

## Sexual Health Education and Family Planning: A Vital Component of the Healthy Start Program

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**Abstract:** The paper will describe the Healthy Start program as a comprehensive sex education program and implications for preventing subsequent adolescent pregnancies.

The adolescent pregnancy rate in the United States is double the rate in England, France, and Canada and nine times the rate of the Netherlands and Japan (Kirby, 2007; Shimp & Smith, 2008). Each year in the United States, approximately 850,000 or 8% of adolescents between the ages of 15-19 become pregnant (Guttmacher Institute, 2006; Kirby, 2007; Realini, 2004). The cumulative proportion of adolescent women becoming pregnant increases each year, resulting in 30% of girls in the United States having a second child before their twentieth birthday (Kirby, 2007).

Adolescent pregnancies result in consequences to the individual, infant, family, and society as a whole. Adolescent childbearing costs taxpayers about \$7-15 billion per year (CDC, 2009; Kirby, 2007; Shimp & Smith, 2008). Adolescent mothers are less likely to complete school, go to college and are unemployed or underemployed (CDC, 2009; Kirby, 2007; Shimp & Smith, 2008). Adolescent mothers have higher rates of low birth weight infants (LBW), prematurity, and infant mortality (CDC, 2009; Kirby, 2007; Sloane et al., 2008). Children born to adolescent mothers are also at increased risk for abuse, neglect, lower cognitive development, less education, behavior problems, and likely to give birth themselves as adolescents (CDC, 2009; Kirby, 2007; Shimp & Smith, 2008).

Adolescent pregnancies are usually unintended, occur outside of marriage and are more common among poor minority women (CDC, 2009; Finer & Henshaw, 2006; Kirby, 2007; Shimp & Smith, 2008). Unintended pregnancy is defined as a pregnancy mistimed or not wanted at the time of conception and is the result of lack of contraception or failure of contraception (CDC, 2009; Shimp & Smith, 2008). Although 80-90% of adolescents report using condoms the most recent time they had sex, most do not use contraceptives carefully and consistently (Kirby, 2007). Only 70% of adolescent women relying on oral contraceptives report taking the pill every day (Kirby, 2007). The educational prevention programs to reduce adolescent pregnancies usually take two forms: abstinence only and comprehensive sex education programs. Abstinence only programs focus on abstinence as the only sure way to avoid pregnancy, while comprehensive programs present abstinence as the most effective way to prevent pregnancy and contraceptives as an appropriate strategy for those who are sexually active (Kirby, 2007; Miller, 2007; Realini, 2004; Sanie, 2004; U.S. Department and Health and Human Services, 2001).

Healthy Start, a government sponsored program in the state of Florida, offers comprehensive services to pregnant women, infants and children up to three years who are identified as at risk of poor birth, health and developmental outcomes (Healthy Start, 2005). Comprehensive sex education and family planning services are also offered as a part of the Healthy Start initiative to reduce unintended pregnancies. Family planning is defined as deciding the size and spacing of your family and choosing a birth control method that is best to prevent an

unexpected pregnancy (Healthy Start, 2005). The purpose of this paper is to describe the Healthy Start program as a comprehensive sex education program and implications for preventing subsequent adolescent pregnancies. The paper will be organized into four sections: (a) the historical context of adolescent pregnancy, (b) adolescent pregnancy prevention programs, (c) the Healthy Start program and finally, (d) implications for adult learning.

### **Historical Context of Adolescent Pregnancy**

During World War II, six million women entered the workforce and changed the face of the family unit forever (Labor Unions, n.d.). Prior to the war, the nuclear family consisted of a working father, a stay at home mother and their children. With an increase in paternal death as a result of the war, more women were left widowed, and their responsibilities increased to include financial support. This consequence of the war led to the development of several government sponsored programs aimed at providing financial support for the new nuclear family, the single widowed mother. The Aid to Families with Dependent Children (AFDC) established by the Social Security Act of 1935 is a grant program where states provide cash welfare to children whose parents work outside the home and who are deemed to have inadequate parental support (AFDC, 2004).

Adolescent pregnancy or teen pregnancy, defined as conception between 13-19 years of age, first measured in the 1950s, was not always considered a problem (Popeono, 1998). Throughout history, women married and bore children at the age of sexual maturity (Popeono, 1998). Sexual maturity is defined as the onset of first menstruation in women and the ability to conceive and bear children (Medical Dictionary, n.d.). In 1950, the average age of sexual maturity was 16-19 years; however, by the late 1960's, the age dropped to 12-15 years of age (Popeono, 1998). Over 75% of adolescent mothers received cash welfare assistance from AFDC within five years of their first birth and 55% of AFDC mothers were adolescents at the time of their first birth (Nathan, Gentry, & Lawrence, 1999).

In 1967, a law was enacted that mandated states to offer family planning to AFDC recipients in "appropriate cases"; in 1976, sexually active minors were included in the "appropriate case definition" and mandated to be provided family planning upon request (Nathan et al., 1999). Even with the new guidelines, the continued benefits to single welfare mothers led to much debate as to whether such aid acts as an incentive for teens to have children. In an effort to dispel such questions, this act was reformed in 1996.

The new act, The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) or Welfare Reform Act of 1996, replaced AFDC, AFDC administration, the Job Opportunities and Basic Skills Training (JOBS) program, and the Emergency Assistance (EA) program with a cash welfare block grant called the Temporary Assistance for Needy Families (TANF) program (Administration for Children and Family, 1996; AFDC, 2004). PRWORA includes a five year lifetime limit on the length of time a family can receive federal assistance, a mandatory work participation component, and finally a plan to decrease teen and out of wedlock teen pregnancy rates (AFDC, 2004; Kirby, 2007; Nathan et al., 1999). TANF includes mandates on teen parents to continue attending school, to participate in parenting classes, to live with a responsible adult and to engage in educational/training activities (Administration for Children and Family, 1996; Guttmacher Institute, 2006; Kirby, 2007; U.S. Department of Health and Human Services, 2001).

Beginning in 1998, \$50 million was spent each year on abstinence education as a result of the reform. In addition, the Secretary of Health and Human Services (HHS) was mandated to establish and implement a strategy to (a) prevent non-marital teen births, and (b) assure that at

least 25 percent of communities have teen pregnancy prevention programs (Guttmacher Institute, 2006; U.S. Department of Health and Human Services, 2001). Since abstinence only programs have been shown to have little effect on adolescent pregnancy, number of sexual partners, and age of initiation of sex, preventative programs have been developed focusing on reducing teen pregnancy and sexually transmitted diseases (Kirby, 2007; Sanie et al., 2004).

### **Adolescent Pregnancy Prevention Programs**

Preventative programs include youth social development programs, abstinence only programs, comprehensive sex education programs, and sex and contraception counseling (Sanie et al., 2004). The youth social development programs focus on changing high risk behaviors and early sexual activity through social and psychological skill development (Sanie et al., 2004). Abstinence only programs teach that the only way to avoid extramarital pregnancies is to abstain from sexual intercourse; other forms of contraception are not introduced (Kirby, 2007; Sanie et al., 2004). A concern with abstinence only programs is the limited sexual education provided, and, in some cases, misinformation to adolescents regarding healthy sexual practices (Ott & Santelli, 2007). Sex and contraceptive counseling programs can be started in the school setting, at home by parents, or in a primary health care setting (Lindau, Tetteh, Kasza, & Gilliam, 2008). Counseling started in the home has been shown to be most effective in delaying initiation of sexual activity (Sanie et al., 2004).

Comprehensive sex education programs teach adolescents that abstinence is the primary method of preventing pregnancy, and provides an overview of methods of contraception and sexually transmitted disease prevention (Sanie et al., 2004). An evaluation of forty-eight educational interventions revealed that these programs did not accelerate sexual initiation (Kirby, 2007). However, a reduction in adolescent pregnancy, increased condom use, increased contraceptive use, and a decrease in risk taking behaviors were noted (Kirby, 2007). Although some of the programs studied emphasized one or some prevention methods, few incorporated all methods effectively.

### **The Healthy Start Program**

Healthy Start begins with preconception counseling, extends to all mother and childcare services and is targeted to populations at risk for adverse birth, health and developmental problems, such as adolescent mothers (Healthy Start of Miami Dade, 2005). Issues addressed in Healthy Start are preventative services, prenatal care, healthcare needs (nutrition, medications and immunization), psychosocial support, perinatal depression screening and healthcare access inequality (Roberson, 2008).

Core services provided by the Florida State Healthy Start Program are case management by care coordination, outreach and consortium through coalition, health education regarding nutrition, parenting, childbirth and breastfeeding, inter-conceptional care and pregnancy prevention counseling (Healthy Start of Miami Dade, 2005). Selection of services were based on the mission of the National Healthy Start Program to develop community based maternal and child health programs pertaining to infant mortality, low birth weight babies and racial disparities in perinatal care (Roberson, 2008).

Ideally, all pregnant Florida residents are screened for the Healthy Start program based on identified risk of poor maternal, infant, or child outcomes. Ongoing services are provided to ensure optimal health and development (Healthy Start of Miami Dade, 2005). Women and children who are at risk or in need of interventions are funneled into additional services and are followed up (Healthy Start of Miami Dade, 2005).

Interconceptional Care and Counseling (ICC) is an educational service provided through Healthy Start in Florida. Culturally sensitive comprehensive parental education and counseling are given by trained personnel (Healthy Start of Miami Dade, 2005). Activities and counseling are provided to women concerning access to health care, baby spacing, nutrition, physical activity, maternal infections, chronic health problems, substance abuse, smoking, mental health and risk problems (Healthy Start of Miami Dade, 2005). One to one educational activities, support groups and formal education are given about nutrition, family dynamics, child abuse, unintended pregnancies and childhood injury prevention (Healthy Start of Miami Dade, 2005).

### **Implications for Adult Learning**

The outcomes of effective comprehensive sex education demonstrate lower incidences of adolescent pregnancy, increased condom use, increased contraceptive use, and a decrease in risk taking behaviors (Kirby, 2007). Analysis of 19 effective comprehensive sex education programs revealed 17 common characteristics that fall into three categories: (a) the process of developing the curriculum, (b) design and teaching strategies, and (c) the process of implementing the curriculum (Kirby, 2007). Most of these programs started off by setting ground rules for involvement such as not asking personal questions and respect for peer opinion (Kirby, 2007). The content of effective comprehensive sex education programs focus on STD and pregnancy prevention. Short lectures, class discussions, games, skits, videos and simulations demonstrating pregnancy risk and consequences have also been used in these programs (Kirby, 2007).

The Healthy Start Program provides a valuable service in Florida by providing comprehensive sex education and family planning services to adolescent mothers. However, a report released by the organization in 2009 revealed that 25% of women in the program had a repeat pregnancy within 18 months (Northeast Florida Healthy Start Coalition, 2009). Comprehensive sex education provided by Healthy Start should be evaluated for the 17 common characteristics found among the most effective comprehensive sex education programs. By doing so, strengths and weaknesses of the program could be addressed which may result in more sustained behavioral changes that surpass 18 months.

### **References**

- Administration for Children and Families. (1996). The Personal Responsibility and Work Opportunity Reconciliation Act of 1996. Retrieved November 16, 2009, from <http://aspe.hhs.gov/HSP/abbrev/prwora96.htm>
- Aid to Families with Dependent Children. (AFDC) and Temporary Assistance for Needy Families (TANF). (2004, January 28). Retrieved November 16, 2009, from <http://aspe.hhs.gov/HSP/abbrev/afdc-tanf.htm>
- Center for Disease Control and Prevention. (2009). *Preventing teen pregnancy: An update in 2009*. Retrieved November 7, 2009, from <http://www.cdc.gov/reproductivehealth/AdolescentReproHealth/AboutTP.htm>
- Finer, L. B., & Henshaw, S. K. (2006). Disparities in rates of unintended pregnancy in the United States, 1994 and 2001. *Perspectives on Sexual and Reproductive Health*, 38(2), 90–96.
- Florida Department of Children and Families. (2009). *Temporary assistance for needy families state plan renewal October 1, 2008-September 30, 2011*. Retrieved November 16, 2009, from <http://www.dcf.state.fl.us/ess/TANF-Plan.pdf>
- Guttmacher Institute. (2006). U.S. Teenage Pregnancy Statistics National and State Trends and Trends by Race and Ethnicity. Retrieved November 7, 2009, from <http://www.guttmacher.org/pubs/2006/09/12/USTPstats.pdf>.

- Healthy Start of Miami Dade. (2005). *Interconceptional training manual*. Retrieved October 20, 2009, from Healthy Start of Miami Dade website: <http://www.hscmd.org/Interconception.asp>.
- Healthy People 2010. (n.d.) *Healthy people 2010 objectives*. Retrieved November 15, 2009, from <http://www.healthypeople.gov/hpscripts/KeywordResult.asp?n266=266&n362=362&Submit=Submit>
- Kirby, D. (2007). *Emerging answers 2007: Research findings on programs to reduce teen pregnancy and sexually transmitted diseases. The national campaign to prevent teen and unplanned pregnancy*. Washington, DC.
- Labor Unions. (n.d.). *A look back at women in the workplace*. Retrieved November 18, 2009, from <http://www.thelaborsite.com/women1.cfm>
- Lindau, S. T., Tetteh, A. S., Kasza, K., & Gilliam, M. (2008). What schools teach our patients about sex content, quality, and influences on sex education. *Obstetrics and Gynecology*, 11 (2), 226-266.
- Medical Dictionary. (n.d.) *Sexual maturity*. Retrieved November 1, 2009, from <http://medical-dictionary.thefreedictionary.com/Sexual+maturity>
- Nathan, R. P., Gentry, P., & Lawrence, C. (1999). *Is there a link between welfare reform and teen pregnancy?* Retrieved November 16, 2009, from [http://www.welfareacademy.org/conf/papers/nathan\\_p.shtml](http://www.welfareacademy.org/conf/papers/nathan_p.shtml)
- Northeast Florida Healthy Start Coalition. (2009). *Healthy start service delivery plan: Achieving healthy pregnancies through a life-course approach*. Retrieved November 1, 2009, from [www.nefhealthystart.org/2009-2014\\_Service\\_Delivery\\_Plan.ppt](http://www.nefhealthystart.org/2009-2014_Service_Delivery_Plan.ppt)
- Ott, M. A., & Santelli, J. S. (2007) Abstinence and abstinence only education. *Current Opinion in Obstetrics and Gynecology*, 19, 446–452.
- Popeono, D. (1998). *Teen pregnancy an American dilemma*. Retrieved November 16, 2009, from <http://marriage.rutgers.edu/Publications/pubteenp.htm>.
- Realini, J. P. (2004). *Teenage pregnancy prevention: What can we do?* Retrieved November 8, 2009, from American Academy of Family Physicians website: <http://www.aafp.org/afp/20041015/editorials.html>
- Roberson, J. (2008). *Historical overview of the healthy start initiative*. Retrieved November 1, 2009, from [http://www.healthystartassoc.org/HS\\_Overview\\_2008.pdf](http://www.healthystartassoc.org/HS_Overview_2008.pdf)
- Sanie, S., Gantt, A., & Rosenthal, M. S. (2004). Pregnancy prevention in adolescents. *American Academy of Family Physicians*, 70, 1517-1524.
- Shimp, L. A., & Smith, M. A. (2008). Contraception. In P. D. Sloane, L. M. Slatt, M. H. Ebell, L. B. Jacques, & M. A. Smith (Eds.), *Essentials of family medicine* (pp. 395-397). Philadelphia, PA: Lippincott Williams and Wilkins.
- U.S. Department of Health and Human Services. (2001, June). *The Surgeon General's call to action to promote sexual health and responsible sexual behavior*. Retrieved November 1, 2009, from <http://www.surgeongeneral.gov/library/sexualhealth/call.htm>
- United States Department of Health and Human Services. (n.d.). *Maternal and Child Health Services Title V Block Grant*. Retrieved November 1, 2009, from <http://www.mchb.hrsa.gov/programs/blockgrant/overview.htm>