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ABSTRACT

Since 1978, Federal policy has sought to encourage the development of local comprehensive service programs for pregnant and parenting adolescents through demonstration grants, research, and dissemination of information about exemplary program models. The prevailing interventive model used is based on the development of local and comprehensive medical, social, and educational services. Material prerequisites for implementing the comprehensive services model include a pre-existing social welfare infrastructure, flexible funding sources, and support from State policies and funds. Managerial resources required include leadership, coordination, community acceptance, and political support. The consequences of this approach were assessed in a study of how local comprehensive programs were developed in ten communities in four States. The assessment found many of the prerequisites for program development to be lacking in many localities. Funding mechanisms exacerbate resource disparities among communities. A more effective Federal policy would seek to compensate for differences in local capacity, eliminate service gaps, support local planning and coordination, and give emphasis to prevention. (KH)

NATIONAL PROBLEMS, LOCAL SOLUTIONS:

COMPREHENSIVE SERVICES FOR PREGNANT AND PARENTING ADOLESCENTS

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NATIONAL PROBLEMS, LOCAL SOLUTIONS:

PROGRAMS FOR PREGNANT AND PARENTING ADOLESCENTS

ABSTRACT

Since 1978, federal policy has sought to encourage the development of local comprehensive service programs for pregnant and parenting adolescents through demonstration grants, research, and dissemination of information about exemplary program models. This study examined local program development in four states and ten communities. It found the material, managerial, and political prerequisites for program development to be lacking in many localities. Funding mechanisms exacerbate resource disparities among communities. A more effective federal policy would seek to compensate for differences in local capacity, eliminate service gaps, support local planning and coordination, and give emphasis to prevention.

Since 1978, there has been a decided trend toward the devolution of social problem solving to the lowest levels of government.[1] Advocates of decentralization argue that this approach is efficient, responsive to the will of the people, and sensitive to local variations in need. They also point to the growing political and administrative competence of state government to develop and manage complex social programs. Critics contend that localism inhibits national problem solving, and exacerbates inequities in the availability of services and benefits, particularly for the poor. Some also see decentralization as an indirect way of eliminating the social program initiatives of the 1960s.[2] This article examines the development of services for pregnant and parenting adolescents in the context of evolving federalism. It considers why it is that some localities have developed comprehensive service programs for pregnant and parenting adolescents while others with equal or greater need have not.

Teenage pregnancy emerged as a national issue in the late 1960s at a time when federal social problem solving was coming under increasing attack. Its history during the past two decades reflects the tensions between national and local approaches to social reform. Although adolescent birth rates have been declining since reaching their post World War II high in 1957, the association of teen pregnancy and childbearing with a host of related social ills has kept it on the national political agenda. Teenagers account for disproportionately high rates of out-of-wedlock births, abortions, infant mortality and low birth weight infants, school failure and welfare dependency. It is an issue that touches upon divisive national concerns: adolescent sexuality, abortion and contraception, parental control, welfare and single parenthood.[3]

Although it is a national issue, the locus of concern is the individual teenager and her child. Most proposed interventions necessarily require that something be done at the local level, whether it be sex education, the encouragement of chastity, the provision of contraception and abortion, or social services for teen parents and their children. At issue is the extent to which the federal government should prescribe local interventions and assist in financing them. The current federal policy is to foster the development of local services through research and demonstration projects and public information efforts, but with little direct financial assistance. The experience of localities in attempting to respond to adolescent pregnancy provides a test of the New Federalism's approach to social problem solving.

We begin with an examination of the emergence of adolescent pregnancy on the national political agenda in the early 1970s. We describe the origin and characteristics of the prevailing interventive model, one based on the development of local comprehensive services for pregnant and parenting adolescents. We then consider the causes and consequences of the differing local responses to the issue.

FEDERAL POLICY

Prior to the early 1960s, white "illegitimacy" was considered a matter of individual pathology and moral transgression. Social work agencies defined their mission as securing relinquishment of the baby for adoption and helping the mother work through the interfamilial conflicts that led to this particular form of "acting out." Maternity homes offered concealment, subsistence, and medical care during pregnancy, often in exchange for

relinquishment of the baby. They also sought the moral rehabilitation of the young mother.[4] The sexual revolution, the women's and civil rights movements, the growing peer acceptance of teenage pregnancy and the trend toward keeping the child undercut the functions of the maternity homes and rendered obsolete casework interventions based on assumptions of individual psychopathology. A new interventive model was required in keeping with the changing definition of the problem.

The Comprehensive Services Model

The model that emerged and gained wide acceptance among service advocates was based on a program initiated in the 1960s at Washington D.C.'s Webster School. It prescribed what some refer to as the classic triad of services: medical, social and educational. Its acceptance was facilitated by the advocacy of the Children's Bureau. The Bureau sponsored the National Consortium on Early Childbearing and Childrearing, and was a key participant in a Federal Inter-Agency Task Force on Comprehensive Programs for School Age Parents organized in 1971. It funded a number of research projects in the late 1960s demonstrating the problem correlates of adolescent pregnancy and childbearing. It disseminated information about the comprehensive services model, fostered the development state and regional advocacy groups and lobbied indirectly for national legislation.[5]

The immediate impetus for national legislation, however, was the 1973 Roe v. Wade Supreme Court decision decriminalizing abortion. In 1975, bills were offered by Rep. Albert Quie and Senators Edward Kennedy and Birch Bayh that would provide social and health services to pregnant teens as an alternative to abortion. These bills never left committee. However, President Carter and his Secretary of Health, Education and Welfare,

Joseph A. Califano, Jr., also assigned high priority to the issue because of their wish to balance their opposition to abortion with some kind of affirmative policy. The Carter initiative, informally called the "Alternatives to Abortion" bill, was based largely on Baltimore's Johns Hopkins University Hospital comprehensive services program for pregnant and parenting teens, a project supported by Eunice Shriver and the Kennedy Foundation.[6] Pregnancy prevention was not a prominent feature of the final bill, and this deficit as well as the minimal funding it received brought criticism from prevention advocates. Nonetheless, the legislation was strongly supported by health and welfare service organizations, although no women's, black or Hispanic groups offered testimony.[7]

The Adolescent Health Services and Pregnancy Prevention Act (PL 95-626, Health Services and Centers Amendments of 1978) sought to promote the development of services by funding local demonstration projects. Grantees were required to offer, either in a single setting or by means of a linked referral network, the following core services:

1. Pregnancy testing, maternity counseling and referral.
2. Family planning.
3. Primary and preventive health services including pre-and postnatal care.
4. Nutrition information and counseling.
5. Adoption counseling and referral services.
6. Educational services in sexuality and family life.
7. Screening and treatment for venereal disease.
8. Pediatric care.
9. Educational and vocational services.
10. Other health services.

This legislation was replaced in 1981 by Title XX of the Public Health Service Act, but the program of Family Life Demonstration Projects, as they were now called, still included the core services. It continued to stress coordination, integration and linkage of services, but added maternity home referral, outreach to families, and efforts to discourage adolescent sex, earning it the label, "The Chastity Bill."[8]

Since 1978 then, there has been a national policy encouraging the development of local comprehensive service programs, although actual funding has never exceeded the $13.4 million appropriation for FY 1984. In fact, fewer than 100 communities have received federal grants for comprehensive services under these two laws.[9] There are, however, about 40 other federal programs that potentially support services for pregnant and parenting adolescents.[10] These federal resources, along with local charitable support, do make it possible for some communities to develop programs even without special grants. By 1980, a national survey identified 1,117 local programs, of which 274 (25%) were deemed comprehensive as measured by their self-reported inclusion of the ten core services of PL 95-626.[11]

The national strategy has been to encourage the development of local services by sponsoring research and demonstration projects. The assumption is that localities will replicate exemplary program models without direct federal program support. The consequences of this approach may be assessed by an examination of how local programs are actually developed and maintained.

THE STUDY

Ten local communities and their programs for pregnant and parenting adolescents were studied. The objective was to learn what accounted for the differential development of programs in communities of comparable size, demographic composition, and adolescent birth rate.[12] We first selected localities with comprehensive service programs, using a somewhat minimal definition of comprehensiveness. This definition, based on a review of the legislation, several national program surveys and academic commentary, included the following components, which might be provided totally on-site or through a linked referral network:

health services, including contraceptive services, pre- and postnatal care;

academic and/or vocational education;

social services and counseling for adoption, sexuality and family life; and

some followup after delivery.[13]

A number of services considered by many to be essential were not included, to avoid unduly restricting the sample frame. For example, we did not include child care, counseling for the adolescents' extended families, transportation, services for teenage fathers, parenting education, abortion counseling and services, or financial and housing assistance.

Each comprehensive site was matched with another community which lacked comprehensive services. The ten localities in the sample ranged in population from 11,000 to 340,000. Missing were both very large cities and

rural areas, as well as localities with no targeted programs for adolescent parents. The sample included two health-based programs; the remainder were in schools and social agencies.

Three of the four states included in the study were among the relatively few--eight by our count--that have explicit policies and commit state resources to support local adolescent pregnancy programs.[14] These three policy states, Michigan, California, and Massachusetts were selected on the assumption, subsequently confirmed by the study, that state policies and resources were significant in local program development. The fourth state, Tennessee, is more representative of those states without explicit policies or resources, but with high rates of adolescent pregnancy.

A total of 230 persons were interviewed at the state and local levels. The interview data were supplemented by documentary evidence including program descriptions, newspaper articles, statistical reports, policy statements and regulations. The focus was on how and why programs were developed and maintained.

FINDINGS

The requirements of local program development appear relatively straightforward. Specific program components, including health, educational, and social services must be assembled and linked through some coordinating mechanism. Clients must be recruited and steered to the services. Support, material, political, and administrative, must be secured from the professional health and welfare community, local and outside funders, local lay and political leaders.[15] In reality, however, we found the constraints so formidable that only under exceptional circumstances

could localities develop and maintain comprehensive service programs. Below we examine the material, managerial, and political prerequisites to program development, and how and why they are present in some localities and not others. This analysis shows that localities vary considerably both in the availability of the basic resources presupposed by the comprehensive services model, as well as in their capacity to make them accessible to pregnant and parenting adolescents.

Material Prerequisites

1. Social welfare infrastructure. The comprehensive services model presupposes the presence of basic health, education, and social services that may be linked to serve pregnant adolescents. In practice, however, many of the basic programmatic components were absent, unavailable to teens, or severely strained due to federal cuts and/or increased utilization.

For example, all communities have public schools, but they vary considerably in their capacity and willingness to undertake special programs that divert resources from the regular instructional curriculum. Because of their reliance on local property taxes, the poorer districts with the greatest need are often the least able to support special programs. Public schools have also faced additional strains due to past baby boom enrollment declines and the commensurate loss of state funding based on average daily attendance.[16]

Especially important for pregnant and parenting teenagers are pregnancy testing, family planning services, pre- and postnatal care, and pediatric care. Yet for the poor, the lack of affordable health care often poses serious problems. In all but nine states, Medicaid is available for prenatal care for those women whose income qualifies them.[17] However,

bureaucratic roadblocks often impede the determination of eligibility. Pregnancy verification must usually be by medical examination, but there are generally no resources available for free examinations for non-Medicaid eligible indigents. A more pervasive problem is the limited number of providers who accept Medicaid or indigent patients.

A number of factors were cited by our respondents as limiting the availability of health care. They included: the trend toward privatization and absentee corporate management of community hospitals, resulting in the reduction of services to indigents and the closing of unprofitable obstetrical wards; the declining interest of medical students in obstetrics and family practice; the phasing out of indigent care obligations of hospitals built with Hill-Burton funds; the loss of family insurance coverage due to unemployment; and cutbacks in family planning funds.[18] Several family planning providers in our study sites had instituted sharp fee increases. Two had closed clinics in low income areas.

Infant care, where available, was a major inducement for adolescent mothers to participate in programs, and was thought to be an important factor in encouraging school attendance. Several programs also used infant care as a focus for child care training for adolescent mothers as well as non-parents. Some infant care was available to program participants in four of the five comprehensive sites and two of the non-comprehensive ites; however, in all cases, the number of available slots was severely limited in relation to the need. Eligibility was generally of short duration, three months in one instance, to make room for new program participants. Since infant care costs as much as four times more than day care for older children, it is at a competitive disadvantage in local struggles for scarce day care funds.

None of the various definitions of comprehensive services mentions financial assistance and housing; yet these are paramount concerns for women from low income families. Only 20 states provide AFDC in the sixth or seventh month of pregnancy, and then, depending on state regulations it may be unavailable to women under 20 unless they are already living alone.[19] Some welfare departments were reported to be unhelpful and unresponsive in facilitating the AFDC and Medicaid applications of adolescent women. This reflects a pattern of discrimination that has been in evidence since the enactment of the Social Security Act.[20] (As an example of what a more positive approach might accomplish, however, one local office had established a special unit to facilitate the applications of pregnant adolescents and their referrals for medical care.)

Foster care for teenage mothers was also said to be in short supply. Workers spoke of low-income adolescent parents moving from place to place, staying temporarily with friends and relatives, but with no permanent living arrangements. Such impoverished young women are the least likely to participate in programs.

2. Flexible funding sources. While a number of federal programs and policies have some relevance for adolescents, few identify pregnant or parenting teens as a primary target group.[21] Local program managers, lacking a firm source of support, must piece together programs using funds from a variety of sources. This often places them in competition with claimants who can assert a greater priority.

The programs we studied had drawn upon such diverse federal funding sources as Titles I and II of the Elementary and Secondary Education Act, the Education for All Handicapped Children Act, the Job Training Partnership Act, the Vocational Education Act, Jobs Bill Countercyclical Aid grants,

Headstart, the Maternal and Child Health Block grant, General Revenue Sharing, as well as Title XIX (Medicaid), Title XX (Social Services Block grant), and Title X (Family Planning grants). Several of the older programs had also obtained resources from the now defunct CETA, LEAA, Model Cities and Community Services Administration programs. In general, the more comprehensive programs had been able to tap a much wider range of funding sources than the less comprehensive programs.

Perhaps even more important than the number and variety of funding sources was their relative flexibility. In general, federal and state funds had specific limitations on their use. Since many were not primarily intended for adolescent pregnancy programs and were subject to cuts and elimination, it required considerable ingenuity for administrators to fit them together in a coherent package of support. The more successful (i.e., more comprehensive) programs were those that could draw upon flexible, usually local, voluntary funds. These included United Way, local foundation, and more rarely, city revenue sharing dollars, as well as a variety of cash, volunteer, and in-kind contributions from local charitable organizations.

3. State policies and resources. Eight states (including three of the four states in our sample) currently have explicit legislative policies backed by state resources to foster the development of comprehensive service programs.[22] State funds were a significant source of support for the comprehensive programs in our sample. Four of the five comprehensive sites had state funding, each receiving support under two separate state program support mechanisms. Only two of the five non-comprehensive sites reported receiving earmarked state support. These two sites, both in California, had obtained funds under a formula grant that provided relatively small program supplements to a large number of school districts.

Among our study states, Massachusetts' Departments of Public Health and Social Services each uses a competitive discretionary grant process to support local programs. Michigan and California employ a combination of formula and discretionary grants for local program support. Michigan's Model Site program currently funds eight school districts yearly, providing money for non-educational services such as counseling and child care. In addition, all Michigan districts may request teacher salary reimbursements for providing health counseling, child care instruction and services, social services and prenatal instruction.[23] California's Pregnant Minor Program provides reimbursements to local districts amounting to approximately 9% above the average daily attendance rate for each pregnant student enrolled in a special program. Under the School Age Parenting and Infant Development program (SAPID), school-based programs may apply for competitive state grants to serve pregnant and parenting students. Sixty-four SAPID sites were funded in 1982 under a $4.3 million appropriation, and another 50-60 received Pregnant Minor Program funds.[24]

While the receipt of state aid was a significant factor in maintaining some local comprehensive service programs, its distribution raised problems of equity and adequacy. With limited funds, states could choose to distribute a little money to many sites or fund a few sites more adequately. For example, the formula grants in Michigan and California were insufficient to provide much more than supplementary aid to programs supported from other sources. The distribution of more generous discretionary grants also posed serious dilemmas for the funders. The recipients of such grants were usually selected through a Request for Proposal (RFP) process requiring local initiative. This made it more difficult to target resources to areas of greatest need. The localities with the highest incidence of adolescen-

births were often the least capable of developing a viable application, and maintaining an effective program.[25] None of the states had staff esources for technical assistance or oversight of local grantees. The discretionary grant process also locked in funding to the initial successful applicants; funders were reluctant to terminate existing programs in order to support new ones.

Managerial Resources

The administrative tasks necessary for successful program development stretch to the limit the capacities of the constituent organizations and their staffs. In addition to recruiting clients and operating programs, administrators must secure continuing financial support and sanction, coordinate activities with other agencies, and plan for future contingencies. These inherently difficult tasks are complicated by declining and uncertain funding, as well as the taint of an unpopular cause and a stigmatized clientele. The coordinating task is further complicated by the absence of crucial service components, and the diversity of organizational participants who must often compete for funds and clients.[26]

Local service organizations pursue different missions: health, education, social service, financial assistance, vocational training, child development, etc. They have differing service ideologies, in some cases reflecting deeply felt religious convictions. They may differ sharply with respect to adoption or keeping, prevention and services, abortion and family planning, and encouragement of chastity. That any system could accommodate such potentially divisive constituents is testimony to the commitment, skill, effort, and tolerance of its managerial leadership. Not surprisingly, the more comprehensive programs were those with a number of skillful professionals in leadership roles and with the resources and mechanisms to facilitate interagency coordination.

1. Leadership. Leadership was a necessary though not sufficient determinant of program success. In the localities with comprehensive programs, those individuals performing leadership functions lived in the same community and had worked together over the years on a number of issues. They often served together on various local civic committees and agency boards. They knew each other well. This is in sharp contrast to localities, less successful in maintaining services, where most of those in leadership roles were originally from outside the area, lived out of town, and where there was a rapid turnover in leadership.

Leadership roles were distributed among many individuals and organizations. This is not to deny the unique contributions of those outstanding individuals who were generally acknowledged to have played essential roles in program development. Such key persons were variously described as "outstanding," "exceptional," "dynamic," "charismatic," "strong," "hard-working," "dedicated," "a one-woman army," "a veritable legend." But even in these instances, we found many persons, some unheralded, whose involvement was crucial.[27] The specialized leadership roles we identified were:

Administrative leadership. This refers to those persons in administrative roles who were particularly effective at internal management, program development and planning, and coordinating with other organizations.

Grantsmanship. We identified a number of persons who were particularly skillful at seeking out funds and packaging collaborative, multiple funding arrangements. Such skills are most important given the variety of funding sources, some of which had little apparent connection with adolescent pregnancy.

Political leadership. An essential program development task was to secure political and popular support and to lobby for funds. This generally required the enlisting of support from local elites, influential administrators, bureaucrats, and state legislators.

Institutional leadership. In several unusual instances, local institutions, most notably the schools and United Way organizations, and in one case, the juvenile court, were instrumental in facilitating collaborative program arrangements. More frequently, the absence of such leadership was an obstacle to be overcome.

Outreach. Clients are an essential program prerequisite. We encountered a number of individuals who were especially talented at locating and recruiting them. One legendary figure, a veteran of anti-poverty programs of the 1960s, was said to have "button-holed" pregnant teenagers on the street. Another "plucked them" out of local hospital waiting rooms. Such aggressive recruitment often spelled the difference between programs that served only the most motivated and those reaching the more needy and more challenging clients.

2. Coordination. In those localities where coordination was most successfully accomplished, we observed several pre-existing conditions that were more or less permanent features of the service environment. The same kinds of strategies that worked best in such a supportive environment had difficulty taking hold in the absence of these favorable conditions. These conditions included:

a service climate supportive of community planning;

staff resources to support community coordinating efforts;

a history of successful social welfare planning and coordinating;

an experienced cadre of agency administrators and representatives who knew each other well;

a relative permanence of organizations and workers;

physical proximity of the coordinating organizations;

and a strong authoritative community planning body like the United Way.

3. Community Acceptance and Political Support. Douglas Yates has likened the items on the local community issue agenda to the targets in a shooting gallery. They move by quickly popping up momentarily and then dropping out of sight.[28] Only a portion of the many potential concerns receive sustained attention. The issues that gain salience in the local social welfare community present funding possibilities to agencies, have strong advocates, receive media attention, and reflect community concern. Adolescent pregnancy is a concern in some localities, but not others. Our findings suggest that this variance is not so much a reflection of the incidence of teen pregnancies as the capacity and willingness of the social welfare community and local elites to address the issue.[29]

Adolescent pregnancy programs compete with a host of equally worthy claimants--services to combat hunger, homelessness, child abuse, mental retardation, infectious disease, etc. Yet as an issue vying for attention and support, adolescent pregnancy confronts unique and severe obstacles. We found that the stigma of adolescent pregnancy makes support by local elites--the Junior League, United Way, socially and politically prominent individuals and families--especially important. The issue lacks a vocal constituency to lobby for resources. The adolescents and their families are not inclined to call attention to their situations. Service providers are generally on the defensive. They are sometimes attacked by extremists whose

religious and political beliefs are threatened by programs deemed to encourage premarital sexual activity and abortion. Many service providers have responded by adopting a defensive, low profile stance and stressing services over prevention. While the service providers are predominantly female, the resources needed to mount and sustain services are largely controlled by males who often share less than sympathetic attitudes toward sexually active teenage girls.[30]

CONCLUSION

The study identified a number of factors associated with the successful development and maintenance of local comprehensive adolescent pregnancy programs. The comprehensive programs were located in communities with relatively well-developed social welfare infrastructures. They had access to state and local funds that could be used flexibly to fill program gaps. They received basic state support and were also able to tap a wide variety of federal, state, and local resources. These comprehensive programs were managed by skillful administrators and drew upon a broad range of leadership talents. There were strong local coordinating mechanisms that facilitated interagency coordination, and the service climate supported collaborative effort.

Unfortunately, these capacities and resources are not evenly distributed across the nation or within states. Only a minority of exceptional communities possess the essential prerequisites. A national strategy of fostering local comprehensive service development has produced distributional biases that favor the more well-endowed and capable communities and the more highly motivated clients.[31] Within states, grant

mechanisms favor those few localities that can put together the winning proposal, or that have the organizational capacity to draw upon a variety of funding sources. They are not always the communities with the greatest need.

Within communities, even the most comprehensive programs serve only a small proportion of the potential clientele. The programs are limited in scope, duration of eligibility, and geographical coverage.[32] They reflect a brief, crisis intervention orientation to a problem that is complex and long-lasting in its origin and consequences.[33]

The study further demonstrates the political vulnerability of local services for stigmatized and powerless groups in the absence of a strong national mandate. Service providers keep a low profile to avoid the attention of potential opponents. Advocates of prevention also fare poorly at the local level. School personnel are generally loathe to undertake efforts outside the regular instructional program, especially when they engender controversy. Vocal minorities have been particularly successful in blocking the introduction of sex education curricula despite predominantly favorable public opinions.[34]

A national strategy based on the sponsorship of a limited number of demonstration projects and the dissemination of information about exceptional, exemplary programs is unlikely to accomplish very much. While it may serve a politically useful symbolic function by suggesting that something is being done, it does not significantly increase the number of programs, improve their effectiveness, or distribute them to areas of greatest need.[35]

The evidence suggests that the lack of a national policy commitment to pregnancy prevention contributes to the high rate of adolescent pregnancies.

Teen fertility rates in the U.S. are considerably higher than in the majority of Western nations. According to a recent study, the rate per thousand women 15-17 was 62 in the U.S., 27 in England and Wales, 19 in France, 28 in Canada, 20 in Sweden, and 7 in the Netherlands.[36] These wide differentials were not attributable to differences in sexual activity, race, or socioeconomic status. The study concluded:

> Among the most striking of the observations common to the four European countries included in the six-country study is the degree to which the governments of those countries, whatever their political persuasion, have demonstrated the clear-cut will to reduce levels of teenage pregnancy....In the United States, in contrast, there has been no well-defined expression of political will.[37]

With respect to adolescent pregnancy programs, the New Federalism reflects a kind of social Darwinism for states and localities, especially in view of shrinking federal support for health and social welfare. The existence of a few exemplary programs helps perpetuate a Horatio Alger myth for community services. If some localities can mount comprehensive service programs, then those that don't must somehow lack the will or interest. In reality, as in the fictional Horatio Alger stories, the few "successes" reflect highly exceptional circumstances--the presence of a major research and teaching hospital, an especially service-oriented school district, generous foundation support, etc.[38] However, as our study shows, there are significant political and administrative barriers to local program development that inhibit the provision of preventive or remedial services for adolescent in most localities.

A more effective federal policy would seek to compensate for differences in local capacity, eliminate basic service gaps, support local planning and coordination, and give emphasis to prevention. The mechanisms for accomplishing these objectives existed in an older federalism that sought to use federal aid and direction on behalf of disadvantaged groups. They include formula grants to states based on need and fiscal capacity, renewed efforts to assure greater health care access, especially for poor adolescents, and federal mandates and funding to encourage sex education in the public schools and wider availability of family planning services.

One must be cautious about expecting too much from limited federal intervention. As yet, there is no technological "magic bullet" that will solve the problem, despite continuous efforts to find one.[39] Comprehensive service programs that focus on the already pregnant have had limited results in preventing repeat pregnancies and ignore those sexually active teens at greatest risk.[40] The evidence suggests that adolescent pregnancy and parenthood is at least in part related to poverty, racism, and sexism. Effective corrective efforts must ultimately address these more intractable problems.[41]

NOTES

1. The decentralization rhetoric began with the Nixon Administration, but it was not until 1978 in the Carter Administration that the number and amount of federal categorical grants to states and local governments began to decline from previous levels. George E. Peterson, "Federalism and the States: An Experiment in Decentralization," Ch. 7 in John L. Palmer and Isabel V. Sawhill, eds. The Reagan Record: An Assessment of America's Changing Domestic Priorities. Cambridge, MA: Ballinger, 1984, p. 228.

2. Richard Wade, "The Suburban Roots of the New Federalism," New York Times Magazine (August 1, 1985):p.20; Milbrey McClaughlin, "States and the New Federalism," Harvard Educational Review, 52(4) 1982, p. 564; Michael Levine, On the Brink: Programs for Pregnant and Parenting Teenagers in Ten American Communities. Doctoral dissertation, The Florence Heller Graduate School, Brandeis University, November 1984. Advisory Committee on Intergovernmental Relations. The Future of Federalism in the 1980's, Washington D.C.: July 1981.

3. Lewayne D. Gilchrist and Steven Paul Schinke, "Teenage Pregnancy and Public Policy, Social Service Review (June 1983):307-22; Susan Phipps-Yonas, "Teenage Pregnancy and Motherhood: A Review of the Literature," American Journal of Orthopsychiatry 50 (July 1980):403-431; Wendy H. Baldwin, "Adolescent Pregnancy and Childbearing--Growing Concerns for Americans," Population Bulletin 31 (January 1980):1-37; The Alan Guttmacher Institute. 11 Million Teenagers: What Can Be Done About the Epidemic of Adolescent Pregnancies in the United States. New York: The Alan Guttmacher

Institute, 1976. Recent studies suggest that many of the problems associated with adolescent parenthood are due to the underlying conditions of poverty that afflict teenage parents and their families. See Elizabeth R. McAnanarney, M.D., ed. Premature Adolescent Pregnancy and Parenthood. New York: Grune and Stratton, 1983, esp. Ruth A. Lawrence and T. Allen Merritt, "Infants of Adolescent Mothers: Perinatal, Neonatal and Infant Outcome," Ch. 8, pp. 149-68; Dorothy R. Hollingsworth et al., "Impact of Gynecological Age on Outcome of Adolescent Pregnancy," Ch. 9, pp. 169-190; E. Milling Kinard and Lorraine V. Klerman, "Effects of Early Parenthood on the Cognitive Development of Children," Ch. 14, pp. 253-65; and James F. Jekel and Lorraine V. Klerman, "Comprehensive Service Programs for Pregnant and Parenting Adolescents," Ch. 17, pp. 295-310.

4. The maternity homes were generally a last resort for young white women who were pregnant for the first time and who lacked other options. Theodora Ooms. Teenage Pregnancy in a Family Context: Implications for Policy. Philadelphia: Temple University Press, 1981, esp., pp. 23-25; Leontine Young. Out of Wedlock. New York: McGraw Hill, 1954; Prudence M. Rains, "Moral Reinstatement: The Characteristics of Maternity Homes," American Behavioral Scientist 14 (November/December 1970):403-35.

5. Lorraine V. Klerman and James F. Jekel. School-Age Mothers: Problems, Program and Policy. Hamden, CT: Linnet Books, 1973, pp. ix-xii; Sylvia B. Perlman. Nobody's Baby: The Politics of Adolescent Pregnancy. Doctoral Dissertation, The Heller School, Brandeis University, November 1984, pp. 59-60.

6. Gilbert Y. Steiner. The Futility of Family Policy. Washington, D.C.: The Brookings Institution, 1981, pp. 70-88; Joseph A. Califano, Jr. Governing America. New York: Simon and Schuster, 1981, pp. 53-61, 70-71, and 205-6; Eugene Declercq, "Agenda Building in Health Policy: The Case of Adolescent Pregnancy," paper presented at the annual meeting of the American Political Science Association, Washington, D.C., September 1, 1979.

7. Stiener, pp. 83-85; Ooms, pp. 26-39; Maris, A. Vinovskis, "An 'Epidemic' of Adolescent Pregnancy? Some Historical Considerations," Journal of Family History 6 (Summer 1981):205-30. Annual appropriations for this law and its successor have varied from $.74 to $13.4 million according to the federal Office of Adolescent Family Life Programs.

8. Jekel and Klerman, p. 297; The Congressional Quarterly Almanac, 1981, pp. 487-8.

9. Personal communication from staff of the Office of Adolescent Pregnancy Programs.

10. Kristin A. Moore. School-Age Parents: Federal Programs and Policies Relevant to Pregnant or Parenting Secondary Students. Washington, D.C.: The Urban Institute, 1983.

11. James F. Jekel and Lorraine V. Klerman, "Comprehensive Service Programs for Pregnant and Parenting Adolescents," in Elizabeth R. McAnarney, M.D., ed. Premature Adolescent Pregnancy and Parenthood. Grune and Stratton, 1982, pp. 295-310; JRB Associates, Inc. Final Report of the National Study of Teenage Pregnancy. Submitted to the Office of Adolescent Pregnancy Programs, DHHS, August 15, 1981.

12. The field work was conducted during 1982 and '83. For details on the research sites and the sample selection, see Richard A. Weatherley et al, Patchwork Programs: Comprehensive Services for Pregnant and Parenting Adolescents. Center for Social Welfare Research, School of Social Work, University of Washington Seattle, September 1985.

13. The criteria for the selection of comprehensive programs was based on a review of the provisions of PL 95-626, the Health Services and Centers Amendments of 1978; Title XX of the 1981 Public Health Services Act; JRB Associates, Inc., Final Report; and James Jekel and Janet Forbush, "Characteristics of programs serving pregnant adolescents in the United States," paper present at the annual meeting of the American Public Health Association, 1977.

14. The eight "policy" states are Michigan, Massachusetts, California, Illinois, Delaware, New York, Texas, and Florida. For a survey of state policies, see National Association of State Boards of Education, Overview of State Policies Related to Adolescent Parenthood, Washington, D.C., 1980.

15. The prerequisites of program development and implementation are discussed in Gordon Chase, "Implementing a Human Services Program: How Hard Will It Be?" Public Policy 27 (Fall 1979):385-435; and P. Sabatier and D. Mazmanian, "The Conditions of Effective Implementation: A Guide to Accomplishing Policy Objectives," Policy Analysis 6 (1979):211-220.

16. Richard Weatherley, Betty Jane Narver and Richard Elmore, "Managing the Politics of Decline: School Closures in Seattle," Peabody Journal of Education 60 (Winter 1983):10-24; Richard Elmore and Milbrey W. McLauglin. Reform and Retrenchment: The Politics of California School Finance Reform. Cambridge, MA: Ballinger, 1982.

17. Children's Defense Fund. American Children in Poverty. Washington, D.C., pp. 67-8.

18. Martin Tolchin, "As Companies Buy Hospitals, Treatment of Poor is Debated," New York Times, January 25, 1985, pp. 1, 10; Orr, Margaret T., "The Family Planning Program and Cuts in Federal Spending: Impact on State Management of Family Planning Funds," Family Planning Perspectives 15 (July/August 1983):176; A. Torres, "The Family Planning Program and Cuts in Federal Spending: Initial Effects on the Provision of Services," Family Planning Perspectives 15 (July/August 1983):184.

19. Children's Defense Fund, pp. 67-8.

20. For earlier evidence of discrimination against young unmarried women by public welfare agencies, see Mary Brisley, "The Illegitimate Family and Specialized Treatment," The Family 19 (May 1938):67-70; Mary S. Labaree, " Unmarried Parenthood Under the Social Security Act," Proceedings of the National Conference of Social Work, 1942, pp. 446-57; and Leontine Young, "The Unmarried Mother: Problems of Financial Support," Journal of Social Casework 35 (March 1953):99-104. For a discussion of the informal means used to restrict access to public welfare benefits, see Michael Lipsky, "Bureaucratic Disentitlement in Social Welfare Programs," Social Service Review 56 (March 1984):3-27.

21. Moore, School-Age Parents.

22. This is our assessment based on secondary sources and interviews with federal officials and leaders of state, regional and national advocacy groups. See also Sharon Alexander, C. Williams, and Janet Forbush. Overview of State Policies to Adolescent Parenthood. Washington, D.C.: National Association of State Boards of Education, 1980.

23. The appropriation for the 1981-82 school year was $558,000. Sixty-six districts received funds at about $4,000 per teacher. The Model Site appropriation for FY 1982 was $240,000.

24. Some cities had two or more SAPID sites. For a description of state policies and programs in the four study states, see Richard Weatherley et al, Patchwork Programs.

25. Reliable birth statistics were available for six of the eight study sites located in states offering discretionary grants. The three comprehensive program sites all had state grants, while the three non-comprehensive sites did not. Those sites with the grants all had a much lower percentage of births to adolescents than the sites without grants. See Levine, On the Brink, pp. 189-90.

26. Sylvia B. Perlman and Richard Weatherley, "Limits of the Comprehensive Service Model: The Case of Adolescent Pregnancy Programs," paper presented at the annual meeting of the Association for Public Policy and Management, New Orleans, Louisiana, October 1984.

27. Zellman found individual leadership to be a significant factor in the development of exemplary school-based programs. Gail Zellman. Response of Schools to Teenage Pregnancy and Parenthood. The Rand Corporation, submitted to the National Institute of Education, April 1981. Our findings are also consistent with small group and

organizational research that stresses the importance of multiple leadership roles. For a summary of this literature, see Victor H. Vroom, "Leadership," in Marvin D. Dunnette, ed. Handbook of Industrial and Organizational Psychology. Chicago: Rand McNally College Publishing Co., 1975, pp. 1527-51.

28. Douglas Yates. The Ungovernable City: The Politics of Urban Problems and Policy Making. Cambridge: MIT Press, 1977.

29. Weatherley et al. Patchwork Programs, pp. 166-184; Perlman. Nobody's Baby.

30. Richard A. Weatherley, "Patriarchy and the Politics of Transgression: The Case of Adolescent Pregnancy Programs," paper presented at the annual meeting of the Western Political Science Association, Los Vegas, Nevada, March 1985. Edwin M. Schur offers a sociological analysis of the stigmatization of female sexuality and maternity in Labeling Women Deviant: Gender, Stigma and Social Control. Philadelphia, Temple University Press, 1983, esp. pp. 81-118. For a graphic account of how the attitudes of male state legislators constrain policy development, see Virginia G. Cartoof. Massachusetts' Parental Consent Law: Origins, Implementation and Impact. Doctoral dissertation, The Florence Heller Graduate School, Brandeis University, November 1984.

31. Furstenberg observes, "When services are difficult to utilize, they assist primarily the relatively privileged and supermotivated." Frank F. Furstenberg, Jr. Unplanned Parenthood. The Social Consequences of Teenage Childbearing. New York: The Free Press, 1976, p. 227.

32. Helen M. Wallace, John Weeks and Antonio Medina, "Services for Pregnant Teenagers in the Large Cities of the United States, 1970-1980," Journal of the American Medical Association 248 (November 12, 1982):2270-73; JRB Associates, Final Report.

33. Furstenburg calls this an "inoculation bias"--that pregnancy is "an affliction from which one recovers", Furstenburg, pg. 00.

34. Gilchrist and Schinke, pp. 316-17. For opinion poll data showing support for sex education, see Alan Guttmacher Institute, "School Sex Education in Policy and Practice," Issues in Brief, February 1983, 3:1; and Sol Gordon, Peter Scales, and Kathleen Everly. The Sexual Adolescent: Communicating with Teenagers About Sex. Scituate, MA: Duxbury Press, 1979, p. 9. The tactics of extremist groups seeking to block school sex education programs are described in Suggestions for Defense Against Extremist Attack: Sex Education in the Public Schools. Commission on Professional Rights and Responsibilities, National Education Association, U.S. DHEW, Office of Education, March 1970.

35. Murray Edelman. The Symbolic Uses of Politics. Urbana, IL: University of Illinois Press, 1964. For discussions of the symbolic significance of adolescent pregnancy see Steiner, The Futility of Family Policy, esp. pp. 73-85; and Vinovskis, "An Epidemic of Adolescent Pregnancy?"

36. Elsie F. Jones et al., "Teenage Pregnancy in Developed Countries: Determinants and Policy Implications," Family Planning Perspectives 17 (March/April 1985):p. 55.

37. Jones et al., p. 61.

38. Most recent Congressional efforts are focused on the replication of another exemplary program, that operating in the St. Paul, Minnesota high schools. Kathleen Teltsch, "Teenage Pregnancy: Solutions Elusive," New York Times, June 10, 1985, p. 9.

39. The continuing quest for a technological fix is illustrated by the New York Times' editorial call for a $500 million per year investment in research for "long-acting, anti-fertility vaccines and reversible nonsurgical methods of sterilization." "The Perfect Contraceptive: When?" The New York Times, July 1, 1985, p. 22.

40. Janet C. Quint and James A. Riccio. The Challenge of Serving Pregnant and Parenting Teens: Lessons from Project Redirection. New York: Manpower Demonstration Research Corporation, April 1985; Martha R. Burt, Madeleine H. Kimmich, Jane Goldmuntz and Freya L. Sonestein. Helping Pregnant Adolescents: Outcomes and Costs of Service Delivery. Washington, D.C.: The Urban Institute, February 1984.

41. See footnote 3 and Jones et al. For a discussion of how these issues were addressed in Sweden, see Birgitta Linner. Sex and Society in Sweden. New York: Random House, 1967, 1972.

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