government Center, 1st Floor

153 4th Street, Rochester

Ramsey County

MDH Distance

Learning Center

3rd Floor, Metro Annex

130 East 7th Street, St. Paul

St. Louis County

Government Services Center,

Room 709

525 W. 2nd Street, Duluth

Stearns County

Rm. 21, 205 Courthouse Square,

St. Cloud

Registration is limited by site. To register, please contact Jan Pearson by email (pearson@epi.umn.edu) or phone (612.626.8644). Please visit <http://www.epi.umn.edu/mch/mchsite/events.html> for any changes to these sites.

We do not understand, fully, what youth see as the rewards and the functional meanings of parenthood. We are especially ignorant of how young people with a bleak perspective on future educational and economic success think about the potential benefits of pregnancy and parenting. Current research into pregnancy intention among adolescents focuses on the limited view adolescents may have of their adult options. Some argue that adolescents do not necessarily intend to become pregnant, but are simply not motivated to avoid doing so.^{5,6} In other words, parenthood may be reduced to "nothing to lose". Because adolescents often enter their pregnancies with high economic and social risks, their pregnancies, and subsequent health, may be compromised.

Sexually Transmitted Diseases

Sexually active adolescents are at risk for Sexually Transmitted Diseases (STDs) preceding or during pregnancy. STDs are associated with several adverse pregnancy outcomes, including ectopic pregnancy, as well as infant outcomes including pneumonia, death, mental retardation, immune deficiencies and neoplasia.⁷

Approximately 60% of all cases of sexually transmitted diseases (STDs) in the U.S. are among individuals who are 25 years of age or younger.⁷ It is estimated that one in eight 13-19 year-olds (and about one in four 13-19 year-olds who have ever had sexual intercourse) will acquire an STD every year.⁸

Chlamydia trachomatis infection is the most common STD in the U.S. Incident and recurrent cases of chlamydia are highest among adolescent females.⁷ Therefore, the Centers for Disease Control and Prevention recommends chlamydia screening of all sexually active females who are younger than 20 years of age when they undergo pelvic examinations.⁹ Because some researchers have found the prevalence of chlamydia to be as high as almost one-third of clinical samples of adolescent females, there is some support for universal screening.^{10,11} Chlamydia is not the only STD to affect adolescents: more than half of the reported gonorrhea infections occur among adolescent females and syphilis has increased in minority group adolescents in the past decade.⁷ And, although relatively rare, HIV is also a concern of youth: it is estimated that about 25% of all new HIV infections occur among 13-21 year-olds.⁸

Violence

Adolescent mothers may be disproportionately exposed to violence and may have high rates of physical and sexual abuse histories.¹² For example, a 1991-1994 study of 7,178 women (including 910 adolescents) in Alaska showed that about 10% of the adolescent mothers were physically harmed by someone they knew during pregnancy or shortly after delivery; their reported risk of violence was twice that of mothers who were 20 years of age or older. The study also found that two-thirds of the pregnancies of the few mothers who were younger than 16 years of age at delivery were associated with statutory rape.¹³

Substance Use

Sexual risk-taking, including behaviors that result in pregnancy, is strongly correlated with the use of legal and illegal substances, including tobacco, alcohol, and cocaine.^{14,15} Not surprisingly, several researchers have found that adolescents

may be more likely than adults to use tobacco,^{16,17} alcohol and illicit substances during pregnancy,^{16,18,19} though the elevated risk has not been found consistently.²⁰

"In a money-driven society, how can impoverished youth develop a sense of future when they don't even fit in the present?"

There are very little data about the use of substances among adolescents postpartum or about the association of substance use to adolescent maternal health or parenting practices. A small study of urban adolescent mothers, however, found that, at four months postpartum, the prevalence of alcohol and/or illicit drug use was 42%,²¹ suggesting that attention should not only be paid to prenatal substance use but to its use after delivery. The authors of this study found that substance use was associated with maternal depression, stress, and the need for social support, but it was not clear if the use of substances preceded these psychosocial needs.²¹

Stress and Depression

The variety and magnitude of social and economic stressors experienced by adolescent mothers may contribute to high interpersonal stress. A recent analysis of data from the National Longitudinal Survey of Youth (1979-1992) showed that adolescent mothers reported more stress than adolescents who were not mothers. Adolescent childbearing was associated with feelings of failure, low self-

esteem, external locus of control, and having ever run away from home.²² Adolescent mothers may experience more depression than adult mothers. Data from the 1988 National Maternal and Infant Health Survey showed that adolescent mothers were much more likely than 25-34 year-old mothers to report symptoms of depression.²³ In an analysis adjusted for income and marital status, 15-17 year-old black adolescents and 18-19 year-old white adolescents were 1.6 times more likely than adult mothers to report symptoms of depression.²³

Prenatal and Obstetrical Risks

Compared with adult mothers, adolescents are at higher risk for less-than-adequate prenatal care⁴ and for some prenatal complications such as anemia, hypertension and poor nutrition.^{3,4,24} Year 2000 national data on births showed that only 64% of women who delivered live births when they were younger than 20 years of age received first-trimester prenatal care compared with 83% of all women; 9% of adolescents received late or no care compared with 7% of all women.⁴ There are few reliable data about the factors associated with late access to prenatal care, but financial concerns²⁵ and fear of disclosure to parents²⁶ could play a role.

Wiemann, et al.,²⁷ in a small study of adolescent prenatal clients, presented a thought-provoking hypothesis that adolescents with pre-pregnancy health risks (e.g., substance use, STDs) may be more linked to health-care providers than low-risk youth and, thus, may be most likely to receive an early confirmation of pregnancy and early enrollment into prenatal care. They found that the following factors were associated with late prenatal care entry for the adolescents in their study: no previous

history of abortion; no alcohol use in the 30 days preceding the survey; unemployment; black or white race (compared with Mexican-American ethnicity); limited education; one sex partner (vs. multiple partners) in the 12 months preceding the survey; and no relationship with the baby's father.

Studies have not consistently found that adolescents are at higher risk than adults for complications of pregnancy, such as preeclampsia, or complications of labor and delivery. However, it appears that the adolescent mothers at highest risk are very young mothers and that poverty, rather than maternal age, could be an important factor in pregnancy complications.^{1,2,20,28}

Maternal Postnatal Risks

Health Risks: The long-term health risks associated with adolescent childbearing are not well understood; however, there are several areas for future research, including whether excessive prenatal weight gain might predispose young mothers to adult obesity. Because adolescent mothers have more children in their lifetime than women who delay childbearing,^{29,30} they are also more vulnerable to parity-related health risks. The most severe health risk associated with parity is maternal mortality. Although it is rare in the U.S., maternal mortality is 1.5 times higher in women younger than 15 years of age compared with all women and 2.5 times higher among women younger than 15 years of age compared with women who are 20-24 years of age.³¹



continued on page 4

Greetings from Erica Fishman, MCH's New Director of Community Outreach

I am extremely pleased to introduce myself as the new Director of Community Outreach for the Center for Leadership Education in Maternal and Child Public Health at the School of Public Health. I am excited to be back at the University of Minnesota where I earned my Master's degrees in public health and social work. My passion for public health stems from the field's grounding in social justice and the science of epidemiology. My work experience over the past twenty years has been in the area of reproductive health as director and health educator of a community based agency and, most recently, as a health planner at the Minnesota Department of Health. My primary areas of focus have been family planning and teen pregnancy prevention within the framework of healthy youth development. In this capacity, I conducted needs assessments, collaborated with many state-level and community based programs, and assisted with the development of a state-level teen pregnancy prevention initiative. I also provided technical assistance on a variety of topics including family planning, social marketing, program planning and evaluation, policy development and advocacy, grant writing, exploring the role of public health agencies in MCH-related areas, and management and sustainability of programs.

Recently, I have been working on this issue of Healthy Generations and on our upcoming Summer Institute on Addressing Health Disparities. I am very interested in providing support and assistance to MCH faculty, students, and professionals at both the state and local levels throughout Minnesota, South Dakota, North Dakota, Wisconsin, Kansas, Iowa and Nebraska. Please feel free to contact me at erica.fishman@epi.umn.edu or at 612.625.4891. I am looking forward to working with many of you in the future!

Socioeconomic Risks : While the pregnancy-specific health risks are not clear, it is evident that the socioeconomic outlook for adolescent mothers is not good.^{30,32-34}

- Approximately 50-80% of mothers younger than 18 years of age live in poverty.^{30,34} This is not surprising because about two-thirds of adolescent mothers live in or near poverty at the time of delivery³⁵;
- Approximately 50% of adolescent mothers receive welfare and about 70% receive Medical Assistance within five years of giving birth.³² Approximately half of the 1994 welfare caseload was comprised of women who gave birth as adolescents. One national study of sisters showed that welfare receipt is independent of family circumstances: sisters who had children in their teen years were more likely to have received welfare than their sisters who delayed childbearing.³⁴ To date, it is not clear what the effects of welfare reform will be on the welfare or economic status of adolescent mothers and their children;
- There is strong evidence that adolescent mothers have fewer average years of schooling than adult mothers and are not likely to attend college.^{29,33,34,36} National data indicate that about two-thirds of adolescent mothers complete high school, compared with completion rates of about 90% for all adolescents.³² One national study estimated that having a child before the age of 20 years reduced educational attainment by almost three years.³⁶ It should be recalled that adolescent pregnancy, and especially parenting, are often preceded by poor academic performance^{29,37};
- Adolescent mothers have higher rates of early marriage – and divorce – compared with women who delay childbearing. Because of their greater likelihood to divorce or to never marry, adolescent mothers spend more time as single parents than those who delay childbearing^{29,34,38}; and
- Because adolescent mothers have less education – and perhaps because they tend to have more children than those who delay childbearing^{29,39} and are more likely to be single parents – they have less stable, less remunerative, and less satisfying employment than women who delay childbearing.³⁰ Overall, adolescent mothers may be less likely to be employed.^{33,34}

Current research makes it difficult to disentangle whether the poorer socioeconomic status of women who begin childbearing in their teens is associated with early childbearing itself or with the generally poorer socioeconomic circumstances of most adolescent mothers prior to their pregnancies.

Summary

The pregnant adolescent has often not completed her own physical, cognitive and emotional development. She thus must integrate the normal passages of adolescence with the new challenges and responsibilities of motherhood. Many adolescent mothers struggle with adulthood and motherhood in hazardous economic and social environments. Unfortunately, the extant data do not offer blueprints for the resolution of the many problems adolescent mothers and their families face. The data, however, do challenge us to understand and address the severe social, economic and psychological stressors that challenge young parents.

References:

1. Clark JFJ, Westney LS, Lawyer CJ. Adolescent pregnancy: A decade in review. *J Natl Med Assoc* 1987;79:377-380.
2. Satin AJ, Leveno KJ, Sherman ML, Reedy NJ, Lowe TW, McIntire DD. Maternal youth and pregnancy outcomes: Middle school versus high school age groups compared with women beyond the teen years. *Am J Obstet Gynecol* 1994;171:184-187.
3. Fraser AM, Brockert JE, Ward RH. Association of young maternal age with adverse reproductive outcomes. *New Engl J Med* 1995;332:1113-1117.
4. Martin JA, Hamilton BE, Ventura SJ, Menacker F, Park MM. Births: Final data for 2000. National vital statistics reports; vol 50 no 5. Hyattsville MD: National Center for Health Statistics; 2002.
5. Coley RL, Chase-Lansdale P. Adolescent pregnancy and parenthood: Recent evidence and future directions. *Am Psychol* 1998;53:152-166.
6. Zabin LS, Astone NM, Emerson MR. Do adolescents want babies? The relationship between attitudes and behaviors. *J Res Adolescence* 1993;3:67-86.
7. Institute of Medicine. The neglected health and economic impact of STDs. In: Eng TR, Butler WT, editors. *The hidden epidemic*. Washington, DC: National Academy Press; 1997. p. 28-67.
8. Office of National AIDS Policy. Youth & HIV/AIDS: An American agenda. Washington, DC: Office of National AIDS Policy; 1996.
9. Centers for Disease Control and Prevention. Recommendations for the prevention and management of Chlamydia trachomatis infections. *MMWR* 1993;42(RR-12): 6-7.
10. Burstein GR, Gaydos CA, Diener-West M, Howell MR, Zenilman JM, Quinn TC. Incident Chlamydia trachomatis infections among inner-city adolescent females. *JAMA* 1988;280:521-526.
11. Han Y, Coles FB, Hipp S. Screening criteria for Chlamydia trachomatis in family planning clinics: Accounting for prevalence and clients' characteristics. *Fam Plann Perspect* 1997;29:163-166.
12. Bayatpour M, Wells RD, Holford S. Physical and sexual abuse as predictors of substance use and suicide among pregnant teenagers. *J Adolescent Health* 1992;13:128-132.
13. Gessner BD, Perham-Hester KA. Experience of violence among teenage mothers in Alaska. *J Adolescent Health* 1998;22:383-388.
14. Graves KL, Leigh BC. The relationship of substance use to sexual activity among young adults in the United States. *Fam Plann Perspect* 1995;27:18-22, 33.
15. Santelli JS, Beilenson P. Risk factors for adolescent sexual behavior, fertility and sexually transmitted diseases. *J School Health* 1992;62:271-279.
16. Cornelius MD, Taylor PM, Geva D, Day NL. Prenatal tobacco and marijuana use among adolescents: Effects on offspring gestational age, growth, and morphology. *Pediatrics* 1995;95:738-743.

17. Ventura SJ, Mathews TJ, Curtin SC. Declines in teenage birth rates, 1991-97: National and state patterns. National vital statistics reports; vol 47, no 12. Hyattsville, Maryland: National Center for Health Statistics; 1998.
18. Amaro H, Zuckerman B, Cabral H. Drug use among adolescent mothers: Profile of risk. *Pediatrics* 1989;84:144-151.
19. Kokotailo PK, Adger H Jr, Duggan AK, Repke J, Joffe A. Cigarette, alcohol, and other drug use by school-age pregnant adolescents: Prevalence, detection, and associated risk factors. *Pediatrics* 1992;90:328-334.
20. Geronimus AT, Korenman S. Maternal youth or family background? On the health disadvantages of infants with teenage mothers. *Am J Epidemiol* 1993;137:213-225.
21. Barnett B, Duggan AK, Wilson MD, Joffe A. Associations between postpartum substance use and depressive symptoms, stress, and social support in adolescent mothers. *Pediatrics* 1995;96:659-666.
22. Kowaleski-Jones L, Mott FL. Sex, contraception and childbearing among high-risk youth: Do different factors influence males and females? *Fam Plann Perspect* 1998;30:163-169.
23. Deal LW, Holt VL. Young maternal age and depressive symptoms: Results from the 1988 National Maternal and Infant Health Survey. *Am J Public Health* 1998;88:266-270.
24. Stevens-Simon C, White MM. Adolescent pregnancy. *Pediatr Ann* 1991;20:322-31.
25. Kinsman SB, Slap GB. Barriers to adolescent prenatal care. *J Adolescent Health* 1992;13:146-154.
26. Young CL, McMahon J, Bowman VM, Thompson D. Adolescent third trimester enrollment in prenatal care. *J Adolescent Health* 1989;10:393-397.
27. Wiemann CM, Berenson AB, Pino LG, McCombs SL. Factors associated with adolescents' risk for late entry into prenatal care. *Fam Plann Perspect* 1997;29:273-6.
28. McAnarney ER, Hendee WR. Adolescent pregnancy and its consequences. *JAMA* 1989;262:74-77.
29. Hotz VJ, McElroy SW, Sanders SG. The costs and consequences of teenage childbearing for mothers. In: Maynard RA, editor. *Kids having kids: Economic costs and social consequences of teen pregnancy*. Washington, DC: The Urban Institute Press; 1997. p. 55-94.
30. Maynard R. editor. *Kids having kids: A Robin Hood Foundation special report on the costs of adolescent childbearing*. New York, NY: The Robin Hood Foundation; 1996.
31. Morris NM, Warren CW, Aral SO. Measuring adolescent sexual behaviors and related health outcomes. *Pub Health Rep* 1993;108(S1):31-36.
32. General Accounting Office. *Teen mothers: Selected socio-demographic characteristics and risk factors*. Letter Report, 6/30/98. GAO/HEHS-98-141.
33. Grogger J, Bronars S. The socioeconomic consequences of teenage childbearing: Findings from a natural experiment. *Fam Plann Perspect* 1993;25:156-161,174.
34. Hoffman SD, Foster EM, Furstenberg FF Jr. Reevaluating the costs of teenage childbearing. *Demography* 1993;30:1-13.
35. Alan Guttmacher Institute. *Sex and America's teenagers*. New York: Alan Guttmacher Institute; 1994.
36. Klepinger DH, Lundberg S, Plotnick RD. Adolescent fertility and the educational attainment of young women. *Fam Plann Perspect* 1995;27:23-28.
37. Wu LL. Effects of family instability, income, and income instability on the risk of a premarital birth. *Am Sociologic Rev* 1996;61:386-406.
38. Moore KA, Driscoll AK, Lindberg LD. A statistical portrait of adolescent sex, contraception, and childbearing. Washington, DC: National Campaign to Prevent Teen Pregnancy; 1998.
39. Maynard R, Rangarajan A. Contraceptive use and repeat pregnancies among welfare-dependent teenage mothers. *Fam Plann Perspect* 1994;26:198-205.

Did you know? The Hispanic teen pregnancy rate in Minnesota is increasing....

Nearly one in six Hispanic teens in Minnesota became pregnant in 1999, more than five times the rate for white teens. During the 1990s, when the teen pregnancy rate declined statewide for nearly every ethnic group, the rate for Hispanics rose 80 percent. Minnesota may have one of the highest rates of Hispanic teen pregnancy in the U.S. The reasons for the high number of teen pregnancies in the Hispanic community are likely complex. Many Hispanics in Minnesota are recent immigrants with little education, thus they may have heavy workloads (multiple jobs, long hours) to make ends meet. This could result in children left unsupervised. Also, it is known that educational attainment is negatively associated with pregnancy risk and in Minnesota one in three Latino teens drops out of school. School drop-out could be related to language barriers or to lack of local role models that encourage Hispanic youth to attain higher educations. There may also be strong cultural taboos related to discussing sexual matters or parents may simply lack information about birth control methods, especially if they are recent immigrants. It is known that Hispanic women of all ages are much less likely (54%) to use contraception at first intercourse than African-American (74%) or White (84%) women. The data on the increase in Hispanic teen pregnancies – and the data on school attainment and contraceptive use – clearly show different patterns for Hispanics than other Minnesotans. It is important to understand how Hispanics themselves perceive these trends and what their desires for programming and services are. With such understanding we can evaluate, and hopefully enhance, the capacity of educators and administrators to effectively deliver relevant programs to Hispanic youth and their parents.

Beyond Disparities: Nurturing Our Young People

Michael D. Resnick, Ph.D.
Professor and Director of Research
Division of General Pediatrics and Adolescent Health
Director, National Teen Pregnancy Prevention
Research Center
University of Minnesota

Today, a growing number of politicians call for programs and policies based solely on 'good common sense'. A familiar pattern reasserts itself during times of budget scarcity: the elimination of programs that foster healthy youth development in the name of 'common-sense' decision-making. Such decision-making is framed by exalting notions of personal responsibility within an idealized societal concept where hard work and good intentions are universally and consistently rewarded, where chance and circumstance can always be overcome, and where safety nets are firmly held not by government, but by

"Parent and family connectedness means that adolescents believe that their families understand them, care about their feelings, and respect them."

"Monitor and supervise your kids. Meet their friends. Know where they're going, who they will be with, and whether there will be appropriate adult supervision."

faithful family and community members. But the best research about protecting young people and promoting their well-being reflects societal circumstances objectively and provides us with a more measured view of the impact personal responsibility has in challenging environments. Now more than ever, public health professionals, researchers and advocates need to keep their voices strong and clear about the importance of evidence in crafting decisions that affect the health and life chances of young people.

For more than 15 years our interdisciplinary research team at the University of Minnesota's Center for Adolescent Health and, more recently, our National Teen Pregnancy Prevention Research Center, have been implementing and studying the results of state, national and international surveys to learn more about protective factors in the lives of youth. These are the experiences, events, and circumstances that promote health and well-being, and buffer young people from involvement in risky behaviors, including sexual behaviors that result in pregnancy. What has become clear is that there are protective factors that nurture *all* kinds of adolescents, whether they are African-American, White, Asian, Hispanic, or American Indian, boys or girls, or from urban, rural or suburban areas.

Protective Factors that Nurture All Adolescents

There is a consistent beneficial effect of feeling close to and cared for by parents and family members – whether in a single-parent, dual-parent, adoptive or foster family. Beyond the home environment, better emotional health and less risky behavior also occur when youth report feeling connected to school. This is true even when students are marginal academically.

Connectedness to Parents and Family

Parent and family connectedness means that adolescents believe their families understand them, care about their feelings, and respect them. When parents and families do not provide that kind of connectedness, it can come from other adults who are consistently involved in the lives of youth. This is why successful mentoring programs are those characterized by sustained adult commitment.

Not only is it important that youth feel connected to adults, the quality of parenting and adult supervision also matters. Adults who care for youth must be supportive, nurturing, have high expectations, clear rules, and a clear rationale for expectations and rules. This is not the same as permissive parenting, which is inconsistent enforcement of rules or the absence of rules. The message for parenting is this: parents are the most

important adults in the lives of youth and thus have an enormous effect on what teenagers do and value and believe about themselves and about the world. Because some may struggle with parenting, there is a role for schools, cultural centers, YWCAs and community centers in providing parenting classes with a specific adolescent focus. To reach these parents it is important not only to offer classes at times when parents can participate but in some communities, to teach parenting classes in trailer courts, housing projects, and other settings convenient to where the parents live or work.

There are some very specific messages that all parents need to hear. Monitor and supervise your kids. Meet their friends. Know where they are going, who they will be with, and whether there will be appropriate adult supervision. Practice communicating your expectations, rules, and consequences for breaking the rules. Follow through and explain why you do what you do. Make clear which behaviors are and are not acceptable. But be sure to give your kids the message that if they find themselves in an unsafe situation – if they are drunk, high or otherwise impaired and without a safe way home – they can call you and you will give them a ride, *and* a ride to their friends, no questions asked.

Consistent Parental Presence in the Home

In addition to the nature of the relationship youth have with adults, the quantity of time spent together is also important. Another significant protective factor for better adolescent emotional health and less risky behavior is consistent parental presence in the home. A parent or other adult should be consistently available at one or more of the following times: when the adolescent gets up in the morning, when the adolescent comes home from school, at family dinner time and when the adolescent goes to bed. Does this mean adults have to be home all the time to keep children safe and healthy? The evidence shows us that parents do not have to be home 24 hours a day to protect their adolescents from harm. However, adults do have to ask tough questions related to their own use of time, including work and recreational demands that affect the time they spend with their children. Policymakers also need to ask questions about workplace policies and national priorities which leave many full-time workers in this country not making a livable wage and needing to work additional jobs to keep the family going. Many of these workers may not have the ability to spend consistent time with their children. Research indicates the young people at higher risk were the ones who said: "I can't count on anyone being there at any consistent time."

Connectedness to School

Young people report a strong sense of connection to school when they indicate that teachers are fair, teachers care, and school is a place where they feel they belong. Students report a sense of belonging in school when there is at least one adult who is willing to listen and who they believe cares about them. Someone in that school environment is consistently delivering a message to young people that says: "I know who you are, I know your name, and I'm glad that you're here."

Young people also feel a sense of belonging in school when their friendship networks are in school rather than among out-of-school groups. Participation in school-based activities like service-learning projects that lead to overlapping friendship networks can promote the opportunity to relate to many groups of students who share interests and activities. Relationships among these students builds what sociologist Roberta Simmons called an "arena of comfort" in school. Many schools are building on the idea of connecting new students with someone in school who already knows the "lay of the land". This orchestrated pairing of students creates an infrastructure, acknowledging that connectedness to school is what gives young people a sense of community. In addition, connectedness is reinforced through individualized adult attention, whether from a teacher, coach, mentor, tutor, or someone else in the environment of the adolescent who is personally welcoming of them. And school connectedness is enhanced when there is good classroom management, promoting a desire and the ability to learn. One question we have to ask ourselves, based on the evidence about school connectedness, is: are we creating mechanisms that welcome and facilitate young people feeling part of this community that we call "school"?

Other building blocks of school connectedness

include making schools a place students regard as "safe". One of the elements measured in many student surveys is the extent to which hallways, bathrooms and schools overall are perceived to be safe or dangerous. Increased safety monitoring is needed in ways that are appropriate and yet not open to charges of harassment or voyeurism. These considerations take us directly into the politically contentious issue of physical safety in our schools and in the neighborhoods in which young people live and travel. Schools must be viewed within the context of neighborhood and community, with the understanding that fears about physical safety can drive young people to avoid school altogether.

Another element that undermines a sense of connection to school is the perception that many students have prejudicial attitudes. When students believe that many other students are prejudiced, whether based on sex, race, disability status, sexual orientation, or social class, it undermines their perceptions of security and belonging. Addressing prejudice against fellow students and appreciating individual differences can affirm a sense of school connectedness.

Healthy Human Development

What are the messages that caring adults should convey at home and at school? They are messages that encourage healthy emotional, intellectual, and physical development. A vision of what adolescents need for healthy development comes from *Professor Emerita* at the University of Minnesota, Dr. Gisela Konopka. In 1972, Dr. Konopka wrote a paper articulating the fundamental requirements for healthy adolescent development. Against the tumultuous backdrop of the Vietnam War, the civil rights movement, and growing disparities in health, Dr. Konopka identified the following fundamental

continued on page 8

Minnesota's Teen Pregnancy Prevention and Parenting Action Plan

Minnesota now has available a guiding document in the area of teen pregnancy prevention and parenting. Representatives of community based agencies, state agencies, and the University of Minnesota have been working to develop the plan. Included are two special focus areas: 1) addressing the disparities in pregnancy and birth rates between youth of color and white teens, and 2) teens as parents.

Overarching recommendations include:

- ~ Ground the program in a youth development approach
- ~ Use data and evaluation to inform program planning and continuous improvement
- ~ Involve parents and other caring adults
- ~ Assure community partnerships
- ~ Endorse sexuality education
- ~ Include men and boys
- ~ Support and coordinate resources and services for teen-parented families
- ~ Eliminate health disparities
- ~ Implement only comprehensive programming

Recommendations on programs that work as well as suggestions for what can be done are included.

For more information contact: prc@umn.edu or call 612.625.1674.

requirements for healthy adolescent development. Adolescents need

- to participate as citizens, household members, and valued members of society;
- to gain experience in decision making;
- to interact with peers and acquire a sense of belonging;
- to reflect on self, in relation to others, and to discover self by looking outward as well as inward;
- to discuss conflicting values and formulate one's own value system;
- to experiment with one's own identity, with relationships to other people, with ideas; to try out various roles without having to commit oneself irrevocably;
- to develop a feeling of accountability to others; and
- to cultivate a capacity to enjoy life.

These ideas from a generation ago still reflect our current thinking about protective factors in the lives of young people and what all youth need from us.

Our young people need constructive contact with adults who can guide their talents into useful, satisfying pathways. They need opportunities to participate in community activities that they value and adults value, especially service to others. They need an education that will serve them now and in the future and they need first jobs that offer a path to confidence, accomplishment and career opportunity. All of our young people need access to safe and satisfying recreation with encouragement and opportunity to be physically active and vigorous.

And – they need to be healthy.

Role of Public Health Workers

Ultimately, assuring the presence of protective factors in the lives of all adolescents is a multi-level, society-wide effort. Public health workers are well trained to communicate the message that pro-family policies are those that strengthen the capacity of families to function effectively. In some communities that means advocating for the concept of full-service schools and vibrant, accessible centers, that offer health, social, educational and vocational services for parents. It means expansion of the Child Care block grant that is only funded at 12% of projected need and for Head Start which is funded at only two-thirds of projected need. We need to realign resources and policies in schools, workplaces and communities and make personal choices to achieve the overarching goal of fostering positive connections in the lives of all young people.

What a difference it makes to our communities and to our young people when there is an active cadre of adults who advocate for healthy youth development, grounded in evidence about what works! What a difference it makes when our schools and communities are places of welcome that prepare adolescents for a future full of options, when there are ample opportunities for active engagement, valued contribution and fun. What a difference it makes when there are imaginative public health advocates who refuse to reduce adolescents to a narrow set of risk indicators. In times of scarcity, when competition among social sectors runs high, a vibrant and dynamic public health imagination is what young people truly need and deserve from us.

Resources upon which this material is derived:

- Borowsky I, Ireland M, Resnick MD. Adolescent suicide attempts: Risks and protectors. *Pediatrics* 2001;107:485-493.
- Konopka G. Requirements for healthy development of adolescent youth. *Adolescence* 1973;8(3):292-316.
- Resnick MD. Protective factors, resiliency and healthy youth development. *Adolescent Medicine: State of the Art Reviews* 2000;11(1):157-164.
- Resnick MD, Bearman PS, Blum RW, Bauman KE, Harris KM, Jones J, et al. Protecting adolescents from harm: Findings from the National Longitudinal Study on Adolescent Health. *JAMA* 1997;278:823-832.
- Resnick MD, Harris LJ, Blum RW. The impact of caring and connectedness on adolescent health and well being. *J Paediatr Child H* 1993;29s:1s-9s.
- Rosenberg M, Simmons R. Black and white self-esteem: The urban school child. Arnold M and Caroline Rose Monograph Series. Washington, D.C.: American Sociological Association; 1972.
- Sieving RE, Beuhring T, Resnick M, Bearinger LH, Shew M, Ireland M, et al. Development of adolescent self-report measures from the National Longitudinal Study of Adolescent Health. *J Adolescent Health* 2001;28(1):73-81.

See also our website: <http://www.prc.umn.edu> and the linked website of the Division of General Pediatrics and Adolescent Health at the University of Minnesota (<http://www.allaboutkids.umn.edu>).

Nutrition and the Pregnant Adolescent

Nutrition and the Pregnant Adolescent: A Practical Reference Guide is a resource for health professionals and educators on nutrition and adolescent pregnancy. The book focuses on the clinical application of current knowledge on adolescent pregnancy. Topics include adolescent growth and development; nutritional needs and eating disorders; nutrition assessment and management; interviewing, counseling, and education; and postpartum issues. Cost (including shipping): 1-10 copies, \$20/copy; 11 or more copies, \$18/copy. Additional charges for Canadian and international orders. To order contact: Kathy Kosiak, Division of Epidemiology, University of Minnesota, 1300 South 2nd St., Suite 300, Minneapolis, MN 55454-1015; Phone: 612.626.7143; Fax: 612.624.9328; Email: kosiak@epi.umn.edu. Order form and downloads also available at: <http://www.epi.umn.edu/let/nmpabook.html>.

Aligning Reproductive Health Policies with Reality and Research

Nancy Nelson, Executive Director,
Minnesota Organization on Adolescent Pregnancy,
Prevention and Parenting

Teen pregnancy prevention is a complicated issue with no simple solutions. It does not lend itself well to sound bites or factoids. And it is a topic fraught with value judgments, stereotypes, and misinformation. Given these challenges, how do we advocate for and create effective policies that will have a positive impact on preventing teen pregnancy?

KEY ISSUES

Family Planning

The Centers for Disease Control and Prevention (CDC) characterize family planning as one of the "Ten Great Public Health Achievements" of the 20th century because of its focus on prevention and its considerable impact on morbidity and mortality. According to the CDC, "Access to family planning and contraceptive services has altered social and economic roles of women. Family planning has provided health benefits such as smaller family size and longer intervals between the birth of children; increased opportunities for preconceptional counseling and screening; fewer infant, child, and maternal deaths; and the use of barrier contraceptives to prevent pregnancy and transmission of human immunodeficiency virus and other STDs."¹

Each year in Minnesota, publicly supported family planning services prevent more than 23,000 pregnancies.² Yet, for the past few years, the Minnesota House of Representatives proposed eliminating state grant funding to any provider that counsels about, refers to or performs abortions. Most family planning providers and organizations that provide comprehensive sexuality education cover the range of services and options for pregnant women and individuals who want to prevent pregnancy. Eliminating funding to these providers would paralyze the capacity of Minnesota's community clinics and public health agencies to prevent unintended pregnancies and births because these agencies are major providers of educational and clinical family planning services to low-income, high-risk women and men.

There are also concerns about current restrictions on how the state-appropriated Family Planning Special Project grant monies can be used. Many community-based adolescent health clinics depend on these funds to provide education, outreach and medical services to adolescents who need

confidential, low or no-fee services. However, none of these funds can be used to provide services in secondary schools, a key site for reaching youth at risk for pregnancy.

Welfare Reform

Research shows that comprehensive sexuality education that includes information about abstinence and contraception is effective in delaying the onset of sexual activity and increasing the use of protection. Other successful programs incorporate service learning, youth development strategies, and family planning services.³ Instead of investing in programs that research shows to be effective, the current administration in Washington, D.C. and the social conservatives in our state legislature continue to propose strategies that have not been proven effective, including supporting abstinence-only-until-marriage education. These strategies are not research-based but instead are linked to the political ideology underlying endorsement of "personal responsibility" that permeates welfare reform legislation.

An overarching goal of the 1996 federal welfare reform law placed a strong emphasis on reducing out-of-wedlock childbearing and teen pregnancy. Since 80% of teen births are non-marital and families that started with a teen birth account for more than half of Minnesota's welfare recipients⁴, teen pregnancy prevention should be a key strategy in preventing future welfare dependency.

During the 2002 Congressional Session, the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (welfare reform) will be reauthorized. The reauthorization debates will provide an opportunity for reframing the provisions to better meet the goals of welfare reform, including "preventing and reducing the incidence of out-of-wedlock pregnancies." This includes reconsidering the investment of \$50 million per year in abstinence-until-marriage funding to states to teach that sexual activity outside the context of marriage has "harmful psychological, emotional and physical effects." In addition, programs that use the abstinence-until-marriage funds cannot provide medically accurate information about contraception. Minnesota currently receives \$2.1 million in state and federal funds annually to provide abstinence-only education to youth under 14 years of age.

At the time welfare reform was launched and to this day, there is no evidence that abstinence-only approaches have had any effect on adolescent pregnancy. Reauthorization of welfare reform provides an opportunity to increase the states' flexibility to implement effective teen pregnancy prevention efforts, and to implement programs that reflect best practices.

Visit our website to review past issues of *Healthy Generations*

Adolescent Tobacco Use

Childhood Obesity & Nutrition

Women's Reproductive Health

Child Abuse & Neglect

Adolescent Alcohol Use

Child/Adolescent Mental Health

www.ept.umn.edu/mch/mchsite/resources.html

WHAT CAN WE DO?

Reproductive health issues are often hidden and are always sensitive and political, and thus they do not receive the full debate necessary to create responsible policy. People who know about these

Interested in making a difference?

Consider a Master's of Public Health (MPH) degree in Maternal and Child Health (MCH).

What is the MCH Program? It is a training program for MPH students who are interested in promoting and preserving the health of families, including mothers, children and adolescents. The Program is part of the Division of Epidemiology in the School of Public Health at the University of Minnesota.

Who are the faculty? The MCH staff and faculty are multidisciplinary with expertise in epidemiology, medicine, nursing, psychology, nutrition, family studies, health education social work, and program administration. MCH faculty focus their research, teaching, and community service on reproductive health and family planning; pregnancy outcomes; social inequities in health; women's health; infectious diseases, substance use; child, adolescent, family, and community health promotion; risk reduction; resiliency; and child and family adaptation to chronic health conditions.

Who should apply? People who care about vulnerable populations and want careers in program planning and development, evaluation, surveillance, assessment, teaching or research. The program offers a special emphasis on MCH epidemiology for interested students. Clinical professionals, and others with advanced degrees who are interested in administering MCH-related health programs or conducting research projects are also encouraged to apply. Individuals with advanced degrees may have the option of completing the two-year MPH Program in one year.

Individuals who have taken the GRE or have medical degrees may still apply for enrollment in August 2002.

For further information about the MCH Program. Call 612.626.8802 or 1.800.774.8636; email gradstudies@epi.umn.edu; or visit <http://www.epi.umn.edu/mch> and <http://www1.umn.edu/twincities/>.

issues must connect with national and state-level professional and advocacy organizations to stay on top of the debates and the votes. Also, the strongest advocates for reproductive health issues are often brought together by religious or political concerns, not public health concerns. Thus, public health professionals who understand the complexities of sexual behaviors and the consequences of inadequate reproductive health care must work to educate policymakers. The following are some actions that public health professionals can become engaged in.

Implement recommendations from *Call to Action to Promote Sexual Health and Responsible Sexual Behavior*.

In the summer of 2001, Dr. David Satcher, the former Surgeon General of the United States, issued a *Call to Action to Promote Sexual Health and Responsible Sexual Behavior* to address the significant sexual health challenges facing Americans.⁵ The former Surgeon General sounded the alarm on the high rates of sexually transmitted disease and HIV/AIDS infection, unintended pregnancy, abortion, sexual dysfunction, and sexual violence. Dr. Satcher urged all communities to begin a dialogue about sexual health, encouraging all parents to talk with their children about responsible sexual behavior, and to support teachers in their roles as sexual health educators. According to Dr. Satcher's report, "Approaches and solutions might be complex, but we do have evidence of success. We need to appreciate the diversity of our culture, engage in mature, thoughtful and respectful discussion, be informed by the science that is available to use and invest in continued research." A key theme in this report is that many options for education and services must be available to support reproductive health.

Support legislation to fund comprehensive sexuality education.

A Family Life Education Act (HR3469) was introduced in Congress in December 2001 as an effort to provide funding over five years to states for comprehensive sexuality education that includes information on abstinence and contraception. The funding would appropriate \$100 million for each fiscal year, beginning with fiscal year 2003, and does not require states to provide a match.⁶ Surveys conducted nationally and in Minnesota indicate that adults, and especially parents, expect schools to provide comprehensive sexuality education, and do not support the claim that teaching youth about contraception encourages sexual activity.⁷ The Family Life Education Act is based on the research that shows that young people who receive accurate, comprehensive information are more likely to postpone sexual activity. When they become sexually active, they are also more likely to protect themselves from sexually transmitted infections and/or unintended pregnancy.

Reduce disparities in teen pregnancy and birth rates.

While teen pregnancy and birth rates have decreased significantly over the past ten years in the United States, they are substantially higher than any other Western industrialized country. The U.S. adolescent pregnancy rate is twice that of Canada or Great Britain and nearly four times that of France or Sweden. A study conducted by

the Alan Guttmacher Institute in 2001 reported that levels of sexual activity and the age at which teenagers initiate sex do not vary across the countries. The differences are due to three things all related to education and contraceptive use: 1) sexually active teens in the United States are less likely to use any contraceptive method; 2) they are especially less likely to use highly effective hormonal methods than their peers in other countries; and 3) U.S. teens have less access to adequate sexuality education and affordable, confidential reproductive health services. Pregnancy and birth are also more common among U.S. teens in part because the U.S. has a greater proportion of disadvantaged families.⁸ Such families are most affected by policies that govern health access and public sex education.

Minnesota's teen pregnancy rates have always compared favorably with national statistics; in 1997, the rate of pregnancies for Minnesota's 15-19 year olds was 46.1 per 1,000 compared to 94.3 per 1,000 in the U.S.⁹ However, Minnesota teens of color experience some of the highest rates in the country, with teen pregnancy rates three to five times higher than their white peers. While overall teen pregnancy rates have been decreasing over the past ten years, rates for Latino and Asian teens have increased.¹⁰ Policymakers and communities must work in partnership to reduce the disparities through both appropriation of resources and implementation of research-based and promising programs and services.

The Eliminating Health Disparities Initiative, developed by the Minnesota Department of Health and enacted by the Minnesota Legislature in 2001, has the potential to positively affect racial disparities by providing resources directly to community organizations that serve populations of color and ensuring services are culturally responsive. Twenty "healthy youth development" grants have been provided to community organizations around the state to decrease infant mortality by preventing teen pregnancy for the period of March 2002 through December 2003.

Become engaged in the development of responsible adolescent and reproductive health policies.

To better align our adolescent and reproductive health policies with research-proven strategies, we all need to be engaged in the development of responsible policies. Taking part in candidate forums, finding out candidates' positions on reproductive health issues, and participating at all levels of the political process, are strategies to ensure that the best possible policymakers are elected. Reproductive health issues

affect a great portion of the population that does not vote and, thus, it is even more important that the adults who are informed take the time to educate decision-makers. Involving young people in educating policymakers is an important way to teach them about the democratic process, to provide them with public speaking opportunities and it is also a very effective strategy to put a face on the issue for the decision-makers. Letters to editors, commentary pieces, radio interviews, and alerting the media to events related to teen pregnancy prevention are all important strategies for educating the broader public.

Research shows what programs are effective in promoting reproductive health and preventing teen pregnancies. We need a stronger base of support to advocate for improving adolescent health in general as well as preventing teen pregnancies. The reproductive health status of our youth will not improve if we keep this vital information about what works and what is needed to ourselves. Share what you know often and continuously in many different ways. Coordinate your efforts with the professional and advocacy organizations that you trust. You owe it to the young people you care about.

References:

1. Centers for Disease Control and Prevention. Ten great public health achievements-United States 1900-1999. MMWR 1999;
2. Alan Guttmacher Institute (AGI). Contraception counts: State-by-state information. Issues in Brief, Series No. 3. New York: AGI; 1999.
3. Kirby D. Emerging answers: Research findings on programs to reduce teen pregnancy. Washington, DC: The National Campaign to Prevent Teen Pregnancy; 2001.
4. Minnesota Department of Human Services, December 1999.
5. Office of the U.S. Surgeon General. The Surgeon General's call to action to promote sexual health and responsible sexual behavior. Rockville, MD: U.S. Government Printing Office; 2001. Available from <http://www.surgeongeneral.gov/library/sexualhealth/default.htm>. Accessed on April 10, 2002.
6. Sexuality Information and Education Council (SIECUS). Family Life Education Act is introduced in U.S. House of Representatives. SIECUS Policy Update, December 13, 2001. Available from <http://www.siecus.org/policy/PUupdates/pdate0041.html>. Accessed on April 10, 2002.
7. Minnesota Organization on Adolescent Pregnancy, Prevention and Parenting (MOAPPP). What we want: Minnesotans attitudes on sexuality education. Minneapolis, MN: MOAPPP; 2000. Available from <http://www.moapp.org>. Accessed on April 10, 2002.
8. Boonstra H. Teen pregnancy: Trends and lessons learned. Washington, DC: Alan Guttmacher Institute; 2002. Available from <http://www.guttmacher.org/pubs/journals/gr050107.html>. Accessed on April 10, 2002.
9. Martin JA, Hamilton BE, Ventura SJ, Menacker F, Park MM. Births: Final data for 2000. National Vital Health Statistics Report 2002;50(5). Available from http://www.cdc.gov/nchs/data/nvsr/nvsr50/nvsr50_05.pdf. Accessed on April 10, 2002.
10. Minnesota Department of Health, Center for Health Statistics; April 2002



“Partners in Health” - What’s Up?

Wendy Hellerstedt, MPH, Ph.D.
Associate Professor
Division of Epidemiology
University of Minnesota

Some people think that university-based programs are just about data collection and publications. However, university researchers exist within communities and are often drawn to public health research because of personal values that compel them to address social injustices. Many researchers are involved in small outreach programs that are poorly funded but incredibly enriching to everyone involved. These programs don’t make the headlines, but they do make an impression on those who donate their time and energy to keep them running.

‘s Up: Empowering Youth Through Peer Education

An example of a great program that has been run on a shoestring for years is the Students Uplifting Peers, or ‘s Up program. This is a collaborative youth development education intervention, administered by Wendy Hellerstedt of the MCH Program and Jenny Oliphant from the National Teen Pregnancy Prevention Research Center (PRC). It is funded by a small family-based grant to the School of Public Health and the PRC. It is staffed by MPH graduate students – often from the MCH Program – who are interested in developing health education skills and in working with high-risk youth. ‘s Up is a peer education program in the heart of Phillips, the largest and poorest neighborhood in Minneapolis. Sixty-nine percent of the youth in Phillips live in poverty and many experience school failure, early pregnancy, and exposure to drugs and violence. It is home to the city’s largest American Indian population (24%); nearly one quarter of its residents are African American, and less than one half are white.¹ It is also a neighborhood where many youth are difficult to engage in programming because drugs, violence and ambivalence compete for the youth’s attention. In spite of these challenging circumstances, the ‘s Up program flourishes. And it flourishes because of the kids who get involved.

This program focuses on youth as a resource to be developed rather than a problem to be solved. Teens, ages 13-18, attend approximately 30 hours of unpaid training at a local park on topics pertinent to adolescent life such as decision-making, sexually transmitted infections, birth control, career readiness and basic job skills training. The two-hour training sessions challenge the youth to examine their own beliefs, values, knowledge and practices. They then use these skills to teach others. A mixture of structured curricula (taught by MCH students who lead the groups) and guest speakers from other community sites is used.

For many, adolescence is a difficult time. An adolescent’s changing roles and physical development place him/her in the awkward position of wanting to be an adult before being prepared – developmentally or physically – to take on the responsibilities of adulthood. Youth in the Phillips Neighborhood face challenges beyond those of normal adolescent development. Poverty, violence, gangs and teen pregnancy are everyday occurrences for many of these teens. However, the resiliency of youth is their greatest asset, and it

is upon this that ‘s Up builds. ‘s Up follows the *empowerment health education model* which puts learners’ interests, needs, and questions about health central to the process and makes learners active participants in the learning process. Empowerment health education focuses on the facilitation of individual choices by supplementing knowledge acquisition with values clarification and decision-making practice. In addition, ‘s Up uses peer education as a mechanism for service learning. The kids who participate become teachers to their siblings, friends, and one another. Research on peer education has shown positive associations between involvement as a peer educator and positive changes in attitudes, skills and behaviors. And we know that youth benefit from receiving accurate information from a preferred and influential source: their own peers. In addition, the MPH students who coordinate the program gain invaluable health education experience. As a past coordinator said, "This is one of the most rewarding and challenging jobs I have ever had." Finally, the community benefits when youth feel connected, cared about, responsible, and know they have something to offer others.

‘s Up and Teen Pregnancy

‘s Up strives to prevent teen pregnancy and promote healthy adolescent development by providing participants with an opportunity to replace risk-producing behaviors with health-enhancing behaviors while developing leadership and job skills. Specifically ‘s Up has these objectives: (1) provide 14 health enhancing educational sessions to 8-10 male and female teens annually who live or go to school in the Phillips neighborhood of Minneapolis; (2) increase participants’ knowledge of sexuality issues and other "real life" issues facing teens; (3) encourage opportunities for participants to apply their new knowledge in their own environment; (4) increase participants’ decision-making skills and values clarification; and (5) introduce basic job skills and have each participant develop his or her first resume.

‘s Up has been going strong – training youth and MPH graduate students – for years and we hope it will continue to do so. This year, like every year, there are more youth interested in participating than the program can accommodate. And this year, like every year, the MPH students who provide the instruction are enthusiastic, challenged, and rewarded by the incredible young people who are truly leaders in their community.

1. Minnesota Department of Health (MDH). Populations of color in Minnesota. Minneapolis, MN: MDH; 1997.

