

Core Service Report

Teen Parents / Pregnant Teen Education Programs

Consumer Category:
Educational / Employment Limitations

Primary Consumer Group:
**Persons with Educational Disadvantages
Preschool and K-12**



February 2007

TABLE OF CONTENTS

Companion Reports	ii
Acknowledgements	ii
Snapshot.....	iii
I. Foreword	1
Introduction	1
Methodology.....	1
II. The Core Service Environment.....	3
Core Service Environment	3
Public Policy Issues	4
III. The Core Service Consumers	7
Definition Of Target Population	7
Demographic Characteristics	7
Realized Access To Service.....	9
IV. Core Service Delivery	10
Core Service Definition.....	10
Background On Core Service	10
Funding Of Core Services	14
Identified Revenues	16
Reimbursement/Cost.....	17
V. What Works; What Doesn't	18
Impact On Individuals/Families	18
Impact On Community.....	23
Accreditations/Standards/Certifications	23
VI. Gap Analysis	24
VII. Summary	26
References.....	27
Attachments	31
Attachment 1: Researcher List.....	31
Attachment 2: Technical Notes	32
Attachment 3: Actual Consumer Demographics.....	40
Attachment 4: Actual Consumer Zip Codes.....	42
Attachment 5: Profile Of Core Service Providers – 2005.....	44
Attachment 6: Providers And Functions – 2005	46
Attachment 7: United Way - First Call For Help Requests – 2000-2004.....	47
Attachment 8: United Way - First Call For Help 2000-2004: Unmet Need	48
Attachment 9: Service Site Index.....	49
Attachment 10: Map	50

COMPANION REPORTS

In addition to the information included in this report, a report of the other core services (80 in total), community leader key informant interviews, United Way - First Call for Help staff focus groups, consumer snapshots, and e-survey of United Way funded executive directors, board presidents, and United Way Community Investment staff are available at <http://www.uws.org>.

ACKNOWLEDGEMENTS

We are grateful to the multiple public and private funders, provider agencies, experts in the various fields of interest, and staff of United Way of Greater Cleveland for their assistance, support, information, and insight. We would specifically like to acknowledge the substantial contributions of Invest in Children, Cuyahoga County Help Me Grow and the Cuyahoga County Family & Children First Council.

This report was written by a team under contract with MCS Consulting Service, LLC, including the following in alphabetical order:

- Renée Aten, Aten Enterprises
- Carey Wiant Nyberg
- Jennifer Slusser, IntelliSolve, Inc.
- Marlene C. Stoiber, MCS Consulting Service, LLC.
- Jamie Watkins, IntelliSolve, Inc.
- Jacqueline Kirby Wilkins, IntelliSolve, Inc.

This report reflects the comments from reviewers and United Way Community Investment Committee cluster volunteers.

Suggested Citation: MCS Consulting Service. (2007). Core service report: Teen parent/pregnant teen education programs. United Way of Greater Cleveland. Available at <http://uws.org>

SNAPSHOT

AIRS Code Level I: Education (H)

AIRS Code Level II: Educational Programs (HH)

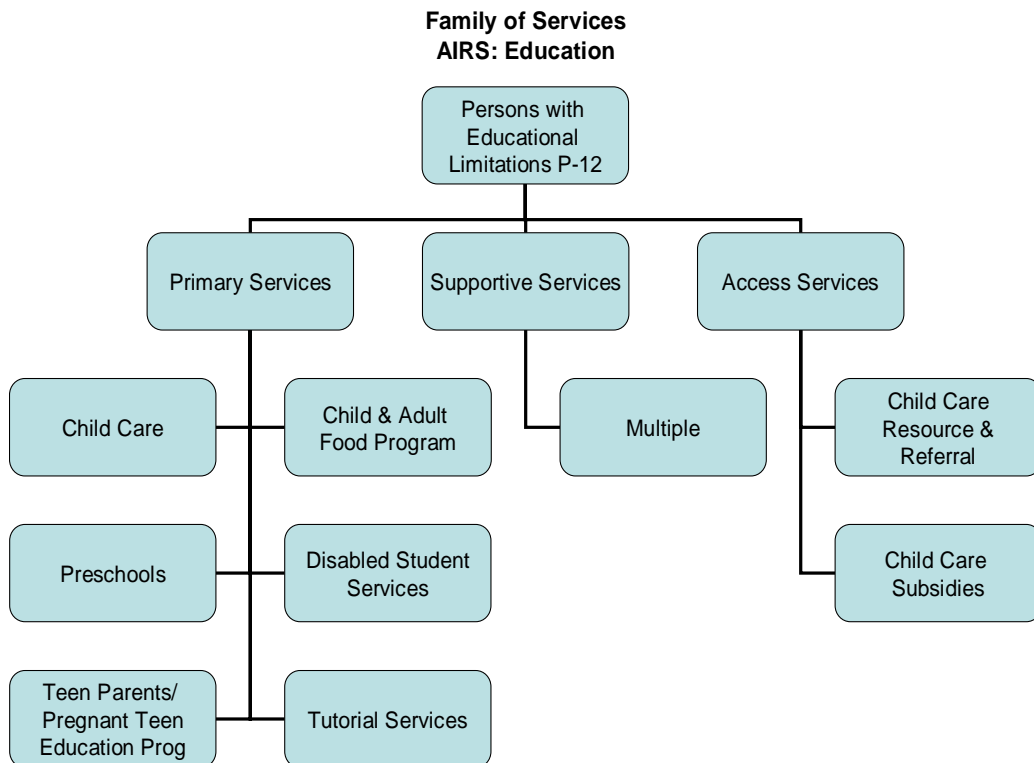
Core Service: Teen Parent/Pregnant Teen Ed Programs (HH-850)

Investment Committee: Learning and Earning for Life

Cluster: Education

AIRS Definition: Programs, usually available within the regular high school curriculum, that provide opportunities for pregnant teens and teenage students who are parents to complete their high school education and receive diplomas. Classes that focus on child development, infant care, mother/infant nutrition, and childbirth preparation are available in addition to the basic graduation requirements and academic electives. Students enrolled in the program may also receive nutritionally balanced meals (breakfast and lunch), prenatal care, family planning, and counseling services.

The Teen Parents or Pregnant Teens Program is part of a family of services for persons with educational limitations grades P through 12. It is one of six services targeting this consumer group. In addition two services help consumers access some of the primary services. (See figure below.)



Core Service Environment

The United States has the highest rate of teen pregnancy in the developed world, and Ohio is ranked 28th among the states (Alan Guttmacher Institute [AGI], 2004). The teen pregnancy rate in the U.S. is at least twice that in Canada, England, France, and Sweden, and 10 times that in the Netherlands. Experts cite restrictions on U.S. teens' access to comprehensive sexuality education, contraception, and condoms along with the widespread American attitude that a healthy adolescence should exclude sex.

Teen pregnancy can be the catalyst for other problems and concerns. Typical problems related to teen pregnancy and parenting include but are not limited to health problems for the mother and child, lack of education for both the mother and child, and increased poverty. In addition teen parents are generally less cognitively prepared for parenting, which results in less understanding of child development, more negative attitudes toward parenting, unrealistic expectations of behavior, and increased stress (O'Callaghan, Borkowsky, Whitman, Maxwell & Keogh, 1999).

In 1996, President Clinton proposed a teen parent initiative to help teens who receive Aid to Families with Dependent Children (AFDC) remain in school, and to assist those who dropped out to return to school. It called for every state to develop a plan to keep teen parents in school. In addition, the U.S. Department of Health and Human Services directed states to develop alternative educational programs for teens who were not likely to succeed in conventional schools and to offer services that prepare them for self-sufficiency including life skills, money management, problem-solving, decision-making, conflict resolution, and parenting skills (National Institute for Literacy, 1996).

The 1996 Temporary Assistance for Needy Families (TANF) program prohibits states from spending federal funds on assistance to an unmarried, custodial minor parent caring for a child 12 weeks of age or older unless the minor parent has completed high school or its equivalent or participates in appropriate educational activities. In the TANF legislation, Congress included two rules specific to minor parents: 1) minor parents live in an approved arrangement and 2) minor parents participate in education leading to a high school diploma or GED.

Under President Bush, the issue of teen parenting has all but disappeared. A scan of the United States Health & Human Services website offers no information or links to programs that deal with teen pregnancy, only teen pregnancy prevention. Furthermore, most is couched in policies of abstinence-only unless married programs. Nationally, however, programs implemented by and in the State of Ohio have become national models for organizing social, human service, and educational programs to provide support for teen pregnancy and teen parents.

Core Service Consumers

The target population addressed in this core service report is females ages 14-19 who are assumed to be first time pregnant/teen parents and need assistance to obtain a high school diploma or GED.

Each year in the United States, approximately 1 million adolescents, or 10 percent of females 15 to 19 years of age, become pregnant. These pregnancies, which account for 13 percent of all births, usually are unintended and occur outside of marriage. Since 1991, the adolescent pregnancy rate in the United States has fallen by 25 percent, from 116 to 87 per 1,000 females 15 to 19 years of age. This decline has been attributed to delayed initiation of sexual intercourse, decrease in sexual activity, increased contraception use, fear of sexually transmitted diseases, education and

prevention programs, and the declining approval of premarital sex (Population Reference Bureau, 1999 in CWLA, 2003).

In Ohio, there were 29,650 teen pregnancies in 2000. Non-Hispanic whites had the most teen births with 19,550, followed by African Americans with 8,760, then Hispanics with 1,130. Ohio's number of teen births declined by 20 percent between 1990 and 2000 while the national average declined by 24 percent during the same period (U.S. Census, 2000).

Currently in Cuyahoga County, there are approximately 1,900 births to teenage parents each year. Close to 18 percent of these births are to teenage parents with another child. Children of adolescent parents are more likely to be born prematurely and at low birth weight; be affected by adverse conditions such as infant death, blindness, and mental retardation; grow up in homes without fathers with less emotional and cognitive stimulation; end up in foster care; and perform significantly worse on tests of cognitive development.

An issue is that pregnant teens are not allowed to attend classes during the third trimester of a pregnancy which creates a major barrier to them completing their coursework. In research conducted by the Cuyahoga County Early Childhood Department/Invest in Children found that many (50 to 75 percent) of the pregnant teens have learning disabilities. However, many do not have Individual Education Plans (IEPs), nor are they involved in special education programs. (Personal communication with M. Barni, February 8, 2007)

In 2000, 2,859 girls between 14 and 19 in Cuyahoga County were estimated to be first-time teen mothers and/or pregnant. However, this number has been fluctuating since 1990; it is projected to decrease to 2,875 by 2015. This is primarily because of fluctuations in the population.

Core Service Delivery

The definition of the core service for this report is: programs, usually available within the regular high school curriculum, that provide opportunities for pregnant teens and teenage students who are parents to complete their high school education and receive diplomas. Classes focus on child development, infant care, mother/infant nutrition, and childbirth preparation in addition to the basic graduation requirements and academic electives. Students who are enrolled in the program may also receive nutritionally balanced meals (breakfast and lunch), prenatal care, and family planning and counseling services.

Currently Cuyahoga County has limited programs specifically focused on supporting teen parents or pregnant teens to complete their education, i.e., graduate from high school. The Graduation, Reality, and Dual-Role Skills ("GRADS") program was a family instructional and intervention program originally piloted in Ohio in 1980 and funded by the Comprehensive Education Training Act (CETA). It was designed to keep pregnant and parenting teens in school, encourage good health care practices, and help young parents set occupational goals. However, the program has not been operating in the last few years. The Help Me Grow, Enhanced Services for Pregnant and Parenting Adolescents, has self-sufficiency as one goal among many. This is also true of the MomsFirst program.

Also no longer operating, the Ohio LEAP (Learning, Earning, and Parenting) program used financial incentives to motivate pregnant and parenting teens that received welfare to complete high school, and attend school regularly.

A program that specifically targets pregnant teens for education is the DePaul Young Parent program operated by Catholic Charities Health and Human Services.

Based on United Way - First Call for Help's (FCFH) database (February 2005), there are 11 teen parent/pregnant education program providers operating from 13 different sites, 9 are government and 2 are nonprofit. In FY 2004 (July 2003 to June 2004), United Way funded one provider. FCFH call data shows an increase in the number of total requests for teen parent/pregnant education programs in the county: from 10 in 2000 to 23 in 2004. FCFH had 84 requests for information about teen parent/pregnant education programs.

The federal government's funding for teen pregnancy programs tends to focus on abstinence efforts through programs such as the Department of Health and Human Services' Community Based Abstinence Education Program, which was funded at over \$100 million in FY 2005. However, the focus is not specifically on academic achievement of pregnant teens or teen parents.

Teen parent/pregnant teen programs are funded through Help Me Grow and Invest in Children. However, the goals are broader than education of teens.

As of May 11, 2006, nearly \$1.3 million in revenues for teen parent/pregnant teen programs has been identified countywide. Ninety-six percent of the revenues are from Foundations. United Way of Greater Cleveland funds 3 percent from both Investment Committee allocations and designations . Federated giving accounts for the remainder.

What Works; What Doesn't

Minor parents are a special target in TANF. Available research on the school requirement (often called "Learnfare") suggests that positive outcomes occur largely for those still in school, since Learnfare has had little success with "retrieving" those who have dropped out.

In 1997, a meta-analysis of school- and community-based pregnancy prevention programs found that community-based models had a strong significant effect on contraception use and were more successful in decreasing teen pregnancy rates (Corcoran, O'Dell Miller, and Bultman, 1997 in CWLA, 2003).

In a recent request for proposals, Invest in Children (2005) identified core programming components for pregnant/parenting adolescents as part of what they found works in teen parent/pregnant teen programming. Components included access to a consistent, caring adult/professional; self-sufficiency goal (education/employment); peer supports/group activities in a community/neighborhood setting; consistent, quality health care (pre and post); recognizing the dynamics of a teen's family; and comprehensive, wrap-around services.

There is little evidence that teens who participate in abstinence-only programs abstain from intercourse longer than others. In fact, 88 percent of students who pledged virginity in middle school and high school still engage in premarital sex. The students who break this pledge are less likely to use contraception at first intercourse, and they have similar rates of sexually transmitted infections as non-pledgers (Walters, 2005; Bearman and Brueckner, 2001). Meanwhile, students in comprehensive sexuality education classes do not engage in sexual activity more often or earlier, but do use contraception and practice safer sex more consistently when they become sexually active (AGI, 2003a; Lemmott, et al., 1998; Kirby, 1999; Kirby, 2000; NARAL, 1998).

Every reputable sexuality education organization in the U.S.—as well as prominent health organizations including the American Medical Association—has denounced abstinence-only sexuality education. A 1997 consensus statement from the National Institutes of Health concluded that legislation discouraging condom use on the grounds that condoms are ineffective “places policy in direct conflict with science because it ignores overwhelming evidence. Abstinence-only programs cannot be justified in the face of effective programs and given the fact that we face an international emergency in the AIDS epidemic” (NIH, 1997 in Planned Parenthood, 2005).

Gap Analysis

The estimated universe of possible consumers is 2,859, including both realized (126) and unrealized (2,733) access.

I. FOREWORD

INTRODUCTION

United Way of Greater Cleveland (UW), in partnership with the Cuyahoga County Board of Commissioners, has initiated a large scale core service planning process to generate data and engage in community-wide dialogue about the community's safety net of core service and consumer needs in the Greater Cleveland area. In addition, UW envisions this process as an opportunity to better understand its role in the community and its long term capacity to improve the lives of Greater Clevelanders.

The primary goal of the Cuyahoga County core service research is to identify consumer needs and assess whether there are service gaps/duplications on a community-wide level. The findings from this research will guide future funding decisions at UW, and they will also be used to stimulate dialogue with other funders and groups in the community. United Way intends to continue to fund a broad array of "safety net" services that are important to the Greater Cleveland area. But it is hoped that the research findings will inform how UW dollars may be dispersed to have the greatest impact on current realities, needs, and priorities in the Greater Cleveland community.

METHODOLOGY

United Way contracted with MCS Consulting Service, LLC, to conduct the core service research, which focuses on both the consumers served and services provided. (See Attachment 1 for list of members of the research team.) The research team has obtained information about each core service from multiple data sources. At the end of the research process there will be substantial information available for some services and less for others, which will provide a clearer picture of what information *is* available and where there are *significant gaps*.

The questions addressed are:

- Including public policies, what are the environmental influences that are impacting both service consumers and the capacity for service delivery?
- Who are the service consumers? What are the factors that lead to a need for services? How many consumers are there? How many have there been in the past several years and what factors influenced the historic trend line? What are the projected numbers for the future? What is their demographic profile? Where do they reside? How many are receiving services funded by government and/or United Way?
- What is the philosophy that drives service delivery? Has it changed? What does the service consist of? Who provides the service?
- What are the funding sources? What are the annual revenues from government sources, federated fund raising organizations, foundations, and United Way of Greater Cleveland? What are the historic government funding trends and what is projected for the future? What is the reimbursement amount?
- What works and what doesn't work in service delivery?
- Are there service gaps, duplication, under-utilization?

The primary information sources used for this report are:

- Results of 20 focus groups with 159 direct service staff of United Way member agencies and non-members, and key informant interviews with 93 experts in the respective service areas (February 2005). Participants were asked about consumer populations that are increasing and those with unmet needs; they provided insight about specific service gaps and duplication, as well as services they perceive to be outdated or under-utilized.
- United Way Program Report data for FY 2004 (July 2003 to June 2004). Each year United Way member agencies submit information to their respective investment committees on each funded core service they provide. Among other things, this information includes a demographic profile of the consumers served, the zip codes where the consumers reside, and all revenue sources that support the service. The research team has aggregated this information for each core service.
- United Way - First Call for Help call data (2000 to 2004) - United Way - First Call for Help provides a 24/7 information and referral service through its 211 telephone line. The research team analyzed data from its large database, which includes the names of service providers for most core services, the activities they provide and the zip codes in which they and those they serve are located, the number of calls received, and whether the need was met or unmet. Unmet needs are those for which there was no resource to reference.
- Literature reviews on service trends and issues as well as best practices (i.e., what works/ what doesn't work in service delivery), including impact on the individual/family and on the community.
- Searches for information on public policies that are currently impacting consumers or service delivery.
- U.S. Census and American Community Survey data for various time periods.
- Data from funders on actual consumer populations and funding levels.

(See Attachment 2 for technical notes on the research methodology as well as limitations of the data.)

II. THE CORE SERVICE ENVIRONMENT

CORE SERVICE ENVIRONMENT

The United States has the highest rate of teen pregnancy in the developed world and Ohio is ranked 28th among the states (Alan Guttmacher Institute, 2004). The teen pregnancy rate in the U.S. is at least twice that in Canada, England, France, and Sweden, and 10 times that in the Netherlands. Experts cite restrictions on U.S. teens' access to comprehensive sexuality education, contraception, and condoms, along with the widespread American attitude that a healthy adolescence should exclude sex. By contrast:

... the European approach to teenage sexual activity, expressed in the form of widespread provision of confidential and accessible contraceptive services to adolescents is . . . a central factor in explaining the more rapid declines in teenage childbearing in northern and western European countries (Singh & Darroch, 2000).

Teen pregnancy can be the catalyst for other problems and concerns. Typical problems related to teen pregnancy and parenting include but are not limited to health problems for the mother and child, lack of education for both the mother and child, and increased poverty. According to the National Campaign to Prevent Teen Pregnancy (2004), several issues result from teen pregnancy:

- Only one-third of teen mothers receive a high school diploma and only 1.5 percent has a college degree by age 30.
- Over three quarters of unwed teen mothers end up on welfare.
- Newborns of teen mothers tend to have lower birth weights.
- Newborns of teen mothers are more likely to do poorly in school.
- There are serious health risks for teen mothers.
- Daughters of teen mothers are more likely to experience teen pregnancy themselves.
- The children of teen parents are more likely to receive welfare and fall victim to abuse and neglect.

In addition to the items noted above, early adolescent sexual experience and pregnancy can be emotionally devastating (CWLA, 2003). Teen parents are generally less cognitively prepared for parenting, which results in less understanding of child development, more negative attitudes toward parenting, unrealistic expectations of behavior, and increased stress (O'Callaghan, Borkowsky, Whitman, Maxwell & Keogh, 1999). Teen mothers often experience high levels of depression during their first year of parenthood (Barnet, Joffe, Duggan, Wilson & Repke, 1996; Wasserman, Brunelli & Rauh, 1990).

Unintended childbearing by teens poses significant costs for teen parents, their families, and society. Almost 60 percent of teens with a school-age pregnancy drop out at some point between 8th and 12th grade, with more than a quarter of these teen mothers dropping out *before* they get pregnant. Further, teen mothers are less likely than mothers who delay their childbearing to have a high school diploma or GED by age 30 (61 percent versus 91 percent), and their children have poorer school performance. As a result, the ability for these young mothers and their families to achieve economic self-sufficiency is a considerable challenge. Historically under the welfare

system, over three-quarters of these individuals began receiving cash assistance within five years of giving birth as a teen, and women who gave birth as teenagers made up almost half the welfare caseload.

In a longitudinal study for the Minnesota Family Investment Program (MFIP), 248 women (all teens when they newly applied for welfare in Minnesota) told interviewers about a lifetime of experiences (Crichton, 2003). Thirty months after application for assistance, 60 percent had finished high school, 60 percent were working, 55 percent had left MFIP, and 18 percent had family incomes above 200 percent of poverty. Yet there were still many challenges for teen mothers: 44 percent had given birth to a second child; 26 percent were on MFIP and unemployed; and 40 percent had incomes below poverty. Furthermore, 11 percent had suffered a serious illness or injury in the previous six months, and 9 percent of children had special needs. Mental health issues were reported by one in five, and one in five scored high on a depression screener. Having enough money for the family was a problem for 41 percent of the teen mothers.

Teen parents may need help learning to avoid a rapid repeat birth. About 20 percent of the roughly 500,000 teen births each year are not a teen mother's first child; about 100,000 teenagers gave birth to a second, third, or subsequent child in 2000. While it is not evident how much of a contribution, if any, the specific TANF teen parent requirements make toward reducing subsequent births, in an effective program a case manager working with an at-risk teen mother might engage this mother in a set of activities that could ameliorate this problem.

When teen mothers have more than one child, problems are compounded for both mother and child. Teen mothers with more than one child are less likely to complete high school or obtain a GED; babies born to a teen already with one child are more likely to be born premature or at low weight.

When discussing teen pregnancy and teen parent education it is important to look both at programs for teens who are either already parents or parents-to-be and at prevention programs. One California longitudinal study showed that low income was the greatest indicator of adolescent pregnancy (Kirby, Coyle, & Gould, 2001). Most teen pregnancy prevention models are primarily developed for girls—leaving teenage boys to learn from school, peers, and TV. Adolescent boys who are involved with teen pregnancy are more likely to have substance abuse problems, problems in school, and involvement with the criminal justice system (Sonenstein, 1997). Young fathers tend to have less economic and educational success, work more hours, and work for more years than boys who are not involved with teen pregnancy (Maynard, 1997).

PUBLIC POLICY ISSUES

NATIONAL

Abstinence Education

The current administration emphasizes abstinence only education. Since 1996, at least \$533 million in federal and state matching funds have been earmarked on abstinence-unless-married programs, and it is not known whether these programs work for increasing abstinence, avoiding pregnancy, and averting sexually transmitted diseases. Through an expansion of the Maternal and Child Health (MCH) block grant enacted as part of welfare reform, \$50 million in federal funds are made available each year to support abstinence programs that preclude education about contraception (Title V). A state match of \$3 for every \$4 federal dollars is required, and all but one of

the states have accepted the federal funds. In addition, millions more in abstinence-unless-married education funding has been made available through two other federal funding sources since the passage of TANF. All three of these funding sources are subject to an eight-point definition laid out in the welfare law, which requires that any abstinence-unless-married program has as its “exclusive purpose, teaching the social, psychological and health gains to be realized by abstaining from sexual activity” and that the program teach that “sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects.”

Temporary Assistance to Needy Families and the Personal Responsibility and Individual Development for Everyone Act

The 1996 Temporary Assistance for Needy Families (TANF) program prohibits states from spending federal funds on assistance to an unmarried, custodial minor parent caring for a child 12 weeks of age or older, unless the minor parent has completed high school or its equivalent or participates in appropriate educational activities (standard school or approved alternatives, including training programs). A “minor” under TANF includes persons under the age of 19 who participate full-time in school. The term “participation” in education/training is left to the states to define. No similar federal requirement exists for married minor parents or teen parents who are not minors, but states may elect to impose such requirements as a condition of receiving benefits. States may also use their own funds, in accordance with federal regulations, to assist those ineligible for federal TANF assistance.

In the TANF legislation, Congress included two rules specific to minor parents (parents under age 18). One rule requires that minor parents live in an approved arrangement. Generally it is expected that minor parents live with their parents, adult relatives, or guardians, although the state has discretion to approve other living arrangements. The other rule requires that minor parents typically participate in education leading to a high school diploma or GED.

The Personal Responsibility and Individual Development for Everyone Act or PRIDE Act - Title I: TANF - (Sec. 101) amends Part A of TANF to require state TANF plans to:

- Establish specific measurable performance objectives for pursuing TANF purposes;
- Describe any strategies and programs the state is using or plans to use to address employment retention and advancement, reduction of teen pregnancy, services for struggling and noncompliant families, and for clients with special problems, and program integration; and
- Describe any strategies and programs the state is undertaking to engage faith-based organizations in the delivery of services funded by TANF.

PRIDE includes activities for marriage education, marriage skills training, conflict resolution counseling in the context of marriage, and participation in programs that promote marriage. This policy replaces individual responsibility plans with family self-sufficiency plans.

Section 118 amends the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 to add to TANF a new Part C (Responsible Fatherhood Program) directing the secretary to award grants to: (1) up to ten eligible states to conduct demonstration programs to promote responsible fatherhood; and (2) eligible entities, such as charities or faith-based organizations, to conduct demonstration programs. It also makes appropriations for FY 2006 through 2010.

PRIDE directs the secretary to contract with a nationally recognized, nonprofit fatherhood promotion organization to: (1) develop, promote, and distribute a media campaign that encourages the appropriate involvement of parents in the life of any child; and (2) develop a national clearinghouse to assist states and communities in efforts to promote and support marriage and responsible fatherhood. It authorizes appropriations for FY 2006 through 2010.

PRIDE directs the secretary to contract with a nationally recognized, nonprofit research and education fatherhood organization to: (1) provide technical assistance and training to public and private agencies and grass roots organizations that promote responsible fatherhood and healthy marriage; and (2) develop a clearinghouse of resource materials to assist community-based organizations in developing local responsible fatherhood programs, with an emphasis on training and outcome evaluation. PRIDE requires the secretary to make a grant to one nationally recognized nonpartisan nonprofit organization to establish and operate a national teen pregnancy prevention resource center.

Title II: Abstinence Education (Section 201) revises, reauthorizes, and extends the program for abstinence education under SSA Title V (Maternal and Child Services Block Grant) through FY 2010. This makes any funds that will not be used to carry out an abstinence program of a particular state available for re-allotment to other states with such programs.

In December 2003, an update on women’s health policy entitled “Teens and TANF: How Adolescents Fare Under the Nation’s Welfare Program” was issued and included the following information:

Teen parents are sanctioned at higher rates than adults on TANF. To encourage a minor teen parent to continue her education/training, TANF allows states to impose an enforcement or incentive mechanism reduction for non-compliance and a bonus for participation. But a recent Center for Law and Social Policy (CLASP) survey found that teen parents appear to be sanctioned at disproportionately higher rates than their adult counterparts. In a single month, nearly 2,500 teen parents were sanctioned in the five states that gather such data related to school participation—a higher rate than that for the overall TANF caseloads there. These survey findings are consistent with broader studies of sanctions, which find that younger recipients are more likely to be penalized. Research on the Ohio LEAP program found that a majority of teen parents with multiple sanctions spent less on essentials such as food and clothing (Henry J. Kaiser Family Foundation, 2003).

III. THE CORE SERVICE CONSUMERS

DEFINITION OF TARGET POPULATION

The target population addressed in this core service report is females ages 14-19 who are assumed to be first time pregnant/teen parents and need assistance to obtain a high school diploma or GED.

DEMOGRAPHIC CHARACTERISTICS

National

Each year in the United States, approximately 1 million adolescents, or 10 percent of females 15 to 19 years of age, become pregnant. These pregnancies, which account for 13 percent of all births, usually are unintended and occur outside of marriage. The total number of teen pregnancies in the United States was 821,810 (84 pregnancies per 1,000 people) compared to Canada with 38,600 (38 pregnancies per 1,000 people) in 2000.

Since 1991, the adolescent pregnancy rate in the United States has fallen by 25 percent, from 116 to 87 per 1,000 females 15 to 19 years of age. This decline has been attributed to delayed initiation of sexual intercourse, decreased sexual activity, increased contraception use, fear of sexually transmitted diseases, education and prevention programs, and the declining approval of premarital sex (Population Reference Bureau, 1999 in CWLA, 2003).

Ohio

In Ohio, there were 29,650 teen pregnancies in 2000. Non-Hispanic whites had the most teen births with 19,550, followed by African Americans with 8,760, then Hispanics with 1,130. Ohio's number of teen births declined by 20 percent between 1990 and 2000; however, the national average declined by 24 percent during the same period (U.S. Census, 2000).

As mentioned before, Ohio is ranked 28th among the states for teen pregnancy, 25th for the birthrate among teens and 27th for abortion. Research by the Alan Guttmacher Institute has found that pregnancy rates, birth rates and abortion rates steadily declined between 1998 and 2000.

Cuyahoga County

Currently in Cuyahoga County, there are approximately 1,900 births each year to teenage parents. Close to 18 percent of these births are to teenage parents with another child. Recent literature reveals that there are significant consequences of teenage pregnancy to both the teenage parents and their children. For instance, children of adolescent parents are more likely to be born prematurely and be low birth weight; be affected by adverse conditions such as infant death, blindness and mental retardation; grow up in homes without fathers with less emotional and cognitive stimulation; end up in foster care; and perform significantly worse on tests of cognitive development.

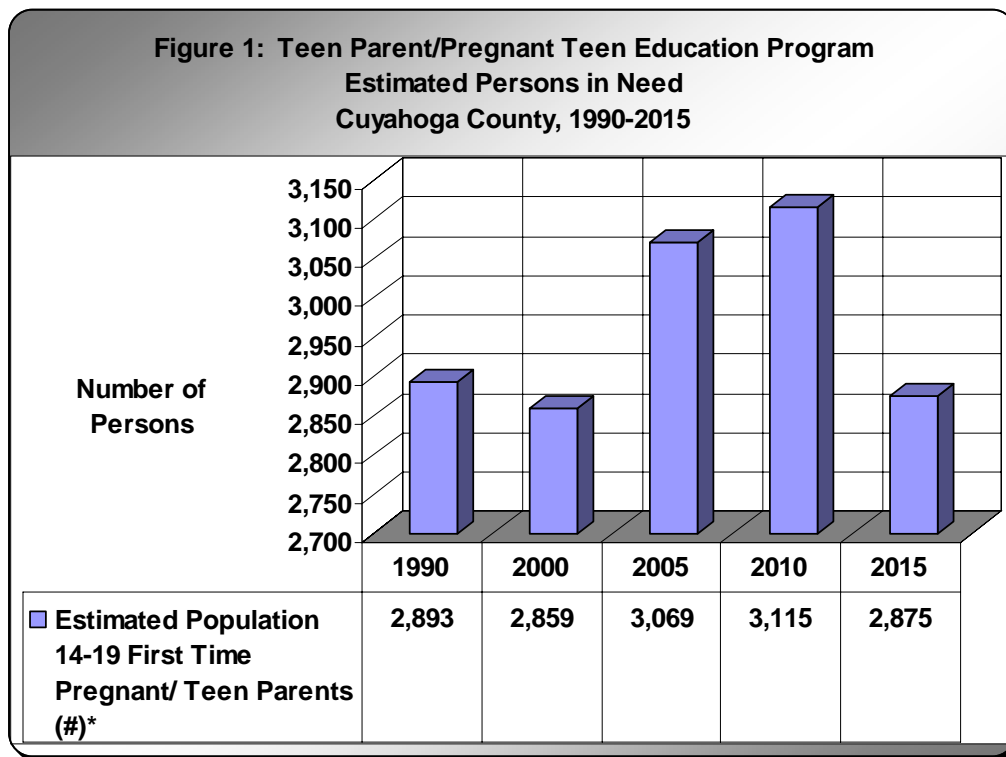
According to the Ohio Department of Health (2002), the teen pregnancy rate per 1000 females ages 15-19 in Cuyahoga County was 95.9, while the overall Ohio rate was 75.1. The Annie E. Casey Foundation (2000) conducted a survey and found that the City of Cleveland had one of the highest teen pregnancy rates in the country at 19.2 percent.

An issue is that pregnant teens are not allowed to attend classes during the third trimester of a pregnancy which creates a major barrier to them completing their coursework. In research conducted by the Cuyahoga County Early Childhood Department/Invest in Children found that many (50 to 75 percent) of the pregnant teens have learning disabilities. However, many do not have Individual Education Plans (IEPs), nor are they involved in special education programs. (Personal communication with M. Barni, February 8, 2007)

Estimated Persons in Need

In Cuyahoga County, 2,859 females between 14 and 19 were estimated to be first-time teen mothers and/or pregnant and in need of teen parent/pregnant teen educational programs. This number is based on applying research by the National Campaign to Prevent Teen Pregnancy (2004) to Cuyahoga County population figures. The Campaign estimated that in a given year 1 percent of 14 year olds, 4.29 percent of 15-17 year olds, and 9.94 percent of 18-19 year olds would be pregnant for the first time.

This number is projected to decrease to 2,875 by 2015, primarily because of fluctuations in the population. (See Figure 1.)



Source:
* The National Campaign to Prevent Teen Pregnancy: "Fact Sheet: How is the 34% Statistic Calculated?" Feb 2004. Percent of teen girls pregnant for the first time that year: 14 (1percent); 15, 16 & 17 (4.29 percent), 18 & 19 (9.94 percent). Average 5.4 percent. Assumes same average percentage across periods.

This estimate of persons in need of teen parent/pregnant teen education programs begins to offer clarity about the extent of need in Cuyahoga County.

REALIZED ACCESS TO SERVICE

Realized access to service is represented by the number of consumers actually served. It includes the actual number of consumers reported by agencies funded by United Way and by government funders from which it was possible to obtain data. Thus, it is an underestimate of actual numbers of consumers receiving service.

In FY 2004, United Way funded 126 individuals for teen parent/pregnant teen education programs . (See Attachment 3.) Cuyahoga County’s Help Me Grow (HMG) program was able to provide the following statistics: in FY 2004 they served 1,148 teen parents through Welcome Home and 1,067 through Early Start funding in CY 2004, totaling 2,215. However, HMG was not able to distinguish a specific number of teens who received services helping them complete their education. The HMG program, Enhanced Services for Pregnant and Parenting Adolescents, has multiple goals including self-sufficiency.

Twenty-eight percent of consumers funded by United Way were female, less than 1 percent male, and the rest unreported.

In 2000, according to the U.S. Census, 60 percent of the county’s total female population between 14 and 19 was Caucasian, 34 percent African American, and 2 percent Asian. Of the United Way funded teen parents/pregnant teens reporting race, 3 percent were Caucasian, 23 percent were African American, and 0.2 percent were Asian. Close to 28 percent were between ages 10 and 19 with the rest not reported.

While 4 percent of the county’s 14-19 female population was Hispanic, 0.2 percent of United Way funded consumers were Hispanic.

Only 20 percent of United Way funded consumers reported income and it was scattered across the 0 to \$30,000 range.

Forty-eight percent of consumers funded by UW reside in Cleveland and the same percentage was in the suburbs. Countywide, 33 percent of females 14 to 19 years resided in Cleveland and 67 percent in the suburbs. (See Attachment 4.)

IV. CORE SERVICE DELIVERY

CORE SERVICE DEFINITION

The definition of the core service for this report is: programs, usually available within the regular high school curriculum, that provide opportunities for pregnant teens and teenage students who are parents to complete their high school education and receive diplomas. Classes focus on child development, infant care, mother/infant nutrition, and childbirth preparation in addition to the basic graduation requirements and academic electives. Students enrolled in the program may also receive nutritionally balanced meals (breakfast and lunch), prenatal care, and family planning and counseling services.

BACKGROUND ON CORE SERVICE

Ohio and Cuyahoga County have limited programs that specifically focus on teen parent or pregnant teen education, i.e., supporting them to complete high school.

The Graduation, Reality, and Dual-Role Skills (“GRADS”) Program

No longer funded in Ohio, the Graduation, Reality, and Dual-Role Skills (“GRADS”) program was a family instructional and intervention program first piloted in Ohio in 1980 and funded by the Comprehensive Education and Training Act (CETA). It was designed to keep pregnant and parenting teens in school, encourage good health care practices, and help young parents set occupational goals. Instruction included managing work and family responsibilities; problem-solving; relating to others; leadership; self-development; pregnancy; wellness; prenatal, postpartum, and neonatal care; parenting; child development; creation of healthy and safe environments; relationships; social support systems; and economic independence and employability. Pre- and post- test instruments showed that pregnant and parenting teens enrolled in the program were more likely to stay in school and have increased knowledge of positive parenting (U.S. Department of Education, 1995). The GRADS program was available for students in 80 percent of Ohio’s school districts and was disseminated to schools in 17 other states.

Each year, the program served approximately 6,657 pregnant and 3,622 adolescent mothers, and 1,283 teen fathers. On-site childcare, available at the option of the local school district, was provided for 300 children. The population served included white (67 percent), African-American (28 percent), Hispanic (2 percent), multiethnic (2 percent), Native American (less than 1 percent), and Asian (less than 1 percent) persons ages 12 to 20.

Also no longer operating, the Ohio LEAP (Learning, Earning, and Parenting) program used financial incentives to motivate pregnant and parenting teens that received welfare to complete high school, and attend school regularly. The three components of the program were financial incentives, case management, child care and transportation assistance (Child Trends, 2003).

MomsFirst Program (Originally Healthy Families/Healthy Start)

According to Invest in Children (2005), the current fiscal constraints on school districts, a depressed local economy and the ever-growing need for resources, among other factors, contribute to absences or gaps in services available to pregnant and parenting adolescents throughout Cuyahoga County. Invest in Children is a community-wide, public/private partnership that mobilizes resources



and energy to ensure the well-being of young children in Cuyahoga County. Through its strategic planning process, Invest in Children established increasing family stability and health outcomes for children as one of its goals. A major strategy recommended to reach this goal is to provide prenatal service to more pregnant teens.

Invest in Children, in partnership with Help Me Grow of Cuyahoga County and the City of Cleveland's MomsFirst Program (originally Healthy Families/Healthy Start), has assembled a countywide prenatal task force to begin addressing this strategy by focusing on a service delivery framework for pregnant and parenting adolescents, an enhancement to the core services of Help Me Grow and MomsFirst. One step in the creation of this framework was to identify the current needs of pregnant and parenting adolescents.

The primary strategies used to address the project's objectives include the following core services: outreach, case management, health education, inter-conceptual care, and perinatal depression screening and referral. Much of MomsFirst's success is based on blending a grassroots approach with evidence-based interventions (Invest in Children, 2005).

Invest in Children is seeking to increase the number of pregnant teens served prenatally and postpartum through new and enhanced services that build from the core services of Help Me Grow and MomsFirst, including service coordination, home visiting parent and health education, and developmental screenings. It is anticipated that by providing services to pregnant/parenting teens that are better suited to their unique needs and offered in environments that may increase their participation, teens will be more apt to receive the assistance they need when they need it, resulting in positive outcomes for both the parent and the child(ren) (Invest in Children, 2005).

MomsFirst's goals are to reduce disparities in infant mortality and poor birth outcomes experienced by African Americans (LBW, VLBW); increase the number of pregnant women making a prenatal visit in the first trimester of pregnancy; and increase the number of women and children with an ongoing source of primary and preventive care services (Invest in Children, 2005).

MomsFirst is administered through the Cleveland Department of Public Health and targets minority women in Cleveland's most impoverished communities, with special efforts to reach adolescents, homeless, substance abusing, or incarcerated women. To accomplish this, MomsFirst subcontracts with agencies that by mission, mandate, or practice assist low-income minority populations. These include seven community centers and Northeast Ohio Neighborhood Health Services (NEON), a system of health clinics funded under Section 330 of the Public Health Services Act (Invest in Children, 2005).

Enhanced Services for Pregnant and Parenting Adolescents

As part of the strategic plan for Invest in Children, for the past two years the Office of Early Childhood/Invest in Children funded Help Me Grow as the lead agency to manage the Enhanced Services for Pregnant and Parenting Adolescents to address the needs of teen parents and pregnant teens. The annual funding amount is \$600,000. However, as with MomsFirst, the program is focused on goals broader than educational attainment of pregnant and parenting teens. It has multiple goals such as healthy births, stability of the whole family, and self-sufficiency, which includes obtaining a high school diploma or equivalent. (Personal communication with M. Barni, February 8, 2007)

DePaul Young Parent Program

In collaboration with Cleveland Public Schools, Catholic Charities provides services to pregnant and parenting teens to keep them in school during and after pregnancy. The program serves pregnant teens residing in Cleveland, ages 14-18 years old. There is no charge for this program

Adolescent Consortium

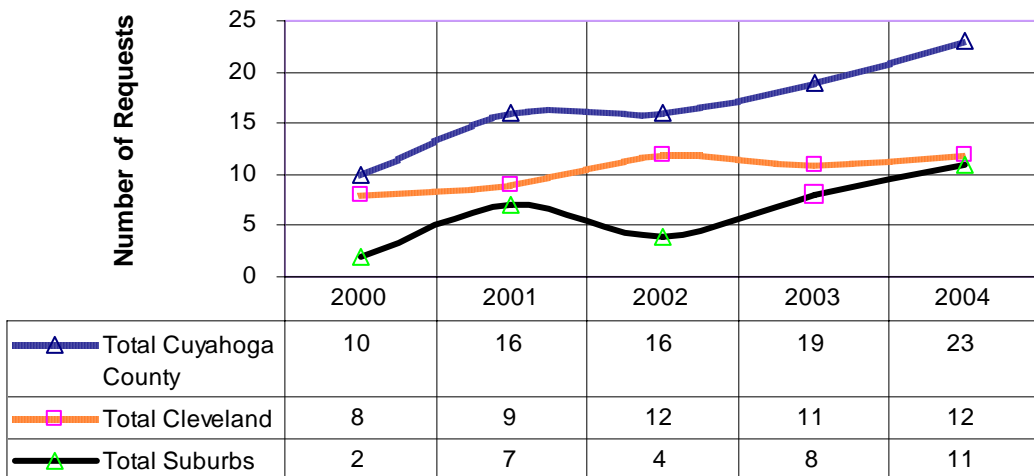
Over the past 15 years the Adolescent Consortium has been known as an exemplary networking organization for youth serving agencies. It has also served as a clearinghouse for coordination of services, information and referral, and networking and professional education. The original and abiding interest of the 100 or so participating health, education and human service providers was the prevention of adolescent pregnancy and intervention for the pregnant and parenting teen. Since its inception, the Consortium has come to address issues of sexuality, violence, substance abuse, chronic illness, school failure and suicide through quarterly educational meetings. Providing community education and providing consultation on these issues remains the centerpiece of the work of the Consortium. The Adolescent Consortium now comprises more than 160 health, education and human service providers that are involved in protecting and promoting the health and well being of adolescents. (Adolescent Health, School of Medicine, Case Western Reserve University, 2007).

United Way – First Call for Help Call Data

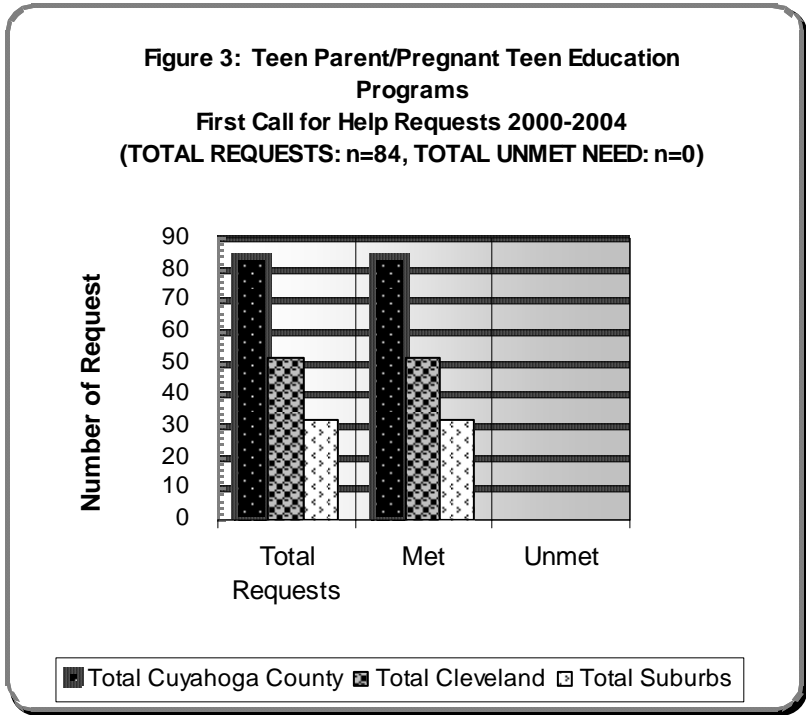
Based on United Way - First Call for Help's (FCFH) database (February 2005), there are 11 teen parent/pregnant education program providers operating from 13 different sites, 9 are government and 2 are nonprofit. Roughly half of service provision sites are located in the downtown Cleveland area, with the remainder in the suburbs. In FY 2004 (July 2003 to June 2004), United Way funded one provider. (See Attachments 5 and 6.)

United Way - First Call for Help call data shows an increase in the number of total requests for teen parent/pregnant education programs in the county: from 10 in 2000 to 23 in 2004 (130 percent) with a 50 percent increase in Cleveland (8 to 12 requests) and a 450 percent increase in the suburbs (2 to 11 requests). (See Figure 2 and Attachment 7.)

**Figure 2: Teen Parent/Pregnant Teen Education Programs
First Call for Help Requests 2000-2004
Greatest Increase/(Greatest Decrease)**



Over the same five-year period, United Way - First Call for Help had 84 requests for information about teen parent/pregnant education programs. Of these requests, they were able to make referrals to 100 percent of callers. Callers from both the City of Cleveland and the suburbs had a 0 percent unmet need rate. (See Figure 3 and Attachment 8.)



FUNDING OF CORE SERVICES

Major Government Funders

There are several major sources of government funding of programs for teen parents and pregnant teens. However, none specifically focuses on the goal of academic achievement of the teens, i.e., completion of high school. However, these programs are described below.

- U.S. Department of Health and Human Services;
- The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA);
- Special Projects of Regional and National Significance (SPRANS); and
- Help Me Grow (HMG) through the Cuyahoga County Office of Early Childhood/Invest in Children.

Most government funding flows from federal sources and is dispersed to state and local health departments and child and family services departments.

U.S. Department of Health and Human Services

The federal government’s funding for teen pregnancy programs tends to focus on abstinence efforts through programs like the U.S. Department of Health and Human Services’ Community-Based Abstinence Education Program, which was funded at over \$100 million in FY 2005. Recently, the Bush Administration has proposed funding for Responsible Fatherhood grants and Maternity Group Homes, but Congress has failed to appropriate funds.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA)

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) created a new funding stream for abstinence-unless-married programs. Technically Section 510 of the Social Security Act, the program is an expansion of the state block grant for maternal and child health. Often called “abstinence-only” or “abstinence-unless-married” programs, the funding stream authorizes \$50 million annually. To receive its allocation, a state must match every four federal dollars with three state dollars. The impetus for the law was a desire to restrict sexual activity outside of marriage. Congressional staff released a paper noting that the program...

...was intended to put Congress on the side of social tradition—never mind that some observers now think the tradition outdated—that sex should be confined to married couples. That both the practices and standards in many communities across the country clash with the standard required by the law is precisely the point.

Special Projects of Regional and National Significance (SPRANS)

Most importantly, a federal competitive grants program called Special Projects of Regional and National Significance (SPRANS) began to award abstinence-unless-married monies targeted at 12- to 18- year-olds, using the same eight point definition discussed previously in this report. The federal executive branch makes all of the decisions regarding which applicant community groups (or states) will be awarded SPRANS funds. In addition, SPRANS grantees who receive abstinence-unless-married funds are barred from using their own funds for other messages or education, including information about contraception or safe sex. More than \$1 billion has been spent in federal and state matching funds through Section 510, AFLA (Adolescent Family Life Act), and SPRANS between 1996 and 2005. The growth in SPRANS grants has been particularly dramatic: rising from \$20 million in its first year, FY 2001 to \$105 million in FY 2005.

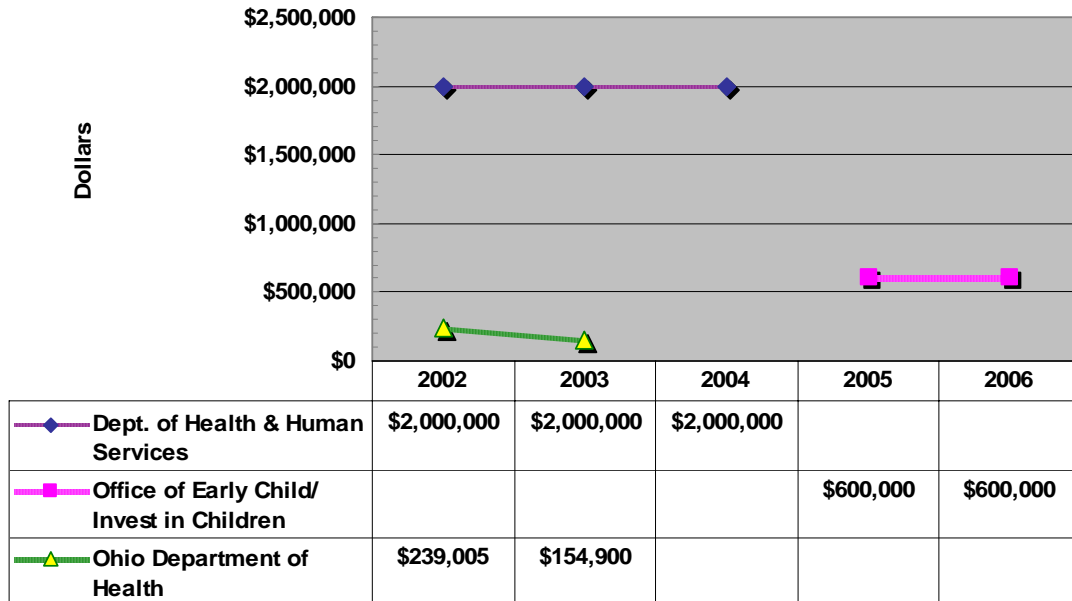
Help Me Grow (HMG)

Help Me Grow is Ohio’s birth to 3 system that provides state and federal funds to county Family and Children First Councils. These funds are then blended with state, local and other federal funds to implement and maintain a coordinated, community-based infrastructure that promotes trans-disciplinary, family-centered services for expectant parents, newborns, infants and toddlers and their families. The lead agency administering the Help Me Grow program in Ohio is the Ohio Department of Health, Bureau of Early Intervention Services. In Cuyahoga County, the Family and Children First Council and Office of Early Childhood Development provide oversight and monitoring of Help Me Grow and the Educational Service Center acts as administrative agent. During the past two years Help Me Grow has received \$600,000 annually from the Office of Early Childhood Development to provide services to pregnant and parenting teens. However, as noted in Section IV of this report, the goals are broader than academic achievement, i.e., completion of high school.

Trends of Identified Government Funders in Cuyahoga County

It is difficult to determine government trends between calendar years 2002 and 2004 because funding was available from most of the identified sources for only one or two years, and much of the funding that covers teen parent/pregnant teen programming is not uniquely identified in budgets that cover general parenting. However, teen parent/pregnant teen program funding through Office of Early Childhood Development/Invest in Children pregnant and parenting teen programs was \$600,000 in both 2006 and 2007. (Personal communication with M. Barni, February 7, 2007) (See Figure 4.)

Figure 4: Identified Government Funding for Teen Parent/Pregnant Teen Programs Cuyahoga County, CY 2002-2006



Source: Help Me Grow

Other Funding Sources

Over a three-year period, beginning in 2002 and ending in 2004, the Cuyahoga County area has benefited from local foundation donations to finance teen pregnancy and parenting activities. For FY 2004, almost \$1.2 million was donated for these activities. Over this three-year time period, the largest foundation contributors included the Prentiss Foundation, The Cleveland Foundation, and the Britton Foundation. However, this funding was not necessarily focused on academic achievement of pregnant or parenting teens.

IDENTIFIED REVENUES

As of May 11, 2006, nearly \$1.3 million in revenues for teen parent/pregnant teen programs has been identified countywide. (See Table 1.) This includes information from foundations; federated fundraising organizations; regional, county and municipal government; and United Way of Greater Cleveland.

Ninety-six percent of the revenues are from Foundations. United Way of Greater Cleveland funds 3 percent from both Investment Committee allocations and designations . Federated giving accounts for the remainder.

Table 1: Identified Annual Revenue for Core Services: Countywide and United Way of Greater Cleveland Teen Parent/Pregnant Teen Programs, 2003/2004.

Funder	Period	A		B	
		Identifiable Total Dollars Countywide		Total Dollars UW-Funded Agencies (Actual FY2004)	
		Amount	% of Total (A)	Amount	% of Total (B)
1525 Foundation		92,000			
Britton Fund		200,000			
Cleveland Foundation, The		253,000			
Gund Foundation, The George		38,000			
Jennings Foundation, Martha Holden		15,000			
O'Neill Foundation, The William J. and Dorothy K.		15,000			
Prentiss Foundation, Elisabeth Severance		460,000			
Sisters of Charity Foundation of Cleveland		15,000			
Wean Foundation, The Raymond John		79,534		10,000	
Other Private Foundations - Not Elsewhere Classified		12,500		6,831	
Brush		17,500			
Other Corporate Foundations - Not Elsewhere Classified		500			
Total - Foundations & Trusts		1,198,034	95.70%	16,831	31.35%
United Black Fund of Greater Cleveland		17,000			
Total - Federated Fundraising Organizations		17,000	1.36%	0	0.00%
Subtotal Non - UWGrCle Support		1,215,034	97.06%	16,831	31.35%
Total - UWGrCle investment committee allocation		36,849	2.94%	36,849	68.65%
Subtotal UWGrCle Support - 4001, 4701 & 4703		36,849	2.94%	36,849	68.65%
Total Support/Revenue		1,251,883	100%	53,680	100%

REIMBURSEMENT/COST

Program group members were in LEAP an average of 22.3 months, at a net cost to the Ohio Department of Job and Family Services (ODJFS) of \$1,388 per program group member, or \$747 for 12 months. (Net cost refers to the average cost per program group member minus the average cost per control group member.) The case management/county administrative cost (\$1,140 per program group member), which accounted for most of the cost, including expenditures for all program-related activities on behalf of LEAP teens: orientation, initial and yearly assessments, referrals for child care, providing transportation stipends, monitoring school enrollment and attendance, and arranging for bonuses and sanctions. In addition, case managers frequently offered guidance in their ongoing contact with teens. The case management/county administrative cost also included expenditures for administrative supervision and general overhead. As was noted previously, this program is no longer being operated.



V. WHAT WORKS; WHAT DOESN'T

IMPACT ON INDIVIDUALS/FAMILIES

What Works

Invest in Children Teen Parent/Pregnant Teen Program Components

In a recent request for proposals, Invest in Children (2005) identified the following core programming components for pregnant/parenting adolescents as part of what they found works in teen parent/pregnant teen programming:

- **Access to a consistent, caring adult/professional** - Teen participants should have regular contact with a caring adult who is knowledgeable about their needs and available to them in a timely manner. This individual should be able to relate well to teens, understand their unique needs, and help them pursue both educational and life goals. S/he could be a service coordinator, social worker, case manager, home visitor, etc.
- **Basic needs continuously addressed** (child care, housing, food, health insurance, etc.) - Continued focus should be placed on assuring that the teen participant has, or is in the process of obtaining, safe and adequate housing, essential baby items, quality child care, access to appropriate health care services, access to needed community-based services, and the like.
- **Self-sufficiency goal (education/employment) / Continues progress towards a high school diploma or GED, at a minimum** - Participating teens who have not yet completed high school must have a goal of obtaining their high school diploma or its equivalency (GED). If a teen has completed secondary school, s/he must have a goal of continuing with his/her education and/or obtaining employment.
- **Peer supports/group activities in a community/neighborhood setting** - Participating teens should have access to a broad range of group activities held in a community setting. Topics should address areas of need and may include parenting education, general education, prenatal health care (birthing classes), budgeting, healthy cooking, baby bonding, etc. To the greatest extent possible, these activities should foster peer support and build upon natural support networks of one's neighborhood.
- **Consistent, quality health care (pre and post) / medical home** - Each participant should have health insurance and be connected to a medical home, the one place they take their child for all of his/her health care needs. Efforts should also be made to assure the participating prenatal teen receives health care services as early as possible and has opportunities for health care classes with her peers.
- **Recognizing the dynamics of a teen's family** (i.e. grandmother, father, etc.) - It is important that the individuals working with pregnant and parenting teens understand the influence of the entire family and are able to address concerns or contentious issues in a positive manner.

- **Comprehensive, wrap-around services** - Services provided to pregnant and parenting teens must be flexible and comprehensive enough to cover a broad range of needs, such as mental health, substance abuse counseling, medical concerns, public benefits program requirements, school demands, etc. To the greatest extent possible, services should take place in one's community and build upon pre-existing relationships.
- **Experiential learning (parenting classes and health education)** - Experiential education entails the process of actively engaging individuals in an authentic experience that will have benefits and consequences. Individuals make discoveries and experiment instead of hearing or reading about the experiences of others. Hence, participating teens should have opportunities to learn, especially parenting and health education, in a "real life" context where they actually experience and apply what they are learning.

Pregnancy Prevention Programs

Successful pregnancy prevention programs must be client-centered, with services and staff approaches that address the needs of the adolescent. Programs should include several services in one building for easy access and cross-service collaboration (CWLA, 2003). The Institute for Educational Leadership study concluded that parenting skills taught to teen parents should include nutrition, health, child development, budgeting, and life-skills. Some schools include parenting education and child development classes as part of their regular curricula. Effective prevention programs provide youth with information on how to avoid pregnancy and teach them how to use condoms (Kirby, 2001). Kirby identified 10 components that the strongest prevention programs all had in common:

- Focus on reducing sexual behaviors;
- Reinforce abstinence or condom use;
- Address social pressures;
- Involve participants;
- Age and culturally appropriate;
- Based on theoretical approaches;
- Provide accurate information;
- Teach communication skills;
- Last a sufficient amount of time; and
- Select trainers who are invested.

In 1997, a meta-analysis of school- and community-based pregnancy prevention programs found that community-based models had a strong significant effect on contraception use and were more successful in decreasing teen pregnancy rates (Corcoran, O'Dell Miller, and Bultman, 1997 in CWLA, 2003). An internationally recognized leader in teen pregnancy prevention, Inwood House, established in 1830, provides support programs to New York City and New Jersey youth. Core programs include the Inwood House Maternity Residence for pregnant teens in foster care, mother/baby foster care, Partners in Parenting, and Teen Choice. Teen Choice was launched in 1978 and serves more than 6,500 teens annually. The program's goals are to assist adolescents in making a healthy transition to adulthood, delay the onset of sexual activity, reduce the incidence of teen pregnancy and disease, and assist with communication between parents and teens. The program directly addresses the behavioral factors that most influence adolescent sexual behavior, utilizes master's level social workers trained in adolescent development, human sexuality, and

group work. These social workers spend 35 hours per week on-site in schools, and provide the following program components:

- Small group discussions on issues relating to sexual involvement;
- Individual counseling and referrals to physical and mental health professionals or school staff;
- Classroom discussion; and
- Parent outreach that provides parents with information and skills to help them communicate with their children about sex and risk-related issues (cwla, 2003).

School Completion Programs

Three programs that have been successful in promoting school completion are LEAP, run by the Ohio Department of Job and Family Services; New Chance; and Jobstart. These programs all actively monitor school attendance and provide child care and transportation to encourage school attendance (U. S. General Accounting Office, 1995).

The LEAP (Learning, Earning and Parenting) program is highlighted along with the GRADS (Graduation, Reality and Dual-Role Skills) program in order to target model programs which encourage pregnant and parenting teens to stay in school. Ohio's Learning, Earning, and Parenting (LEAP) program generally improved enrollment and attendance. LEAP increased the likelihood that in-school participants would earn a GED or high school diploma; however, it did not show these effects for those who had dropped out of school. In-school participants also saw improved employment throughout a four-year follow-up period; while they also saw positive effects on their earnings, the control group caught up at the two-year mark. In contrast to the Ohio program, California's Cal-Learn program's positive impact on graduation rates was greatest among teen parents who had dropped out of school (and had not been held back a grade). Even though participants graduated at a significantly higher rate than non-participants in California, about half the participants failed to graduate. Neither LEAP nor Cal-Learn found impacts on subsequent childbearing.

According to the Center for Law and Public Policy:

Minor parents are a special target in TANF. The TANF caseload includes about 142,000 teen parents. Relatively little research has examined the impacts of the minor parent provisions. Available research on the school requirement (often called "Learnfare") suggests that its benefits are concentrated mostly on improving enrollment and grade completion and less on improving graduation rates and earnings. The research also suggests that positive outcomes occur largely for those still in school, since Learnfare has had little success with "retrieving" those who have dropped out. (Greenburg, Levin-Epstein, Hutson, Ooms, Schumacher, Turetsky, and Engstrom, 2000)

Key Components of Effective Parenting Education Programs

A meta-analysis on teen parenting education entitled "Recommended Practices in Parent Education and Support – A Literature Review," published by the University of Delaware in 2000, outlines key components of effective parenting education programs. When looking at parenting education for pregnant and parenting teens, it is important to consider not only the developmental needs of the

child, but also of the teen parent (Brooks-Gunn & Chase-Lansdale, 1995). Educators should remain alert to signs of depression and get the teen help when needed.

Additional issues that should be addressed in teen parent education programs:

- The teens' perception of their role as parent (Barratt & Roach, 1995).
- Psychological issues—address anxiety and depression; antisocial behaviors; substance abuse; level of intellectual functioning; prior physical, sexual or emotional abuse; and attitudes toward parenting (Wagner & Clayton, 1999).

Programs should encourage teen parents to stay in school. When parents graduate from high school, their children are less likely to be teen parents and more likely to have economic self-sufficiency (Haveman & Wolfe, 1994).

What Doesn't Work

To “confine” sex to the matrimonial state, proponents of abstinence-unless-married education decided to restrict learning. The program limits teaching to the benefits of abstinence; the benefits of contraception are outside the parameter of the program. Thus, abstinence-unless-married educators must choose between not discussing contraception at all or focus on the failure rate of different methods. In contrast, opponents of abstinence-unless-married education stress the need for knowledge about contraception along with lessons about abstinence. They recognize that even when they teach that the consistent practice of abstinence is the only 100 percent effective way to avoid pregnancy and sexually transmitted illnesses, there will be failures to practice abstinence. If that happens, it is important to know about contraceptive options that help prevent pregnancy and/or disease. The federal law stipulates eight points that define what can and cannot be included in the program.

According to Planned Parenthood, abstinence-only sex education does not work. In 1981, Congress passed the Adolescent Family Life Act (AFLA), also known as the “chastity law,” which funded educational programs to “promote self-discipline and other prudent approaches” to adolescent sex, or “chastity education.” Grant applications to create such programs poured in and dollars poured out to churches and religious conservatives nationwide. The American Civic Liberties Union (ACLU) challenged AFLA in court, calling it a “Trojan horse” smuggling the values of the Christian Right—particularly its opposition to abortion—to public-school children at public expense: a classic affront to the principle of separation of church and state (Heins, 2001; Schemo, 2000; Levin-Epstein, 1998; Pardini, 1998).

In 1996, Congress attached a provision to welfare legislation that established a federal program to exclusively fund programs teaching abstinence-only. Since the inception of the abstinence-only movement, approximately \$135 million a year, totaling nearly \$1 billion, has been spent on programs whose only purpose is to teach the social, psychological, and health benefits that might be gained by abstaining from sexual activity (Boonstra, 2004; Take Back Our Rights, 2004).

In FY 2005, Congress devoted approximately \$170 million to abstinence-only education (Committee on Government Reform, 2004). At the state level, legislatures are copying the federal abstinence-only statute, often adding explicit prior-restraint provisions. New Jersey, for instance, proposed the imposition of close surveillance on teaching materials—and teachers (Planned Parenthood, 2005).

Abstinence-Only Education: The Costs — Social and Financial

Since 1996, nearly \$1 billion in federal and state matching funds has been committed to abstinence-only education (Boonstra, 2004). Because of the requirement that states match federal funds for abstinence-only programs, state dollars that previously supported comprehensive, medically accurate sexuality education—which includes but is not limited to abstinence-education—have been diverted to abstinence-*only* programs (Schemo, 2000).

The vast majority of Americans and parents support comprehensive, medically accurate sexuality education. Eighty-one percent of Americans and 75 percent of parents want their children to receive a variety of information on subjects including contraception and condom use, sexually transmitted infection, sexual orientation, safer sex practices, abortion, communications and coping skills, and the emotional aspects of sexual relationships. Fifty-six percent of Americans do not believe that abstinence-only education prevents sexually transmitted infections or unintended pregnancies. Given the choice, only 1 to 5 percent of parents remove their children from responsible sexuality education courses (Albert, 2004; AGI, 2003a; AGI, 2003b; KFF, 2000; Kirby, 1999 in Planned Parenthood, 2005).

Fewer than half of public schools in the U.S. now offer information on how to obtain birth control, and only a third incorporate discussion of abortion and sexual orientation in their curricula. A large nationally representative survey of middle school and high school teachers published in *Family Planning Perspectives* reported that 23 percent of teachers in 1999 taught abstinence as the only means of reducing the risk of sexually transmitted infections and pregnancy, compared with 2 percent in 1988. The study's authors attributed the change to the heavy promotion of abstinence—not sound educational principles (Darroch, et al., 2000; Wilgoren, 1999). Currently, 35 percent of public school districts require abstinence to be taught as the only option for unmarried people and either prohibit the discussion of contraception or limit discussion to its ineffectiveness (AGI, 2003; Planned Parenthood, 2005).

There is little evidence that teens who participate in abstinence-only programs abstain from intercourse longer than others. It is known, however, that when they do become sexually active, they often fail to use condoms or other contraceptives. In fact, 88 percent of students who pledged virginity in middle school and high school still engage in premarital sex. The students who break this pledge are less likely to use contraception at first intercourse, and they have similar rates of sexually transmitted infections as non-pledgers (Walters, 2005; Bearman and Brueckner, 2001). Meanwhile, students in comprehensive sexuality education classes do not engage in sexual activity more often or earlier, but do use contraception and practice safer sex more consistently when they become sexually active (AGI, 2003a; Jemmott, et al., 1998; Kirby, 1999; Kirby, 2000; NARAL, 1998).

California, the only state that has not accepted federal abstinence-only money, has seen declines in teenage pregnancy similar to those seen in European countries. Over the last decade, the teenage pregnancy rate in California has dropped more than 40 percent (Gold, 2004).

Every reputable sexuality education organization in the U.S.—as well as prominent health organizations such as the American Medical Association—has denounced abstinence-only sexuality education. And a 1997 consensus statement from the National Institutes of Health concluded that legislation discouraging condom use on the grounds that condoms are ineffective...

...places policy in direct conflict with science because it ignores overwhelming evidence . . . Abstinence-only programs cannot be justified in the face of effective programs and given the fact that we face an international emergency in the AIDS epidemic (Planned Parenthood, 2005).

IMPACT ON COMMUNITY

The National Campaign to Prevent Teen Pregnancy (2004) states that teen childbearing costs taxpayers billions each year, which includes direct costs for health care, foster care, criminal justice, and public assistance. The federal government spends approximately \$40 billion every year to assist families that began with a teenage birth (The National Campaign to Prevent Teen Pregnancy, 2004).

ACCREDITATIONS/STANDARDS/CERTIFICATIONS

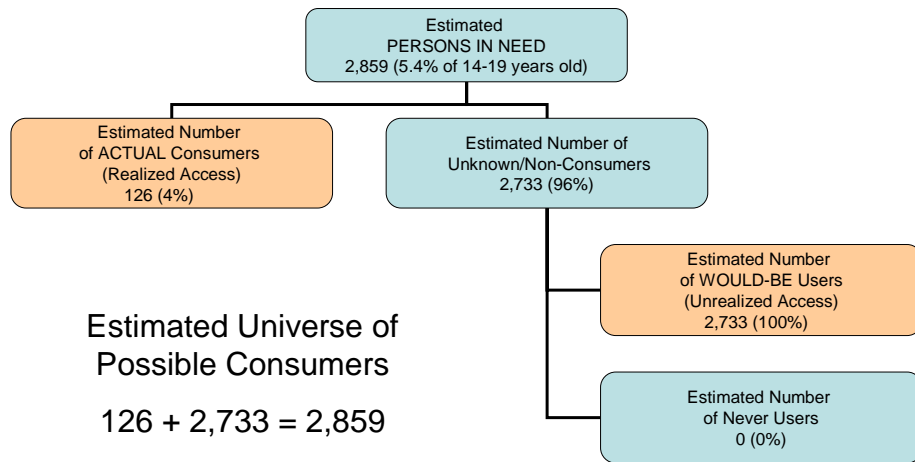
None identified.

VI. GAP ANALYSIS

The following is the formula for arriving at the estimated universe of possible consumers for Teen Parent/Pregnant Teen Education Programs:

- An estimated 2,859 persons need teen parent/pregnant teen programs, which is the estimate of first time pregnant/teen parents in Cuyahoga County.
- Based on available information about actual consumers, approximately 126 teens have realized access to teen parent/pregnant teen programs. This is the sum of persons estimated to receive teen parent/pregnant teen programs funded by UW (126). The 2,215 persons funded by Help Me Grow do not exclusively receive services to help teens complete high school.
- This leaves a net estimate of 2,733 teens either receiving services from Help Me Grow program, from unaccounted-for sources or are not receiving teen parent/pregnant teen programs. (2,859 – 126 = 2,733). It is assumed that these teens are would-be users because they would utilize the service if they knew about it, could afford it, and could access it.
- The estimated universe of possible consumers is 2,859, including both realized (126) and unrealized (2,733) access. (See Figure 5.)

**Figure 5 - Consumer Estimates:
Teen Parent/Pregnant Teen Education
Programs, 2000**



Service Site Index

Countywide, there are 13 service sites for teen parent/pregnant teen education programs. This is a ratio of 220 possible consumers (estimated 2,859 total) to one service site countywide. Service providers report to United Way - First Call for Help which zip codes are included in their respective

service areas. The Service Site Index in Attachment 9 lists the number of sites per zip code and provides a ratio of consumers to service sites for each zip code. This is a measure of potential service accessibility by possible universe of service consumers per zip code area. Note that this measure does not include the capacity of providers to offer the service, for example, the number of consumers it is possible to serve on a daily basis. It is only capturing whether there is a possibility of being a consumer. The lower the ratio, the greater is the chance of receiving teen parent/pregnant teen services.

The ratios on the Service Site Index range from a high of 33:1 in zip code 44136 (Strongsville) to a low of 2:1 in zip code 44114 (Cleveland). In addition to 44136, twelve other zip codes have ratios equal to or greater than 20 consumers to one service site:

- 44146 (Walton Hills/Oakwood/Bedford, 28:1);
- 44105 (Cleveland/NewburghHts/GarfieldHts, 31:1), high minority area;
- 44145 (Westlake, 30:1);
- 44139 (Bentleyville/Glenwillow/Solon, 28:1);
- 44133(North Royalton, 28:1);
- 44120 (Shaker Hts/Cleveland, 27:1) high minority area;
- 44107 (Lakewood/Cleveland, 26:1);
- 44109 (Cleveland/Brooklyn Hts, 24:1) high minority area;
- 44070 (North Olmsted, 23:1);
- 44102 (Cleveland/Brooklyn, 23:1) high minority area;
- 44118 (Cleveland Hts/University Hts/Shaker Hts 22:1); and
- 44017 (Berea 20:1).

(See Map in Attachment 10.)

VII. SUMMARY

The following are the major findings from this report:

- The United States has the highest rate of teen pregnancy in the developed world and Ohio is ranked 28th among the states. The teen pregnancy rate in the U.S. is at least twice that in Canada, England, France, and Sweden, and 10 times that in the Netherlands.
- Teen pregnancy can be the catalyst for other problems and concerns. Typical problems related to teen pregnancy and parenting include but are not limited to health problems for the mother and child, lack of education for both the mother and child, and increased poverty.
- The 1996 Temporary Assistance for Needy Families (TANF) program prohibits states from spending federal funds on assistance to an unmarried, custodial minor parent caring for a child 12 weeks of age or older, unless the minor parent has completed high school or its equivalent or participates in appropriate educational activities.
- Under President Bush, the issue of teen parenting has all but disappeared.
- With funding from the Cuyahoga County Office of Early Childhood/Invest in Children, the Help Me Grow (HMG) provides \$600,000 annually for Enhanced Services for Pregnant and Parenting Adolescents. However, services provided are broader than education.
- An issue is that pregnant teens are not allowed to attend classes during the third trimester of a pregnancy which creates a major barrier to them completing their coursework. In research conducted by the Cuyahoga County Early Childhood Department/Invest in Children found that many (50 to 75 percent) of the pregnant teens have learning disabilities. However, many do not have Individual Education Plans (IEPs), nor are they involved in special education programs. (Personal communication with M. Barni, February 8, 2007)
- As of May 11, 2006, nearly \$1.3 million in revenues for teen parent/pregnant teen programs has been identified countywide.
- In 1997, a meta-analysis of school- and community-based pregnancy prevention programs found that community-based models had a strong significant effect on contraception use and were more successful in decreasing teen pregnancy rates.
- There is little evidence that teens who participate in abstinence-only programs abstain from intercourse longer than others. Eighty-eight percent of these teens break their abstinence pledge and are less likely to use contraception at first intercourse, and they have similar rates of sexually transmitted infections as non-pledgers.
- Every reputable sexuality education organization in the U.S.—as well as prominent health organizations including the American Medical Association—has denounced abstinence-only sexuality education.
- The estimated universe of possible consumers is 2,859, including both realized (126) and unrealized (2,733) access.
- Countywide, there are 13 service sites for teen parent/pregnant teen education programs. This is a ratio of 220 possible consumers (estimated 2,859 total) to one service site countywide.



REFERENCES

- Adolescent Health, School of Medicine, Case Western Reserve University. (2007). Adolescent Consortium. Retrieved on February 7, 2007 from <http://www.case.edu/med/adolescenthealth/consortium.html#members>
- Albert, B. (2004, December). With one voice 2004: America's adults and teens sound off about teen pregnancy. Washington, DC: National Campaign to Prevent Teen Pregnancy. Retrieved on July 24, 2006 from <http://www.teenpregnancy.org/resources/data/pdf/WOV2004.pdf>
- Alan Guttmacher Institute (AGI). (2004). U.S. teenage pregnancy statistics, overall trends, trends by race and ethnicity and state-by-state information. Retrieved on July 26, 2006 from http://www.guttmacher.org/pubs/state_pregnancy_trends.pdf
- Alan Guttmacher Institute (AGI). (2003a). Facts in brief: Sexuality education. Retrieved on July 24, 2006 from http://www.guttmacher.org/pubs/fb_sex_ed02.html
- Alan Guttmacher Institute (AGI). (2003b). Sex education: Needs, programs and policies. Retrieved on July 26, 2006 from http://www.guttmacher.org/presentations/ed_slides.html
- Anderson, R.M. (1995, March). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior*, 36 (1): 1-10
- Annie E. Casey Foundation. (2000). *Kids Count Census Data Online 2000 Census Data - Key Facts for Cuyahoga, Ohio*. Available from <http://www.aecf.org>
- Barnet, B., Joffe, A., Duggan, A.K., Wilson, M.D. & Repke, J. (1996). Depressive symptoms, stress and social support in pregnant and postpartum adolescents. *Archives of Pediatrics and Adolescent Medicine*, 150(1): 64-69.
- Barratt, M.S. & Roach, M.A. (1995). Early interactive processes: Parenting by adolescent and adult single mothers. *Infant Behavior and Development*, 18:97-109.
- Bearman, P.S. & Brueckner, H. (2001). Promising the future: Virginity pledges and first intercourse. *American Journal of Sociology*, 106(4): 859-912.
- Bos, J.M., & Fellerath, V. (1997). LEAP: Final report on Ohio's welfare initiative to improve school attendance among teenage parents. Washington, DC: Manpower Demonstration Research Corporation
- Boonstra, H. (2004). Abstinence promotion and the U.S. approach to HIV/AIDS prevention overseas. The Alan Guttmacher Institute.
- Brooks-Gunn, J. & Chase-Lansdale, P. L. (1995). Adolescent parenthood. In M. H. Bornstein (Ed.), *Handbook of parenting: Vol. 3, Status and Social Conditions of Parenting*, 131-150. Mahwah, NJ: Lawrence Erlbaum Associates.



- Caspar E., McKim, K., McKinley, S., Neumann, J. and Varana, D. (1996). An evaluation of effects of the Learnfare program 1993-1996. Wisconsin Legislative Audit Bureau. University of Wisconsin. Retrieved on December 30, 2006 from <http://dpls.dacc.wisc.edu/Learnfare/index.html>
- Catholic Charities Health and Human Services. (2007). DePaul young parent program. Retrieved on February 8, 2007 from <http://www.clevelandcatholiccharities.org/ccs/young.htm>
- Center for Law and Social Policy. (2003). The education/training requirement for TANF teen parents. Available from <http://www.clasp.org>
- Child Trends. (2003). Guide to effective programs for children and youth: Ohio's Learning, Earning, & Parenting program. Retrieved on July 31, 2006 from <http://www.childtrends.org/Lifecourse/programs/OhioLEAP.htm>
- Cocoran, J., O'dell, Miller, P., & Bultman, L. (1997). Effectiveness of prevention programs for adolescent pregnancy: A meta-analysis. *Journal of Marriage and the Family*, 59:551-567.
- Crichton, L.I. (2003). Minnesota Family Investment program longitudinal study: Special report on teen mothers. Minnesota Department of Human Services. Retrieved on July 31, 2006 from <http://edocs2.dhs.state.mn.us/lfserver/Legacy/DM-0095-ENG>.
- Darroch, J.E., et al. (2000). Changing emphases in sexuality education in U.S. secondary public schools, 1988-1999. *Family Planning Perspectives*, 32(5): 204-11, 265.
- Gold, S. (2004, November 22). Revision marches to social agenda. *Los Angeles Times*, A13.
- Greenburg, M., Levin-Epstein, J., Hutson, R., Ooms, T., Schumacher, R., Turetsky, V. and Engstrom, D. (2000). Welfare reauthorization: An early guide to the issues. The Center for Law and Social Policy. Retrieved on February 4, 2007 from http://www.clasp.org/publications/welfare_reauthorization_an_early_guide.pdf
- Haskins, R. & Bevan, C.S. (1996). Implementing the abstinence education provision of the welfare reform legislation. Presented at American Enterprise Institute Conference on Evaluating Sex Education and Abstinence Programs, Washington DC.
- Haveman, R. & Wolfe, B. (1994). *Succeeding generations: On the effects of investments in children*. New York, NY: Russell Sage Foundation.
- Heins, M. (2001). *Not in front of the children: Indecency, censorship, and the innocence of youth*. New York: Hill and Wang.
- Henry J. Kaiser Family Foundation. (2003). Issue brief, an update on women's health policy; teens and TANF: How adolescents fare under the nation's welfare program. Retrieved on September 30, 2006 from http://www.clasp.org/publications/Teens_TANF.pdf
- Invest in Children (2005). Pregnant/parenting teen focus group themes. Cleveland, OH.
- Jemmott, J, et al. (1998). Abstinence and safer sex HIV risk-reduction interventions for African-American adolescents, a randomized trial. *JAMA*, 279(19): 1529-1536.

- Kaiser Family Foundation. (2000). *Sex education in America: A view from inside the nation's classrooms*. Menlo Park, CA: The Kaiser Family Foundation.
- Kirby, D. (2001). Understanding what works and what doesn't in reducing adolescent sexual risk-taking. *Family Planning Perspectives*, 33(6): 276–281.
- Kirby, D. (2000). Effective approaches to reducing adolescent unprotected sex, pregnancy, and childbearing. Report to the Surgeon General.
- Kirby, D. (1999). Sexuality and sex education at home and school. *Adolescent Medicine: State of the Art Reviews*, 10(2): 195-209.
- Kirby, D., Coyle, K., & Gould, J. (2001). Manifestations of poverty and birthrates among young teenagers in California zip code areas. *Family Planning Perspectives*, 33(2): 63-69
- Levin-Epstein, J., Grisham, C., & Batchelder, M. (2001). Comments to the U.S. Department of Health and Human Services regarding teen pregnancy prevention and teen parents provisions in the Temporary Assistance for Needy Families (TANF) Block Grant. Center for Law and Social Policy.
- Levin-Epstein, J. (2005). To have and to hold: Congressional vows on marriage and sex. Center for Law and Social Policy. Retrieved on July 24, 2006 from http://www.clasp.org/publications/have_and_hold.pdf
- Manlove, J., Mariner, C. & Roman, A. (1997, November). Positive outcomes among school-age mothers: Factors associated with postponing a second teenage birth. *Child Trends*.
- Maynard, R.A. (Ed.). (1996). *Kids having kids: A Robin Hood Foundation special report on the costs of adolescent childbearing*. New York: Robin Hood Foundation. See also Brien, M.J., & Willis, R.J. (1997). Costs and consequences for fathers. In Maynard, R. (Ed.), *Kids having kids: economic costs and social consequences of teen pregnancy*, 95-143). Washington, DC: The Urban Institute Press.
- National Abortion and Reproductive Rights Action League (NARAL). (1998, May). Teens in crisis: A comprehensive strategy to protect adolescent health. Retrieved on July 24, 2006 from <http://www.welfareacademy.org/conf/papers/michelma.pdf>
- The National Campaign to Prevent Teen Pregnancy. (2004, February). Fact sheet: How is the 34% statistic calculated? Washington D.C. Retrieved on December 30, 2006 from http://www.teenpregnancy.org/resources/reading/fact_sheets/education.asp
- National Institute of Health. (1997, February 11-13). Interventions to prevent HIV risk behaviors. *NIH Consensus Statement*, 15(2):15-16.
- National Institute for Literacy. (1996, October 28). Policy update: How to prepare for welfare changes (Part I). Washington, D.C.
- O'Callaghan, M.F., Borkowski, J.G., Whitman, T.L., Maxwell, S.E. & Keogh, D. (1999). A model of adolescent parenting: The role of cognitive readiness to parent. *Journal of Research on Adolescence*, 9(2): 203-225.

- Pardini, P. (1998). Federal law mandates abstinence-only sex ed: Fundamentalists successfully pushed stealth legislation. *Rethinking Schools*, 12(4): 16-18.
- Pavetti, U.A. (1998, November). What will the states do when jobs are not plentiful? Policy and implementation challenges. Mathematical Policy Research, Inc.
- Planned Parenthood. (2005). Abstinence-only "sex" education. Retrieved on September 30, 2006 from <http://www.plannedparenthood.org/pp2/portal/files/portal/medicalinfo/teensexualhealth/fact-abstinence-education.xml>
- Population Reference Bureau for the Demographic and Behavioral Sciences Branch. (1999). Less sexual activity, more education, changes in contraception, key to declining teen birth rates. *Research on Today's Issues*, No. 10. Center for Population Research, National Institute of Child Health and Human Development, National Institutes of Health. Retrieved on July 24, 2006 from <http://www.nichd.nih.gov/cpr/dbs/pubs/ti10.pdf>
- Schemo, D.J. (2000, December 28). Sex education with just one lesson: No sex. *New York Times*, A1.
- Singh, S. & Darroch, J.E. (2000). Adolescent pregnancy and childbearing: Levels and trends in developed countries. *Family Planning Perspectives*, 32(1): 914.
- Sonenstein, F.L., Stewart, K., Lindberg, L.D., Pernas, M., & Williams, S. (1997). Involving males in preventing teen pregnancy. Retrieved July 26, 2006, from <http://www.urban.org/family/invmale.html>
- U.S. Census Bureau. (n.d.). Website. Available from <http://www.census.gov>
- U.S. Department of Education. (1995). Graduation, Reality, and Dual-Role Skills (GRADS). Retrieved on August 21, 2006 from <http://www.ed.gov/pubs/EPTW/eptw3/eptw3d.html>
- U.S. General Accounting Office. (1995). Welfare to Work: Approaches that help teenage mothers complete high school. Retrieved on July 24, 2006 from <http://www.gao.gov/archive/1995/h795202.pdf>
- Wagner, M.M., & Clayton, S. L. (1999, Spring/Summer). The Parents as Teachers Program: Results from two demonstrations. Home visiting: Recent program evaluations. *The Future of Children*, 9 (1): 91-115. Retrieved on August 21, 2006 from http://www.futureofchildren.org/usr_doc/vol9no1Art5.pdf
- Walters, J. (2005, January 2). No sex is safe sex for teens in America. *The Observer*.
- Wan, T.H., Odell, B.G., & Lewis, D.T. (1982). *Promoting the well-being of the elderly: A community diagnosis*, New York: The Halworth Press
- Wasserman, G. A., Brunelli, S. A., & Rauh, V. A. (1990). Social supports and living arrangements of adolescent and adult mothers. *Journal of Adolescent Research*, 5:54-66.
- Wilgoren, J. (1999, December 15). Abstinence is focus of U.S. sex education. *New York Times*, A18.

ATTACHMENTS

Attachment 1: Researcher List

MCS CONSULTING SERVICE

CORE SERVICE RESEARCH TEAM

Co-Lead Consultants

Marlene C. Stoiber, Ph.D. President, MCS Consulting Service, LLC
Bette S. Meyer, M.A.

Research Team

Renee Aten, CFRE, Aten Enterprises, Associate, MCS Consulting Service, LLC
Edwin A. Balcerzak, Ph.D., Associate, MCS Consulting Service, LLC
Louis B. Burroughs, M.S.U.S., Associate, MCS Consulting Service, LLC
Elsie Day, J.D., Associate, MCS Consulting Service, LLC
Jennifer M. Forshey, M.P.P., IntelliSolve, Inc.

Karen Gillooly, M.Ed., IntelliSolve, Inc.
Sue E. Grant, Ella & Associates, IntelliSolve, Inc.
Gary Harris, B.A., M.B.A., IntelliSolve, Inc.
Jeffry D. Harris, M.P.A., J.D., IntelliSolve, Inc.
Kristen Haskell, M.A., Associate, MCS Consulting Service, LLC

Dion Lau, B.A., Associate, MCS Consulting Service, LLC
Kitty Leung, M.S.S.A., Associate, MCS Consulting Service, LLC
Marcy Hunt- Morse Ph.D., Ella & Associates, IntelliSolve, Inc.
Carey Wiant Nyberg, M.U.P., Associate, MCS Consulting Service, LLC
RNR Consulting, Inc.

Jeremy Shapiro, Ph.D., IntelliSolve, Inc.
Jennifer Slusser, J.D., IntelliSolve, Inc.
Sarah Stilgenbauer, M.N.O., Associate, MCS Consulting Service, LLC
Kola Sunmonu, Ph.D., Associate, MCS Consulting Service, LLC
Jamie Watkins, B.A., IntelliSolve, Inc.

Jacqueline Kirby Wilkins, Ph.D., CFLE - President/Director, IntelliSolve, Inc.
Debra Zanglin, Ella & Associates, IntelliSolve, Inc.

Thanks to *The Center for Community Solutions* for providing multiple sources of information.

Attachment 2: Technical Notes

Technical Notes: Methodology, Caveats, Limitations of Data

The following provides descriptions, definitions, methodologies, caveats, or limitations of data for the following components of the core service reports:

- Unit of Analysis
- First Call for Help Data
- Funding Information for Core Services
- Consumer and Financial Data: Caveats
- Gap Analysis Methodology & Limitations
- Service Site Index

Unit of Analysis

The core service is the unit of analysis. United Way of Greater Cleveland either funds or could fund 80 core services. These are the object and subject of the research, specific to Cuyahoga County. A separate report has been developed for each service. It must be noted that the aggregate of any quantifiable data across all of the reports does not comprise a picture of the totality of health and human services in Cuyahoga County because there are many more than 80 services that comprise the community's safety net.

The unit of analysis for estimates of service consumers is the individual, the family, or the household.

United Way - First Call for Help Data

For most core services, United Way First Call for Help (FCFH), the community's resource and referral service data, was used in tables that show the number of service providers and service sites, the geographic location of service providers by zip code, the service area by zip code as reported by providers of the respective services, and to show unmet need and greatest increase/decrease in calls received by FCFH for a particular core service.

It is important to remember that FCFH receives calls from a variety of sources that include people calling on behalf of a prospective consumer such as social workers, provider agencies, relatives, etc. Not all calls come directly from a prospective consumer, so some of the zip codes are for hospitals and business addresses, although the numbers for these zip codes are relatively small.

Calls also may be from people who are not interested in receiving a service, but wish instead to make a contribution to a program such as clothing, household items, food, books, crafts supplies, etc.

Because, in many instances, FCFH codes its data with a different level of core services than the 80 core services identified by the United Way Community Investment staff as fundable services, it was necessary to develop a crosswalk. This crosswalk was used for a number of services, however,

seven services did not have a match in the FCFH database. The staff of United Way - First Call for Help gave explanations which follow each core service):

- Adolescent/Youth Counseling: A caller asking about help with their troubled teenager would be referred by the type of counseling rather than age. (Example: counseling for drugs, family, sexual abuse, etc.)
- Advocacy: FCFH does not receive calls from people about advocacy.
- Child Care: Calls are directed to Starting Point.
- Condition Specific Rehabilitation Services: FCFH would refer caller back to their primary care physician for a referral.
- Early Intervention for Mental Illness: FCFH does not receive calls for this, but if they did, they would refer to the county's Help Me Grow program.
- Family Support Centers: FCFH defines data by specific service rather than type of agency. Depending on the call, the caller may be referred to General Counseling or Early Intervention for Infants and Toddlers with Disabilities, and so on.
- Preschools: Calls are directed to Starting Point.

A different match was used for other services that had no crosswalk.

- Medical Transportation and Senior Ride: FCFH uses "Paratransit" as they do not differentiate between senior transportation, medical transportation, and transportation for the disabled.
- Outpatient Mental Health Facilities: FCFH uses "Mental Health Drop-in Centers."

It must also be noted that, for the most part, the FCFH database does not include for-profit agencies. In the case of home health care providers, we contacted the Long Term Care Ombudsman for a more complete list of provider agencies which includes for-profit organizations.

There were several instances where the FCFH database did not code a United Way-funded agency with the core service for which they were receiving funding. In these instances, the agency was added manually to the Service Provider Table along with their site locations. The core services with the respective United Way of Greater Cleveland agencies that were added are:

- Case/Care Management – Care Alliance, Cystic Fibrosis, Epilepsy Foundation, Golden Age Centers
- Comprehensive Outpatient Substance Abuse Treatment – The Covenant
- Disease/Disability Information – The Muscular Disease Society of Northeastern Ohio
- Early Intervention for Infants and Toddlers with Disabilities – United Cerebral Palsy
- Medical Expense Assistance – North Coast Health Ministry
- Medical Transportation (Paratransit in FCFH) – Kidney Foundation of Ohio
- Senior Centers – Catholic Charities Services Corporation, Jewish Community Center of Cleveland, Jewish Family Service Association of Cleveland, University Settlement House.
- Volunteer Development – Neighborhood Leadership Institute

It must also be noted that when numbers are low for trend data reported, the high percentages are slightly exaggerated.

Funding Information for Core Services

We collected financial information for each core service on a countywide level from multiple sources including major government funders, foundations, federated fund raising organizations, and United Way of Greater Cleveland. While we were successful in gathering a substantial amount of data, there is much that has not been collected. It must also be noted that even if we had all major public and private funding gathered, this would not create a total picture of health and human service funding in Cuyahoga County because there are more than 80 core services provided. The following provide highlights of data collected and some of the limitations for each source. It is important to note that funding in each source is changing and represents point in time amounts. The typical period for trend data, when available, is 2002, 2003, and 2004. Note: some services are funded by private insurance or other self-pay arrangements.

Foundation Funding

We attempted to obtain foundation funding amounts for each core service from the latest annual report or 990 PF (foundation tax return to the IRS) of each major foundation that funds social services in Greater Cleveland. Wherever a description of the grant purpose was given, we used our best judgment to match the grant to the appropriate core service. If the grant fell within more than one core service area, it was not listed. When no description was given, the grant was treated like a general operating grant and assigned to a core service only when the mission of the grant recipient fell mainly within one particular core service. In-kind donations, grants for capital and equipment expenses and administrative salaries were not used. When grants were \$10,000 or greater, they were listed by name of the foundation. All others were placed under Other Foundations and not listed. Typically, we did not attempt to provide trend financial data for foundation funding of core services because of the changing nature of funded programs from year to year.

Federated Funding Sources

We approached the major federated funders of core services in Greater Cleveland for funding and consumer information. Some data provided was for a single point in time; others provided three years of trend data. We often had to do a cross walk of United Way of Greater Cleveland funded core services against those funded by federated agencies to agree on the services.

Government Funding

We approached every major government funder for funding amounts for each core service and also did Internet searches for some federal government sources. Due to the constant state of change in government funding, it is important to note that the data provided is a snapshot in time and that many of the programs funded in 2004 have changed definition, are funded through different revenue sources, or no longer exist at all due to a lack of funding. This is particularly true of Community Development Block Grant dollars which have decreased due to shifting federal priorities.

Every effort was made to appropriately match government funding data to the correct core service area; however, this was not always possible as frequently the service definitions were not a one-to-one match. It was necessary, in some instances, to take the closest match or use the core service which represented a majority of the services being provided.

In other cases, it was not possible to select a specific core service. An example is Medicaid in which Medicaid-defined services crossed over more than four core services in some instances. In cases

where Medicaid is a significant source of revenue, the data was entered as an aggregate total at the appropriate AIRS level. These aggregates are footnoted under the appropriate funding table.

Every effort was made to include data from municipalities. However, many did not respond after repeated requests for information. We would like to thank those who took the time to help with this project.

Medicaid Funding

A significant portion of Medicaid funding was NOT entered under the countywide total in the core service reports for two reasons: first, because many of the Medicaid services are not a one-to-one match with United Way core services, and second because some Medicaid services fall into more than one AIRS Level 1 categories. In the first instance, Medicaid funding was entered as an aggregate total at the AIRS 1 level, and in the second instance Medicaid funding was entered as an aggregate total under Third Party Payee/Direct Bill in the combined Master Revenue file of funding across all nine AIRS Levels. They are as follows:

Entered as Aggregate Total Under Appropriate AIRS Level

- Medicaid Service - Home Care (\$17,787,703 in 2004) - Falls into AIRS 1 Health Care and includes the following core services: daily living aids and home health care.
- Medicaid Service - CADAS (\$8,522,183 in 2004) - Falls into AIRS 1 Health Care and includes the following core services: comprehensive outpatient substance abuse treatment, residential substance abuse treatment programs, substance abuse education and prevention.
- Medicaid Service - Therapy (\$2,257,394 in 2004) - Falls into AIRS 1 Health Care and includes the following core services: condition specific rehabilitation, and speech & hearing.
- Medicaid Service - CMH (\$67,773,487 in 2004) - Falls into AIRS 1 Mental Health Care & Counseling and includes the following core services: supportive therapies, adolescent/youth counseling, children's residential treatment facilities, early intervention for mental illness, general counseling services (outpatient mental health facilities), and psychiatric day treatment.

Entered as Aggregate Total Under Third Party Payee/Direct Bill

- Medicaid Service - Inpatient Hospital (\$188,329,269 in 2004) - Falls into two different AIRS 1 categories: Basic needs and health care. It includes the following core services: condition specific rehabilitation and medical expense assistance.
- Medicaid Service - Waiver (\$128,921,354 in 2004) – This category included all PASSPORT services. Since we reported PASSPORT separately, in order to avoid duplication, we deducted the PASSPORT total of \$52,676,048 from this number and reported the remaining \$76,245,306. This total falls into AIRS 1 Basic Needs, Health Care and Individual & Family Life and includes the following core services: adult day care, home-delivered meals, home health care and in-home assistance.
- Medicaid Service - Habilitation (\$55,550,307 in 2004) - Falls into AIRS 1 Health Care and Individual & Family Life and includes the following core services: condition specific rehabilitation services, early intervention for infants and toddlers with disabilities/delays, and residential living options for people with disabilities.

United Way of Greater Cleveland Funding

Financial data for core services funded by United Way of Greater Cleveland was for FY 2004 (July 2003 to June 2004). It included allocations through the community investment committees and donor designations that United Way funded agencies applied to the respective core services. It is important to note that not all United Way funded agencies applied donor designated gifts, which are unrestricted, to the core service for which they receive United Way funding. It did not include donor designations that non-United Way funded agencies used for any of the 80 core services.

United Way Agency Revenues

Annually United Way-funded agencies submit revenue budgets to United Way for each funded core service. This information for FY 2004 is reported. However, all of the agency data may not be included in the countywide data as agencies may have assigned dollars from unrestricted grants to a specific core service, or allocated a portion of grant monies that fell within two or more core service areas. It was not always possible to match countywide government or foundation funding with that reported by the agencies and that gathered from other funding sources.

Consumer and Financial Data: Caveats

The following applies to revenue sources on tables and graphs and their corresponding consumer data used in the consumer demographics and zip code tables.

All Core Services

Data was self-verified by the funder/provider. Whenever data provided by a funder appeared to be inconsistent or incorrect, an attempt was made to contact the funder. If the funder responded, the data was either adjusted according to their instructions, or the reason for discrepancies footnoted. If they did not respond, or if they said it was correct, the data was left as submitted.

Demographic and zip code data provided by the funder/provider is frequently taken from consumer intake forms which may have missing or incomplete data, or from provider agency databases which contain data entry errors or incomplete consumer intake forms. Whenever possible, the funder was asked for corrected data. In cases where a correction was not possible, the data was counted as either unknown or missing. The usage of these terms is footnoted at the bottom of each table and is explained more fully in the Gap Analysis section of this attachment.

It was not always possible to get information in the format requested as each funder tracks data differently, using different service definitions, terminology and variables. Wherever possible, data was matched to a consistent report format.

When a funder could not provide consumer demographics, but could provide an estimated percentage of consumers by category, we took the total number of consumers and applied the percentages to come up with estimated numbers for the consumer tables. For example, Medicaid tracks individual recipients throughout the year, entering new data if there is a change, each time a claim occurs. Thus, a consumer who has a birthday between claims will appear in the system for that year with two different ages.

To resolve this, the percentage of consumers in each age range was determined for the total number of duplicated consumer ages. Those percentages were then applied to the total number of unduplicated consumers for the year in order to reach a total number of unduplicated consumers for each age range.

The time periods for both revenue and consumers vary by funder/provider. United Way Program Report data is for FY 2004 (July 2003 to June 2004). Other funder/provider data is for either a January to December or July to June fiscal year.

Gap Analysis Methodology & Limitations

Based on Anderson's (1964) seminal needs assessment model, realized access is defined as the number of consumers who receive service while unrealized access is the estimated number of consumers who need and would utilize a service, but are not currently receiving it. This could be considered the service gap. Unrealized consumer access to services drives the need for change in the social service delivery system. Ensuring unrealized consumer access to services requires new models of service delivery related to access, effective use of resources, data management, and funding. There were multiple steps used to conduct a gap analysis:

- *Estimate of persons in need of the service:* Unless local research was conducted to determine need for a given service, this estimate was obtained by either using U.S. Census data for Cuyahoga County or applying percentages from national studies and reports to the census data. All references and percentages are footnoted in the respective graphs or tables. In most cases this percentage was also applied to actual 1990 Census figures and population projections 2005 through 2015 that were done by the Ohio Department of Development.
- *Estimate of number of ACTUAL consumers in the public systems (realized access):* Data submitted to United Way by funded agencies was aggregated to determine the number of consumers for each core service. The period was FY 2004, which is July 2003 through July 2004.
 - In some cases data was “unknown,” defined as data not collected by agency because no tracking system was available or the type of service delivered made it difficult (i.e., group presentations, telephone information and referral, and drop-ins). This also represents data not completed by consumers either deliberately or inadvertently on intake forms.
 - In other cases, data was missing that, for United Way data, represented computational errors or incorrect completion of online reports. For all other data, “missing” represents data funders/providers were unable to provide.
 - There was no check of the accuracy of data submitted by agencies.
 - Major government funders were asked to provide information about the number of consumers for the respective core services that they funded. In most cases, services were not defined in the same way as the United Way core services which are based on the Alliance for Information and Referral Systems (AIRS) taxonomy. To accommodate these differences, customized crosswalks were developed.
 - We assumed that the numbers of consumers across funding sources were not unduplicated and thus made a judgment about which numbers would be the best estimate of an unduplicated number.
 - The estimate of consumers is not inclusive since it does not include numbers of consumers who use their personal resources to pay for services, nor for other private resources such as insurance or agency fundraising. In addition, it was not always possible to obtain information from some government funders.
- *Estimate of number of “unknown/non-consumers”:* This is the difference between the estimated number of actual consumers and the estimate of persons in need.

- *Estimate of number of “would-be users” (unrealized access):* This is the estimate of persons who would use a service if it were available, typically based on research.
- *Estimate of number of “never users”:* This is the difference between the estimated number of unknown/non-consumers and would-be users.
- *Estimate of “universe of possible consumers”:* This is the total of those actually receiving the service (realized access) and those would-be users (unrealized access).

We recognize that this is not a perfect method for assessing either realized or unrealized access to core services. However, we opted to use an imperfect method rather than no method to demonstrate both the complexity and the usefulness of quantifying realized and unrealized access to services as a first step toward a more rigorous methodology. In the business sector this would be a form of market analysis. We also recognize that actual consumer numbers are not unduplicated across funders, or across core services. Thus, there is much work yet to be done to gain realistic estimates of needs.

The numbers we provided are on a countywide level. We recognize that there could be, and often are, differences by demographics and geographical area. In the Actual Consumer Demographics attachment, we have identified the profile of the base consumer group from census, but have little on the estimated persons in need. Occasionally, there is information from other research that describes differences among different racial, ethnic, gender, age, or income groups that is discussed in the narrative. There is also inconsistent information for consumers funded by various governmental bodies. In other words, some funders provided demographic data and others did not. In the Actual Consumer Zip Codes attachment, we have also attempted to identify the geographic profile of the estimated persons in need and actual consumers. However, this information has the same limitations as the demographics.

Service Site Index

For many services a service site index was developed. It provides a ratio of estimated consumers per service site on a countywide level and for each zip code within the county. The ratio is based on the number derived from the gap analysis described in the previous section and on the number of providers who reported to United Way – First Call for Help whether a specific service site includes a given zip code in its service area. A provider site is located in a single zip code, but could serve multiple zip codes. The ratio is a measure of potential service accessibility by estimated universe of service consumers per zip code area. This measure does not include the capacity of providers to offer the service, for example, the number of consumers that can be served on a daily basis. It is only capturing whether there is a possibility of being a consumer. The lower the ratio, the greater is the chance of receiving service. The index also gives an indication of which zip codes have higher ratios which means that consumers have a lower probability of receiving a service as well as any patterns in zip codes that have high percentages of African Americans, Asians, or Hispanics. A map is also attached which provides a graphic picture of the estimated consumers by zip code.

Based on the numbers of providers that report to FCFH whether they serve a given zip code, we had assumed that there would be greater variability across zip codes. In reality, many report that they serve the entire county. Thus the variability across zip codes is often primarily because of differences in the population numbers rather than in service sites that offer service in a given zip code.

Specific Service Issues

Senior Services

“Senior Centers” was used as a catch-all category when the funder-defined service covered more than one senior success core service and could not be accurately allocated among the separate core services. Often, funding for transportation and home-delivered meals was not broken out from senior activities and supportive services at the municipal level, so it was placed under Senior Centers. Because the core services for congregate and home-delivered meals and senior ride were tracked separately, funding for these core services was not included under Senior Centers to avoid duplication of resources, even though senior center activities can and do include congregate meals.

Senior Ride includes disabled individuals of all ages as well as seniors for most funders with the notable exception of Western Reserve Area Agency on Aging (WRAAA) that requires an individual to be 60 years of age or older in order to receive services. If the transportation service was not provided by a senior center, the number of consumers reflects the number of riders using the system and contains duplicates (e.g. paratransit).

Home improvement/accessibility data includes programs for low-income families and people of all ages with disabilities, as well as seniors.

References

- Anderson, Ronald M. (1995, March). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior*, 36(1): 1-10.
- Wan, Thomas T. H., Odell, Barbara Gill, & Lewis, David T. (1982). *Promoting the well-being of the elderly: A community diagnosis*. New York: The Halworth Press.

Attachment 3: Actual Consumer Demographics

Core Service: Teen Parent/Pregnant Teen Education Program HH-850				
			Estimated Persons in Need	Actual Number/Percent of Consumers by Funding Source ****
	Total Population (%)*	Total Population Females 14-19 (%)**	Population 14-19 First Time Pregnant/ Teen Parents (%)***	UW Program Report Data Cuy Cnty Only 29% (%)
PERIOD	1/1/2000-12/31/2000	1/1/2000-12/31/2000	1/1/2000-12/31/2000	7/1/2003-6/30/2004
14 years	1,393,978	9,248	92	
15 years		9,100	390	
16 years		9,426	404	
17 years		9,155	393	
18 years		8,152	810	
19 years		7,729	768	
TOTAL	1,393,978	52,810	2,859	126
Percent		3.8%	5.4%	
GENDER				
Male	47.2%			0.7%
Female	52.8%	100.0%	N/A	28.3%
Unknown Data*****				71.0%
Missing Data*****				0.0%
RACE*****				
White alone	67.1%	59.8%	N/A	3.2%
Black or African American alone/combination	27.9%	34.3%	N/A	23.4%
Asian alone/combination	2.1%	2.0%	N/A	0.2%
American Indian and Alaska Native alone/combination	0.7%	0.9%	N/A	0.0%
Native Hawaiian and Other Pacific Islander alone/combination	0.1%	0.0%	N/A	0.0%
Some other race alone/combination	2.1%	3.0%	N/A	1.1%
Unknown Data*****				72.0%
Missing Data*****				0.0%
HISPANIC*****				
	3.3%	4.4%	N/A	0.2%
AGE				
0-4	6.5%			0.0%
5-9	7.3%			0.0%
10-14	7.1%	187.7%	N/A	1.6%
15-19	6.4%	168.2%	N/A	26.2%
20-34	19.1%			1.1%
35-54	29.3%			0.0%
55-64	8.7%			0.0%
65-74	7.8%			0.0%
75+	7.8%			0.0%
Unknown Data*****				71.0%
Missing Data*****				0.0%
INCOME*****				
Average Household Size	2.4	N/A	N/A	N/A
\$0-\$9,999	11.3%	N/A	N/A	8.5%
\$10,000-\$14,999	6.9%	N/A	N/A	1.4%
\$15,000-\$19,999	6.7%	N/A	N/A	1.1%
\$20,000-\$29,999	13.6%	N/A	N/A	3.0%
\$30,000 and above	61.5%	N/A	N/A	5.5%
Unknown Data*****				80.5%
Missing Data*****				0.0%
Totals	100.0%	N/A	N/A	100.0%

Attachment 3: Actual Consumer Demographics (continued)

* U.S. Census 2000, SF1 (P1); SF4 (PCT144)
** U.S. Census 2000, SF3 (P46)
*** The National Campaign to Prevent Teen Pregnancy: "Fact Sheet: How is the 34% Statistic Calculated?" Feb 2004. Percent of teen girls pregnant for the first time that year: 14 (1 percent); 15, 16 & 17 (4.29 percent), 18 & 19 (9.94 percent). Average 5.4 percent.
****Note: Consumers could be funded by more than one funding source; thus the columns are not necessarily mutually exclusive.
*****Unknown Data - Represents data not collected by agency because no tracking system is available or type of service delivered makes it difficult (i.e., group presentations, telephone information and referral, and drop-ins). Also represents data not completed by clients either deliberately or inadvertently on intake forms.
*****Missing Data - For United Way Data - represents computational errors or incorrect completion of online report. For all other data - represents data funder was unable to provide.
***** The race categories and data utilize US Census SF4 "Race Iterations," which allow for multiple races to be selected by census respondents. As a result, totals will add to > 100% of population. Universe is "Total Races Tallied." Except "White Alone," all racial categories are "... alone or in combination with some other race." This method isolates and minimizes the non-minority population ("White alone").
*****Hispanic - Amount in this field is from data provided by clients on intake forms and may not be accurate as clients may either deliberately or inadvertently provide incomplete data, or data may not be collected by the agency.
*****The U.S. Census reports income by household or family, not individuals. Estimates by income category were derived by applying the ratio of total county population (1,393,978) to total households (571,606) = 2.4. The number of households in each income category was multiplied by 2.4 to arrive at an estimate of individuals by income category. The assumption is that the average household size applies to each income category, which may result in more conservative estimates for children, and the "old old," which may actually have larger proportions of persons in the lower income categories.

Attachment 4: Actual Consumer Zip Codes

Core Service: Teen Parent/Pregnant Teen Education Program HH-850					
				Estimated Persons in Need	Actual Number/Percent of Consumers by Funding Source ^{*****}
	City/Town (% Cleveland)	Total Population (%) ^a 1/1/2000-12/31/2000	Total Population Females 14-19 (%) ^{aaa} 1/1/2000-12/31/2000	Estimated Population 14-19 First Time Pregnant/ Teen Parents (%) ^{aaa} 1/1/2000-12/31/2000	UW Program Report Data (%) 7/1/2003-6/30/2004
Period					
14 years			9,248	92	
15 years			9,100	390	
16 years			9,426	404	
17 years			9,155	393	
18 years			8,152	810	
19 years			7,729	768	
TOTAL		1,393,978	52,810	2,859	126
Percent			3.8%	5.4%	
44017	Berea	1.4%	2.1%	N/A	0.0%
44022	Bentleyville	1.3%	0.8%	N/A	0.0%
44040	Gates Mills/Mayfield Village	0.2%	0.2%	N/A	0.0%
44070	North Olmsted	2.4%	2.4%	N/A	0.0%
44101	Cleveland (100%)	0.0%	0.0%	N/A	0.0%
44102	Cleveland/Brooklyn (95%)	3.7%	4.0%	N/A	11.1%
44103	Cleveland (100%)	1.8%	2.4%	N/A	2.4%
44104	Cleveland (100%)	2.1%	2.6%	N/A	4.0%
44105	Cleveland/NewburghHts/ GarfieldHts	3.9%	4.4%	N/A	8.7%
44106	Cleveland/Cleveland Hts (60%)	2.3%	3.0%	N/A	1.6%
44107	Lakewood/Cleveland	4.0%	3.6%	N/A	0.0%
44108	Cleveland/Bratenahl (90%)	2.6%	3.2%	N/A	8.7%
44109	Cleveland/Brooklyn Hts (98%)	3.3%	3.3%	N/A	3.2%
44110	Cleveland/East Cleveland (98%)	1.9%	2.0%	N/A	5.6%
44111	Cleveland (100%)	3.1%	2.5%	N/A	0.0%
44112	East Cleveland/Cleveland	2.4%	2.7%	N/A	6.3%
44113	Cleveland (100%)	1.4%	1.1%	N/A	0.8%
44114	Cleveland (100%)	0.3%	0.2%	N/A	0.0%
44115	Cleveland (100%)	0.6%	0.8%	N/A	1.6%
44116	Rocky River	1.5%	1.1%	N/A	0.0%
44117	Euclid/Cleveland	0.9%	0.7%	N/A	1.6%
44118	ClevelandHts/UniversityHts/	3.2%	3.9%	N/A	7.9%
44119	Cleveland/Euclid (50%)	1.0%	0.6%	N/A	0.8%
44120	Shaker Hts/Cleveland	3.4%	3.8%	N/A	5.6%
44121	University Hts/South Euclid	2.5%	2.7%	N/A	5.6%
44122	Beachwood/Highland Hills/ShakerHts	2.5%	2.2%	N/A	0.0%
44123	Euclid	1.3%	1.4%	N/A	4.0%
44124	Pepper Pike/MayfieldHts/Lyndhurst	2.9%	2.0%	N/A	0.0%
44125	Valley View/Garfield Hts	2.1%	2.2%	N/A	0.0%
44126	Fairview Park/Cleveland	1.2%	1.1%	N/A	0.8%
44127	Cleveland (100%)	0.6%	0.8%	N/A	0.0%
44128	Warrensville Hts/Cleveland	2.4%	2.4%	N/A	4.8%
44129	Brooklyn/Parma/Cleveland	2.1%	2.0%	N/A	0.0%
44130	Parma/Cleveland	3.8%	2.9%	N/A	0.0%
44131	Independence/Seven	1.5%	1.4%	N/A	0.0%
44132	Euclid	1.1%	1.0%	N/A	7.1%
44133	North Royalton	2.0%	2.0%	N/A	0.0%
44134	Parma/Cleveland	2.9%	2.6%	N/A	0.0%
44135	Cleveland/Linndale (90%)	2.0%	1.9%	N/A	0.0%
44136	Strongsville	3.1%	3.4%	N/A	0.0%
44137	Maple Hts/Cleveland	1.9%	1.8%	N/A	1.6%
44138	Olmsted Twp/Olmsted Falls	1.3%	1.2%	N/A	0.0%
44139	Bentleyville/Glenwillow/Solon	1.6%	2.0%	N/A	0.0%
44140	Bay Village	1.1%	1.2%	N/A	0.0%
44141	Brecksville	1.0%	1.0%	N/A	0.0%
44142	Brookpark/Cleveland	1.5%	1.5%	N/A	0.0%
44143	Highland Hts/Richmond Heights	1.7%	1.5%	N/A	0.8%
44144	Brooklyn/Cleveland	1.6%	1.2%	N/A	2.4%
44145	Westlake	2.3%	2.1%	N/A	0.0%
44146	Walton Hills/Oakwood/Bedford	2.3%	2.0%	N/A	0.0%
44147	Broadview Hts	1.1%	1.0%	N/A	0.0%
44149	Strongsville	0.0%	0.0%	N/A	0.0%
	Unknown Cuyahoga County Zip Codes*****				3.2%
	Missing*****				0.0%
	Unknown*****				245.2%
	Total Cuyahoga County*****	100.0%	100.0%	N/A	100.0%
	Total Known Cleveland	30.5%	33.0%	N/A	48.4%
	Total Known Suburbs	69.5%	67.0%	N/A	48.4%
	Unknown & Missing				245.2%

Attachment 4: Actual Consumer Zip Codes (continued)

* U.S.Census 2000, SF1 (P1)
** U.S. Census 2000, SF3 (P8)
*** The National Campaign to Prevent Teen Pregnancy: "Fact Sheet: How is the 34% Statistic Calculated?" Feb 2004. Percent of teen girls pregnant for the first time that year: 14 (1 percent); 15, 16 & 17 (4.29 percent), 18 & 19 (9.94 percent). Average 5.4 percent.
**** Note: Consumers could be funded by more than one funding source; thus the columns are not necessarily mutually exclusive.
*****Missing Data - For United Way - represents computational errors or incorrect completion of online report. This data may contain zip codes outside of Cuyahoga County so it is not included in the total number served for Cuyahoga County. For all other data - represents data funder was unable to provide.
*****Unknown Data - Represents data not collected by agency because no tracking system is available or type of service delivered makes it difficult (i.e., group presentations, telephone information and referral, and drop-ins). Also represents data not completed by clients either deliberately or inadvertently on intake forms. This data may contain zip codes outside of Cuyahoga County so it is not included in the total number served for Cuyahoga County.
***** Totals vary because of rounding. County total population 1,393,978 does not correspond to the total of zip codes because some zip codes include data from adjacent counties

Attachment 5: Profile of Core Service Providers – 2005

PROFILE OF CORE SERVICE PROVIDERS - 2005		
Source: United Way - First Call for Help Refer Database February 2005		
	Count	Sub-Count: UW-Affiliated
Total Number of Providers	11	1
Number of Providers by Type		
Nonprofit	2	1
For-profit	-	-
Government	9	-
Other	-	-
Total Number of Sites	13	2
Number of Service Sites per Provider		
1	9	-
2 – 5	2	1
6 – 10	-	-
11+	-	-
Geographical Location of Service Sites, by ZIP Code		
44017 - Berea	-	-
44022 - Bentleyville	-	-
44040 - Gates Mills/Mayfield Village	-	-
44070 - North Olmsted	-	-
44101 - Cleveland	-	-
44102 - Cleveland/Brooklyn	-	-
44103 - Cleveland	1	1
44104 - Cleveland	-	-
44105 - Cleveland/Newburgh Hts/Garfield Hts	-	-
44106 - Cleveland/Cleveland Hts	-	-
44107 - Lakewood/Cleveland	-	-
44108 - Cleveland/Bratenahl	-	-
44109 - Cleveland/Brooklyn Hts	-	-
44110 - Cleveland/East Cleveland	-	-
44111 - Cleveland	-	-
44112 - East Cleveland/Cleveland	2	1
44113 - Cleveland	1	-
44114 - Cleveland	2	-
44115 - Cleveland	1	-
44116 - Rocky River	-	-
44117 - Euclid/Cleveland	-	-
44118 - ClevelandHts/UniversityHts/ShakerHts	1	-
44119 - Cleveland/Euclid	-	-
44120 - Shaker Hts/Cleveland	-	-
44121 - University Hts/South Euclid	-	-
44122 - Beachwood/Highland Hills/Shaker Hts.	-	-
44123 - Euclid	1	-
44124 - Pepper Pike/Mayfield Hts./Lyndhurst	1	-
44125 - Valley View/Garfield Hts	-	-
44126 - Fairview Park/Cleveland	-	-
44127 - Cleveland	-	-
44128 - Warrensville Hts/Cleveland	1	-
44129 - Brooklyn/Parma/Cleveland	-	-

Attachment 5: Profile of Core Service Providers – 2005 (continued)

PROFILE OF CORE SERVICE PROVIDERS - 2005		
Source: United Way - First Call for Help Refer Database February 2005		
	Count	Sub-Count: UW-Affiliated
44130 - Parma/Cleveland	1	-
44131 - Independence/Seven Hills/Brooklyn Hts	-	-
44132 - Euclid	-	-
44133 - North Royalton	-	-
44134 - Parma/Cleveland	-	-
44135 - Cleveland/Linndale	-	-
44136 - Strongsville	-	-
44137 - Maple Hts/Cleveland	1	-
44138 - Olmsted Twp/Olmsted Falls	-	-
44139 - Bentleyville/Glenwillow/Solon	-	-
44140 - Bay Village	-	-
44141 - Brecksville	-	-
44142 - Brookpark/Cleveland	-	-
44143 - Highland Hts/Richmond Heights	-	-
44144 - Brooklyn/Cleveland	-	-
44145 - Westlake	-	-
44146 - Walton Hills/Oakwood/Bedford	-	-
44147 - Broadview Hts	-	-
44149 - Strongsville	-	-

Attachment 6: Providers and Functions – 2005

Service Providers & Functions	
Source: United Way - First Call for Help Refer Database February 2005	
Agency	Services
Catholic Charities Services Of Cuyahoga County	Alternative School For Pregnant Teens
Cleveland Heights-University Heights City School District	Remedial/Summer School/Teen Parent - Parents
Cleveland Municipal School District	Remedial/Summer School/Teen Parent - Out Of School Youth, Remedial/Summer School/Teen Parent - Parents
Cuyahoga County Employment And Family Services	Educational Support - Youth Recipients Of Cash Benefits
East Cleveland City School District	Remedial / Summer School / Teen Parent
Euclid City School District	Remedial / Summer School / Teen Parent - Youth Parenting
Maple Heights City School District	Remedial/Summer School/Teen Parent - Parents
Polaris Joint Vocational School District	Remedial/Summer School/Teen Parent - Youth Parenting
South Euclid-Lyndhurst City School District	Remedial/Summer School/Teen Parent
Warrensville Heights City School District	Remedial/Summer School/Teen Parent
YWCA of Greater Cleveland	Parenting/Life Skills for Young Parents/Young Parents-to-be

Bold represents agencies funded by United Way for this service.

Attachment 7: United Way - First Call for Help Teen Parent/Pregnant Teen Education Programs Requests – 2000-2004: Greatest Increase/Greatest Decrease

HH-850 Teen Parent/Pregnant Teen Education Programs United Way - First Call for Help Requests 2000-2004 Greatest Increase/(Greatest Decrease)								
Zip Code		TOTAL REQUESTS					%Change*	Avg. #
		2000	2001	2002	2003	2004	00&04	Calls 00-04
44128	Warrensville Hts/Cleveland	1	0	1	1	2	100%	1
44114	Cleveland	0	0	0	0	2	N/A	N/A
44102	Cleveland/Brooklyn	0	2	1	0	2	N/A	1
44110	Cleveland/East Cleveland	0	1	0	0	2	N/A	1
44112	East Cleveland/Cleveland	0	0	0	4	2	N/A	1
44111	Cleveland	0	1	0	1	1	N/A	1
44113	Cleveland	0	2	0	0	1	N/A	1
44106	Cleveland/Cleveland Hts	0	0	0	1	1	N/A	N/A
44118	ClevelandHts/UniversityHts/ShakerHts	0	0	0	1	1	N/A	N/A
44132	Euclid	0	0	0	0	1	N/A	N/A
44107	Lakewood/Cleveland	0	1	0	0	1	N/A	N/A
44137	Maple Hts/Cleveland	0	1	0	0	1	N/A	N/A
44130	Parma/Cleveland	0	0	0	2	1	N/A	1
44134	Parma/Cleveland	0	0	0	0	1	N/A	N/A
44127	Cleveland	1	0	0	0	0	(100%)	N/A
44109	Cleveland/Brooklyn Hts	2	0	0	1	0	(100%)	1
**Total Cuyahoga County		10	16	16	19	23	130%	17
**Total Cleveland		8	9	12	11	12	50%	10
**Total Suburbs		2	7	4	8	11	450%	6
* Extremely high percentages are due to low numbers.								
** These totals do not reflect the sum of the numbers above which are the zip codes reflecting the greatest increase or decrease. Rather, they are the total of calls from ALL zip codes many of which do not appear on this table.								

Attachment 8: United Way - First Call for Help 2000-2004: Unmet Need

HH-850 Teen Parent/Pregnant Teen Education Programs				
United Way - First Call for Help Requests 2000-2004				
Unmet Need				
Zip Code	TOTALS 00-04			%
	Requests	Met	Unmet	Unmet
* Total Cuyahoga County	84	84	0	0%
* Total Cleveland	52	52	0	0%
* Total Suburbs	32	32	0	0%

FCFH DATA NOTES

Met = service request resulting in referral to an organization. (Does not mean agency was able to provide the service.)

Unmet = service request for which there was no referral.

Note: Zip Codes shared by Cleveland and surrounding suburbs whose boundaries fall 50% and greater within the city of Cleveland are highlighted and totaled as Cleveland. Others are totaled as Suburbs.

* These totals do not reflect the sum of the numbers above which are the zip codes reflecting unmet need in 2004. Rather, they are the total of calls from ALL zip codes some of which do not appear on this table.

Attachment 9: Service Site Index

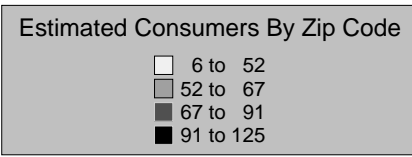
Core Service: Teen Parent/Pregnant Teen Education Programs HH-850								
Service Site Index								
Zip	Number of Sites****	City/Town (% Cleveland)	Proportion of Minorities in Geographical Area	Total Population (#)*	Total Population Females 14-19 (#)**	Estimated Universe of Possible Consumers per Geographical Area***	Number of Service SITES Serving Geographical Area (Per Agencies Reported Intended Service Area to First Call for Help)*****	Potential Service ACCESSIBILITY by Service Consumers per Geographical Area Ratio of CONSUMERS to SERVICE SITES
Period				1/1/2000-12/31/2000	1/1/2000-12/31/2000	1/1/2000-12/31/2000	1/2005	
14 years					9,248		92	
15 years					9,100		390	
16 years					9,426		404	
17 years					9,155		393	
18 years					8,152		810	
19 years					7,729		768	
TOTAL	13			1,393,978	52,810	2,859	13	220:1
Percent					3.8%		5.4%	
44113	1	Cleveland (100%)	Hispanic 23.5%	19,466	589	32	4	8:1
44102		Cleveland/Brooklyn (95%)	Hispanic 20.4%	52,108	2,127	115	5	23:1
44109	-	Cleveland/Brooklyn Hts (98%)	Hispanic 20.3%	45,783	1,743	94	4	24:1
44114	2	Cleveland (100%)	Asian 20.3%	3,891	123	7	4	2:1
44115	1	Cleveland (100%)	African Am 98.4%	8,186	438	24	4	6:1
44104	-	Cleveland (100%)	African Am 97.5%	28,904	1,362	74	4	18:1
44128	1	Warrensville Hts/Cleveland	African Am 95.8%	33,612	1,246	67	6	11:1
44112	2	East Cleveland/Cleveland	African Am 95.2%	33,222	1,412	76	7	11:1
44108	-	Cleveland/Bratenahl (90%)	African Am 94.9%	36,456	1,676	91	5	18:1
44103	1	Cleveland (100%)	African Am 80.2%	25,348	1,293	70	5	14:1
44120	-	Shaker Hts/Cleveland	African Am 76.7%	47,349	2,024	109	4	27:1
44110	-	Cleveland/East Cleveland (98%)	African Am 74.7%	26,536	1,054	57	4	14:1
44106	-	Cleveland/Cleveland Hts (60%)	African Am 62.2%	32,417	1,567	85	5	17:1
44105	-	Cleveland/NewburghHts/GarfieldHts	African Am 61.9%	54,834	2,324	125	4	31:1
44117	-	Euclid/Cleveland	African Am 53.1%	12,078	371	20	5	4:1
44017		Berea		19,005	1,119	60	3	20:1
44022		Bentleyville		17,720	430	23	2	12:1
44040		Gates Mills/Mayfield Village		2,883	119	6	2	3:1
44070		North Olmsted		34,081	1,272	69	3	23:1
44101		Cleveland (100%)		0	0	0	2	N/A
44107	-	Lakewood/Cleveland		56,710	1,893	102	4	26:1
44111	-	Cleveland (100%)		42,967	1,324	71	4	18:1
44116	-	Rocky River		21,122	607	33	2	16:1
44118	1	ClevelandHts/UniversityHts/ShakerHts		45,279	2,060	111	5	22:1
44119	-	Cleveland/Euclid (50%)		13,493	343	19	5	4:1
44121	-	University Hts/South Euclid		35,185	1,421	77	6	13:1
44122	-	Beachwood/Highland Hills/ShakerHts		34,883	1,147	62	7	9:1
44123	1	Euclid		18,363	720	39	3	13:1
44124	1	Pepper Pike/MayfieldHts/Lyndhurst		40,334	1,046	56	4	14:1
44125	-	Valley View/Garfield Hts		29,876	1,154	62	4	16:1
44126	-	Fairview Park/Cleveland		17,196	590	32	5	6:1
44127	-	Cleveland (100%)		8,403	429	23	4	6:1
44129	-	Brooklyn/Parma/Cleveland		29,658	1,035	56	5	11:1
44130	1	Parma/Cleveland		53,615	1,532	83	5	17:1
44131	-	Independence/Seven Hills/BrooklynHts		20,666	721	39	4	10:1
44132	-	Euclid		15,322	551	30	3	10:1
44133	-	North Royalton		28,665	1,039	56	2	28:1
44134	-	Parma/Cleveland		40,396	1,371	74	4	19:1
44135	-	Cleveland/Linddale (90%)		28,561	1,025	55	4	14:1
44136	-	Strongsville		43,858	1,809	98	3	33:1
44137	1	Maple Hts/Cleveland		26,107	970	52	5	10:1
44138	-	Olmsted Twp/Olmsted Falls		18,046	655	35	3	12:1
44139	-	Bentleyville/Glenwillow/Solon		22,231	1,048	57	2	28:1
44140	-	Bay Village		16,076	617	33	2	17:1
44141	-	Brecksville		13,676	530	29	2	14:1
44142	-	Brookpark/Cleveland		21,132	809	44	5	9:1
44143	-	Highland Hts/Richmond Heights		23,730	804	43	5	9:1
44144	-	Brooklyn/Cleveland		21,805	625	34	5	7:1
44145	-	Westlake		31,972	1,094	59	2	30:1
44146	-	Walton Hills/Oakwood/Bedford		31,648	1,039	56	2	28:1
44147	-	Broadview Hts		15,954	513	28	2	14:1
						0		

* U.S. Census 2000, SF1 (P1)
 ** U.S. Census 2000, SF3 (P8); 3.8 percent of Total Population. Age 100 percent 14-19 years.
 *** The National Campaign to Prevent Teen Pregnancy: "Fact Sheet: How is the 34% Statistic Calculated?" Feb 2004. Percent of teen girls pregnant for the first time that year: 14 (1 percent), 15, 16 & 17 (4.29 percent), 18 & 19 (9.94 percent). Average 5.4 percent.
 **** United Way First Call for Help Call Data, February 2005

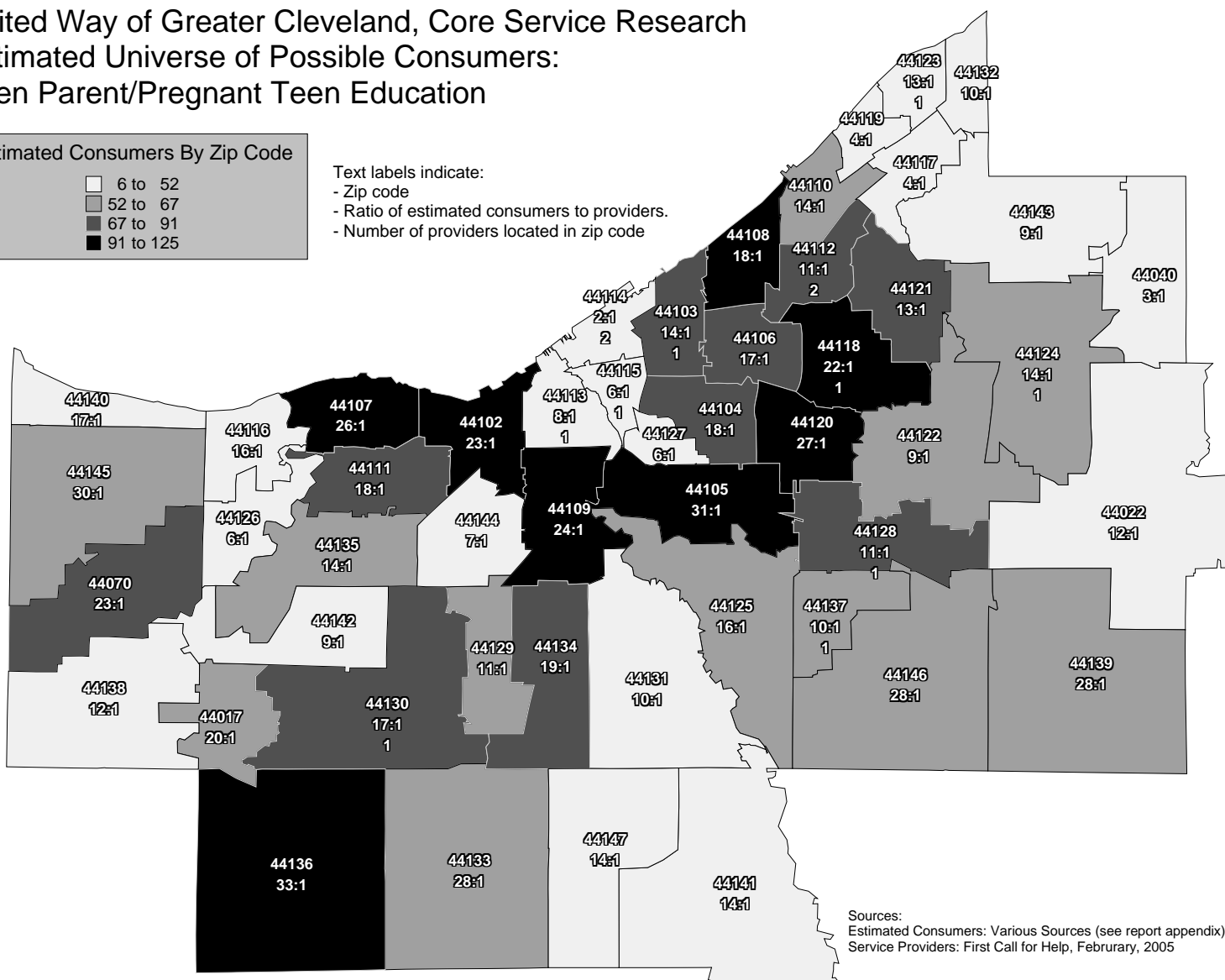


Attachment 10: Map

United Way of Greater Cleveland, Core Service Research
 Estimated Universe of Possible Consumers:
 Teen Parent/Pregnant Teen Education



Text labels indicate:
 - Zip code
 - Ratio of estimated consumers to providers.
 - Number of providers located in zip code



Sources:
 Estimated Consumers: Various Sources (see report appendix)
 Service Providers: First Call for Help, February, 2005



**United Way of
Greater Cleveland**

1331 Euclid Avenue
Cleveland, Ohio 44115

uws.org/CoreServicesPlanning