

NWX-OS-OGC-RKVL (US)

Moderator: Sabrina Chapple
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1:00 pm CT

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode. During the question-and-answer session, please press star 1 on your touch-tone phone. Today's conference is being recorded. If you have any objections, you may disconnect at this time. Now I will turn the meeting over to Ms. (Sabrina Chapple). Ma'am, you may begin.

(Sabrina Chapel): Thank you. Good morning and afternoon everyone and welcome to the OEH hosted Webinar Working in Rural Communities to Prevent Teen Pregnancy. My name is Sabrina Chapple and I thank you for joining us today.

The Office of Adolescent Health within the Office of the Assistant Secretary for Health in collaboration with the Family Abuse Services Bureau within the Administration for Children and Families and the Division of Reproductive Health within the Center for Disease Control and Prevention are proud to present a series of events for Teen Pregnancy Prevention Awareness Month.

Today's Webinar will include a presentation by the national campaign to prevent teen and unplanned pregnancy on their recently release report Teen Childbearing in Rural America.

In addition, two TPP OEH grantees - Morehouse School of Medicine and the Youth Opportunities Unlimited - will present on how they are working to prevent teen pregnancy in rural communities.

Today's Webinar is scheduled for 1-1/2 hours and we'll take all questions at the end of today's call. Participants may also use the Q&A feature of the Webinar to ask their questions. However again we will hold all questions to the conclusion of today's call.

Before we begin, I would like to formally introduce all of our speakers in order of presentation. Kelleen Kay is the Senior Research Director of the National Campaign to Prevent Teen and Unplanned Pregnancy, a private non-profit initiative organized in 1996 that focuses on preventing both teen pregnancy and unintended pregnancy among youth adults.

Before joining the campaign she spent 12 years as a Senior Analyst at the U.S. Department of Health and Human Services. She has served on several advisory committees including the interagency forum on child and family statistics at the interagency working group for the national survey of family growth.

Her colleague Cara Finley is the Manager of Research and Evaluation at the National Campaign to Prevent Teen and Unplanned Pregnancy. In this role she assists with the development of new resources and fact sheets, updates resources and manages evaluation of campaign activities and projects.

Previously she's worked with Social Solution International conducting research and evaluation projects for women's health both domestically and

international. Dr. Evelyn Jossell currently serves as CEO of Youth Opportunities, Unlimited.

She's worked in this capacity for 20 years managing the day-to-day operations of Youth Opportunities, Unlimited and overseeing the design and implementation of pregnancy prevention, mentoring and educational intervention programs to address the needs of high-risk youth in Mississippi delta.

Dr. Jossell serves as a member of the governor blue risk task force on teen pregnancy prevention and is also a member of the Mississippi Department of Health Family Planning Advisory Council.

(Shirley French) is Project Director for the Delta Dream, a Aban Aya program. Ms. (French) has served as an absence educator director with Youth Opportunities Unlimited for seven years; however, she possesses over 25 years of experience working with human services medical and community-based organizations.

Prior to joining Youth Opportunities, Unlimited Ms. (French) worked as a Project Administrator and Case Manager with the Total College Health Start Initiative Project serving the Mississippi delta.

In addition we'll have Dr. Langley. Dr. Langley is the Director of the Health Promotion Resource Center and a social professor in the Department of Community Health and Preventative Medicine at Morehouse School of Medicine in Atlanta, Georgia.

Dr. Langley received a bachelor's of nursing from Sanford University in Birmingham, Alabama and a master's of public health at the University of

Alabama in Birmingham. She later received her doctorate degree from Georgia State University in Atlanta.

Dr. Langley has worked extensively in community development in both urban and rural communities. I will now hand the floor over to our first presenters Kelleen Kay and Cara Finley.

Kelleen Key: Good afternoon, this is Kelleen. (Sabrina) was kind enough to introduce myself and Cara Finley. I also wanted to mention (Alison Stewart). She's not going to be joining us today but she did do a huge amount of the heavy lifting on the data analysis.

Now before we jump into our results, I wanted to thank our colleagues at OAH for organizing this Webinar and for including our presentation and of course the standard disclaimers apply.

These results that we're presenting today do reflect the work here at the campaign so of course any views that we convey and for that matter any mistakes that we've made are all ours and they're not a reflection of our colleagues at HHS.

So why focus on rural teens and we realize that for some of our listeners today this may be a question with an obvious answer but for some out in the broader field, rural teens do not always readily come to mind.

We began this project because we had been frequently asked a very basic question that much to our surprise hadn't been addressed in the existing research and that is how prevalent is teen childbearing in rural areas and how does this compare to other areas?

For many we know that teen childbearing brings to mind images of disadvantaged urban centers which are of course important areas too but we also know that 3/4 of the U.S. lies in rural areas and in fact one in six teens live in rural areas.

We also know that the geography of rural areas can make serving teens uniquely challenging and that each rural area itself is unique from each other rural area.

Now there is some research out there on rural teens but it's quite dated. A lot of what we found was from the 1990s and even the early 1990s. To people like me that seems like yesterday but I have to remind myself that it was actually over 20 years ago and a lot has changed since then.

So we started this research to first answer this threshold question of whether teen childbearing is more of a rural or an urban phenomenon but also to then look at what factors might account for these differences between rural and urban teen childbearing and how that might inform prevention efforts out in the field.

And equally importantly to see how these factors might play out differently and uniquely in different rural areas say for example the Midwest compared to Appalachia.

Of course there's a lot of different ways one can define rural America and this is a point that we're going to come back to frequently but for now I just wanted to say a bit about how we're defining for the purposes of these very initial analyses and here our definitions is largely population-based.

It's the definition used by our colleagues at the National Center for Health Statistics who are the keepers of the vital statistics data on births that we're using.

As you can see by the red arrow in the slide, our definition of rural includes what are called micropolitans and non-core areas, essentially that's those counties with populations below 50,000.

As I mentioned earlier, the rural counties shown here in green account for the vast majority of land area across the U.S. all the way from up in New England to down in the Southwest.

There is again no single rural America and this is something that we will be focusing on heavily as we continue our research on rural teen childbearing in the coming months.

Rural America is diverse in a whole lot of ways. This includes the racial ethnic composition of the population. You'll see some strong regional patterns here. There are many more communities of color in the Southeast and Southwest.

We're not saying that's surprising but it's just an important reminder that when we talk about rural America, we're not just talking about America's breadbasket or one single population that all looks the same.

Rural America is poorer on average than the rest of America but this is by no means to say that every single rural county is a county of high poverty. In this map the counties with the higher rates of poverty are shaded darker and lower rates of poverty are shaded lighter and again we see a lot of diversity and some pretty strong regional patterns.

Residents in rural areas also tend to have less access to healthcare. One measure we see here is the percent of the population with health insurance. Again rural areas have lower coverage on average but this is not the case in every single rural county.

If we look much more towards the Midwest, we see higher rates of coverage for example. This diversity and other dimensions of diversity is something that we're going to be able to tap into a lot in our upcoming analyses over the summer but for now let's go back to that threshold question; is teen childbearing higher or lower in rural areas?

So here we see the rate of teen childbearing in fact is quite a bit higher in rural counties and again some of our listeners on the phone today may not be surprised by that but when we were talking to a lot of people just sort of out in the public, we found an almost equal number who speculated that it was higher in urban counties than in rural counties.

Here we see the rural counties shown in the green bars and it follows that as the rate of teen childbearing follows an almost stair-step pattern downwards as the level of urbanization increases.

The one outlier you'll notice in blue is the large fringe counties. Those are predominantly suburban counties and we can probably think of all kinds of reasons why that might be but overall the teen birth rates in rural counties do tend to be much higher.

Here we're looking at that same rural/urban differential separately for younger teens and for older teens although we've collapsed the rural/urban categories just a bit to make it easier on the eyes. We see that among young teens shown

here on the left. There are still some rural/urban differences but they're fairly small.

It's really among the older teens shown on the right where the differences between rural and urban are most pronounced. Again the green bar is showing the teen birth rate for rural counties and the blue bars are showing increasingly urbanized metro counties. Similarly we looked at this rural/urban difference separately within each racial ethnic category.

We continue to see these same rural/urban differences among white teens, among black teens, Hispanic teens, Asian and Pacific Islander teens and among Native American teens which we think is important because it shows us that this difference isn't simply a function of the demographic makeup of the counties.

Adding to our concern is the fact that the gap between rural and urban counties is growing over time. Now teen birth rates have been falling across the board and that's very good news; however, these rates have been falling more slowly in rural areas.

So while rural counties did not have the highest rate back in 1990 shown over on the left, again because these rates have been coming down more slowly, they do now have the highest rates.

And the green line is the line what's showing the rates for the rural counties and we also see the small or the medium metro fringe and the large central counties so again we see that the rate for rural counties is falling more slowly.

Now before I go on I'm going to pause for just a minute and point out that while rural teens do have higher rates of teen childbearing, this is a different question than whether most teen childbearing occurs in rural areas.

While the rural teens do have higher rates in fact they only account for about 20% of all teen births. This is actually not that surprising given that they only account for about 1/6 of the population. Quite simply there are just fewer teens living in rural areas. Even so we think that these findings, these higher rates are important.

They highlight a population at risk and a population that may not be on the radar screen for everybody out there who cares about teen pregnancy prevention but I did want to clarify this difference, that is the difference between a population that's at higher risk versus a population that's accounting for the greatest share.

They've both very important but they answer a little bit different questions so what accounts for these differences and this is what we're really going to be digging into in the coming months. Of course in the most basic sense, much of it is a function of either more teens having sex or fewer sexually-active teens using contraception.

We started to look at this just a bit and in fact teens in rural areas are more sexually active than teens in metropolitan areas. This is true when we look at the proportion of teens who have ever had sex which we see on the left.

It's also true when we look at the proportion of teens who are currently sexually active, that is, they've had sex in the past three months and this is shown on the right so for example 29% of teens in metropolitan areas are currently sexually active compared to 41% of teens in rural counties.

There are also differences in contraceptive use among sexually-active teens but these differences are less pronounced. When we look at whether a teen used the method the first time they had sex and those are the bars on the left, we see that 71% of rural teens used the method so almost $\frac{3}{4}$ compared to 81% of teens in metropolitan areas so there's a difference but it's not huge.

Now when we look at the method they used the last time they had sex, those are the bars shown on the right, there's virtually no difference at all. Of course it matters not just whether they're using a method but what method they're using. Some methods are more effective than others.

On this indicator however we actually see that rural teens are in fact at lower risk, that is they tend to use better methods. For example if we look at the lightest blue slice where you see the red arrows pointing, this the proportion who are only using a condom.

This is quite a bit higher for the metropolitan teens compared to the rural teens. Seventy-two percent or almost $\frac{3}{4}$ of the metropolitan teens only used a condom whereas that's only a little more than half for the rural teens. The rural teens are much more likely to use hormonal methods either by themselves or in combination with a condom.

Now this is looking at the first time they've had sex. In this next slide, we see the method the last time they had sex. Here the rural teens and the metropolitan teens look even more alike but again the rural teens tend to use somewhat better methods.

In particular we look at the medium blue slice again where the red arrows are, we see that rural teens are a little more likely to be dual method users than the

metropolitan teens so most of the differences we are seeing here are in levels of sexual activity rather than use of contraception.

One more interesting indicator we thought that we'd point out here and that's where they get their methods from. Here we're focusing just on prescription birth control.

There weren't as large of differences here as we might have been expecting although one that we thought was particularly interesting are those who used the county health department again highlighted here by the red arrows.

So the Title 10 health departments are much more important to teens in rural counties, accounting for 14% compared to metropolitan teens. We're not saying this is shocking or surprising but we do think that it's important as we start to tease out what these differences might imply for our prevention efforts.

And I'll stress here again that we're really just in the exploratory phase of these analyses. What we'll be working on is boiling down these results to get to something that we hope is actually going to offer some insights for providers and practitioners.

What else accounts for these differences? If we're seeing these behavioral differences in sexual activity and contraception, we want to then take a step back, look at those factors that are indirectly related, that is, what's driving that sexual activity and contraceptive use?

It's not just that rural teens are intrinsically different. It's not that there's something in the water in rural counties. There obviously are a whole lot of other underlying factors as to why the risk might be higher.

I'm sure our listeners today probably already have a lot of ideas and experiences that speak to this question or are thinking about them a lot as well, you know, factors like healthcare access, economic and educational opportunities, public policy, cultural factors and a whole lot of other things that we're going to be untangling over the summer and trying to sort of sort-out what the relative importance of these factors are.

The last thing I'm going to comment on is one other factors that many of you may be wondering about. The measure we're focusing on here is teen birth rates but of course it's possible that one reason the teen birth rates are higher is simply that teens in rural counties are less likely to get an abortion and more likely to carry their pregnancy to full term and result in a birth.

Ideally we would be wanting to focus on teen pregnancy rates instead of teen birth rates. Unfortunately we don't have the county-level data to do this. Now in our more-detailed analyses over the summer, we are going to include measures of access to abortion as best we can so that we can start to try to control for some of the role that that may be playing so stay tuned on that.

And our hope is to have a report later this year that we look forward to sharing with all of you so thank you so much.

(Sabrina Chapel): Thank you Kelleen and Cara for providing us with this foundational overview of childbearing in rural America. Now let's turn our attention to the grantee practical side of things. I'd like to give a warm welcome to Dr. Jossell and (Shirley French).

Evelyn Jossell: Like to send to you greetings from the Mississippi delta. We are extremely excited to share with you information on our Delta Dream (abutting) our

program and I'm going to start us off by providing a general overview of the Delta Dream program and the framework for program implementation.

(Shirley) will come later and discuss the specifics of the Aban Aya program model and afterwards I will return with final comments so we're going to begin by looking at Delta Dream's mission or purpose.

It's a very simple mission which is to educate, empower and to advocate. The program provides age-appropriate health education to fifth through eighth-grade students using the Aban Aya curriculum.

We engage two cohorts of fifth-grade students that the program normally follows with a scaled-up curriculum throughout their eighth-grade year. Programs participants are empowered to make sound life decisions by learning self-awareness, increasing their coping and (resiliency) skills, increasing their goal-setting and decision-making skills and acquiring an appreciation for their cultural heritage.

So to evaluate the effectiveness of the lesson, students are required to participate in scenarios where they must apply the skills they have learned during the class session. Finally Delta Dream is an advocate for sexual abstinence and making responsible reproductive health choices.

And we try to do this by promoting abstinence from risky behaviors and unhealthy lifestyle choices. You will note throughout the presentation that Delta Dream is synonymous with this purpose, to teach young people in the Mississippi delta to dream and to just hope for a better future.

As we look at some of the common characteristics in the communities we serve, we see that we have rural isolation and this means that the small

communities that we serve, they're often 75 to 150 miles from the next largest city and 20 to 25 miles from the cities that offer decent shopping and medical opportunities.

Unfortunately poverty is pervasive. There are no industries in the smaller communities which leads to higher adult and youth unemployment and the majority of the families living in these communities are on some kind of public assistance.

We will find that illiteracy rates are high because many adults and children have poor reading and comprehensive skills, thus this leads to poor performance school districts that are perpetually on academic probation.

We have there are no organized public transit systems. If you don't have a car, you have to pay overpriced fees to get to and from your destinations. There's a total lack of organized cultural and recreational outlets for both youths and adults.

We have no boys and girls clubs, no YMCAs, no movie theaters, no skating rinks so therefore the schools in these communities become the hub of the social hub of the communities.

Unfortunately what we do have is an abundance of substandard homes and abandoned buildings making these areas unattractive for prospective administrators, teachers or business to relocate to.

And finally the delta has the highest teen pregnancy rate in the State of Mississippi with rates ranging between 48% and 60% in each of the 10 school districts we serve. Youth opportunities (I mentioned) carefully consider the target populations for Delta Dream.

And as a result we decided to focus on fifth through eighth-grade boys and girls because based on our prior experience we found that young people in this age category appear to be the most vulnerable of making poor choices. The population is 98% African-American and something because this is the demographic makeup of the schools we serve.

This population of students often have very low reading and comprehension skills and we have to make sure that our lessons and test surveys are they are in simple, easy-to-follow language and is explained thoroughly and we also have to make sure that we are cognizant of each student's individual learning style.

There is an alarming percentage over 65% of the students we worked with are from single head of households where there is no positive male role models and often there are any positive female role models and this is because a lot of the teens that work with us - the parents who work with their teen parents skills and they have child parenting skills.

Unfortunately most of the youth we serve are plagued with multiple risk factors which includes low self-esteem and lack of self-worth, identity issues that makes them vulnerable to gang activity because they're seeking to belong to something whether it's positive or whether it's negative.

These youth often have too much idle time on their hands with absolutely nothing constructive to do but hang out on the nearest corner or frequent homes where there's little or no parental presence.

And then again there's a pervasive and ever-present poverty. Everywhere you look you're going to see rundown homes, abandoned, dilapidated buildings and (school) buildings that are a resemblance of the 1960s era.

And there's just a general sense of hopelessness and helplessness because many of our young people drop out of school by the time they're in ninth of tenth grade and they often condemn themselves to a life of hanging out on the streets and (being into havens).

And even the ones who stay in school and pursue some type of college education cannot find jobs when they return to their communities so you have too many teen parents and absent fathers in the home, young people have few positive role models to really emulate positive behavior.

So because of the many risk factors that I frequently mentioned, youth often resort to substance abuse for escape as well as income and crime as a general way of life so I have provided for you the issues that serves the framework for the Aban Aya program and Ms. (French) will come to you and discuss the model itself.

(Shirley French): Good afternoon. I'm (Shirley French) and thank you for having us on this afternoon. We chose the Aban Aya replication model based upon factors previously mentioned by Dr. Jossell.

The Aban Aya model is an Afro-centric social development curriculum instructed over a four-year period beginning in the fifth grade. The number of sessions varies each year. The curriculum encourages abstinence, protection from unsafe sex and avoidance of drugs and alcohol.

The name of the intervention is drawn from two words in the (acon garnian) language, Aban which means fence signifies double social protection. Aya represents the unfurling firm. It signifies self-determination.

The purpose of the interventions is to promote abstinence from sex and to teach students how to avoid drugs and alcohol and how to resolve conflict nonviolently.

The intervention targets African-American youth, emphasizes cultural pride and strengthens family and community ties. The intervention promote African-American values and use culturally-appropriate teaching methods.

The Aban Aya model is replicated in 28 delta schools. The interventions are delivered during 55-minute sessions on a weekly basis throughout the school year. The curriculum advances from fifth to the eighth grade. In addition to the classroom intervention, supplemental services are provided.

An overview of the supplemental services are mentoring. This is where high school youth mentors are paired with youth mentees to serve as big brothers and sisters to assist with homework, make weekly contacts, to encourage them to excel in school, working to encourage them to make healthy lifestyle choices and mentors also act as chaperones on field trips.

Our dream girl after-school club. The club member serves as ambassadors to other teams. The goal is to instill respect, resiliency, character, responsibility in young teens.

We also allow for field trips. Field trips allows a chance for fun and exposure. As many of our youth in the program have limited opportunity for travel and

outings. Trips to the movies, skating rink, indoor amusement parks serves as a real treat to our participants.

We also strive hard to teach the youth to give back through community services by providing enjoyable and educational community service projects such as cleanup days, in-school projects, providing information on major health issues such as drug awareness, HIV/AIDS, breast cancer and Teen Pregnancy Prevention Month.

In our leadership capacity, our teams learn about mentoring-ship and also about leadership through our state task force on abstinence. Not only do they learn to be mentors but ambassadors to their other peers. Our annual camping trip brings students together from across our seven-county service area.

The students enjoy fun activities while meeting new people. Field day activities include health education sessions, karate, movie night, basketball tournaments and pizza parties and they always enjoy the opportunity to attend professional and college sports events such as attending the Grizzlies versus the Lakers game.

We realize that positive core values should be reinforced continuously but we get our parents involved. Our health educators strive hard to reach out to parents at TTO meetings, parenting workshops, back-to-school rallies and each adult basketball tournament where the children are encouraged to cheer their parents on.

The project encourage highly parent and child interaction and communication. It is vital for parent and child to be able to talk to each other. Our program challenges, transportation for the staff is a problem. A vast amount of time is spent traveling to the school sites to implement the program.

After-school programs and moving the students to activities and returning them home is a challenge. Our high turnover with school administration. Class scheduling poses problems. Less-focused students create behavior problems in some of the schools served.

Low reading and comprehension level of participants. There's still a need to increase parental involvement. The Aban Aya curriculum is very good; however, updates need to be made in technology, poems and music selection. The information need to be made more current to today's teens.

There's a great demand for the program but it is limited by the amount of available resources. With two years left in the program, the long-term challenge is sustainability. Some of the strategies that we use, we purchase agency vehicles, partner with school sites in providing transportation to and from after-school activities.

Due to the frequent turnover with school administrators, the Aban Aya administrative staff meet with the new school administrators to reintroduce the program and to discuss the memorandum of agreement signed by the prior administration.

Our schedule is adaptable to meeting with students after school or meeting with groups at a later date assigned by the school staff in order that we may reach our goal. Flexibility and accommodating with the school is essential.

We've always tried to allow enough time to complete our class sessions which are they span from 16 to 21 sessions. The program also offers incentives such as gas cards, McDonald cards and recreational events in order to increase parent-child involvement.

Lastly to maintain fidelity, the agency follows the curriculum and only change those materials that were approved by the curriculum developer. Sometimes when you just travel a few miles east or west of our original site, you will see a contrasting difference between service sites.

We have two of the 10 sites that we have categorized as urban/rural sites because the lack of populations, they have public transportation models, businesses and of course more job opportunities. We found that the students in the urban/rural sites performed at an academically and in many cases there's a striking contrast in the school cadre itself.

Because of the urban/rural districts are larger and there are more opportunities for advancements, we found that the administrators often change each program year whereas in contrast in rural areas, the administrative (apree) is stable unless they are terminated or the district goes into conservatorship and they are replaced by the State Department of Education.

A common bond with both rural and urban/rural sites is that sometimes there is an inconsistency when it comes to adhering to the schedules they've assigned us. This normally occurs because the majority of the schools we work with are on academic lots and during a certain time of year they go into sort of a panic mode and will not allow you to adhere to our scheduled classes.

You will also find that in urban areas you will have more resources to work with. You have more partners, more youth organizations, more businesses as well as slightly better parental involvement and I have to say that parental involvement whether you're dealing with urban/rural or rural still remains a challenge for us.

We experience fewer discipline problems in the urban/rural schools because there appears to be more structure and appropriate personnel to handle discipline issues.

So among the schools that we work with, there appear to be fewer teen pregnancies with the high school teen (pregnancies) and they seem to have more of a sense of purpose and direction than those in the rural schools.

The rural students we work with were less transient and easier to track than urban/rural students. We take away from very valuable lessons from the 20 years we've implemented pregnancy prevention programs. (Sabrina), we're having problems. Our computer has crashed so would you forward to the next slide for us please?

Okay so lessons learned, again we take away some very valuable lessons from the 20-plus years we've implemented pregnancy prevention programs. We've learned that programs cannot be single focus but they must have supplementary activities such as recreation, after-school clubs, sports because of the many gaps that exist in the rural communities and the extremely high teen risk factors.

We also realize that our health educators' preparation must be no different than that of a regular classroom teacher. They must be prepared in the subject matter and they must have some knowledge of classroom management and this was a general understanding of individual learning styles.

We found that it was (unintelligible) that hold we establish gatekeepers at each site such as secretaries and counselors. We found that they help us to kind of work through the veracity when it came to scheduling problems and access and students.

Also during implementation we learned that students respond better and are more engaged when we have interactive acts such as role play, board games and technology to impart and reinforce curriculum information.

Another lesson that we learned is that when we give some incentives like fruit snacks, pencils, paper that this yields greater participation from students in turning in the Aban Aya homework assignments and also in getting responses from our parents.

Many of the students that we talk to admit that they're not having sex but they want to be viewed - they don't really want to be viewed - as being uncool. We realize that these students they have goals and dreams and aspirations as any other students but peer pressure often clouds their judgment.

Finally collaborative partnerships are vital because it takes the collaborative efforts of the entire community, churches, schools, businesses and other CDOs to make the program work so that they're just not presenting a program, we are creating a system for them people.

And Youth Opportunities, Unlimited is really proud the staff has partnerships that we have with all the school districts we work with. We have partnerships that extend as long as 20 years old and we also have partnerships with local community colleges and universities, local banks, elected officials, local churches and other community-based organizations.

Move to the next slide (Sabrina). Informational program outcomes are taken from our annual evaluation reports and focus groups is used with school personnel and program participants. The resulting staff report and information

revealed that participants they normally show an increase in the sense of pride and self-identity as a result of program participation.

We've noticed also a decrease in risky behaviors and an overall enjoyment of the program to the point that they want to be active during the program year and they said that they would recommend the program to a friend.

School administrators have also reported that in many instances there's a decrease in office referrals and improved behavior in classes. They also noted a new sense of pride in some of the student participants.

What I think is really unique about the Aban Aya program that it allows us to follow student participants from the fifth through the eighth grade and this way we can conduct a longitudinal study to compare and contrast behavioral changes over time.

And as we look at our final slide, at the end of the day our ultimate goal is that the Delta Dream Aban Aya program has empowered youth to dream beyond the pervasive poverty that surrounds them and they can envision a future of promise, of hope and success. We invite you to visit us on our Webpage at youmsdelta.org or contact us directly. Thank you.

(Sabrina Chapel): Thank you both for sharing your work and experiences and I really believe that the testimony from the field is really what make people take action and further affirms the importance of the services. We'll now go ahead and proceed to hear from another great leader in the field, Dr. Mary Langley.

Mary Langley: Good afternoon. I am Mary Langley. I am the Director of the Health Promotion Resource Center in the Department of Community Health Inventive Medicine here at Morehouse School of Medicine and the Project

Director for the Morehouse School of Medicine Carrera adolescent pregnancy prevention program.

This is a five-year project that Morehouse received the funding in 2010. Let me give the disclaimer up-front. The contents of this presentation are solely the responsible of the author and do not necessarily represent official views of OAH or any other federal agency or the U.S. Department of Health and Education. As I simply said, the buck stops here.

It is a five-year grant funded by the Office of Adolescent Health. I am getting acclimated to these slides. Let's give a brief overview of the Carrera program. The children aid society Carrera teenage pregnancy prevention program as we call it the Carrera program was developed by Dr. Michael Carrera in 1984.

The goal of the program is to help young girls and boys avoid becoming mothers and fathers during the second decade of their lives. The program philosophy is youth are a promise and not at risk. Those of us in the field often talk about at-risk youth.

It is a holistic approach above the waist approach that Dr. Carrera likes to tell the steps. He was here with us in January and met with all of the staff of the Carrera program.

Morehouse was funded to implement the Carrera program in three geographical locations: metropolitan, micropolitan and urban. Today we just want to talk about two of our locations as the rural and the micropolitan states.

The Carrera model has seven components: education, employment which is our job club, (fam delight) and sexuality education, self-expression, lifetime individual sports, poor medical and dental care and mental health services.

The program's an after-school program and we have the program five days a week and at least one Saturday a month. This would give you an idea of the locations of the program.

As you can see we have three sites. Morehouse is in Fulton County, this is Atlanta and we're about 20 minutes from our metro site in Cobb County, about an hour to 15, hour and 20 minutes from our other two sites.

I want to talk about the micropolitan site first, our program site. Earlier we heard the definition of a micropolitan community. The program is located in Lamar County with a population of 18, 317 in residents.

Our actual site is Bondsville which is the largest city and the county seat. This program is operated by the Lamar County Activity Center. This is a community-based non-profit organization and let me say at this point that we operate all three sites through a subcontract with community-based organizations.

We were funded to recruit 60 students per site to serve 180 students over a five-year period so we encouraged however the sites to over-enroll so that we can adjust for attrition.

The Lamar site serves two counties, Lamar and Spalding County. They have about 57 active participants out of the 94 they originally enrolled and they serve primarily African-Americans but we do have some Caucasian youth that's involved in the program.

Here you see at the Lamar site - the College of Lamar Spalding Carrera - youth there (promise) they're doing some self-expression. I think they're step dancing.

Our rural site which is in Jasper County, the actual location is in Monticello, Georgia which is the largest city in the country and the county seat is operated by the Monticello get-ahead house. This is a community-based organization that was started by the former police chief in Monticello.

He stated that he was tired of arresting young people that he wanted to put something together that would put them in positive environments. This site enrolled about 87 students and has the highest retention rate. They have about 55 that are active.

This site only serves young people in Jasper County and primarily African-American and Hispanics. In order to serve the Hispanics we had to employ a biracial staff person that help us. Most of the Hispanic parents do not speak English or do not speak it well so we wanted to make sure that they felt welcome to the program.

Here you see the Jasper County kids at the bank. They take banking very serious. This is part of the job club because this is the session that they love. They go once a week to a job club and the job club they get paid for attending this session.

They learn about banking, they learn about developing their budget. They determine how much they are going to bank on banking day and so we are trying to (billing) them away from what we call check-cashing place so you can see how serious these young people are about their money.

We also encourage young people to be involved in community service and we do a lot around national awareness and this is an October red ribbon week is a week of talking about preventing drug abuse and substance abuse. The young people went out and decorated, putting red ribbons around Monticello.

We have successes in our program at two levels, the organizational level as the programmatic level. We've been successful in building the capacity of these community-based organizations partnering with the institutions like Morehouse School of Medicine.

The funding we've gotten from the Office of Adolescent Health have provided evidence-based programs for these communities. It's the longest - the large amount - of funding they've had for adolescent program has helped these organizations to establish their 501C3 and to become subcontractors and develop a history of providing programs using federal funds.

We've improve their visibility in the community. The connection with Morehouse School of Medicine has opened a lot of doors for the community-based organizations. We have improved their ability to account for federal funding and we are helping them to develop sustainability plans after the grant ends.

Some of our program successes. We are in the third year of the grant but the second year of program implementation because the first year was spent in planning so we've had a lot of successes academically. Seventy-three percent of our students have an overall passing average and an increase of 6% from the fall. All of our young people have opened bank accounts.

All of them have receive preventive mental health services weekly during our power group and we also when we identify some behavior problems, they can

have individual counseling and we've also scheduled family counseling. Ninety-five percent of our students have medical insurance and 85% of our students have primary-care physicians.

We had to educate parents that having an up-to-date immunization did not mean that you had a physical and so this 95% and 85% that we are very proud of at the Carrera program and we always it full to staff and full to community that our youth are a promise, they are not at risk. This is a picture of the inaugural ball for the Lamar Spalding Carrera program.

The young people got involved with the election and they saw all the balls and they informed that the (miss mack) the program coordinator that they wanted to have a ball so we see that they elected a female as president in her white gown and we had to attend because we had a formal swearing-in into their office.

Here we have another example of success with partnership. This is the first African-American mayor for Monticello and he came over to bonds. We had the participating red ribbon and the next year the first thing he did was to give me a key to the city. There's an opening and thing but he's appreciative of Morehouse School of Medicine, a commitment to the youth in Monticello.

Here we have another partner, the Chamber of Commerce in Monticello. They allow us to have meetings with parents and with the community. At the Carrera program we are assigned from the Children Aid Society a fidelity manager and this is Mr. (Ron Skeets).

He's talking to trends because we're fixing to make the transition in our family life sex education to contraceptives and we need to have the parents

understand that our basic premise is abstinence but we want these young people to have information on contraceptives.

Here's another part of the Lamar County Fire Department participating in our red ribbon. We also had the firemen to talk to the young people about positions like EMT, emergency medical technician and becoming a fireman.

As part of the program is medical care and annual physicals so even though 85% of our young people have Medicaid or some type of medical insurance, those I call the working poor they make a little bit too much to have this needed their physicals.

So at Morehouse the residents in the community health and preventive medicine department volunteered and gave physicals to those that needed it from the Lamar County site.

As I want to end talking about it's a great program. It's a longitudinal program and it's a comprehensive program. It's above the waist program but it's to implement it in small towns, communities and rural communities, we have some major challenges.

In our educational component, finding certified educators within the community that want to think outside the box so we had to recruit from surrounding counties sometimes and we had to adjust schedules to allow them to get to the program.

Employment, the job club component is a challenge because of limited employment opportunities so we use the Internet, guest speakers and we go on field trips to show them opportunities.

This is a picture of Jasper County coming to Atlanta to Hartsfield Airport to show the different jobs and give them - they love this opportunity - to get outside of the community.

Other child with the FLSE wherein solved the parental taboo on sex education especially not only with parents but also in the community so we had to make a lot of presentations and have parenting sessions and emphasize again that this is a top-up approach, that we are trying to help our young people to plan beyond and not become parents as teenagers.

Individual sports, this is the south and football and basketball are keen but we are required to expose for the model to other lifetime sports so we do a trade-off. We let them play a little ball and then we use 21st Century technologies that we and vendors to expose them to other type of sports.

Here again we are Jasper County and I'm presenting to the parents and convincing them I promise you that we are not teaching to use contraceptives. We have given them information. We had hoped to give them the correct information.

We use a lot of volunteers. Once the community bought into the Carrera program, people came out to volunteer their skills. This is a black belt who volunteered to teach our young people the martial arts. They love this lifetime sport.

Other child with the self-expressions. Everything is hooked to limited funding and resources in small towns and rural communities but it's amazing to me how once the community catch on that we are really trying to empower these young people, we have community volunteers, even staff members that are paid to be group leaders in some things use their other talents.

And we had a young lady who has a very great voice who organized the Lamar County Lamar Spalding Carrera Chorus that performs at different events.

Here the young people in Jasper County wanted to sew as part of their self-expression. A volunteer came forth to teach them sewing, from the community even volunteered some sewing machines and you can see that they are very proud of their pocketbooks that they created.

Again full medical and dental is a challenge for a small town and rural communities. We had to facilitate this by those who are eligible for Medicaid, our community organized work with parents for them to enroll. Sometimes people who were eligible but they did not enroll into the program. We used the health department in the country for physicals.

Again residents here at Morehouse did physicals for those that did have insurance. Dental is the great (chap) preventive dental care but we hooked into the smile bus so the mobile dental services and mental health is limited in the county of this rural county.

There are no mental health services but we have region of mental health so the get ahead house opened up a room for the mental health specialist to come once a week to do individual sessions as well as conduct our group sessions.

The model requires that we use a master's of social worker for our power groups. Finding one in a rural community has been a challenge so we have adjusted to use school counselors that work with us. This is a picture of the smile bus that comes out, help a child smile. It's been a great partner.

Transportation is a challenge not only in the rural area but also in the metro area. We were fortunate to be able to purchase a couple of vans during the first year.

We partnered with the school system to have our sites as a drop-off point and when we take the kids home, we have drop-off points that parents can meet us, those that do not have transportation, we have to take the child directly home.

We have limited parental support. We get about 25 to 30% of parents that actively participate in educational sessions and given other type of support to come out to events like coming out to the inaugural ball so we make home visits. Our community organizer makes home visits and we assist parents with some of the issues that they are facing.

Limited funding is going to be the issue around everything and so we have to use fundraising as part of the job club to take kids on experimental learning, take field trips. We get to take them on things up here in Atlanta, coming to Atlanta to a lot of the activities in Atlanta that are free. That's a great treat for the young people and low-cost field trips.

This is one of the vans that we were able to - 15-passenger van - that we were able to purchase for the rural sites in Jasper County. We have a limited number of potential partners so we have - we call it partners without borders - we follow the money so wherever the parents shop, that's where we would go and ask a business or an organization or entity to help us support our program.

Wal-Mart and Walgreen have been very helpful in donating things to our program. Intergenerational poverty and hopelessness and another thing,

educational and community climate of low expectations for our target population.

But intergenerational poverty, our model is that we help our young people to look beyond now and we expose them to education and cultures, field trips. When I go out to the site, I talk to them.

Deal with where you are on the way to where you want to be and so with the community we share our success. We brag about the things that we have achieved especially our high academic achievement on standardized test scores.

Here are some of the - the 100 black men - and fidelity manager helped us to get tickets to bring the young people to Atlanta for March Madness. They got basketballs and T-shirts and this was a great treat for them.

If you want to prevent and reduce teen pregnancy in small-town rural communities, we have to build resiliency and social skills. You have to let the young people know that they can bounce back regardless of where they are now, provide opportunities for engaging within and outside of the communities.

They need to see that the things that they can achieve if they stay in school and that they don't become teen parents. Provide a nurturing and supportive environment. Show them that you care but establish rules of conduct. This is what Dr. Carrera calls firm it. Be firm but nurturing.

Set realistic expectations and goals. Don't put it so far. If they're a C student, help them to be good C students and one of the things that we like to say as our motto at Morehouse that we love unconditionally and we never give up.

Once a Carrera kid, always a Carrera kid and further we may give them a little of what we call four Ts, take time to think and when they come back, we ask them what did you learn while you were taking some time to think?

This has just been a brief overview of our program at two of our sites. If you want more information about the Morehouse School of Medicine, Carrera, teenage pregnancy prevention programs, this is my contact information. You can call me, e-mail me.

If you want to talk about anything specifically at the sites. (Angela Mack) is the program coordinator for our micropolitan. In Lamar Spalding Carrera program, Ms. (Roberta Anderson) is the coordinator for our rural site, the Jasper County site. They would be glad to talk to you because we love bragging about our young people in the Carrera program.

Thank you for this opportunity to share a little bit about the Morehouse School of Medicine Carrera teenage pregnancy prevention program.

(Sabrina Chapel): Thank you so much Dr. Langley. All your pictures are definitely worth a thousand words. They're wonderful pictures, thank you. We will now open up the Webinar to questions and answers. Operator, could you please assist? We would like to take questions first from the phone line and then we'll move to online.

Coordinator: Thank you if you would like to ask a question over the telephone, please press star 1 at this time. To withdraw a request, press star 2. Once again to ask a question over the telephone, please press star 1. One moment, please.

(Sabrina Chapel): While people are waiting, we do have some wonderful closing statements from the national campaign so everyone please stay with us but now we just have time for - taking a pause - for questions and answers.

Coordinator: Once again to ask a question over the telephone, please press star 1. Currently there are no questions.

(Sabrina Chapel): Okay, well I do have questions from online and I'll just read them aloud and address them to the speakers. To the folks, this is (Rachel Narwach). To the folks at the Dream, thank you so much. This is a great presentation.

I'm wondering if you've had any opportunity to look at the county team birth data and if so, if you've been able to measure real decreases in teen birth rates. This is for Dr. Jossell and (Shirley French).

(Shirley French): Yes, we have been able to measure some decreases in teen birth rates. We would love to say that we contributed to this decrease but we know that there are several contributing factors but within the population we are working with and the school districts that we are affiliated with, we are seeing some measureable decreases.

(Sabrina Chapel): Great, thank you Dr. Jossell and (Shirley). Another question. What is your attendance at the Lamar - I think that's the Lamar site - out of your 57 regular sites and this is from (Frances).

Mary Langley: We run an average of 35 to 50 students daily in attendance. One of the things that we are having a problem with at Lamar and at all the sites is the competing extracurricular activity sports, basketball, football season and so rather than trying to compete, we use these activities as field trips and we take

the kids to the sport event but we run average about 30 to 40 kids on a daily basis.

(Sabrina Chapel): Excellent, thank you Dr. Langley. We have another question here from (Merrill) and this is for Dr. Langley. Is there a cost per student for the Carrera program?

Mary Langley: It's free for the students and one of the key things with Dr. Carrera program is that it must be - it can be no cost - to the students of the families and that's what makes this a challenging program. It is a costly program but it is a free program for the young people.

(Sabrina Chapel): Great. I have no additional questions here on the Webinar portion. Operator, do we have one last call for anybody out in phone land?

Coordinator: Once again to ask a question, please press star 1. I have a question in queue from (Denise Torrez). Your line is open.

(Denise Torrez): Hi, my name is (Denise) and I'd like to thank everybody. It's been a great Webinar. My question really is about our HQs in the female community because I think that there are one of the challenges we have here in Deschutes County in Oregon is actually bridging the cultural issues that really create a problem for the female parents, especially non-English-speaking parents - who want their children to participate in any kind of program with regard to sexual health and pregnancy prevention because there's so many religious values and other cultural values and stuff like that make it more prohibitive.

We've had difficulty reaching out to other major partners including religious partners because of again the religious cultural issues that have been a major

barrier. I would really love to hear someone talk about any ideas you might have about further bridging for the female in the Latino community.

Mary Langley: Well, we do have at the Jasper County site we do have a core of Hispanic students that come to the program and we didn't get them until we did get a bilingual staff person. She first volunteered to work with the parents and again we emphasize above the waist.

We have a lot of religious support for the Carrera program and we had to do this by going out to the faith community and talking with them about the program and all the other aspects and that sexuality as a case was only one component.

And I've also had to talk to some pastors without knowledge that people perish and so we want to give our young people some knowledge so that they will know what is facts and what are myths.

(Denise Torrez): And this is Kelleen Kay. I really appreciate that question because it is important and it, you know, each community does present its own unique needs and challenges.

I would certainly suggest looking through the - we are fortunate enough now - to have a very long roster of effective teen pregnancy prevention programs and we encourage every community to think about their own unique needs and which program might best fit those needs.

In addition to the actual more formalized curricula, here at the campaign I know we have a variety of services that our Latino initiative has developed, resources that can be used in reaching out to parents, resources that can be

used in reaching out to the faith communities, resources that can be used in reaching out to the teens themselves within the Latino community.

So we certainly invite you to check these resources out on our Website. I know near the end of our presentation we have some contact information. If you go up on our Website and you can't find what you're looking for, we would certainly encourage you to give us a call or reach out and we'd love to help you out with that.

(Sabrina Chapel): Thank you. We have one question that came in from the Webinar portion and this is from (Anna) and this is open up to all presenters. I appreciate the suggestions for the challenges of working in rural areas such as working with the school system to solve the transportation issue.

My question is when dealing with very limited resources in the rural communities, we work with TPP programs in Alaska native villages and the most common challenge we share is dealing with this issue. What methods do you engage when dealing with the transportation issue? Grantees?

(Shirley French): I think the most effective issue - the most effective route we've taken - is partnering with the school district. It can get to be a bit expensive because although we're partnering with them, they're still going to charge us a little over \$1.50 per mile.

And we have our own agency vehicles and that helps a little but we work with over 2000 young people in 10 different school districts so it is still somewhat of a challenge for us and again even with the partnership with the school districts, it's not enough so yes, it's still a barrier.

Mary Langley: This is Mary Langley. At Morehouse it is a problem especially when the gas went up so high but we developed a partnership with the schools. They will drop them off but we still have to get them home so we had to purchase previously-used 15-passenger vans and to also develop drop-off points for our students but transportation continues to be a major problem for our program sites.

(Sabrina Chapel): Thank you all for your questions.

Kelleen Kay: Well, I was just going to add - this is Kelleen at the campaign - we would also suggest where possible relying on digital resources and again later in our slide deck we'll show a couple of those resources.

It's not to suggest at all that it's a panacea or that it solves the transportation challenge but they can be used I think to great effect to help stretch people's time and resources and be a great supplement to whatever you're actually able to do sort of boots on the ground.

(Sabrina Chapel): Well Kelleen you've done a great shifting for us. We're going to go ahead and move since there are no additional questions online and on phone line, we'll go ahead and shift to the closing aspects of today's Webinar. Kelleen and Cara from the national campaign will share some lasting remarks.

Cara Finley: Thank you (Sabrina). This is Cara from the national campaign and thank you so much to our friends in the Mississippi delta and Georgia for talking about the great work that they're doing.

These next couple of slides have some of the challenges that we often hear about and that can be found in the literature as well and I think, you know, the speakers you just heard touched on many of these, specifically transportation

and the location of services, the confidentiality issue experience when you're in a small town and if you go into the clinic, you know, you know everyone.

It's your mom's friends. This can be a little bit discouraging for teens to go visit clinics and as we mentioned earlier, regardless of the curriculum you're using, these are some of the challenges that most of you probably face.

Here's a few of the others and then the next couple of slides are from some qualitative analysis that we've done at the campaign in the past. These are from older teens but gives you sort of an idea of what they're saying about some of the concerns that they have.

These are a few you can read through later about their experiences with the health departments in their rural communities, touching on the confidentiality issue and sort of trusting the health department if that's the only option for a clinic and then accessing contraceptive services so transportation which we've talked a lot about today and the costs especially in resource-limited areas.

And then here you see some of their ideas about their own motivation and the social norms and the areas that they're living in so this is just sort of something of interest if you want to look through them in more detail later.

And then these are a few of the resources that we recommend. That top one is a link to our very new science says about rural teen childbearing so much of what we've presented today is in this document so if you want to access it later and look at the numbers and graphs, it's that top link and then a couple of the rural resources and things that we've pulled for this presentation.

And as Kelleen just mentioned earlier, digital resources are something that can be great especially in rural areas to supplement what you're already doing so

if you aren't familiar with our bedside Website already, this is really for older teens or twenty-somethings but we have sort of the 18 edition. Hopefully you've seen this Website.

There's now a birth control method selector. You can ask questions. You can locate clinics on here so you can type-in your zip code and it'll pull-up all the clinics in your area.

So this is helpful for teens to kind of go more anonymously and find out about birth control methods or if they have only heard of one clinic in their area, there might be some other ones so this is a great resource.

Kelleen Kay: And I'll just jump in here and add, you know, sort of drawing on the comments made during the earlier presentations, the goal of this information isn't to promote teens having sex and to get everybody on birth control but it's really focusing on that fact that information is power and informed teens make better decisions.

Cara Finley: Great, and if you have any questions about bedside or 18, feel free to contact us. This is a little more about the national campaign and this is our contact information for anything you've seen here today.

(Sabrina Chapel): Well, thank you all. On behalf of the Office of Adolescent Health and all our federal partners, Kelleen, Cara, Dr. Jossell, (Shirley) and Dr. Langley, we want to thank you all for your presentations and sharing your expertise and experience with all of us. As well I'd like to give many thanks to the participants for joining today's Webinar.

Now before we depart I would like to make two announcements that we would like to share. For National Teen Pregnancy Prevention Awareness

Month, there are additional planned Webinars as you can see. To get more information, visit our OAH Website. That's www.hhs.gov/ash/oah.

As well I'd like to also announce or OAH is pleased to announce the launch of the new teen pregnancy prevention resource center. This center is a collection of training and materials and resources for professionals working to reduce teen pregnancy in the United States.

So we definitely welcome everyone to visit the resource center and let your networks know about this new resource and our future planned Webinar events so with that, we thank you again for joining us and please stay tuned and connected with us through these various means. We look forward to having you on our next Webinar. Have a wonderful day.

Evelyn Jossell: Thank you.

Coordinator: Thank you for your participation. You may disconnect at this time.

END