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ABSTRACT

The Mott Foundation has been involved with the issue of teenage pregnancy for 15 years, and has supported a network of programs with the main objective of finding new ways to deal with the negative consequences of teenage pregnancy. This report, which reflects the Foundation's perspective, is divided into six sections. The first provides an overview of the problem. The effect of teenage pregnancy on the family is described in the second section, while the third outlines programs that are sponsored by Mott. This is followed by detailed descriptions of two of these programs: (1) Health Education for Youth, an outreach project at Columbia-Presbyterian Medical Center in New York City, and (2) the Parent/Infant Interaction Program, conducted by the St. Louis, Missouri, Public Schools. Finally, the paper presents an interview with Dr. Anita M. Mitchell, head evaluator of the projects in the Mott network. Also included in the report is a list of steps for evaluating program impact. (AOS)

MOTT FOUNDATION SPECIAL REPORT

TEENAGE PREGNANCY:
A CRITICAL FAMILY ISSUE

Table of Contents

TEENAGE PREGNANCY:
A CRITICAL FAMILY ISSUE

Teenage Pregnancy: A Critical Family Issue, is a special section reprinted from the 1981 annual report of the Charles Stewart Mott Foundation.

A Message from the President:

For more than 15 years, the Mott Foundation has been involved with the critical issue of teenage pregnancy. Since 1978, the Foundation has supported a network of programs with the common objective of finding new ways to deal with the negative consequences of teenage pregnancy once it occurs and the mother has opted for delivery. It is now our objective to move into a phase of disseminating the results of those efforts.

There is no doubt that the issue of teenage pregnancy and parenting is both complicated and value-laden. There are many beliefs concerning the issue and we are aware of the range and intensity of feeling it can evoke.

Our purpose in preparing this special section, then, is not to advocate any one particular view, but rather to present the problem in an objective manner and to share with you the Mott Foundation's approach to supporting programs that address the tragedies implicit in too-early childbearing.

William S. White
President
The Charles Stewart Mott Foundation

TEENAGE PREGNANCY: A CRITICAL FAMILY ISSUE

Imagine yourself in a classroom with twenty 14-year olds, evenly divided between boys and girls. Most appear to be self-possessed young people; some have begun to think about college and careers. But that's still in the future. For now, they are coming to terms with mathematics, reading, science and social studies. They are learning to become comfortable with their growing bodies — and with the opposite sex.

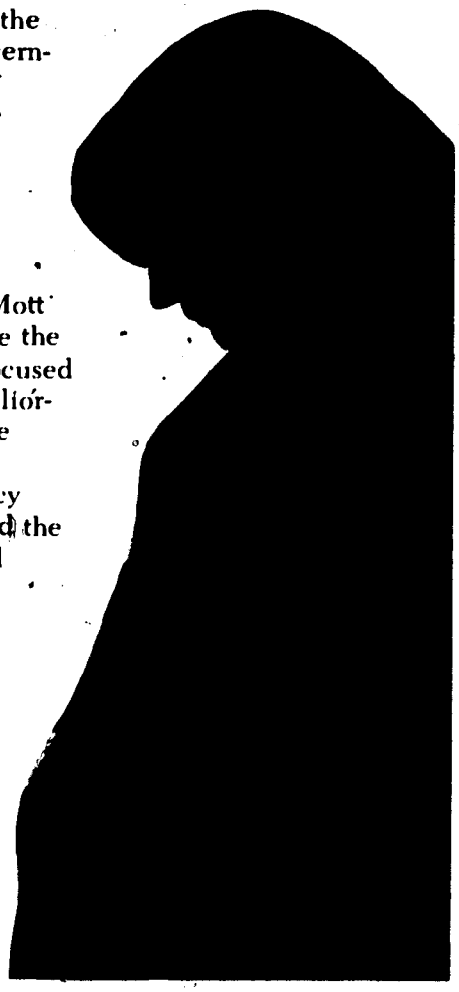
But the startling fact is that, if this is an average U.S. classroom and present trends continue, three or perhaps four of the 10 girls will be pregnant before they celebrate their twentieth birthday, according to a recent Alan Guttmacher Institute study. No less staggering are the potential costs implied in these trends both to the individuals concerned and to society. For the individuals, the risks include birth complications for the young mothers and developmentally disabled infants. For society, there is the likelihood of unabating poverty for the young families and the need for publicly supported health, welfare, and other special services.

In the past decade, public attention has focused increasingly on problems associated with adolescent sexuality and, more specifically, with teenage pregnancy. As a result, researchers have produced a range of facts and figures, hundreds of communities have adopted programs, and the federal government has intervened through policies and legislation. But the impact of teenage pregnancy continues to be felt poignantly in every community and in every social and economic class, and the issues connected with adolescent sexuality continue to stir sharp controversy.

The Mott Foundation's interests in the problems of adolescent girls long antedate current concerns with their sexual behavior. In 1938, the Foundation was instrumental in the establishment in Flint of the Stepping Stone Program for teenage girls. Mirroring the values of the day, the program's initial interest was in personality and character building and the teaching of home-making skills.

As the problems of adolescent girls broadened and became more complicated, it was inevitable that these changes would be reflected in the Foundation's program concerns. In the early 1960s, consequently, Charles Stewart Mott himself asked the Mott Children's Health Center, another Flint agency, to provide space for a maternal and child care program supported by the Clara Elizabeth Fund. A spinoff program, Family Life Education, was created with Foundation support and then picked up by the Flint Board of Education. And in 1967, the Foundation began 14 years of funding to Flint's Continuation School, an alternative high school for pregnant teenagers.

The Foundation continues its funding in this area today, but given the dollars now available from other sources, it has shifted its targets to maximize its impact. To date, most of the support from governmental sources and other private foundations has been directed toward pregnancy prevention. In contrast, the Mott Foundation, since the late 1970s, has focused primarily on ameliorating the negative consequences of teenage pregnancy once it occurs and the mother has opted for delivery.



After nearly four years of funding, an impact evaluation program of the Mott-funded activities has resulted in a number of short-term findings we feel are significant. These include:

- **Teenagers can be taught, at a modest cost, to control their own fertility.**
- **Birth complications to young mothers can be reduced through proper medical care and supervision.**
- **Participants in one program, in St. Louis, had fewer low birth-weight babies than peers who were not in the program.**
- **The self-esteem of young mothers who participate in these types of programs was increased.**
- **Knowledge about parenting skills was gained and the skills practiced.**
- **Repeat pregnancies of the program participants were reduced.**
- **Teens that participate in the programs stay in school and achieve at grade level or better.**
- **Early findings indicate that high school juniors and seniors enrolled in these programs were more likely to complete high school.**

In previous years, this special section of our annual report has highlighted specific programs of support in such areas as neighborhoods and black higher education. This year, the section focuses on the pressing problems of adolescent pregnancy. Collectively, the following six articles reflect our perspective on the issue. The first provides an overview of the problem. The second describes the effect teenage pregnancy has on the family. The next article outlines the programs that are part of the Mott network today, and is followed by descriptions of two of those programs. We complete this section with an interview with the evaluator of the projects in the Mott network.

A Look at the Problem: The Tragedy, the Costs, and the Consequences

Marie was considered to be the brightest — and most independent — child in her white-collar family. But after graduating from high school, Marie decided to try independence. She moved to another city and found a minimum-wage job.

A year later, she was pregnant. When her employer found out, she was fired. Her family, shocked and dismayed, unsuccessfully urged her to return home. Instead, Marie collected welfare and sought some outside help in deciding her options. A counselor suggested she put the baby up for adoption, and she agreed.

After the baby was born, Marie went back to work, but she found only a series of low-paying jobs. She and the baby's father gradually drifted apart. Today she tries not to think, in her lonely moments, about the healthy little girl she has never seen. No one in the family ever mentions the incident anymore; some family members don't know about it yet.

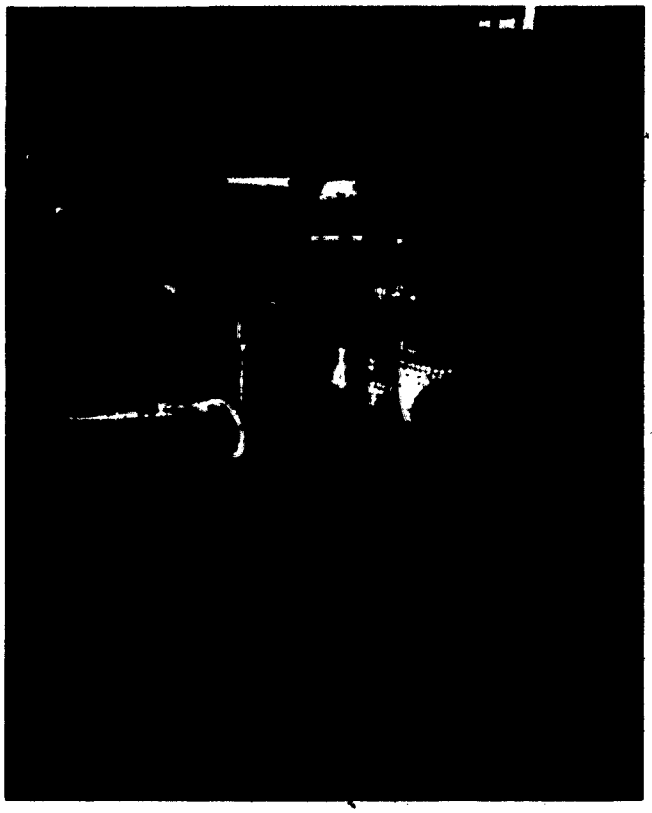
Marie's problems are among the most prevalent and burdensome family issues in the United States. Because of the increased sexual activity of today's teenagers, there are few households that have not been touched at some time and in some way by the pregnancy, or risk of pregnancy, of a daughter, a niece, a cousin, or the girlfriend of a son, a nephew, a brother. Even those families whose teenagers have refrained from early sexual activity have had to help pay the rising costs in financial and social terms.

And costs there are.

To the young woman, there are medical, educational, emotional and economic consequences. The baby faces risks of impaired health and development. For the father-to-be, and the families, there are also emotional and economic effects. And taxpayers share part of the burden, up to an estimated $8.3 billion, to provide health and welfare assistance from birth through childhood, to all of the babies born to teens in just one year.

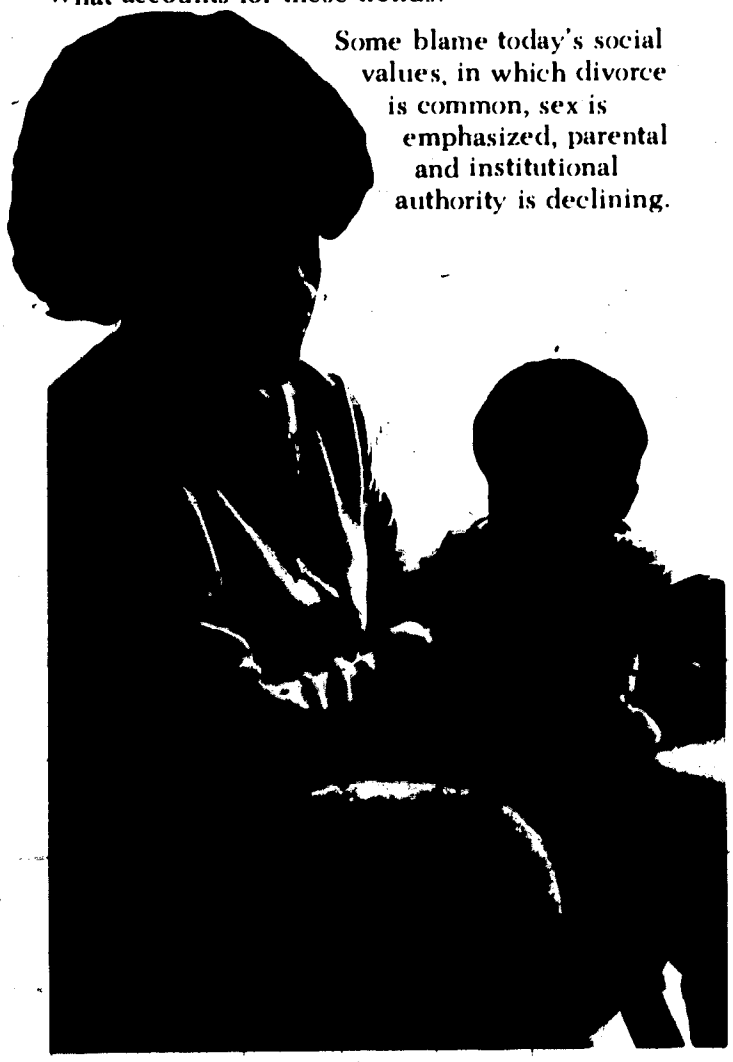
Although early motherhood was more prevalent in the 1920s and mid-1950s than it is today, it was considered a personal and private matter until the last decade or so. Today, however, the federal government, the states, school districts and private organizations, including some foundations, have zeroed in on too-early pregnancy as a critical national and local issue. Why the attention to this issue today?

- **More teenage girls are becoming pregnant — some 1.2 million annually. About one in 10 girls age 15 to 19 becomes pregnant each year. If current trends continue, more than one-third of today's 14-year-old girls will have experienced at least one pregnancy before reaching their 20s.**
- **While only one-half of the 1.2 million teenage pregnancies result in birth, this is mainly because of the rising number of abortions. About 38 percent of the pregnancies result in abortion, the rest in stillbirths or miscarriages.**
- **While the birth rate for teenagers is declining, the portion of babies born out of wedlock is on the increase. In 1978, nearly half of the births to teens occurred outside of marriage, compared with less than one-third eight years earlier.**



- **Two-thirds of today's pregnancies to teens are unintended, and among unmarried teens, seven-eighths are unwanted.**
- **In 1979, the majority of teen pregnancies — about 685,000 — occurred to older teens, 18 and 19; about 425,000 to girls 15 to 17, and about 30,000 to those under 15. However, the birth rate is rising slightly among the young teens, who are in the highest risk category.**
- **Nine out of 10 teenage mothers, unlike Marie, take their babies home with them instead of releasing them for adoption. This places heavy economic and social burdens on the mother.**
- **Teenage mothers tend to have more babies and have them closer together than older women. Six in 10 teen mothers who deliver before they are 17 become pregnant again before they turn 19. Medical risks for the infant, moreover, increase with each successive child.**

What accounts for these trends?



Some blame today's social values, in which divorce is common, sex is emphasized, parental and institutional authority is declining.

Others note that young people in this country are maturing physically at an earlier age. Studies show that two-thirds of the teens who have sex regularly do not use an efficient form of birth control due to lack of knowledge about sex and contraception, perceived difficulty in obtaining contraceptive devices, parental consent issues, or adolescent reluctance to plan contraceptive use.

The tragedy is that young women must be making adult types of decisions at a time when they should simply be preparing for adulthood. Moreover, young women who choose motherhood can suffer consequences far beyond social disapproval. If they keep their babies, they end up juggling elements of their lives — baby sitting, finances, schooling or a job.

Teenage mothers also are more likely than older mothers to suffer from medical complications in pregnancy and childbirth without good prenatal care and nutrition. But many put off such care until the second or third trimester or the delivery itself. Teens also are more likely to die as a result of childbirth, and to sufffer from toxemia, anemia and complications from premature births. They also have a higher incidence of prolonged labor, prenatal and postnatal infections and surgical deliveries.

Their children also have a greater chance of dying than those born to older mothers or of developing serious childhood illnesses, birth injuries and neurological defects. Crucial is the fact that a teen's baby is more likely to be premature or of low birthweight.

Those teens who choose marriage may not be better off. Divorce is common among them. Frequently, early parenthood forces young men and women to leave school and find employment — and married mothers are twice as likely to drop out as unmarried ones. There also is some evidence that abuse is commonly faced by those who marry after they become pregnant.

Pregnancy is a leading cause of school dropout at a time when there is more reason than ever for young people to continue through high school and college. Many professionals believe the curtailment of education is a factor leading to severe economic consequences for these young people. Teen mothers, for example, have an income only half that of older first-time mothers. There also is a strong association between early childbearing and being on welfare: Six out of 10 women in AFDC families gave birth as teenagers.

Additionally, teenage parents are more likely than their classmates to hold low-prestige jobs. They are over-represented in the blue-collar working class and under-represented in the professional classes before they reach the age of 30.

What's been done?

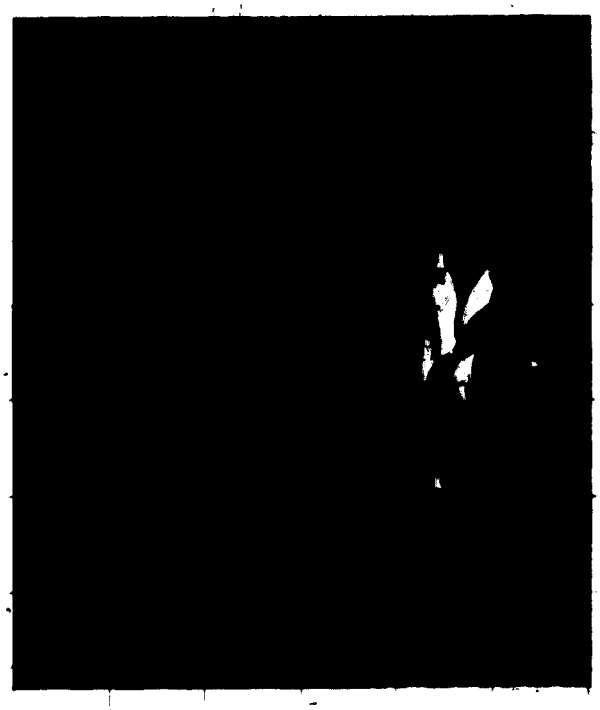
Two decades ago, there were few specialized services for teenagers who did not want to become pregnant or who were already pregnant or parenting. Great strides have been made in providing today's teenagers with family planning, medical, educational and social services. Social consciousness has changed. Today's parents are worried about pregnancy among their children and 80 percent favor sex education in the schools. Family planning services avert nearly 700,000 premarital pregnancies in one year. School districts are required to allow pregnant students in the classroom, and many offer special or alternative programs for them.

Programs themselves have begun to be more flexible in the hours they are open, and in providing an atmosphere congenial to today's young people, outreach, subsidized transportation, and peer or one-to-one counseling. They have begun to seek out teens who would otherwise fall through the cracks in the system.

Although some programs have been successful in meeting the needs of the young people they serve, however, there is still a long way to go in solving the problem.

Professionals in the field say we need better preventative methods, whether through education, outreach or development of new medical contraceptives. We need to increase the number of comprehensive programs that link teens with medical and social services in the community and fill the gaps that exist. We need to help young parents cope with the difficulties of rearing children while they themselves are not fully grown. We need to educate the parents of today's and tomorrow's teenagers in dealing with sexual activity.

But most of all, we need to continue to care about young parents and pregnant teens.



"Mom, I'm Pregnant."
The Impact on the Family

The words "Mom, I'm pregnant" can produce a crisis for the girl's entire family. When the shock wears off, there are consultations to arrange, decisions to make.

"Until I got pregnant, I was the apple of my father's eye," said one 15-year-old mother. "My mother wanted me to have an abortion, but I was too far along. Then both of them wanted me to put the baby up for adoption. I wouldn't talk to my dad."

She kept the child.

Parents have few legal rights concerning whether their daughters carry their babies to term or terminate the pregnancy. However, they do have influence. They help decide where their daughter will live during and after the pregnancy, whether she will leave school or stay, and how the child will be cared for.

In the past, those families who could afford it sent their daughters away from the community, either to have an abortion quietly or to give birth away from home. Those less well off married quickly or bore their children under the disapproving eye of the community. This difference between economic classes continues today: Those who are poor or black are less able to pay for an abortion and are less likely to get one.

However, researchers have learned that if the daughter decides to have the child, her status in the family may change. Often a scapegoat, she may become the favored family member. Her baby, when born, will be welcomed; often the grandmother develops maternal feelings toward the child. The effect on the teen's siblings may be less positive; sometimes they feel displaced or in competition.

Family support is critical to a teen mother's future. It has a definite effect, for example, on whether she will finish high school and become employed later on.

A study of more than 300 pregnant teenagers and their mothers over a five-year period found that teen mothers who lived with their families were more likely to receive substantial amounts of financial and emotional support and assistance in child care. The families were more likely to help if the teen remained single and in school, and if there were two parents in the home.

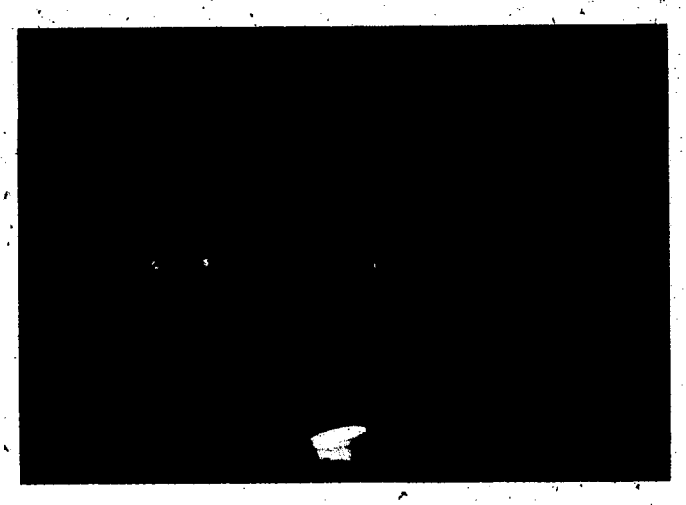
If they lived with their parents, 87 percent of adolescent mothers remained in school, 62 percent graduated from high school, 60 percent had jobs, and only 43 percent received welfare five years later. If they lived alone, 76 percent stayed in school, 47 percent graduated from high school, 41 percent got jobs and 65 percent received welfare payments.

Living with the mother's family also has a positive effect on the infant. The child's cognitive development is better when a grandmother or the child's father are involved than when the mother rears her child alone.

Thus, the family can ameliorate the outcomes of early childbearing.

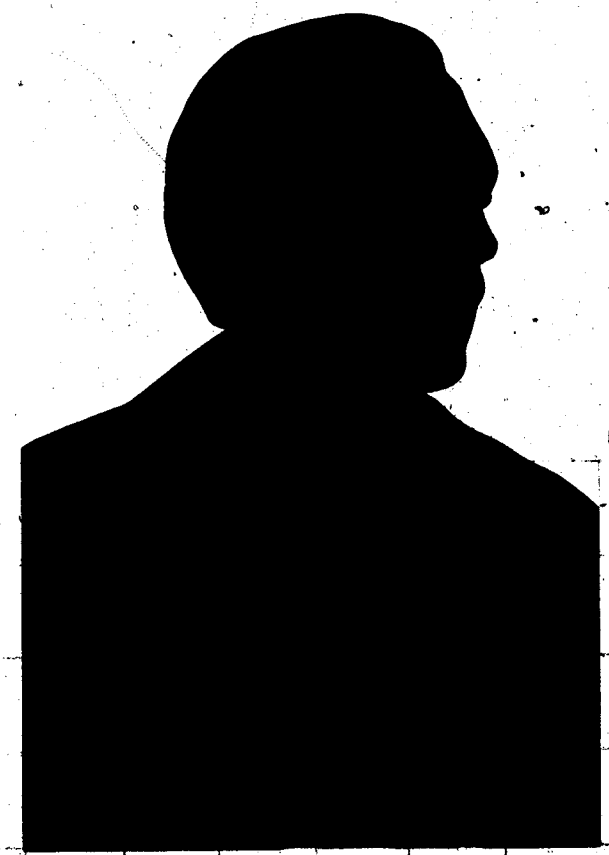
In contrast, the role of the baby's father has been studied very little. Legally, the unwed father has few rights unless the mother decides to give up the baby for adoption or unless he acknowledges paternity and thus has a financial responsibility. The attitude of the girl's family toward the young father also has a definite effect on whether he is accorded any rights. We also know that if he marries during his school years, the young father faces the same likelihood of dropping out as his teenage spouse, and that he is likely to hold a lower-prestige and lower-paying job.

A small study of male partners in teenage pregnancies in a rural county of Michigan in the late 1970s found that certain family characteristics are related to the pregnancy. The young fathers tended to come from considerably larger families and were found to be in the last half of the birth order regardless of family size. Additionally, nearly half of the males in the study had brothers or sisters known to be involved in teenage pregnancies.



There is some evidence that although friends have the greatest influence on a teen's sexual decisions, males who have a close relationship with their families engage in sexual activity less often than other young men. However, the sexual double-standard still prevails. Most young men say it's acceptable to tell girls they love them to persuade them to have sex. Most also say they are against abortion.

In the Michigan study, 80 percent of the males thought they should be involved in the pregnancy's resolution. Interestingly, the females perceived the male's influence on the decision as stronger than he did. When he used his influence,



he was successful in getting his decision carried out 83 percent of the time. Most of the time, direct pressure was used to argue the abortion outcome and was completely successful, according to the researchers.

Even without the complication of teenage pregnancy, the social issue of teenage sexuality raises difficult questions for families. Most families today must grapple with the problem of ensuring that their children have the facts about sex and birth control without encouraging their participation.

Many parents feel the schools should offer such education, and some may be privately relieved if they do. Parents in one study, for example, enthusiastically endorsed the concept of community help in assisting them to teach their children about sex. While sex education programs improve a student's knowledge of sexuality, however, they do not seem to affect the values guiding his or her behavior. The family remains the earliest and primary structure through which values are taught to young people.

The family is, after all, a mediating institution — like the church, the neighborhood and voluntary associations — and serves as a vehicle through which society can channel values and action, and through which family members make their values known to society. The family is thus a pivot point for a wide variety of issues.

Historically, sociologists thought teenage pregnancy was a product of poor family relationships; therefore, helping agencies focused on individuals rather than families. Many believe today, however, that families can serve as an effective and efficient conduit to provide services to many pregnant or parenting teenagers. While more research is necessary, some professionals have recently voiced an opinion that parents should be viewed as equal, or senior partners, in dispensing services to pregnant or parenting adolescents.

The issue of parental notification by agencies that provide family planning or abortion services to teens is extremely controversial today. Many parents feel that federal dollars should not support programs that undermine the authority of the family by allowing a teenager to obtain these services without its consent or knowledge. In contrast, many observers and professionals believe that if such notification is required, teens will not use contraceptives or will use those available in drug stores, which may be less effective.

There is little doubt that if and when this dilemma is resolved, others will take its place. Sexuality is that kind of an issue. However, the paramount consideration must be how any policies will affect the adolescents, whose main task at this point in life is to develop their independence. Normally, this is accomplished over a period of time; unfortunately, pregnancy speeds up the process, forcing teenagers to take on adult roles and responsibilities and, at the same time, making them more dependent than ever upon their families.

Mott Network

Projects that Can Make a Difference

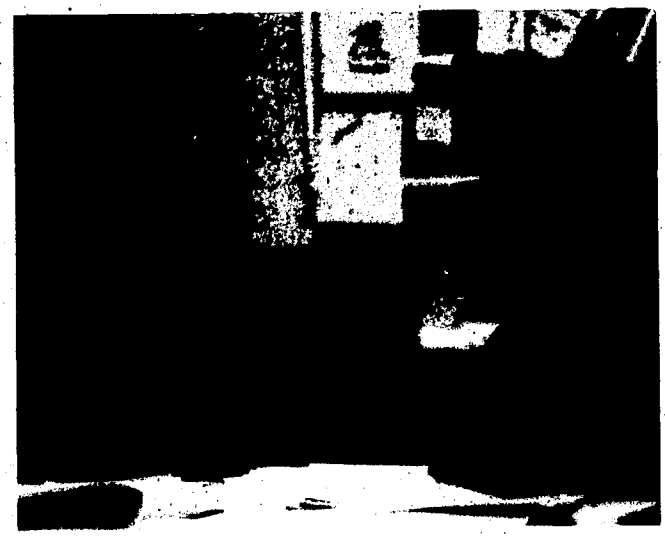
From a small network of eight prevention and/or treatment programs, the Mott Foundation is learning that certain program elements can make a difference in preventing or ameliorating the consequences of teenage pregnancy.

Collectively, programs in the Mott network serve a wide range of teens — black, white, Hispanic, Chicano and Native American. Their services range from prevention and outreach to hand-holding during labor and delivery, infant care, and follow-up beyond their participation in a formal program.

The network evolved from a program funded by the Foundation in Flint, Michigan, its hometown, in the early 1960s, and expanded in 1978 to four other communities:

The Continuation School for Girls. Fifteen years ago, this alternative program was introduced by the Flint Board of Education to provide academic coursework and social services to pregnant students to help them continue their education, to increase the quality of health care and birth outcomes, and to reduce repeat pregnancies. The program also provides an infant-care laboratory.

Cyesis. Three academic options are available for participants in Cyesis (the Greek work for pregnancy), a program operated by the School Board of Sarasota County. The options are: individualized coursework at the program center, specialized instruction for handicapped students at the county student center, or graduate equivalency classes at the vocational center. Depending upon her needs, a student can get transportation, free meals, day care and individual or goup counseling as well.



Parent/Infant Interaction Program. This is a year-round, after-school program operated by the St. Louis Public Schools. It is described in an article beginning on page 29.

Comprehensive Adolescent Health and Education Program. Columbia University developed this prevention program in New York City to increase the number of teens — primarily Hispanic and black — using a clinic for pregnancy prevention and other services. An article about it begins on page 25.

Home Front. This program, a component of The Bridge, Inc., in Boston, serves alienated, out-of-school youth to help them improve their living conditions, avoid repeat pregnancies and improve their child-care skills. (Sixty percent of the 90 women in the program during a 15-month period had child neglect or abuse petitions filed against them). The project, which received two years of Mott funds, offers health education, life skills training, child care and counseling, and linkage with community services.

In 1979, a fifth program was added and three more received Mott support during 1981:

Helping Oakland's Pregnant Teenagers. The Oakland, California, Unified School District received a Mott grant in 1979 to plan how to retain pregnant and parenting students in the school system and return dropouts to the classroom. The resulting program includes vigorous outreach, multi-disciplinary teams who deliver the actual services, participant advocates and liaisons and linkages with other community services. Students may attend classes in a regular, alternative or continuation school, or a combination, or enroll in independent study and/or work experience.

Adolescent Pregnancy Prevention and Supportive Services Program. This new program, a collaboration of the Rochester, New York, Board of Education and the Monroe County Health Department, includes coordination of existing services and development of a maternal and child health team for prevention, casefinding, outreach, follow-up and home visitations. It also includes an infant-care center.

Comprehensive Adolescent Health and Education Program. This is a comprehensive prevention and service program for teens and families; primarily low-income Mexican-Americans in the Corpus Christi, Texas, barrio. Girls are referred for prenatal care, social and health services, and receive home, individual and peer counseling in such subjects as sexuality, health, and child growth and development. Services in the program, operated by the Gulf Coast Council of La Raza, continue after the delivery of the child.

Teenage Pregnancy Program. This project, operated by the Seattle Indian Health Board, provides both prevention services to Native Americans at risk of pregnancy and services to teens already pregnant or parenting, their infants and their families. Components include outreach and advocacy, the establishment of a working relationship with local tribal programs, and comprehensive medical and social services, such as family planning, maternity care, individual counseling and assistance, referrals and family counseling. An infant care program is staffed with Indian grandmothers and young parents can enroll in an educational or vocational program.

Impact Evaluation. Although it was not the Foundation's original intent to develop a network, it soon became apparent that programs could both

learn from each other and share their experience. This exchange now occurs during two formal conferences each year and through informal contact.

Soon after the early programs were in place, moreover, it became apparent that there was a need for statistically significant data on their effectiveness.

In 1978, consequently, Dr. Anita Mitchell, aided by Dr. Deborah Klein Walker, began providing technical assistance to measure the impact of the programs. These evaluations were supported through grants to the Southwest Regional Laboratory, where Dr. Mitchell is a senior scientist. Dr. Walker is an assistant professor in Harvard's School of Public Health.

An article on their work begins on page 33.

The Foundation, since 1978, has also funded several programs directly related to teenage childbearing but not encompassing actual services to pregnant adolescents. One project trained teens to provide to their peers information on sexuality and family planning. Another was a research study of pregnant adolescents and their partners in a rural county of Michigan. Two others analyzed the effect of governmental policies about teenage pregnancy.

Over the years, the Foundation has granted nearly $2.3 million for projects to reduce the negative consequences associated with teenage childbearing. Although it is too soon to have accumulated longitudinal data, our early results indicate it's been a worthy investment.

The Mott Network

PROGRAM	DESCRIPTION	MOTT SUPPORT TO DATE	SERVICES																	
			SUPPORT GROUPS	FOLLOW-UP	HOME VISITS	PREVENTION	COORDINATION OF HEALTH SERVICES	CHILD CARE	SCHOOL CONTINUATION	COUNSELING	FAMILY SERVICES	TRANSPORTATION	SERVICES TO FATHERS	LUNCHES OR BREAKFASTS	JOB TRAINING OR CAREER COUNSELING	PEER COUNSELING	OUTREACH	SOCIAL SERVICES	REFERRAL
Continuation School for Girls Flint, Michigan	Full-day, school-based alternative high school. Operated since 1966. Serves 150 girls annually	$781,495 (1966-1982)				X	X	X	X	X				X					X
Cyesis Sarasota, Florida	School based with academic and home-and-family living components. Developed out of community education model but now a part of vocational education. Serves 45 annually	$32,364 (1978-1982)	X	X		X	X	X	X	X		X		X				X	X
Parent Infant Interaction Program St. Louis, Missouri	After-school program featuring multi-disciplinary approach and strong outreach. Serves 355 annually	$192,162 (1978-1982)	X	X	X	X	X	X	X	X	X		X	X	X	X	X	X	X
Comprehensive Adolescent Health and Education Program New York, New York	Developed out of Columbia University, serves primarily Hispanic and Black community. Works with variety of institutions. Major goal is prevention. Serves estimated 5,500 annually	$362,323 (1978-1982)		X	X	X	X		X	X	X		X			X	X		
Home Front Boston, Massachusetts	Serves alienated teens who are pregnant or mothers in non-traditional setting. Teaches life-skills in "kitchen table" setting. Served 120 annually	$185,000 (1978-1981)	X			X	X	X	X	X				X	X	X		X	X
Helping Oakland's Pregnant Teenagers Oakland, California	School based program that works closely with community agencies to provide comprehensive services to teens. Multi-disciplinary approach using advocates. Planning started in 1979, implementation in 1980. Estimated 285 girls helped annually	$151,989 (1979-1982)	X		X	X	X	X	X	X	X				X		X	X	X
Adolescent Pregnancy Prevention and Supportive Services Program Monroe County, New York	Collabrative program between Board of Education and county health department to reduce drop-outs, infant mortality and welfare families. Demonstration infant care center to teach parenting skills. New program with capacity for 200	$78,000 (1982)		X	X	X	X	X	X	X	X						X	X	X
Comprehensive Adolescent Health and Education Program Corpus Christi, Texas	Prevention and comprehensive service program for pregnant or parenting teens. Serves primarily low-income, Mexican-American population. Strong emphasis on school retention. New program with capacity for 75	$79,380 (1982)	X		X	X	X	X	X	X	X		X		X		X	X	X
Teenage Pregnancy Program Seattle, Washington	Serves Alaskan and American Indians in Puget Sound region. A new program, it is expected to develop prevention and service components, as well as comprehensive medical and social services. New program with capacity of 250.	$80,000* (1981)	X		X	X	X	X	X	X	X	X	X		X	X	X	X	X
Impact Evaluation	Evaluation process for the above listed programs which will provide statistical data to determine what program elements do and don't work.	$177,000 (1978-1981)		X															

The Mott Foundation is not alone in its efforts in the field. Other foundations working the areas of teenage pregnancy and population issues include the Pew Memorial Trust, the Lilly Endowment, the Educational Foundation of America, and the Andrew W. Mellon, Robert Wood Johnson, Rockefeller, Ford, San Francisco, Danforth, Hewlett, New York, Philadelphia, Geraldine Dodge, Daisy Marquis Jones, Playboy, El Paso Community, and the William Penn Foundations.

The Columbia Connection: Adolescent Health Education

The neighborhood of Washington Heights near 168th St. and Broadway in New York retains some of its early charm, despite the ever-present traffic and the deterioration of buildings that line the sidewalks. There are no front lawns here, but stoops where people sit when the sun is out.

There are storefronts, some with iron gates, others without windows or signs. A corner grocery has a tidy assortment of fruits and vegetables displayed outside to attract buyers. There's a park and pool a couple of blocks away — empty now.

Twenty years ago, this was an upper-middle-class white neighborhood. Today it is primarily Hispanic. Reportedly, 80 percent of the residents are Dominican, 60 percent of them illegal aliens. They work in sweat shops when they can find jobs, but the neighborhood, especially east of Broadway, is poverty-ridden. Living conditions are difficult: One resident describes rats in his apartment building "as big as cats;" another talks about a building that has recently collapsed.

Not surprisingly, this is a neighborhood with many health needs. Teen sexual activity is high. So are rates of venereal disease. Although the residents comprise 16 percent of the population of Manhattan, they contribute 20 percent of the total pregnancies.

On the west side of Broadway, where the Columbia-Presbyterian Medical Center is situated, the neighborhood changes. The buildings are newer — and the atmosphere different. The medical center includes a number of health institutions — among them, Presbyterian Hospital as well as Columbia's Center for Population and Family Health.

Presbyterian Hospital operates a Young Adult Clinic (YAC) for Washington Heights teens who require family planning as well as venereal disease control, pregnancy testing, cancer screening and gynecological care. It operates in the late afternoon and early evening, when teens are out of school.

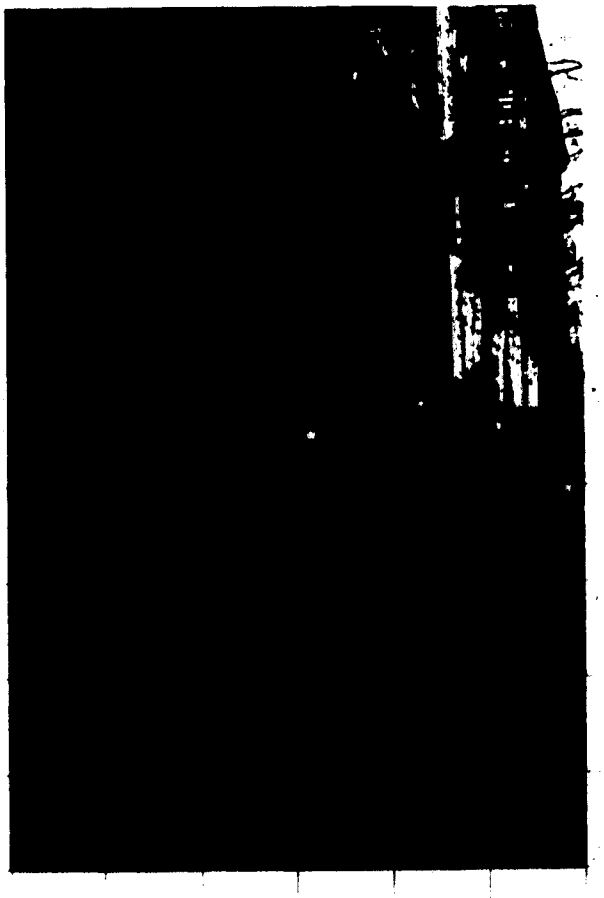
In 1978, the Center for Population and Family Health was searching for ways to bring more teens into the clinic. With seed funds from the Presbyterian Hospital Auxiliary and the Women's Opportunity Giving Fund, a program was developed to deepen community understanding of the risks of adolescent childbearing and to educate sexually active teens about pregnancy prevention. Health educators would work in schools and informal settings; promote links with the area's churches, community groups and parents, and improve communication between parents and their teens. Another component, Peer Education Resource Team (PERT), would train a dozen teenagers to provide information about the clinic to teens outside the traditional school setting. This outreach strategy — titled Health Education for Youth (HEY) — is what the Mott Foundation funded in 1978.

According to Judith E. Jones, assistant director of the Center for Population and Family Health, the outreach program has played a key role in developing and expanding available health services for teens. During the first two years of HEY, more than 4,000 teenagers were contacted through sex education classes in the schools and the community and through informal gatherings such as health fairs. The classes concentrated on improving students' knowledge of when conception is most likely to occur. While staff found that they received just as many referrals to the clinic from informal as from formal contacts, the programs in the schools resulted in more changes in attitudes about contraception.

Most important, the community itself has been highly receptive to outreach. One of the health educators, for example, is Aurea Martinez, a dynamic woman fluent in both Spanish and English. She has had prime responsibility for health education training and counsels teenagers in the clinic program as well. She thus serves as a direct link between the outreach and service components of the program.

On a particular day, Mrs. Martinez has set up shop in the waiting room of the daytime ob/gyn clinic. It's standing room only — the small space is crammed with mothers, children and staff. Despite the noise, Mrs. Martinez commands attention. She discusses — first in Spanish, then in English — a variety of topics relating to sexuality. Today she concentrates on the risk of pregnancy during the menstrual cycle. At first, the women respond shyly, then with enthusiasm, finally asking questions of their own.

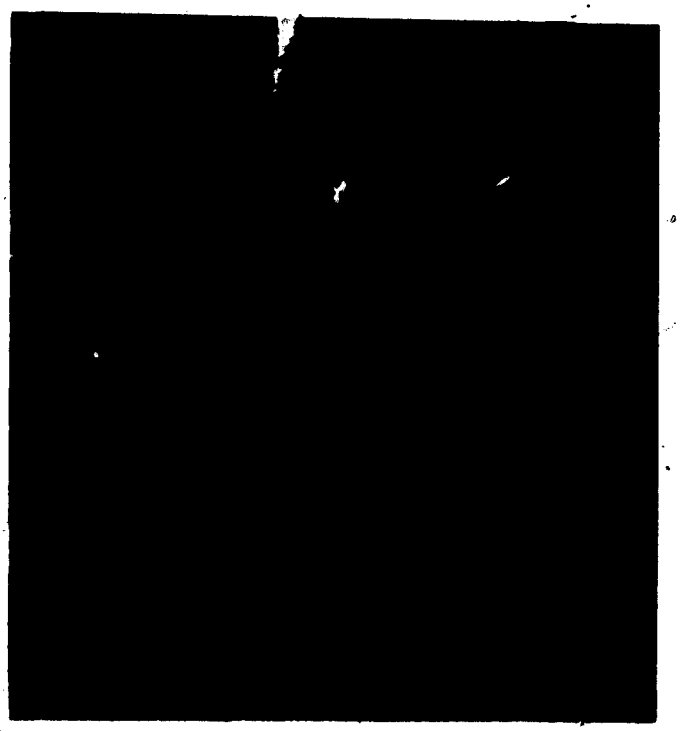
The members of the Peer Education Resource Team were bright, motivated teens who went to parks, summer recreational programs and churches to pass out pamphlets about YAC and discuss pregnancy prevention. Although the referrals generated were disappointing, the program's impact on the PERTs was immense. Some now serve as group facilitators in clinic discussion sessions; others have become involved in Teatro HEY.



Teatro is a bilingual, health education theater group started in the fall of 1981 to improve communication between parents and teens by using improvisational dramatizations about real-life family situations. Based on New York's innovative Family Life Theatre, the Columbia project was funded primarily by the Ruth Mott Fund in Flint and some Mott Foundation dollars. The purpose of the class is to provide a vehicle for self-expression, increased communication among parents and teens and sharing of teen issues with the community. The effort was so successful that the St. Louis PIIP program adapted it.

Another new program element was added in 1981: community health advocacy. This outreach program focuses on finding those teens who have a high risk of troubled pregnancies, their families and young males. Currently, there are six advocates who concentrate their efforts in a 10-block area bounded by 165th and 175th streets and Audubon and Amsterdam. The advocates, who work in teams for safety, speak both Spanish and English. They first visited residences, agencies and churches to introduce the program, but now deal directly with individuals and their families.

Eva Jaramillo and Rosa Kesser are partners. Ms. Jaramillo, who has children 10 and 13, first became interested in the program after attending several HEY seminars about parenting. Ms. Kesser worked with the mentally retarded in a day



treatment center, heard about the advocacy program and was accepted in the program. As they walk to the office, they greet people they have visited before, stop and ask about a little girl's amblyopia, or discuss a resident's attempt to improve the condition of his apartment building.

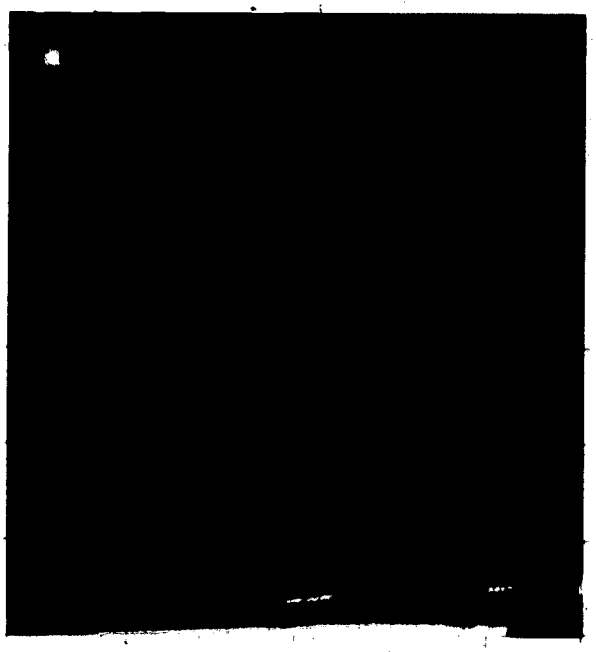
Like the other advocates, they have found that the community accepted them more easily if they could also provide information about needs other than health — jobs, the economy, housing, how to apply for Medicaid.

"At first we had to knock on doors cold," said Ms. Kesser. "We told them we worked for the hospital and asked them if they had any questions about contraception. We do that still, but people are calling about other problems."

As part of the advocacy effort, health education and counseling programs are being developed for individuals and groups about such topics as adolescent pregnancy, pregnancy prevention, and the effect of pregnancy on the family and the male partner. The staff anticipates forming community groups for men, parents, grandmothers and young fathers. It is also developing "natural helpers" in the neighborhood, people who can contact pregnant teens who are not receiving prenatal care or who need health and social services, and sexually active teens who need preventive health services.

Eventually, the advocates plan to add "*doulas*" to the network — people with motherly personalities who can help young women rear children and who can encourage such health-related practices as breastfeeding.

"We're trying to develop community self-sufficiency, so that the community has the tools to use the services available to them. It doesn't make much sense to keep the knowledge here," said Ms. Jones. "The young people we see at the clinic have already demonstrated this ability. But those at greatest risk need assistance in seeking and utilizing preventive care.



"There's a lot of risk with this program," she added. "This is a very transient population, so the strategy may not work."

At the Young Adult Clinic, 43 teens have already signed in for services. Because this is a holiday weekend, attendance is down from its normal level of 60 or 70. Since it opened, the clinic has served more than 6,000 teens who have made 19,000 visits.

Those making their first visit sit in a separate area, where they learn what to expect here. While they are waiting to see the doctor or nurse-midwife, however, they can participate in a group discussion on sexuality.

A young woman leading the discussion asks, "Is it all right to have a baby so that your boyfriend will know that you love him?" Said one young woman: "When they find you're pregnant, they leave you." Said a male: "I'd probably grow to hate my girlfriend, although I would probably take care of my kid. I wouldn't get married. I love books too much."

Across the hall, teens who have been at the clinic before have also been discussing sexuality, but by this time they have received their services and have left. There are still several young women sitting in the waiting room, peering into little brown paper bags they have been given. Inside are contraceptives.

Ms. Jones believes that private foundation grants have special value in a project such as this since they enable one to take chances on a strategy that would be impossible with federal dollars. Foundations can help support programs with their parent institution. This is important here, since one of the goals is to demonstrate the mutual benefits of community/institutional partnerships.

"Our greatest success has been our acceptance by the community. We have proven in a limited way that there is tremendous benefit in institutional-community partnerships. There is a spinoff benefit to the institution, too, in terms of being able to network within. Our greatest challenge is to see that this is not a one time, isolated effort, but that it will continue after the original staff has moved on."

Parent/Infant Interaction Program: The Spirit of St. Louis

Betty put her hand to the small of her back and sat down carefully in an uncomfortable schoolroom chair. At 19, Betty is a teenage mother and pregnant for the second time.

"We wanted another baby," explained Betty, who is lively, even in her seventh month of pregnancy. "We wanted to get it out of the way." She and her husband, a hospital technician, didn't want Drake to be an only child. After she receives her high school diploma, Betty intends to study to become a nurse.

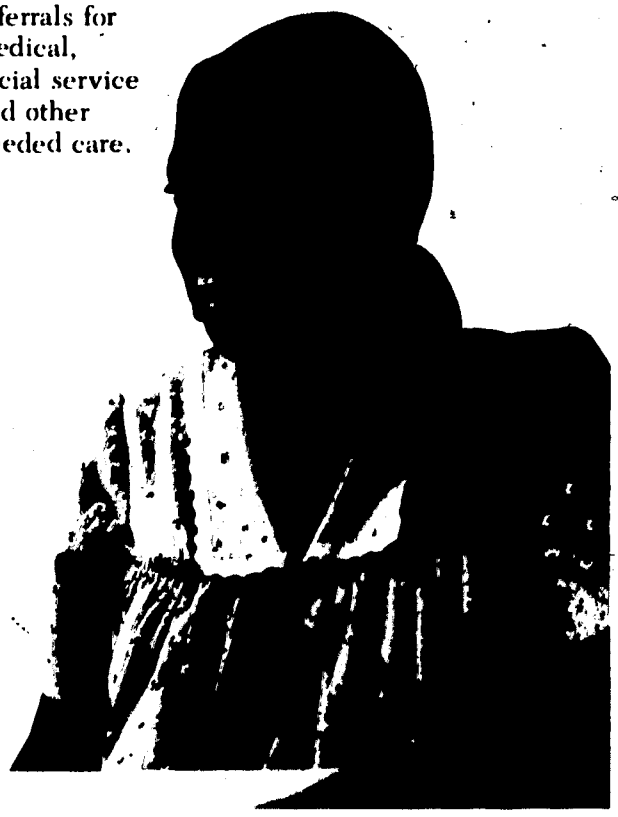
For a while, it was doubtful whether she would graduate from high school at all. Nearly two years ago, after Drake was born, Betty dropped out. Someone needed to watch the baby; her husband and his family were working, and Betty's mother isn't living. "It hurt me to drop out of school, because I had only nine months to go," said Betty, who attended the city's Continued School during her pregnancy.

Some 19 months later Betty had a second chance. She was contacted by the recruitment staff of the Parent/Infant Interaction Program (PIIP) of the St. Louis Public Schools. PIIP is a low-cost, school-based program for teens who are pregnant or parenting. Now in its fourth year, it encourages high school completion and offers educational and counseling services directed toward that goal. PIIP is basically an after-school program, and operates 12 months of the year.

More important, it offers advocacy, a shoulder to cry on, hand-holding during labor and delivery, and networking with other community agencies. Although small in number, the staff is concerned, enthusiastic, dedicated and open.

Put simply, PIIP attracts teens. Since 1978 when it began, PIIP has served more than 1,000 teenage parents in a school district where an estimated 10 percent of the secondary school students are pregnant or parents. The program seeks out those students who do not know their way around the system, who can be easily frightened off. Most of the PIIP participants are from the lowest-income population of the city. Most are black. Many live in public housing. Of the 2,800 teens who delivered babies in St. Louis last year, 700 had some contact with the program.

The PIIP includes five basic components — recruitment, individual case management, home visitation, classroom education and peer support groups. In the fall of 1981, PIIP with the support of Vashon High School, opened an infant day care center, known affectionately as The Crib. In March of 1982, a creative theater class for teens was added to the network of youth support services at the high school. The program also maintains strong ties with community agencies that provide and accept referrals for medical, social service and other needed care.



Operating simultaneously is a unique spinoff called Teen Outreach. In these discussion groups, non-pregnant and non-parenting teens discuss problems of adolescence. The students are required to perform several hours of community volunteer work each week in day care centers, hospitals or other settings. Participation in the groups, which offer high school credit, has kept young students in school until they graduate and has prevented pregnancies.

The Crib provided the immediate solution to the major obstacle facing Betty's return to school. The Crib also serves as an infant learning laboratory for young parents and parents-to-be. The area is bright and cheerful, with bright colors, lots of toys and an atmosphere of affection. A visitor can always find one or two youngsters napping in another section that is lined with a dozen cribs. A high chair and table for feeding are in an adjacent area, which serves as the parenting education classroom.

The Crib is not free. Student parents pay a small fee because the staff wants them to get used to the idea of budgeting funds for day care. The Crib, they emphasize, provides only temporary care for children ranging in age from 6 weeks to 20 months.

Many of the PIIP participants are recruited by telephone or by mail. Most are referred; some refer themselves. Those who do not join are then contacted every three months for a year after the first referral to find out how she and the baby are. If necessary, PIIP refers the teen for needed services.

Program staff attempt to visit the home of every participant to find out what the environment is like and who in the family gives her support and guidance. The visit also enables the family to discuss how they feel about the pregnancy or the baby, and to be invited to program activities. If the student is in the program long enough, home visits are made before and after the baby arrives. At the second visit, the staff member talks with the mother about her labor and delivery, maternal feelings and her infant, and the teen is encouraged to participate in postnatal groups. If the teen cannot attend the classes, she is offered individual instruction and counseling, although this is limited because the staff is small.

"The need for ongoing, intensive home counseling and instruction is great," said Ms. Brenda Hostetler, PIIP coordinator. "PIIP is one of the few programs doing home visitation in St. Louis. The need for support and instruction in the home is critical, especially for the alienated and isolated teenage mother."

This component, individual case management, was added at the beginning of the third year of the program, after the staff found that more than half of the referred teens preferred intensive individual attention and would not participate in group activities. This aspect of the program requires that staff spend a great deal of time developing a network for the teen to provide the services she needs. Much time also is spent in counseling; discussing such issues as family planning, family problems, career choices or school.

In addition to their regular school curriculum, PIIP students are offered prenatal and postnatal classes that provide practical information on prenatal development, the birth process, family planning, child growth and development and parenting. These weekly group sessions emphasize peer group discussion, films, field trips and guest speakers. The students can get high school credit by completing both classes.

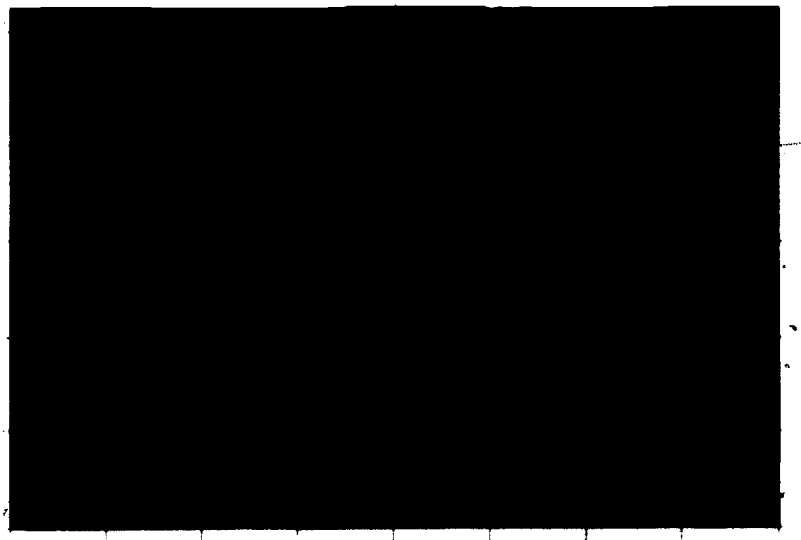
PIIP is not limited to females. For example, William, 18, is a senior who participates in both PIIP and the theater class. A teenage father who intends to enter the Navy after graduation, he joined "to help me learn a lot of things, to help me understand more things about fathering, to help me understand my child more, especially during times when he's irritable." William has encouraged other boys to come to the classes — so far, without success. Yet there is a sizable proportion of males in the outreach groups and PIIP has consistently attracted some of the fathers or new boyfriends. Sometimes, the staff say, the father will attend a parenting class when the mother cannot come.

Throughout its development, PIIP has been shepherded by Jane Paine, a program officer at the Danforth Foundation in St. Louis.

In 1977, Ms. Paine gathered together representatives of the education, health and social service systems in St. Louis, as well as some outside consultants. The resulting coalition developed a proposal for a city-wide program, operated within the educational system through the community education division.

The Mott Foundation funded PIIP for the first year, then a second and third, with the St. Louis schools funding increasing proportions. This year, PIIP is supported entirely by the schools, with the Mott Foundation providing impact evaluation funds. The St. Louis Junior League supports most of the Outreach program, following Danforth's early funds. Danforth also provided the initial funds to get The Crib into operation.

The Teen Outreach group was begun in the fall of 1978 as a way to recruit students. However, after it was organized, the group decided to make staying in school a primary goal, with deterring pregnancy as a means to that end.



During the first year, 18 students participated, Ms. Hostetler said.

"These were not necessarily good students and it was strictly volunteer," she explained. "All have graduated: one girl in that class became the first in her family to graduate from high school. She's in college now. None of them has become pregnant and all have gotten summer jobs from their volunteer experience. Every year they have been active in fund-raising and recruitment." About 80 or 85 students now participate in Outreach, she said.

Outreach was slated to end after its first year, because of a tight budget. But the original group had already recruited 20 more students who wanted to enroll. When they found out that the program would not be offered, the students wrote letters and met with representatives of Danforth and the schools. They got their program.

The outlook for PIIP during the coming fiscal year is not bright. The St. Louis schools must slice $23 million from their budget and PIIP is not in the bare-bones category. Components with outside funding, such as the theater group, will be continued. But beyond a proposal for federal funding, the future of PIIP is unclear.

That could negate all of PIIP's accomplishments — positive effects on school continuation, normal birthweight babies, pregnancy-avoidance, and postponement of second pregnancies.

Impact Evaluation: Not to Prove, but to Improve

Since the mid-1940s, when she established a resident school for disturbed youth on a 350-acre ranch, Dr. Anita M. Mitchell has been involved in education — as a teacher, guidance director, university professor, director of research and pupil services, and consultant. She holds a doctorate in educational psychology from the University of Southern California. Dr. Mitchell's book, **Ways to Evaluate Career Education Activities: A Handbook of Models**, published by the Olympus Press in 1978, is one of her many publications.

Today, Dr. Mitchell, a senior scientist at the Southwest Regional Laboratory in Los Alamitos, California, heads the Mott evaluation team. We talked with her about impact evaluation before she presented a number of evaluation workshops to grant makers.

Would you describe the impact evaluation process you designed for the Mott Foundation and its family mission?

Impact evaluation is a process of gathering evidence of the long-term effects of a program. Impact evaluation goes that extra mile, to ask, "Hey, you taught them this, but so what? What difference will it make?"

It also establishes relationships between what is done by staff and what is achieved by clients, which many evaluations fail to do. It answers the "if then" questions. Some program developers and managers tend to focus on the process, the service delivery, the things they're going to do. When you ask what will happen if they do these things, their jaws drop. They're not really sure.

So the focus is on the participant, rather than on the giver of service?

The thrust is toward the participant. On the other hand, if you get to the point where you're looking only at outcomes and paying no attention to how they are being achieved, you can't replicate. You have to know and document exactly what you're doing. That forces planning.

Evaluation of the adolescent pregnancy programs is not something that's laid on. It's not an audit, and it's not a situation in which someone comes in from the outside and takes a static picture. Rather, it is a motion picture that follows from the initial planning stage, through the development, implementation, and evaluation, to provide for consistency every step of the way.

We develop a logic model in each program to determine the needs of the population, what the resources are — time, money, facilities and outside agencies — and what is the best the staff can do with what they have.

Can impact evaluation be used for any kind of social program?

Yes. It's a process, it has no content. Therefore, you can put in any content in any context.

Q. Let's talk about results. Based upon the two years of data, what have we learned that works, or what have we learned that doesn't work?

A. Well, we have learned that it is possible to do outreach.

The New York outreach program really has shown that you can reach sexually active young people who were once isolated, put them in touch with a clinic and they will follow through.

The St. Louis outreach program has shown that it is possible to prevent pregnancy through outreach. They have a fantastic record of a group of young people who sort of contracted not to get pregnant. They haven't gotten pregnant and they're so proud of it! The peer group pressure is enormous.

Another thing that we have learned is that a school program can be extremely supportive. For instance, in St. Louis, Flint and Sarasota — all school-based programs — we have found positive pregnancy outcomes. There are very few low birthweights, very few complications of pregnancy, such as urinary tract infections. The Sarasota and St. Louis programs also have a very high rate of girls returning to school, and apparently going on to graduation.

Q. Have you found other results?

A. Not so far. We saw good bonding between mother and child, but that is not a new finding. What we're looking for is continuation in school, economic independence for the girl and that the children mature well. We're getting at some of this through follow-up by finding out what the girls do, for instance, when the baby becomes ill.

I'm hoping that the federal government will fund longitudinal studies here, where good initial data have been collected, because it could provide coordination of some very important findings about what works. Unless programs continue contact with the girls until they're really launched, they might just as well forget long-term impact and concentrate on pregnancy outcomes.

Q. Would you walk us through the model that you developed for the Mott Foundation programs?

A. Ours is different in that it is a management model, not a research model in which everything is held constant whether it's working or not. Our model encourages change. It gives feedback and monitors every step so you can see whether plans are being implemented with fidelity. It's important to know that you're doing what you said you

would do. And then, you take spot checks to see that the clients are moving toward the target. If they aren't, and getting them back to that target is terribly important, you need to re-do your program. One of the most important happenings in impact evaluation is that when you find something doesn't work, you abandon it, you try something else.

If you really design your evaluation well, it does not take more time, it takes less time. It really facilitates management and implementation, because you're not doing a number of things that are unnecessary; you're concentrating on what's necessary. You're focusing on objectives. Instead of a frenetic approach to disaster, you have a well-organized system of documenting what you're doing as you go along.

The first step of your program involves a needs assessment, doesn't it?

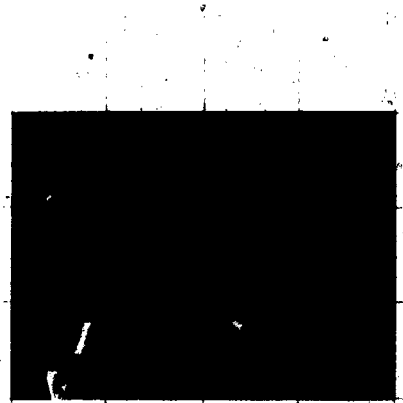
Yes, only we call it needs sensing. The first and most important thing is to define the population and to know what it really needs. Some programs did that maybe ten years ago and just keep on going, with no thought to the fact that the population and the needs have changed. So needs sensing needs to be continuous. You also should ask whether you're serving the appropriate population.

The next step is to determine your objectives, what you can realistically offer. I think one of the biggest problems with programs is that they're going to save the world. Frankly, the most important thing anyone can do with limited resources is to provide those services that we know work. We do know that good prenatal care results in better health for the mother and baby. That sould be a primary objective, and it is in all of our Mott programs.

Everybody also seems to think that another primary objective is school continuation for pregnant and parenting teenagers. I'm not sure that that's the best and most important primary objective. I thing economic independence is important, and sometimes going back to school is a deterrent to economic independence for these girls. As a society, we are moving toward a different kind of work ethic, from getting a job to making a job. For many of these girls, entrepreneurial jobs are far more important, and they're not going to be improved by going back to school. I realize this is a pretty maverick type of thought.

But if you can't spell and you can't add, then maybe you need to go back to school before you can become an entrepreneur.

You must remember, not all of these girls are ignorant. I'm talking here about girls who don't have much of a support system. Where there are different kinds of supports for the girls — like at Sarasota — they nearly all go back to school and most of them do graduate. That's fine. But it depends upon the circumstances in the individual community.



Once the objectives have been set, what is the next step?

The next step is a statement of the information needs. Once the objectives are set, decisions have to be made — by managers, by the board, by the funding agencies or all three. You have to determine which components will work, the costs, and whether the outcomes are worth it.

Then, you have to determine what the indicators will be, what will give you the information on which to base those decisions. Sometimes it's something very simple, like the child's birthweight. Other times, you have to observe or look at unobtrusive measures.

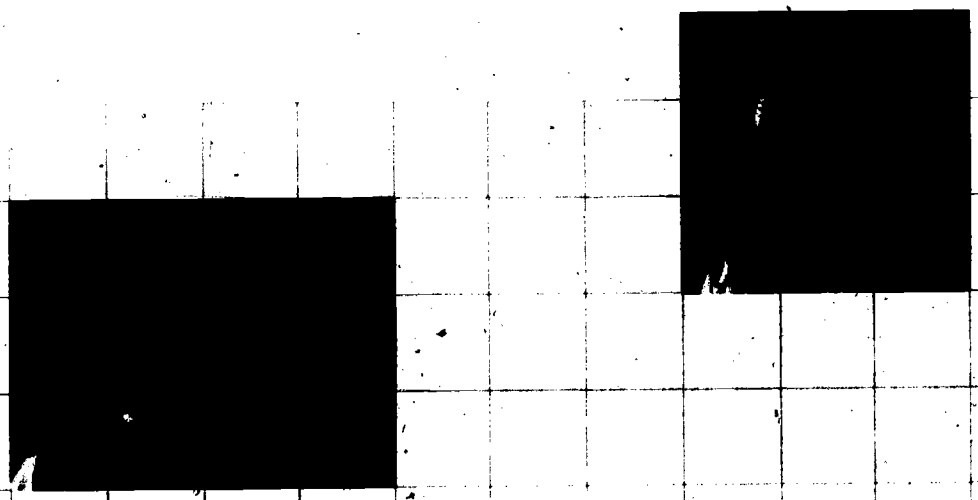
Once the indicators have been decided, you choose the instruments, how you're going to get that information. The first thing people think of is standardized tests. Now, there are darn few standardized tests that have any meaning at all for individuals — they're mostly group tests. So we tend to develop our own tests. Yet, test construction is a refined process that few program people know how to do. It's something that we're still working on.

If you don't have a good standardized test, what are some of the other things you can do?

One of the ways to measure is by direct observation — then you don't have to test. But if you do observations, you have to train the observers and make sure there is inter-rater reliability. You also have to be sure they are consistent. Sometimes you can measure by using records. With good documentation — which is sometimes onerous — you can get trend data on how things are changing.

This leads us to comparison standards, where our model differs from most. Many of the evaluations in this field do not use comparison standards. But without them, there is no way of knowing the program is responsible for a change.

Right away people think we mean control groups. We don't. First of all, we call them comparison groups. And we don't call the participants experimental groups, but treatment groups. I think that's an important distinction, because there's absolutely no way you can control a human experiment. There's no way you can get truly equal groups, so you look at key variables, like sex, age, race, school, schoolwork.



However, that's not the only kind of comparison standard. You can use historical data that have been verified in study after study. Or you can use trend data within your program, or time series studies, looking at improvement over time. Another is the absolute standard: If you want to decrease the incidence of pregnancy by 40 percent, you need to know only how many pregnancies exist now, and whether there are 40 percent fewer at the end of the program.

The next step is data collection and management, an area in which many programs are sloppy. So we've tried to get very easy forms that can be kept at hand and filled in with simple marks. To keep the system well organized, everyone has to know who keeps what information. So we have what we call the T/T/T — time, task and talent analysis — where you list every task, who is responsible for it, and when it should be done.

The next thing is data analysis and recording. If there are a lot of data, it's helpful to have access to a computer.

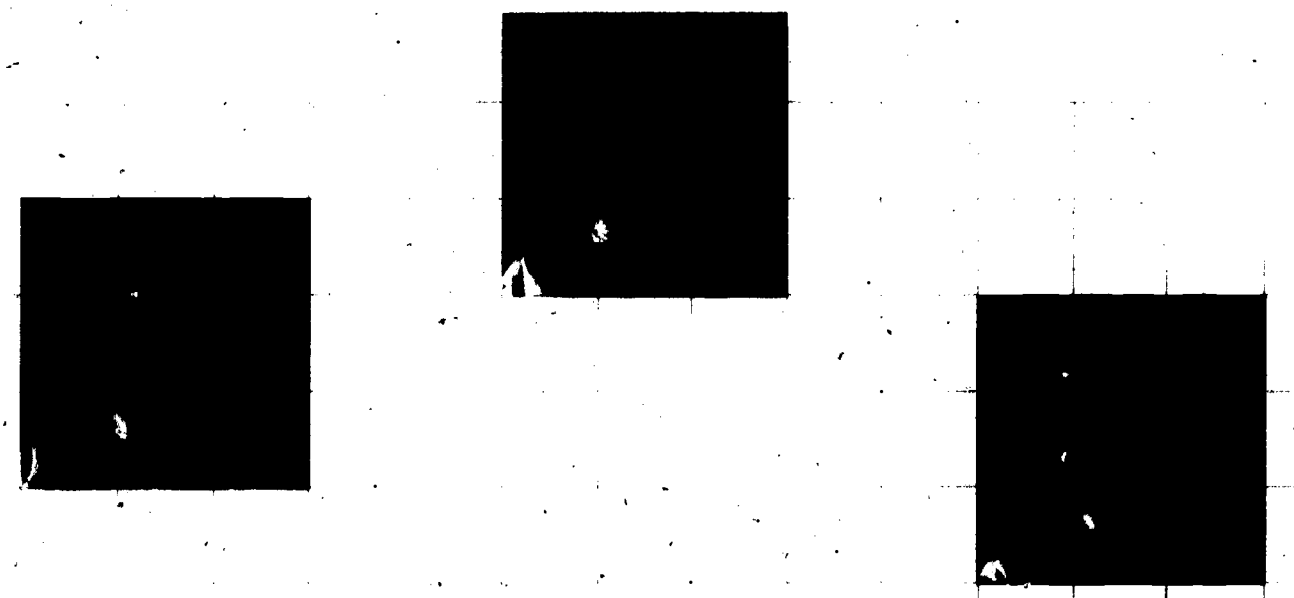
The final step is reporting. Program operators frequently do not know how to report, or what to put into a report. It's important for each program to know what each funding agency wants or needs or expects. They also should report to the professional audience through articles, which takes a different kind of reporting.

How did the evaluation team go about using this process in the Mott-funded programs?

We went in bright-eyed and bushy-tailed. We put on a big evaluation seminar for the directors of the programs, which were already funded and underway. We thought they would be delighted at our precious process. But some of the participants were just overwhelmed and wondered what they had gotten into. Others challenged our approach, because they believed in the research evaluation model.

We then asked the program staffs to give us copies of their plans and other documents. Debbie Walker and I performed detailed analyses of these materials, and found that only one program, New York's, was evaluable.

So we spent the first year helping the staffs make the programs evaluable, and giving them technical assistance. Retrospectively, they had to go back and look at their population, ask whether it was the right one, determine whether they were offering the correct services, look at their resources, and decide which components to keep. It was amazing how many "little programs" they had — components that did this here and that there. Some were disconnected or had nothing to do with the objectives.



Q. Are there any program components that could be replicated elsewhere with success?

A. Definitely. I don't know if any of them are terribly unique, except for the outreach program in St. Louis. I think the community advocacy program in New York is unique and could be replicated. The Teatro HEY has some promise, too. We saw the advocacy program operating in Spanish Harlem in the middle of winter, in places where windows were broken out, there was no food, no heat. If they can make that program work in that community, it's an excellent example of what can be done anywhere.

I also feel that Flint and Sarasota have done well in situating their programs near other school programs that students opt to attend, like the vocational school in Sarasota and the Schools of Choice in Flint. The girls can move into another program without too much difficulty.

The thing I feel most strongly about, of course, is that I wish we'd be put out of business by prevention programs. I'm just sick about the fact that money is still being poured into amelioration rather than prevention. We really need to get into the schools and other agencies that work with children and we also need to do a lot of parent education. I think parents have been terribly neglected.

The Steps of Impact Evaluation

1. Assessment of the need for the program
2. Statement of program objectives
3. Statement of information needs
4. Selection of indicators
5. Determination of comparison standard
6. Selection of evaluation design
7. Data collection and management
8. Data analysis and processing
9. Reporting of results

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