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Teaching adolescents about pregnancy, parenting, adoption and abortion

Shelly Kay Cobb

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TEACHING ADOLESCENTS ABOUT PREGNANCY, PARENTING, ADOPTION AND ABORTION

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Arts
in
Education

by
Shelly Kay Cobb
December 1994
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A Project
Presented to the Faculty of California State University, San Bernardino

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Approved by:

Dr. Alvin Wolf, First Reader

Dr. Irvin Howard, Second Reader
ABSTRACT

Teaching Adolescents About Pregnancy and Abortion

(There is a growing rate of teenage pregnancies each year despite the various programs for pregnant minors ages nineteen and under (Christopher & Roosa, 1990, p. 68). The National Center for Health Statistics estimated that minors are responsible for 1.1 million pregnancies annually, and 42% of these pregnancies end in abortion (Griffin-Carlson & Mackin, 1993).) (The author addressed the issue of teaching adolescents about pregnancy and abortion, and not sex education (Christopher & Roosa, 1990).) (Students understand the concept of sex, yet too often they do not understand the consequences of sex (Harrington-Luekker, 1991).)

(Therefore, the author provided a resource manual on the facts, consequences, and alternative options available to the adolescent.) (The author's desire was that by providing such material students would make an informed decision regarding pregnancy and abortion (Compton & Hughes, 1990).) The chapter topics cover: (a) physical aspects of pregnancy and abortion (b) the psychological impact on pregnant and post-abortive minors (c) social and economic aspects of teen parenting and abortion, (d) the historical and legal aspects of reproductive freedoms, (e) and the resources available to the adolescent.
The San Bernardino Unified School District Curriculum Coordinator, Dee Torango, along with Redlands' Curriculum Coordinator, Dr. Raumin, Yucaipa's Mr. Jessop, Colton's Donna Wickman, and Fontana's Dr. Nancy Walsack said there is no established curriculum regarding abortion and pregnancy other than the chapter in Health Education on sex and pregnancy. When asked, "If a curriculum that covered pregnancy and abortion in light of the social, historical, economic and physical aspects were made available to them, would they consider it a valuable resource and use it?" All said they would, provided that it was done without the moral questions involved.
DEDICATION

In loving memory of my grandmother

Violet Rosella James
Acknowledgements

I would personally like to thank my family for their love and support throughout this project. It would not have been possible to finish without their help, thanks! There are a few other people that have contributed much of their time. They are: Eric Beatty, who drew all of the illustrations; Candace Johnson who helped type and edit the manuscript, and was also a big support; Kim Davison for her insight and guidance. Anne Duffy for editing; Cobb’s Printing for helping put this manuscript together; and the ladies at the Working Women’s Study who listened and encouraged me through this long process. Thank you all very much for your encouragement and support.

Love,

Shelly
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CHAPTER ONE

REVIEW OF LITERATURE

There is a growing rate of teenage pregnancies each year despite various programs for pregnant minors ages nineteen and under (Christopher & Roosa, 1990, p.68). The National Center for Health Statistics estimated that minors are responsible for 1.1 million pregnancies each year, and of these 42% end in abortion (Griffin-Carlson & Mackin, 1993). The author wishes to address the consequences of adolescent sexual activity along with some basic understanding of the physiology and psychology of adolescence (Harrington-Luekker, 1989, p.24).

There are various sources from researchers, educators, and political groups that support the idea of teaching adolescents about pregnancy, abortion, parenting and alternatives. The main reasons for such an education are: (1) to educate teens of all possibilities regarding pregnancy, abortion, parenting, and alternatives in order for them to make an educated decision regarding their own sexuality; (2) to reduce teenage pregnancies and abortions, thereby reducing the social services and financial strain on schools that provide services to pregnant and parenting teens; and (3) to provide teenage parents with necessary and effective skills of parenting (i.e. nutrition information, healthcare management, and decision making skills) (Flamer &
Need For Pregnancy and Parenting Education

Andre, Frevent, and Schuchman (1989) studied college students to find out where they learned about sex and to what degree their parents, peers, schooling and reading played a part in their sexual learning and activity. When students ranked the topics of physiology, anatomy and birth control, they ranked school the highest, and reading ranked second. Thus, Andre et al. (1989) suggest that "sex education be as comprehensive as possible" (Andre et al., 1989, p.261-2; Newman & Perry-Hunnicutt, 1991; Franz & Reardon, 1992). Due to the adolescents stage of development it would be unlikely they would seek parental advice. This developmental factor may explain why students chose schools and reading as their main method of learning about anatomy and birth control. Adolescence is a time where teens form their own identity. Adolescents separate themselves from the family and challenge its belief system. Therefore, it can be reasoned that pregnancy, abortion and alternatives should be taught in a safe and structured environment, such as public school. (Andre et al., 1989, p.261).

Christopher and Roosa (1990) in their article "An Evaluation of an Adolescent Pregnancy Program: Is 'Just Say No' Enough?", suggest schools teach as comprehensively as possible while encouraging abstinence. A comprehensive
education is necessary since many students who have experienced sexual activity are turned off by an abstinence only message. Others who may have been raped, molested or forced into an incestuous relationship may feel guilt, shame or responsibility for the violent act against them if abstinence only message was taught (Franz & Reardon, 1992). Therefore, it is important to teach tactfully and clearly about the aspects of sexual activity, its consequences, rights and freedoms. This is especially needed when 44% of girls who are pregnant have a history of sexual abuse (Christopher & Roosa, 1990, p.72; Colson & Carlson, 1993). Christopher and Roosa also recommend that this type of curriculum be integrated into the normal curriculum of home economics, health, and parenting courses (1990, p.68).

Franz and Reardon (1992) conducted a study of 252 women to assess the differential impact of abortion on adolescents and adults. The researchers found the younger the aborter the more dissatisified she was with her decision for abortion. Along with their dissatisfaction, many suffer, as a result of feeling rushed into abortion, from a psychological disorder known as Post Abortion Syndrome. Women who reported feeling rushed had less than two weeks to decide. The less time contemplating abortion the more likely it is for women to report severe psychological problems afterwards. This may be due in part to such
limitations as: a lack of knowledge regarding the nature of 
the decision made, a narrow perception of all available 
possibilities, and a perception of abortion as the only 
option. Franz and Reardon (1992, p. 170) recommend that 
adolescents "...should be provided with very concrete 
information and be helped to think through all of the 
implications of the decision.... Abortion clients should be 
encouraged to avoid rushing into a decision without careful 
analysis of all possible options." By providing adolescents 
with information on all possible options, students will have 
the opportunity to make an informed decisions concerning 
their well being.

There are several demographic changes taking place in 
our schools today; two of them are teenage pregnancy and 
parenting teens. Many students drop out of school near the 
birth of their children, since many educational systems do 
not provide on-site daycare or alternative schools for teen 
parents. Educator Betty Fry Williams, PhD (1992) says 
"...the challenge for educators is to identify and implement 
effective educational strategies and to provide appropriate 
educational personnel to reduce this disadvantage" (p. 157).
The cycle of failure can only be broken when there is 
teacher preparation (Vincent, Clearie, & Schulter, 1987; 
Newman & Perry-Hunnicutt, 1991), special services 
administered, and curriculum revised to meet the needs of
students (Harris, 1992). Therefore, the author suggests adding or revising curriculum to deal with the whole scope of pregnancy, parenting, and abortion, in order to reach students before they become sexually active (Newman & Perry-Hunnicutt, 1991). Senior Editor of "The American School Board Journal", Donna Harrington-Luekker (1991) agrees with the idea that such curriculum needs to be taught before adolescents become sexually active. Harrington-Luekker believes abstinence only programs should be taught in middle schools before the young adolescent gets involved. In a comprehensive program that should be taught in high school when integrated into the appropriate fields of studies, students should learn not only about the physical aspects but also the emotional, psychological, historical and legal aspects concerning their well-being. It is beneficial to involve the community when developing or choosing a curriculum (Harrington-Luekker, 1991, p. 22; Harrington-Luekker, 1989, p.24).

Most of all, decision making skills need to be taught to students which will equip them to make sound decisions regarding their lives, including sexual practices (Vincent, Clearie, & Schulter, 1987; Harrington-Luekker, 1991).

A research study was conducted of ten focus groups of teenagers to provide insight into their beliefs about sex, pregnancy and contraception. Five of the groups were ages
sixteen and seventeen, and five groups were ages eighteen and nineteen. Eight of the groups were all female, and two of the groups were all male (Kisker, 1985). The discussions revealed some identifiable problems. The major fallacies of these young adults knowledge included: they could not get pregnant due to the infrequency of sexual activity; they could not identify the safe period of a woman’s cycle; their information on abortion was incorrect or vague; and the males thought they would not be held responsible if they impregnated a girl (Kisker, 1985). Kisker suggests further education is needed on these matters concerning adolescents since most of what they believed was based on heresay or misinformed family beliefs (p.85).

In McCullough and Scherman’s (1991) study, "Adolescent Pregnancy: Contributing Factors of Adolescent Pregnancy and Strategies for Prevention," the following were found:

1. Teens are more sexually experienced at younger ages. This may be due in part to lack of supervision, especially in dual wage earners or single parent homes.

2. Communication breakdown may cause adolescents to seek love and comfort elsewhere thus resulting in sexual behavior and possible pregnancy.

3. Sexual abuse was reported by 43% of teen mothers. The woman may feel it is necessary to engage in a sexual manner in order to keep the relationship working.
4. Rejection of a significant other may lead an adolescent to sexual activity to show they are "adult" and boost their self worth by having a baby.

Because of these factors the researchers suggest that teens need to understand the consequences of pregnancy and parenting, and they recommend providing support services and counseling, "...prevention of pregnancy through education should also be given high priority" (McCullough & Scherman, 1991, p.815). In Arlington County Schools, VA (1990), a program was conducted to encourage education and job training in order to break the poverty cycle and enhance economic independence (Harris, 1992; McCullough & Schermann, 1991). The teenage mothers who participated found the classes on nutrition, health, and decision making skills beneficial. The support groups also helped the young mothers deal effectively with issues they were struggling with. These authors encourage looking at the demographic make-up of young mothers and addressing the broader issues such as poverty, low income, and family life. Bucholz and Gol (1986) also contend that in order to help these young mothers, educators need to capitalize on the positive attributes and encourage psychological development of adolescents through the teens' parenting. Often times teen pregnancy is only one more factor of a larger problem, such as abuse, whether it be physical, psychological or emotional
(Bucholz & Gol, 1986, p.349; Harris, 1992). There is now a need for education to adapt to the changing needs of adolescents in regards to teaching about pregnancy, abortion, and parenting. Additionally social services to teens in need should be provided, whether that need is transportation, counseling, flexible schedules or job training (Compton & Hughes, 1990, p.9). Needs of adolescent fathers are often overlooked but must be met. Male students need to know their rights and responsibilities as fathers (Robinson, 1988; Flamer & Davis, 1990), and have proper training in nutrition and healthcare of children (Kahn & Bolton, 1985). While schools may be able to provide all these services, it would be beneficial to incorporate the parents, community and established social services with the school district, thus alleviating the strain on the education services (Flamer & Davis, 1990; Kahn & Bolton, 1985; Freedman, 1990).

Need for Abortion Education

While there is not overwhelming support for schools to educate students regarding abortion, it is necessary for students to understand what it is and what effects it has on people (Flamer, 1990). There are educators, researchers and physicians that support such a notion. One main reason for educating students on this topic is that female adolescents can have an abortion, which is a surgical procedure, without
Therefore, it is imperative they understand their individual rights and the risks involved with such a surgery. As standard practice most abortion clinics do not inform their clients of such rights and/or risks. If a young lady decides on abortion, she should be equipped with the correct knowledge on the subject to make an informed decision, and not one based on emotion or heresay (Franz & Reardon, 1992, p.169). The Alan Guttmacher Institute for Planned Parenthood Federation (AGI) recommends education as a means of reducing pregnancies and abortions (1993).

(Franz & Reardon (1990), in their study, "Differential Impact of Abortion on Adolescents and Adults," surveyed females who had an abortion to evaluate their reactions concerning their abortion experience.) The results showed adolescents were significantly more dissatisfied with their abortion than were their adult counterparts (Franz, 1992, p.161). The reasons adolescents gave for their dissatisfaction were: they were given misinformation, and/or they felt forced or pressured into the abortion. (Franz (1992, p.170) recommends improving education to cover abortion.) "They [students] should be provided with very concrete information and be helped to think through all the implications of the decision....be encouraged to avoid rushing into a decision without careful analysis of all
possible options." What better way to provide such information than through neutral ground in school where the student can learn about all aspects before being faced with such a personal decision.

In Kisker’s article, "Teenagers Talk About Sex, Pregnancy and Contraception," "school was the most frequently cited" (1985, p.85) source of information and "teaching in all public junior high schools is surely advisable" (p.89). Pregnant teens regardless of their "ultimate plan for pregnancy resolution can benefit from prenatal care, counseling, and education, especially when these are part of a comprehensive service delivery program" (Weinman, Robinson, Simmons, Schreiber, & Stafford, 1989). The author proposes to develop a comprehensive manual on pregnancy, abortion, parenting and adoption which can either be used in conjunction with existing programs or be used on its own (Compton, 1990).

Irving B. Harris' (1992) article, "Prevention versus Intervention," recommends for school implementation to "develop the child’s awareness of the consequences of personal behavior, develop a sense of responsibility, work on the unspoken causes i.e.– motivational, attitudinal, and societal, and integrate family life education into all areas of the curriculum." (Harris, 1992, p. 1). (This corresponds to adolescent abortions and pregnancies) (Educators need to
equip their students with accurate information and critical thinking capabilities in order for them to make wise decisions for their own being.) The State of Wisconsin Legislative Council on Teenage Pregnancy Prevention recommended a human growth and development course which includes abstinence, prenatal development, abortion, responsibility, consequences for both male and female, and decision making skills (Sweet & Russell, 1991).

Need for Adoption and Options Education

Many students know the choices they have concerning teenage pregnancy: parenting, adoption or abortion. Yet, there are alternatives which should be examined. It is therefore necessary for students to know all options available to them, so that they can choose the best one for their situations (Franz & Reardon, 1992). There is very little research available on this topic, but a few sources do exist.

Kallen, Griffore, Popovich and Powell (1990) gathered information from adolescent mothers and their mothers' view of adoption, along with adolescents who released their baby for adoption. The researchers found that adolescents who released their baby for adoption were more positive toward adoption than adolescents who kept their babies. This was due in part to a lack of understanding of the adoption procedures and details. Both groups viewed open adoption
more positively than closed adoption. While "releasers" were more positive than "keepers", due to a lack of understanding, all were positive about open adoption. Since knowledge and information was mixed, it should be expounded upon or taught (pp.314-315). Kallen et al. (1990) recommends that "family professionals must take advantage of the opportunity to provide information, guidance and counseling in support of open adoption."

Crittenton Services (Weinman et al., 1989) did a two year study of 474 pregnant adolescents whose ages ranged from 10-20 years. The majority were in the 14-17 year old group. They examined three main groups: parenters, adopters and switchers. Crittenton wanted to see what program changes were needed to best meet the group of switchers. About half of all who planned to place for adoption switched after the birth of their babies. Adoption planners and switchers were more apt to come in late for counseling, had less prenatal care, and had low birthweight babies. They also had more psychological problems, parental drug and/or alcohol abuse, and contained more minority clients. It is necessary that education be stressed in regards to parenting and adoption to provide these girls with the foundation of decision making skills and proper knowledge of parenting and adoption in order for them to make and accept the lifelong impact of their decision. This can be taught in a
comprehensive program that addresses adoption, parenting and abortion (Weinman et al, 1989, p.53).

There is a high correlation between teenage pregnancy and low socioeconomic, minority status. Many of these girls must drop out of school to provide for their children (Compton & Hughes, 1990). Since most do not have established job skills at such a young age, a cycle of poverty results. (Harris, 1992). Also, many of these babies will have a higher degree of special needs to be met than the general population. The special needs are due to lack of: proper nutrition during the mother’s pregnancy and after birth, appropriate stimulation given to the child, and a healthy environment. Adolescent mothers are not taught in school what is appropriate stimulation for the developmental stages or how to prepare food for the infant and toddler. Also, many lack the resources and finances necessary to provide the basics. However, one option that could alleviate this cycle of poverty is adoption. By being able to choose the parents and place the baby for adoption this would not only benefit the baby, but the birth mother as well by giving her the opportunity to finish her education and hopefully break the poverty cycle. Education could help inform students of the possibility of adoption and its benefits for both mother and child (Sweet & Russell, 1991).

Although adoption is a known alternative, there are
several resources available that are unknown or unused such as maternity homes that provide housing and job training, and several assistance programs ranging from daycare, food, and finances. Also, there are Pregnancy Centers that provide counseling, maternity and baby clothes, baby furniture, baby supplies, and medical referrals, and some provide medical assistance, free pregnancy tests, and referrals for financial aid. Abortion clinics (i.e. Planned Parenthood, Family Planning) provide pregnancy terminations, free pregnancy tests and birth control devices (condoms and birth control pills). By not presenting all available options to our youth, educators are taking away their freedom to choose what is best and appropriate for them. We need to be open minded and truthful about all aspects of teenage pregnancy, abortion, parenting and adoption if we are going to help our teens learn about their sexuality and freedoms. So students will be responsible persons of society.
AIM AND GOALS OF THE PROJECT

The aim of the project is for the adolescent student to learn critical thinking skills and apply them towards the knowledge learned about adolescent sexuality, pregnancy, abortion, and adoption. This will hopefully reduce the number and frequency of teenage sexual encounters, pregnancies and abortions by empowering the student with the necessary knowledge and skills.

GOALS: The student will:

1. list the consequences of teenage sexuality.
2. describe the consequences of teenage pregnancy.
3. identify main aspects of teen parenting.
4. list the consequences and impact of adoption.
5. explain the consequences and impact of abortion as an adolescent.
6. recognize and apply the social and economic impact of his or her decision in regards to pregnancy.
7. recognize and apply the social and economic impact of his or decision in regards to parenting.
8. recognize and apply the social and economic impact of his or her decision in regards to adoption.
9. recognize and apply the social and economic impact of his or her decision in regards to abortion.
10. apply the developmental stages and limitations of adolescence in regards to teenage parenting.
11. identify and apply the developmental stages and limitations of adolescence in regards to teenage adoption.
12. recognize and apply the developmental stages and limitations of adolescence in regards to teen abortions.
13. know the legal aspects regarding sexual freedoms, privileges, and rights.
14. know the legal aspects concerning teenage pregnancy and parenting.
15. know the legal aspects of adoption and abortion.
16. identify the historical importance concerning teenage pregnancy and parenting.
17. explain the historical importance regarding sexual freedoms, privileges and rights.
18. identify the historical importance of adoption and abortion.
19. describe the role of the teenage father in regards to his rights of parenting, child support, assistance and abortion.
20. locate the resources available to them in their society regarding pregnancy, parenting, adoption and abortion.
STATEMENT OF OBJECTIVES

This project is designed for high school students in social science, psychology, sociology, economics, government, American history, and health education. The reason for the diversity is so all the main aspects of pregnancy, parenting, abortion, adoption, and resources may be addressed as comprehensively and succinctly as possible. This is a resource manual that teachers, parents, and students may be able to use in the classroom or individually. This project could be adopted at the middle school level. However, due to some of the sensitive information presented in the manual it is best suited for the older adolescent. Discretion should be used if adopted at the middle school level.

The major objectives of the project are: to encourage critical thinking skills in relation to sexuality; to present the facts to students about teenage pregnancy, parenting, adoption and abortion and encourage them to examine and analyze the causes and reasons given; to reflect upon the consequences of each action taken; and for students to be able to make the best decisions as they continue to mature into responsible young adults.

The final objective is to help empower students and have them know that only they can stop the abuse in relationships and prevent teenage pregnancies.
OBJECTIVES OF THE PROJECT

PREGNANCY OBJECTIVES: The student will:

1. identify at-risk groups and at-risk behaviors for adolescent pregnancies.
2. know gestational stages of pregnancy and describe the main development of each stage.
3. determine the cost of having a baby and parenting the child for the first year.
4. learn the psychological impact of teenage pregnancy and parenting and explain the main factors adolescent parents are faced with.
5. describe the cycle of poverty and extrapolate on ways to break the cycle.
6. visit a teen pregnancy program or a pregnancy center and write about their experience.
7. identify social services available to the adolescent parents.
8. identify the legal responsibilities of adolescent parents.
9. write a narrative from both the mother and father's perspective of how or why they got pregnant and whether they would choose to parent the child based upon the information learned.
ADOPTION OBJECTIVES: The student will:

1. learn the psychological impact of adoption and explain the motivating reasons adolescents choose adoption.
2. explain how adoption is the alternative option to abortion and parenting.
3. identify and explain the main characteristics of closed adoption, open adoption, and private adoptions.
4. interview an adoption agency or someone who has been adopted and write of their experience.
5. use the information on adoption, and write a narrative about adoption from the releaser’s point of view and how it affected their life.
6. write a letter from the releaser to the child whom they released and what they hope for or want for the child in his/her life.
7. identify resources available to the teenagers who released their child for adoption.

ABORTION OBJECTIVES: The student will:

1. identify at-risk groups and at-risk behaviors for adolescent abortions.
2. examine the methods of abortion and explain how and when such procedures are performed.
3. list and argue the main reasons for choosing an abortion and compare those reasons in favor of or against legislating abortion, as well as explain any
discrepancies in thought and logic.

4. learn the psychological impact of abortion on teenagers, what the short-term and long-term impacts are, and list ways to deal effectively with them.

5. visit an abortion clinic and write about their experience, or they will read a chapter in "Sweet Illusions" and do the assignment at the end of the chapter.

6. identify their legal rights concerning abortion and their parents or guardians.

7. identify social services available to adolescent aborters, their parents, and their partners.

8. identify the best method of birth control and give supporting reasons for it.

9. write a narrative of a girl's reason to abort based upon the information learned, or they will write a narrative from the partner's point of view.
SUMMARY OF THE PROJECT

There is a growing rate of teenage pregnancies each year despite the various programs for pregnant minors (Christopher & Roosa, 1990, p.68). The National Center for Health Statistics estimated that 1.1 million pregnancies each year occur in minors, and 42% of these pregnancies end in abortion (Griffin-Carlson & Mackin, 1993). The author wishes to deal with teaching adolescents about pregnancy and abortion, not just sex education (Christopher & Roosa, 1990). Students understand the concept of sex, yet too often they do not understand the consequences of sex (Harrington-Luekker, 1991).

Therefore, the author will provide a resource manual on the facts, consequences, and alternative options available to the adolescent. It is the author's desire that by providing such material students will be able to make an informed decision regarding pregnancy and abortion (Compton & Hughes, 1990). The chapter topics will cover: (a) physical aspects of pregnancy and abortion (b) the psychological impact on pregnant and post-abortive minors (c) social and economic aspects of teen parenting and abortion, (d) the historical and legal aspects of reproductive freedoms, (e) and the resources available to the adolescent.
The San Bernardino Unified School District Curriculum Coordinator, Dee Torango, along with Redlands' Curriculum Coordinator, Dr. Raumin, Yucaipa's Mr. Jessop, Colton's Donna Wickman, and Fontana's Dr. Nancy Walsack said there is no established curriculum regarding abortion and pregnancy other than the chapter in Health Education on sex and pregnancy. When asked, "If a curriculum that covered pregnancy and abortion in light of the social, historical, economic and physical aspects were made available to them, would they consider it a valuable resource and use it?" All said they would, provided that it was done without the moral questions involved.
DESIGN OF THE PROJECT

This project is designed around five main topics: (1) health, (i.e. human growth and development, surgical procedures), (2) psychological impact of teen pregnancy, parenting, adoption and abortion, (3) social and economic impact of abortion and teen parenting, (4) historical and legal aspects of teenage pregnancy, parenting, adoption and abortion, and (5) resources available to the student. This project can be used: (1) as a resource manual; (2) or in each related field of study where the teacher can adopt the whole section as a unit; (3) throughout the course at the appropriate time of study.

Due to the nature of topics covered in this project, it is important for the educators and students to set aside their personal beliefs and examine the facts. Once examined thoroughly, a decision can be made in regards to personal beliefs. Basing beliefs on ignorance, false information or hearsay may one day fall apart. It is important to know what one believes are and why they believe them. One can defend their position and live with it knowing these issues have been thought out thoroughly. It is the author's hope that teens would not be confronted with a teen pregnancy or abortion so they can enjoy their youth. Until then, the author wishes to best equip our students with necessary and important knowledge so students can best enjoy their lives.
CHAPTER TWO

PROJECT

PHYSICAL ASPECTS OF PREGNANCY AND ABORTION

Menstruation

When a girl becomes a woman her body changes in order for her to one day become a mother. Certain changes occur such as the growth of breasts, hair under her arms and in the pubic area and onset of menstruation (Martin, 1991, p.22).

A woman carries eggs (ova) in her two ovaries inside her body. They are located on each side of the uterus (womb). Each ovary is connected by the Fallopian tubes to the uterus. Each month one egg matures, it then bursts from the ovary (ovulation) and passes into the Fallopian tube travelling down the tube to the uterus.

If the egg is not fertilized by a sperm within 24-48 hours after it has left the ovary, the egg will begin to break down and exit the body in the normal flow of fluid from the vagina. Prior to this time the uterus has been preparing to receive a fertilized egg. Hormones have thickened the wall of the uterus to nourish the fertilized egg. When no fertilization occurs, the lining of the uterus sheds through the vagina. This process is called menstruation (The Diagram Group, 1978, p.15). The menstrual period occurs every 24 to 32 days on average and lasts from
3 to 5 days in length. Most women experience a 28 day menstrual cycle. In other words, every twenty-eight days counting from the first day of last period to the first day of the next period a new menstruation cycle will begin.
Figure 1: Menstruation
Illustrated by Eric Beatty
Figure 2: Ovulation
Illustrated by Eric Beatty
Conception

When sperm are deposited in or near the opening of the vagina and one of them meets a ripe egg in the Fallopian tube, conception occurs. Next, the fertilized egg travels through the Fallopian tube and begins dividing its cells at 24 hour intervals at first. Cell division becomes more rapid with each day. Once the fertilized egg exits the Fallopian tube it enters the uterus. It will continue to divide and grow while floating in the uterus. It is necessary to float around the uterus until it grows out of its protective covering. Once the covering is shed, it will attach itself to the uterine wall which will nourish the baby embryo (an unborn child is called an embryo the first two months of life). Next, the woman will miss her period and suspect she is pregnant. At no other point in time can life begin except at the point of conception when the sperm and egg meet (Diagram Group, 1977; Kiester & Kiester, 1990). It is human from the onset of conception and will not produce anything else but a human life (Diagram Group, 1977).
Figure 3: Fertilization

Illustrated by Eric Beatty
Figure 4: Implantation
Illustrated by Eric Beatty
Stages of Pregnancy

A pregnancy is usually counted from the first day of the last menstrual cycle. However, ovulation must first occur in order to become pregnant, which is generally 10 to 16 days after a menstrual cycle. The number of weeks a woman is pregnant is between 38 and 42 weeks, the average being 40 weeks. It should be noted only 10% to 20% of women have their baby on the exact due date (Graham, 1991, p.15).

During the first two months of pregnancy the baby is called an embryo which signifies the early developmental stage of life (American Heritage Dictionary, 1981, p.325). At no other time will the baby grow more rapidly than when it is in its mother womb. At two months of age the baby is called a fetus, since the major features of its body have appeared (Curtis, 1989).

Following is a breakdown of the forty weeks of pregnancy:

Month One: 0 to 4 1/2 weeks:

Fertilization occurs. If the sperm that penetrates the egg carries a Y chromosome, a boy is conceived. If the sperm carries an X chromosome, a girl is conceived. The first cell division happens within 24 hours after conception. The fertilized egg travels down the Fallopian tube to the uterus where it will implant itself on the uterine wall. At week three the brain begins to form, and
the heart begins pumping blood. The blueprint for every
major organ and tissue is laid down by the chromosomes. By
four weeks the embryo is 1/4 inch long and the woman misses
her period for the first time (Martin, 1991).

Month Two: 4 1/2 to 9 weeks:

At five weeks the eyes, nose and mouth are beginning to
show. By the sixth week he/she is a 1/2 inch long, his/her
spinal cord is present, vertebrae develop, and ribs, muscles
and sweat glands start to form. By eight weeks the baby is
1 1/2 inches long. Everything the baby needs when it enters
the world has already been formed. The following months
allow the body’s system to mature.

Month Three: 9 to 13 1/2 weeks:

He is 2 1/2 to 3 inches in length and weighs 1 ounce.
The stomach, liver and pancreas begin to work. The baby’s
own bone marrow produces blood cells. The arms and legs are
developed. The baby can hiccup, kick and move its arms. The
immune system is established (Martin, 1991; Curtis, 1989).

Month Four: 13 1/2 to 18 weeks:

He or she is now 4 to 6 inches in length and weighs 8
ounces. The facial features are forming, and the eye is
well developed. The hairline is established. Hands are
able to grasp each other. Nails are beginning to grow. The
bones are calcifying from cartilage to bone. Movements of
the baby may be felt by the mother (Curtis, 1989).
Figure 5: Prenatal Development Months One through Four
Illustrated by Eric Beatty
Month Five: 18 to 22 1/2 weeks:

He or she weighs approximately 1 pound and is 9 inches long. The ear is fully formed. Vernix on the skin develops to protect from getting scratched, waterlogged or chapped. The head hair, eyebrows, and fine body hair, or lanugo, grow. Most sonograms are performed during this month to measure the baby and make sure it corresponds with the due date. It is also possible to see what sex the baby is via the sonogram (Diagram Group, 1977; Kiester & Kiester, 1990).

Month Six: 22 1/2 to 27 weeks:

The baby weighs 1 pound at the beginning of the month and will weigh approximately 2 pounds by the end of the month. He or she will grow from 11 to 15 inches by the end of the month. He or she now opens and closes its eyes and sucks its thumb. It takes a rest period on growth (Educational Programs, 1991; Martin, 1991).

Month Seven: 27 to 31 1/2 weeks:

The baby weighs between 2 1/2 to 3 pounds and is 14 to 17 inches in length. The nervous system is now capable of controlling body temperature. Hiccups by the baby may be felt by mother. The baby continues to grow and gain weight (Curtis, 1989; Martin, 1991).
Figure 6: Prenatal Development Month Five
Illustrated by Eric Beatty
Figure 7: Prenatal Development Month Six
Illustrated by Eric Beatty
nervous system developed

Figure 8: Prenatal Development Month Seven
Illustrated by Eric Beatty
Month Eight: 31 1/2 to 36 weeks:

The baby now weighs between 3 1/2 to 6 pounds and is 16 to 18 inches in length. He or she begins to gain fat under the skin. The digestive tract and lungs are fully matured. The bones are calcified. The brain cells form more rapidly than at any other time in a person's life. The baby continues to grow in length (Diagram Group, 1977; Martin, 1991).

Month Nine: 36 to 40 weeks:

The baby continues to gain weight at a rapid speed. Weight gain is 1/2 to 1 pound a week until delivery. Therefore, the range is between 5 1/2 to 10 pounds by delivery. The length is from 16 1/2 to 22 inches at birth. Engagement occurs, this happens when the baby drops into the birth canal. Some women lose a few pounds right before the birth of the baby. Also, there is a possibility of losing the mucus plug a few weeks before birth. The final step is labor and delivery (Kiester & Kiester, 1990; Martin, 1991; Tumulty, 1990).
Figure 9: Prenatal Development Month Eight
Illustrated by Eric Beatty
Figure 10: Prenatal Development Month Nine
Illustrated by Eric Beatty
Labor and Delivery

There are three stages of labor.  
**Stage 1** is broken into two phases: the latent phase and the active phase.

Latent phase: This phase lasts the longest of all the stages. Labor begins generally with contractions but may begin with the rupture of membranes. Contractions are spaced far apart from 5 to 30 minutes, and last only 15 to 40 seconds at a time. With each contraction labor progresses causing the cervix to dilate and efface.  
Dilation is opening or widening of the cervix to 10 cm.  
Effacement is the thinning out of the thick cervical muscle.  
During the latent phase the cervix dilates to 3 cm.

Active phase: In this phase the contractions get stronger, last longer in duration and are spaced closer together. Contractions may last 1 to 2 minutes and have intervals of 1.5 to 3 minutes between them. The active phase is over when the cervix is dilated to 10 cm.  
**Stage 2:** Dilation and effacement are completed. This is the stage where the baby is pushed through the birth canal and may last as long as four hours although it usually is two hours or less. Once the baby’s head appears, or "crowns," birth is emminent. Now the doctor may perform an episiotomy to prevent tearing of vaginal tissue or to relieve undue pressure on the baby’s head. Finally, the
baby is pushed through the birth canal and out into the world. Next, the umbilical cord will be cut.

Stage 3: This is the shortest part of labor, lasting about fifteen to twenty minutes, during which time the placenta separates from the uterine wall and is delivered (Educational Programs, 1991).

Congratulations on the birth of your baby!

After birth is complete, it is common to experience afterpains. This is your uterus contracting back down. It will take approximately six to eight weeks to get back to its normal size. Afterpains generally are not felt in first time mothers, but often in succeeding births (Educational Programs, 1991).
Figure 11: Dilation
Illustrated by Eric Beatty
Figure 12: Labor and Delivery Stage One
Illustrated by Eric Beatty
Figure 14: Labor and Delivery Stage Three
Illustrated by Eric Beatty
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Definition of Abortion

(There are several types of abortions that are commonly used during pregnancy termination.) (First, abortion is defined according to Webster's New International Dictionary as the: "Act of giving premature birth, specific, the expulsion of the human fetus prematurely, particularly at any time before it is viable or capable of sustaining life (Guralink, 1984, 2nd Ed.).) (According to the New American Heritage Desk Dictionary, abortion is defined as: "Any fatally premature expulsion of an embryo or fetus from the uterus; miscarriage" (New American Heritage Desk Dictionary, 1981, p.3).)

There are two ways abortion can occur. The first is called naturally spontaneous, or referred to as a miscarriage. (The baby dies prematurely in the womb.) The second way an abortion occurs is artificially induced. The mother decides to terminate her pregnancy using one of several methods. These are commonly called abortions.

The methods of artificial abortions shall be examined along with the risk factors involved by undergoing the surgery. (Depending upon the stage of pregnancy the method of abortion will vary.) (There are three trimesters of pregnancy.) The first trimester lasts from week one through week thirteen and a half. The second trimester lasts from thirteen and a half to twenty-six weeks. The third trimester
lasts from twenty-six to forty weeks or until labor and delivery.

Methods of Abortion

Endometrial Aspiration. This method is performed during the first two weeks after a missed period. (The disadvantage of this method is that it may be too early to detect a pregnancy, therefore it may be an unnecessary procedure.)

The equipment used is a cannula (flexible plastic tube) attached to a mechanical pump. The procedure consists of passing the cannula through the cervix (the entrance to the womb or uterus) into the uterus. Once inside the uterus the lining of the uterus is suctioned out along with the tissue of the human embryo (Diagram Group, 1977; National Abortion Federation [NAF], 1990; Reiser & Klein, 1993).

Dilation and Evacuation. Dilation and evacuation is also referred to as D & E, vacuum curettage, suction abortion, or STOP (Suction Termination Of Pregnancy). This is the most common method used and is done during the seventh to twelfth weeks of pregnancy (NAF, 1990).

The preparation needed for surgery requires the woman not to eat six hours before the surgery. The woman’s blood type is also checked in case a blood transfusion is needed.

The procedure begins with a speculum (metal instrument that opens the vagina) being inserted into the vagina giving the doctor a clear view of the cervix. Next, an anesthetic
is given, which can be either a general or local anesthetic. Thirdly, metal dilating rods are introduced into the cervix to open it. This is done because during pregnancy the cervix closes tight to protect the baby from infection, disease and harm. Finally, the human fetus is extracted from the uterus. Once the procedure is completed, the woman is taken to a recovery room for a couple hours of observation. This procedure used to be done in hospitals but is now performed mostly in clinics (Diagram Group, 1978; Reiser, 1993).

There are certain precautions a woman needs to be aware of after an abortion procedure. Strenuous activity should be avoided at least for a couple of days. (Also, it is normal to bleed and shed the uterine lining that provided nourishment to the human fetus. This can last between one to four weeks. However, if severe bleeding and cramping persist seek medical help. This should not be confused with menstruation. Menstruation will start four to six weeks after surgery. Also, intercourse and tampons should be avoided for two to four weeks after the procedure to prevent infection.)
Figure 15: Abortion Technique Endometrial Aspiration
Illustrated by Eric Beatty
Figure 16: Abortion Technique Dilation and Evacuation
Illustrated by Eric Beatty
Dilation and Curettage (D & C).

This is the only method used between twelve and fifteen weeks of pregnancy. D & C is more complicated to perform than a D & E. Since it is more painful, it requires a general anesthetic. Finally, it carries more risk of infection and perforation of organs.

The steps of a D & C are similar to a D & E. First, the blood type is checked on the woman. Next, the general anesthetic is given to the woman. Thirdly, the speculum is inserted into the vagina. Fourth, the cervix is dilated with dilating rods. Once the cervix is dilated a curette (a sharp knifelike scoop) is introduced into the uterus. The curette scrapes and disassembles the human fetus which is then suctioned out with a vacuum aspirator. It is necessary to use a curette since the bones of the fetus have begun to calcify (Diagram Group, 1977; NAF, 1990, April).
Figure 17: Abortion Technique Dilation and Curettage

Illustrated by Eric Beatty

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**Induced-Labor Abortions** (Saline and Prostaglandin).

(This is used for late term abortion. The most common technique is to induce a miscarriage.) The woman goes through childbirth but will deliver a dead baby. This is very distressing for the woman compared to earlier forms of abortion since the women goes through labor and delivery (Tumulty, 1990).

The procedure is a long series of events. First the woman is under local anesthetistic. Secondly, amniotic fluid is withdrawn from the womb. Next, fluid is injected into the womb which is usually saline or prostaglandin. This fluid will kill the human fetus by burning its organs and produce a miscarriage. Within the next 6 to 48 hours after the injection the woman will deliver the dead fetus. Often, she is sent home to wait until labor begins and then is readmitted to the hospital where she will be placed in the labor and delivery section of the hospital to deliver a dead human fetus (Diagram Group, 1977).
Figure 18: Abortion Technique Induced-Labor Abortion

Illustrated by Eric Beatty

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Hysterotomy.

A hysterotomy is used for late term abortion and is generally performed if the saline or prostaglandin abortion has failed to cause a miscarriage. A hysterotomy is the same procedure as a caesarean section with the exception that the umbilical cord is cut before the fetus is removed. The umbilical cord is cut in order to cut off oxygen and nutrients to the human fetus causing it to suffocate in the amniotic fluid. Once it has been determined the human fetus is no longer alive or viable it is then removed through the incision along with the placenta (Diagram Group, 1977).

This type of surgery carries the same risks of a caesarean-section, including infection of the uterine cavity, scar tissue and puncture of organs.
Figure 19: Abortion Technique Hysterotomy
Illustrated by Eric Beatty
Dilation and Extraction (D & X). This is for late term abortions after 32 weeks. The procedure requires three days because the woman's cervix has to be greatly dilated. The first two days are spent opening the cervix with laminaria. The third day is the actual procedure. During which an ultrasound is used to find the leg of the fetus so the doctor can bring it down into the cervical opening and use it to turn the baby face down, toward the woman's spine. The baby's legs, torso, and arms are brought out through the cervix until only the head remains inside. The head is too large to pass through the cervical opening at this point. So, a pair of blunt nosed scissors are then used to puncture a hole in the base of the skull so a suction tube can be inserted to remove the contents. This is done to deliver the skull through the cervix. Finally the placenta is removed with forceps and the uterine wall is scraped out. The risks are not formally assessed since this is a new procedure. Few abortionists use this method in the United States (Reiser, 1993).

The reason for doing this procedure this way is the legal aspects. A fetus or baby is legally considered live when the head is delivered first. If it is still alive after an attempted abortion, the abortionist is bound by law to help preserve its life. Therefore, compressing the skull by means of suction guarantees a successful abortion.
Figure 20: Abortion Technique Dilation and Extraction
Illustrated by Eric Beatty
PSYCHOLOGICAL FACTORS AND
IMPACT ON TEENAGE PREGNANCY, PARENTING,
ADOPTION, AND ABORTION

There are several psychological factors that influence minors to get pregnant and parent, abort, or place their child for adoption. The following is a list of the main motives or reasons why a teen has chosen a particular pathway. Due to the individuality of each pregnancy, the list is in no way inclusive.

**Pregnancy**

One in four women will get pregnant by age 18, and four out of ten will get pregnant by age 20 (Reiser, 1993). Most girls that get pregnant early do so out of ignorance of the male and female anatomy. They have idealistic thoughts such as "It couldn't happen to me" or "I only did it once."

There is a plethora of other reasons. As we have seen earlier, it could be to get out of an abusive relationship, to relieve loneliness or rejection, to feel loved or secure, to keep a relationship from ending, or for economic reasons, for success, for rebellion, or for developmental factors (McCullough & Sherman, 1991, p.812). The majority of young ladies say they had sex because they loved their boyfriends (von der Hellen, 1990), yet they did not think they could get pregnant due to the infrequency of intercourse (Kisker, 1990, p.84). Most teens can not accurately tell when is the
fertile time of a woman's menstrual cycle (Kisker, 1985).

There may be developmental factors in which the adolescent feels or thinks he/she is invincible. The teen may be sexually active because he/she is trying to gain autonomy and independence from the family by acting as an adult in regards to sexual behavior. Mirkin and Koman (1985) state "When parents ignore, deny, or reject teenagers growing sexuality the risks for premature or excessive sexual activity are greater (p.8-9)." However, most do not understand the responsibility that goes with the decision to have intercourse.

Parenting

The girls who decide to continue with their pregnancy will, in general, parent their children. Very few will place their children for adoption, (approximately four percent). (Lindsay, 1987, p.11). The majority of births are out-of-wedlock, with little hope for marriage (Ooms & Owen, 1991). Seventy-three percent of teen mothers will need welfare assistance within the first four years of their children's life (Reiser, 1993). Richard Hanson (1990) in his article "Initial Parenting Attitudes of Pregnant Adolescents and Comparison With the Decision About Adoption," used the Adult-Adolescent Parenting Inventory (AAPI) to examine the initial attitudes. The results were that keepers (parents) scored lower regarding expectations...
of children, which means they had unrealistic expectations for what their children should be able to do at a particular developmental stage. They also had a greater disposition toward corporal punishment and would use it as their primary means of discipline. Yet, they did score higher than the placers and control groups on empathy which means they were more caring about and for their children. This should be used as a building block to encouraging young parents to learn appropriate discipline methods and developmental stages (Robinson, 1988; Vukelich & Kliman, 1985). (See Appendix D for developmental stages).

Abortions

(Many do not realize the permanence of their decisions, partly due to their own developmental limitations.) Their only concern is to get out a situation they do not want to be in or have others to find out about (Griffin-Carlson, & Mackin, 1993). Immaturity was another main reason for teens obtaining an abortion. They felt they would not be able to parent the child or release it for adoption (Alan Guttmacher Institute, 1993). Many recognized the financial limitations they would experience if they had the baby. Therefore, they reason that if they can’t take care of the child, then no one will. One last reason is that the boyfriend or romantic partner wants them to obtain
an abortion. This is especially true if the partner is married or has other children because he does not want to be held responsible for another child (Robinson, 1988). "Many girls do obtain abortions to continue their relationship with their partners (Alan Guttmacher Institute, 1989)."

For girls that do not want abortions but are being coerced into one, here are some suggested ways to offer them help.

1. First of all, it is illegal to obtain an abortion under coercion. It is considered child abuse if parents make or force their daughter to abort her pregnancy against her will.

2. Provide counseling. If she is religious encourage her to seek religious counseling if she desires. Many churches provide free counseling and do not require a particular church affiliation.

3. Show her the options of adoption and parenting.

4. Provide medical and financial aid referrals for help available to her (Franz & Reardon, 1992).

5. Show her that in a few years no one will remember or care that she was a young parent. Pregnancy is a relatively short period of time when one compares it to an entire lifetime.

6. It is a decision she has to live with for the rest of her life. The other people involved now may not be there in the
long run. Her choice will be permanent either way she decides.

**Adoption**

Teens who choose adoption typically are advanced developmentally in so far as they are able to view their future with greater understanding and relate how what happens today may effect them tomorrow. Therefore, many feel optimistic about placing their child for adoption by rationalizing that they are also giving their child a future to enjoy. Many of the girls realize their limitations socially and economically. By choosing adoption they will not be hindered in their future by raising a child and can continue along the path they had choosen (Warren & Johnson, 1989; Weinman et al., 1989; Kallen et al., 1990).

**Reasons For Becoming Sexually Active or Pregnant**

1. Curiosity: teens wanted to see what sex was all about.
2. Loved boyfriend: girlfriend wanted to express love in an intimate way to her boyfriend (Kisker, 1985).
3. Gain independence: By doing adult things hopefully they will be treated as adults.
4. Loneliness: a pregnancy insures there will be another person to care for and love, and to be loved in return.
5. Rejection: If father figure was neglectful many seek for attention and love elsewhere. (McCullough & Scherman, 1991).
6. Abuse: victims hope pregnancy would stop the abuser due
to appearance of pregnancy and a new child.
7. Security: teens wanted to marry their sexual partner.
8. Approval or success: teens reason that having and caring for a child proves they can do something right and worthwhile. Many cultures regard motherhood with high honors.
9. Rebellion: teen wanted to get even with parents or show the parents that they are in control.
10. Ignorance: they thought pregnancy would not occur.
11. Helplessness: victims of sexual abuse often feel or think they are to give in to the demands of their partner or abuser.
12. Economic: adolescent wanted to be independent and get financial assistance.
13. Drugs or alcohol: teen was under the influence of drugs or alcohol.
14. Culture: A rite of passage or a taboo of their culture.
15. Idealism: adolescent hoping pregnancy will change problems for the better.
17. Unplanned/Crisis Pregnancy: pregnancy may be due to abuse, failed contraceptive method, no contraception protection or rape (Franz & Reardon, 1992).
18. Problem solving: many teens think pregnancy will solve life's problems or the problems will go away once pregnant.
Reasons Why Teens Obtain Abortions

1. Convenience: her pregnancy was undesirable, did not plan for it and did not want to be pregnant. This reason is cited most often (AGI, 1989; NAF, 1990, August).

2. Economic: she has no means to support herself or a child, or does not want governmental support.

3. Shame or embarrassment: she does not want anyone to know she was pregnant, or bring shame to herself or the family. She may be embarrassed to be seen pregnant.

4. Future: she has her life planned out and does not want to be hindered from her goals by being pregnant or caring for a child (Warren et al., 1989; Weinman et al., 1989).

5. Fear: afraid parents or boyfriend may get upset at her or harm her if they found out she was pregnant.

6. Immaturity: she is not ready to be a parent, and she lacks the needed skills and maturity (Kisker, 1985).

7. Relationships: she aborts the pregnancy to keep her boyfriend or partner.

8. Blackmail: she threatens abortion to get what she wants, she may not be serious about the abortion but wants to be heard or get what she feels she needs.

9. Rape or abuse: a few cases result in pregnancy due to rape or sexual abuse. This is because the woman's uterine wall changes its acidity level during a sexual assault killing the sperm. It also causes a hostile environment in
the uterine lining so the fertilized egg cannot implant itself resulting in a natural miscarriage. Also, if the woman seeks medical attention immediately after an assault a therapeutic D&C is often times performed to scrape the sperm out of the uterus, and the woman is given a spermicide to kill any remaining sperm. Less than three percent of all rape cases end in pregnancy, yet a few do take place (Reiser, 1993).

10. Health of the mother. At risk of losing both mother and child if abortion is not performed (i.e. tubal pregnancy which will cause death to both the mother and baby).

11. Family of pregnant minor does not support her decision for continuing the pregnancy.

12. Ignorance: adolescent was unaware of what abortion procedure entailed and its side effects.

13. Lack of information: she did not know other options were available to her concerning her pregnancy.

14. Birth defect detected in pregnancy. She did not feel she could take care of a handicapped child.

15. Sex selection: parent(s) did not want a boy or girl, so they aborted it to try again for the desired sex.

Psychological Aspects After an Abortion

Initially women feel relief since the immediate crisis is over. However, in long range studies many women regret their decision and suffer from Post Abortion Syndrome (PAS).
2. Post Abortion Syndrome is often diagnosed as Post Traumatic Stress Syndrome since many symptoms are the same. The symptoms may include: depression, guilt, shame, nightmares, chemical dependency, inability to maintain relationships, frigidity or promiscuity, eating disorders, overinterest or disinterest in children compared to before the abortion, or having an atonement baby to make up for the loss or guilt felt from the abortion (Speckard, 1985).

3. Ambivalence may be felt towards self and life goals.

4. Denial. Generally a pregnancy or abortion is a symptom of a larger problem rather than the problem itself. Sexual abuse may be a key factor in denial since 41 to 61 percent claim to have been a victim of abuse.

5. Adolescents who felt forced or rushed into the decision, or given little time to decide often times struggle after their abortions (Franz & Reardon, 1992; Speckard, 1985).

6. Women felt later that the information given was incorrect and/or incomplete. Some women feel very resentful towards the counselor for being biased and not sharing both sides of whether to continue the pregnancy or not (Tumulty, 1990).

Reasons Why Teens Choose Adoption

1. Teens who choose adoption often are encouraged or supported by their families to place the child for adoption. Mothers of pregnant teens have the most significant impact
in their daughters' decision concerning adoption (Herr, 1989).

2. Many pregnant teens feel they are not ready to be parents.

3. The birth mother wants a better life for the child and herself.

4. The teen who lacks family support to help the parent her child will often place the child for adoption (Herr, 1989).

5. The birth mother does not want the child raised in an abusive situation or unhealthy surroundings.

6. Birth mother is optimistic about giving the child a better start in life than what she could provide. Also, she is optimistic about her future and does not feel limited in her pursuits (Kallen, 1990).

7. She can not follow through with an abortion, but doesn't want to parent either, so she chooses adoption. Pregnancy may be from a violent assault.

8. The birth parents want to act responsibly and assume ownership in their decision. (Warren, 1989).

9. The birth parents were appropriately educated regarding adoption rights and responsibilities, and felt adoption was the best decision (Kallen, 1990).

**Sexual Abuse and Pregnancy**

Eighty percent of minors who become pregnant are single girls living at home with a single parent. 2,700 girls get
pregnant every day. Of those, 50% will carry, 42% will abort, and 8% miscarry (Reiser, 1993). The psychological impact on a pregnant minor varies greatly from excitedness to fearfulness. There are girls who desire to be pregnant and pursue it, yet most are assuming they will not get pregnant. Therefore, abstinence should be stressed as the only method of preventing pregnancy, as well AIDS and various sexually transmitted diseases (Colson, 1993; Christopher & Roosa, 1990).

There is another group of women who need to be examined in light pregnancy. These are victims of sexual abuse, incest and rape (Bucholz & Gol, 1986). At least 41% and as high as 61% of pregnant teens report they have been sexually abused at least once in their lifetime (Butler & Burton, 1990; McCullough & Scherman, 1991). Many girls who have repeat offenders hope that by getting pregnant and "looking fat" it the abuser will stop.

Sexual activity as a victim of abuse may be caused by overwhelming stress or feelings of helplessness which were generated by sexual abuse (McCullough & Scherman, 1991, pp. 810, 812). It is very important for teens to determine why they are seeking or participating in sexual activity. Intervention is needed for the pregnant teen who has been abused (Bucholz & Gol, 1986). First, report the case to the proper authorities. Next, provide professional counseling to
the woman or give her a referral. One must enable the women to move from the mindset of victim to victor. Here are some suggested methods of preventing and dealing with sexual abuse taken from Butler and Burton (1990, p.79).

Methods of Preventing and Treating Sexual Abuse

1. Develop a safe context for talking about sexual abuse.
2. Foster a positive self-worth about females. Provide positive female role models.
3. Teach that they are worth protecting and are not secondary to others.
4. Teach prevention of sexual victimization (i.e. how to say no and enforce it). Teach physical defense mechanisms, especially since many girls have been assaulted by peers or romantic partners.
5. Enable the girl to report the abuse, and if known, identify the abuser in order to stop the abuse. No one deserves to be abused, it is not the victim's fault and should not be viewed as such.
6. Encourage the positive attributes of the girl and her decision for motherhood. Also, reinforce the positive and needed skills for being an effective parent (Bucholz, 1986, p.357).

See Appendix F for more information on sexual abuse.
SOCIAL FACTORS AND ECONOMIC RESOURCES

Social Factors

There are several social factors that correlate to teenage pregnancy. An astonishing eighty percent of teen mothers come from single parent homes. Also, culture, economics, peers, and education play major roles in a minor’s pregnancy (Schwartz, 1991; Flamer & Davis, 1990).

Single parent homes are one major factor correlating to teen pregnancies (B. Williams, 1992). This fact is especially true if the household is led by a female. The reasoning for this, is that females tend to work longer hours to maintain the same level of income as their male counterparts, which results in less time to be involved in their children’s lives. Many parents feel it is not necessary to provide childcare for a teen which leaves the teen unsupervised much of the time to do whatever he or she chooses. In turn this may encourage the teen to seek out relationships to reduce boredom and may result in increased sexual activity. Also, role modeling may play a part in the teen’s decision (i.e. If it was o.k. for mom to be a single parent, it’s o.k. for me too.). (Flamer & Davis, 1990; Schwartz, 1991; Robinson, 1987).

Cultural considerations need to be looked at for their influence on teen pregnancy. As was previously noted many single households are from women who were teen mothers as
well (B. Williams, 1992; Flammer & Davis, 1990). It is socially acceptable in the African-American and Hispanic communities to be young mothers. Yet, in the Asian communities it is unacceptable to be a young mother out of wedlock because it brings shame upon the household. In the Caucasian community it is a split as to whether or not it is socially acceptable.

Media and peers are also an influence on teens since most sexual acts depicted on television are between unmarried adults or between a married person and a single person. Also, the popular idea that everyone engages in sexual acts can influence young teens. Peer pressure plays a role in a teen's decision to become involved. Many times sleeping with someone is a requirement to be part of a group. This is true more so with gangs than with other groups. Peer pressure may be also used to prove one's love for another in order to continue the relationship (Flammer & Davis, 1990).

Education and future aspirations are generally low among teens at risk of becoming pregnant. They are not considered necessary as a means of financial security in the future. Many students who become pregnant drop out of school before or on the birth of their child. It has been hypothesized that it is a result of continual failure of achievement in school thereby causing the teen to search for
success in relationships which often resulted in pregnancy. Consequently, the pregnancy itself may have become a good reason for the student to drop out of school. Since many teen mothers did not have high aspirations for their future or plans for college (B. Williams, 1992; Freedman, 1990).

Low income is another corollary of teenage motherhood. Many feel trapped by the cycle of poverty, and fail to realize the available resources for them (Freedman, 1990). This is especially important in regards to college and post high school training (i.e. R.O.P.). Failing to see other financial options many girls have children in order to receive governmental assistance that otherwise they would be unable to receive. If states do not provide a limit to the number of children per household on governmental assistance, many young mothers will not take precautions from becoming pregnant again, knowing they will receive more aid (Flammer, 1990; Ooms & Owen, 1991).

Due to such limitations as mentioned above, it is necessary to educate teenagers on how to overcome them. Here are some suggested ideas from the author to give to teens:

1. Do not stay at home with only your boyfriend or girlfriend. Go somewhere where there will be peers and adult supervision. Examples of this might be getting involved in sports, getting a job after school until it is time to go
home, going to the library and reading or doing homework, going to a community center, or joining a youth or support group.

2. Although it may be culturally acceptable to be a young mother, find other role models whom you like and respect. Ask if you could spend time with them or have them help you get involved in what they are doing.

3. Do not believe everyone that says they are sexually involved or follow in their footsteps. Many times this is a bluff or a trap to see how easily influenced you are, and whether they can take advantage of you. You do not have to be like everyone else; be yourself and take pride in who you are as a person.

4. Make a list of things you want to do in the near future or what you want to do after graduating high school. Post the list in a familiar place where you can see them daily. Then go and research what will be required of you to obtain your goals and how long it will take. Make a progress chart for yourself and begin your path for success.

5. Achieve your goals and encourage others by to do the same. Or, help or teach others what you have learned from your experiences.

6. Take special classes that can be turned into a job thereby providing economic success.

7. Get counseling if needed, especially if there is
physical, sexual, psychological, or chemical abuse in your family. There are several free support groups and counselors available.

8. Volunteer your time in areas that are of special interest to you. This provides hands-on experience and helps others, generally making you feel better too.

Resources Available

There are several resources available to help lessen the cost of pregnancy and motherhood. If one qualifies for Medi-Cal or Medicare the cost of prenatal care and delivery are covered by the state. If one does not qualify for Medi-Cal, the woman and her family may qualify for AIM (Access for Infants and Mothers), in which the family pays a small portion and the state pays the remainder of the bill. Many doctors and hospitals provide a cash discount on their services if paid in cash before the child is born. Also, many hospitals and doctors have payment plans available that will suit the patient’s needs.

There are AFDC (Aid to Families with Dependent Children) and WIC (Women, Infant and Children) available to those who qualify. AFDC provides monetary support for housing and utilities while WIC provides food supplements for women and children. There are also non-governmental agencies that provide help in a variety of ways including medical services, food, clothing, furniture, baby supplies
and housing. In the back of this book is a list of available resources of where to call and who to ask for.

The following pages are a list of prices for prenatal care, labor and delivery, and abortions. Also, there is a list of other items or services that one may be needed during pregnancy and after the birth.
Table 1: Price List for Prenatal Care

<table>
<thead>
<tr>
<th>Providers **</th>
<th>Prenatal Care*</th>
<th>Caesarean Section*</th>
<th>Assistant for C-Sect*</th>
<th>Sonogram*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Women to Women, San Bndo</strong></td>
<td>$2,000.00 or 20% discount if paid by 8th month.</td>
<td>$2,500.00 this includes prenatal care</td>
<td>$500.00</td>
<td>$200.00</td>
</tr>
<tr>
<td><strong>Dr. Kumar, San Bndo</strong></td>
<td>$2,000.00 or 20% discount if paid by 8th mo.</td>
<td>$2,500.00 this includes prenatal care</td>
<td>unknown</td>
<td>$185.00</td>
</tr>
<tr>
<td><strong>Dr. Hordynski Redlands</strong></td>
<td>$1875.00 or $50.00 per visit, or $ 2 0 0 . 0 0 discount if paid by 7th month</td>
<td>$2,200.00</td>
<td>unknown</td>
<td>$225.00</td>
</tr>
<tr>
<td><strong>Loma Linda Univ. OB/GYN</strong></td>
<td>$1,888.00 no discount</td>
<td>$2,985.00</td>
<td>unknown</td>
<td>$70–235.00 dependent upon insurance</td>
</tr>
<tr>
<td><strong>Temecula Valley OB/GYN, Temecula</strong></td>
<td>$2,100 or 15% discount if paid by 30th week</td>
<td>$2,700.00</td>
<td>$675.00</td>
<td>$225.00 50% discount for cash patients</td>
</tr>
<tr>
<td><strong>Average Cost</strong></td>
<td>$1,972.60 or 1715.64 with discount</td>
<td>$2,577.00</td>
<td>$587.50</td>
<td>$158.5 to $214.00</td>
</tr>
</tbody>
</table>

* These prices do not include lab tests, hospital fees, specialty tests, medical equipment, medicine, or supplies.
** Prices compiled August 1994.

Key: **Prenatal Care** – the 40 weeks of pregnancy, plus the labor and delivery and six week post partum check-up.
**Caesarean Section (C-Sect)** – a necessary surgery for a safe delivery of the child.
**Sonogram** – a diagnostic test that aids the doctor in seeing inside the womb to check the due date and possible problems.
<table>
<thead>
<tr>
<th>Hospitals **</th>
<th>L.D.R.*</th>
<th>Epidural *</th>
<th>Caesarean Section*</th>
<th>Extra day*</th>
<th>NICU One day*</th>
<th>Nursery *</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Bndo Community</td>
<td>$2,040.00</td>
<td>N/A</td>
<td>$3,800–$7,500</td>
<td>$400–$700</td>
<td>1188</td>
<td>370</td>
</tr>
<tr>
<td>Saint Bernardine's</td>
<td>$3,000.00 w/insur.</td>
<td>$1,000</td>
<td>$3,800 for 3 days or $4,300 for 4 days</td>
<td>$800 for mom and baby</td>
<td>1100 to 1500</td>
<td>N/A</td>
</tr>
<tr>
<td>Redlands Community Hospital</td>
<td>$2,600.00</td>
<td>included in LDR price</td>
<td>$7,500 for 3 days</td>
<td>$1100 mom and baby</td>
<td>1000 to 1870</td>
<td>600</td>
</tr>
<tr>
<td>Riverside Community</td>
<td>$3,000.00 w/ins.</td>
<td>included in LDR price</td>
<td>$7,500 w/ ins. $3,800 w/o ins.</td>
<td>$300</td>
<td>1000</td>
<td>300</td>
</tr>
<tr>
<td>Loma Linda Univ.</td>
<td>$2,300.00</td>
<td>included in LDR price</td>
<td>$5,900 for 3 days</td>
<td>1,000</td>
<td>2310</td>
<td>370</td>
</tr>
<tr>
<td>Inland Valley Regional Medical Center</td>
<td>$2,700 w/ins.</td>
<td>$385.00</td>
<td>$4,950 for 3 days or $5390 for 4 days</td>
<td>500 for mom</td>
<td>move to LLUM</td>
<td>300</td>
</tr>
</tbody>
</table>

KEY: L.D.R.=Labor, delivery and recovery.  
Ins.=Insurance.  
N/A= not available.  
N.I.C.U.=Neonatal Intensive Care Unit.  
*These prices do not include doctor fees, speciality equipment, lab tests, medicine, or supplies.  
**Prices compiled August 1994.
<table>
<thead>
<tr>
<th>Abortionist**</th>
<th>First Trimester*</th>
<th>Second Trimester*</th>
<th>Third Trimester*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Planning of Riverside</td>
<td>$275.00 awake or $305 asleep</td>
<td>$650.00 minimum, can be much higher</td>
<td>$1,600.00 minimum, can be much more</td>
</tr>
<tr>
<td>Family Planning of San Bernardino</td>
<td>$275.00 awake or $305 asleep</td>
<td>Does not perform abortions after 13 weeks at San Bndo.</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Price does not include: complications, hospital fees, lab tests, repeat abortions if failed the first time, special equipment, medicine, or medical supplies.

**Prices compiled August 1994.
Table 4: Miscellaneous Fees

Here is a list of possible items or charges that may be encountered during pregnancy and post-partum, as well as for the child and its care.

**During pregnancy and delivery:**
- maternity clothes
- maternity support belt
- laboratory tests – glucose and blood
- diagnostic tests – sonogram
- lactation consultant
- medication – vitamins/insulin
- anesthesiologist

**During post-partum and recovery:**
- sanitary pads
- lactation consultant
- breast feeding bras
- medicine
- breast pump
- breast pads

**Infant needs:**
- baby clothes
- receiving blankets
- infant formula
- baby toiletries
- doctor visits
- immunizations
- circumcision
- bottle caps
- crib
- diapers
- changing table
- diaper pail
- crib blankets
- diaper bag
- pacifier
- bottles
- bassinet
- baby food
- sheets
- bottle brushes
- diaper wipes
- bottle nipples
While it is important to determine what the current laws are in regards to abortion, it is necessary to examine how the past has met this challenge. The timeline will begin with the seventeenth century and lead up to the present day.

1600 and 1700's

In the 1600 and 1700's if a woman became pregnant out of wedlock, the male responsible for the pregnancy either had to pay child support or marry the woman. It may sound odd that he would marry her, but many men promised marriage in order to seduce a woman into a physical relationship. Therefore, upon the woman's pregnancy the man must either honor his word and marry the woman, or pay monetary compensation for the predicament he placed the woman in. It is interesting to note that the man was shunned by the community and looked down upon, while the woman did not lose standing in her community. This was due to the belief that women were weaker and therefore should be protected from such deception and trickery. Also, the community helped the woman to raise her child if she was a single mother.

If a man tried to cause the woman to miscarry or abort the child he would face severe charges of either manslaughter, murder, or negligence. The sentence could range from a fine to imprisonment. Often times it was hard to prove if
the man was guilty due to lack of evidence, witnesses, or bribery. Many men even paid the woman off to keep from going to jail.

Since pregnancy frequently led to marriage with its provision of social and economic protection few women would attempt mid term abortions. Most did not even know they were pregnant until the second trimester because there were no pregnancy tests available to them. Since late term abortions were very dangerous to the mother despite her desperation, many women waited until birth to kill the baby. This is known as infanticide. There are occasional incidents cited but no reliable statistics. The few women that did resort to abortion or infanticide had neither family nor friends to fall back on for support (Olasky, pp. 36,37). There were only four reported cases between 1794 to 1836 in South Carolina (J. K. Williams, 1959, p.54).

1800’s

In the 1800’s urbanization began and the apprenticeship system began to decline. Masters started to treat servants more as hired hands than family members. Servants were less likely to be children of friends of the family and more likely to be immigrants from New England, Ireland, Canada or the Netherlands. Furthermore, seduction and abandonment of women rose as towns began to grow, and a single woman’s family was often not present to press the man for marriage
when extra-marital activity resulted in pregnancy (Olasky, p. 38). However, "at no time was abortion considered legitimate and legal, but the practice did occur when some women fell through the cracks, taking their unborn children with them" (Olasky, p. 41)

Prostitution was another factor that contributed to an increase in abortion in the late 1800's. There was a dramatic increase after the civil war in abortion and prostitution. Prostitution was the largest contributor to abortion despite its illegal nature at the time. It was a big temptation to become a prostitute since these women made three to four times the pay as did a factory girl or seamstress. Many prostitutes were given lavish gifts which would take a long time for most moderate women to purchase.

It is estimated that 100,000 out of 160,000 abortions obtained were by prostitutes. Due to the introduction of birth control devices such as the condom and diaphragm during the late 1800's the abortion and pregnancy rates among prostitutes fell and remained relatively low through 1960.

1900's

By the 1900's abortions were more commonplace in the big cities and remained illegal until 1973. However, laws were making it tougher to convict abortionists. In some states before 1973 abortion was legal but only for the
physical health of the mother. (This would include tubal pregnancy and cancer.)

The risks of complications from abortions dropped in the 1930's after the introduction of penicillin and sulfa drugs which combat infections. It has been noted that it was not the legalization of abortion that reduced the risks involved. It was rather the advancement of medicine and pharmacology that led to a decline of abortion related ailments. The maternal mortality rate dropped from six percent to one to two percent (Olasky, 294).

Throughout the first six decades of the 20th century, unmarried women often placed their children for adoption, or married the father during the pregnancy. Married couples used birth control which also kept the abortion rate down. It is important to note that many relief organizations provided help to women in crisis pregnancies. By 1860 there were 250 maternity homes established throughout the United States and carried on into the 1900’s. (In Appendix I is found a list of help available today.)

Technology did not change the rate of abortion, it was the change in values that begun in the 1960’s. The sexual revolution made premarital or extramarital affairs and its pregnancy consequence a mainstream activity. "The employment revolution of the 1970’s made the major economic loss that could result from pregnancy a major concern" (Olasky, 85)
p.295). In order for women to compete with men in the work force, many decided to abort their pregnancy to avoid a loss of income. The advent of birth control led to the belief that pregnancy could be eradicated, and now women could be sexually active outside of marriage. The idea became popular that women were now liberated from the home and on equal turf with the man. In the 1960's marriage was viewed negatively as a "confining tradition." These attitudes were most evident on college campuses and persons who were eighteen years or older.

In 1973 *Roe v. Wade* was brought before the Supreme Court of the United States, and became the landmark case ruling in favor of abortion. The intent of the decision was to narrow the use of abortion to such cases as rape, incest or the health of the mother. However, the Supreme Court defined health so broadly that it, in effect legalized abortion through all nine months of pregnancy. The court described reasons for a woman's decision to terminate her pregnancy:

Specific and direct harm medically diagnosable even in early pregnancy may be involved. Maternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by child care. There is also the distress, for all
concerned, associated with the unwanted child, and there is the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it (Goldman, 1987, p. 234).
Synopsis of Court Decisions Concerning Abortion

Roe v. Wade, 410 U.S. 113 (1973) (7-2)

Abortion was legalized through all nine months of pregnancy for the health of the mother which entails physical and mental well being.


The Supreme Court decided that neither the parents of a minor nor a husband can veto an abortion decision. (In California, a girl 12 or older may obtain an abortion without her parents knowledge or consent.

Poelker v. Roe, 432 U.S. 519 (1977)

"A city providing services for childbirth at public hospitals need not provide services for non-therapeutic abortions as well."


A state does not violate the Equal Protection Clause when it excludes abortion from the medical procedures that it funds.


The Supreme Court decided states may require parental consent only if states provide judicial bypass.

Harris v. McRae, 448 U.S. 297 (1980)

The Supreme Court upheld the Hyde Amendment to bar use of federal Medicaid funds for abortion except to save the
mother's life. The Court also ruled that both state and federal governments are not required to pay for abortions. **Planned Parenthood, Kansas City, Missouri v. Ashcroft, 462 U.S. 476 (1983)**

States may require a second physician in attendance at post-viability abortions and may require pathology reports by pathologists after all abortions.

Requirements that parents consent before minors have abortions are constitutional if there is an expeditious bypass procedure that permits minors found mature to make their own abortion decisions and that requires judges to approve abortions for immature minors when those abortions are in the minors best interest. **H.L. v. Matheson, 450 U.S. 398 (1981)**

States may require parental notification of unemancipated minors to be notified before receiving an abortion. **Thornburgh v. American College of Obstetricians, 106 Supreme Court 2169 (1986) (5-4)**

Informed consent is unconstitutional. States may not require physicians to convey certain information before abortions when the information is designed to dissuade women from having abortions. **Webster v. Reproductive Health Services, 492 U.S. 490 (1989)**

States may include "findings" in statutory preamble that human life begins at conception. They may disallow
public facilities and public personnel for elective abortions. States may require tests, where appropriate in medical judgement, to determine the viability of fetuses believed to be at least 20 weeks old. Roe’s trimester framework is too rigid, and states may protect potential life before viability.

**Hodgson v. Minnesota 58 L.W. 4957 (1990)**

States may not require that both parents be notified (where practical) forty eight hours before minors receive abortions, unless there is provision for expeditious judicial bypass of notification.


The Supreme Court gave approval to information regulations applying to publicly funded Title X family planning clinics. The government may use its funds to discourage abortion. This prohibited recipients (clinics) of Title X Family Planning funds from counseling or referring persons for abortion. This has been reversed under the Clinton Administration.

**Planned Parenthood v. Casey (1992)**

The Supreme Court upheld in Pennsylvania the following: (A) informed consent, (B) 24 hour waiting period before an abortion, and (C) parental consent. It did not uphold the spousal notification requirement.
Adoption

A minor who is pregnant may consider and choose adoption for herself and child. There are two routes one can take for adoption. The options are agency (or closed adoptions) and private or (open adoptions).

Agency Adoptions

When a person goes through an agency for adoption the birth parent(s) first go through counseling to make sure this is the best decision for themselves and their child. If the decision is made to go through with an adoption, the birth parents will relinquish (surrender, release) their child to the adoption agency. The agency will ask the birth parents about their concerns, beliefs, and desires for their child and what type of family they desire for the child. Once the baby is born and the relinquishment papers are signed, the agency will place the child with a carefully selected family. In some agency adoptions, the birth parents never meet the adoptive parents. Many times the birth parents do not know their baby’s new parents’ names, nor do the adoptive parents know theirs. However, birth parents who deal with an agency usually have some choice in the family who will receive their child. The case worker generally describes several families or has the birth parents read anonymous files by prospective adoptive parents. Once the birth parents relinquish their rights to
the child, it is considered final, unless there is a stipulated time period that is either state mandated or part of agency procedure. The waiting period is generally 45 days in case the birth mother or birth father change their mind. Most do not change their mind if they had been given good objective counseling.

Open Adoption

Independent or open adoption by definition means, adoption in which the birth parents select the adoptive family. It is highly recommended by Warren (1988) that the birth parents seek out professional help from an independent adoption agency rather than doing this single-handedly. A private adoption agency interviews and selects prospective adoptive families as well as counsels them and also does follow-up checks in the home to insure that the family are worthy to be adoptive parents. The birth parents who desire to place their child for adoption are also counseled thoroughly to make sure this is the best decision for them and the baby. Once this is established, the birth parents are given various files to read through on prospective families that will match up with the birth parents attitudes on parenting, discipline, desires and wishes for their child. Once the birth parents have selected a family they can meet with them as little or as much as desired to determine if this is the family they want to care for their
child. If not, they can continue to interview until they decide upon a family to best suit their child. The adoptive parents can pay medical and legal costs incurred by the birth mother in order for the child to be received by the adoptive parents. The adoptive parents may also pay a portion of her living expenses if it pertains to maternity. The bills and receipts are usually sent to a lawyer or the judge presiding over the case, anything other than legal, medical or immediate living expenses before, after or during hospitalization is considered illegal payment.

Once the birth parents have chosen a family, they can then stipulate in their contract a desire if any letters and pictures and sent to them, any visitation rights they desire (such as coming over on Christmas), a desire to send letters or gifts periodically. Most of this type of correspondence drops off within the first one to two years of the child’s life. Yet, this correspondence is important and often necessary for the birth parents to insure they made the best decision for the baby. Photos showing the child is taken care of and happy can reassure birth parents. Many times the birth mother writes a letter to be given to her child when he or she is ready to know why they were placed with this family. The adoptive parents many times want the child to know who their mother was to lessen anger or hurt, in which case the letter is a very precious gift to the child.
Adoption Laws

If a pregnant women is between 12 and 18 the permission of her parents is not required to place her child for adoption. But, before the birth mother can place her child for adoption, both the birth mother and birth father must sign relinquishment forms. If the mother does not know the father or refuses to name him, a thorough search must be made before the court can terminate his parental rights. Otherwise, the father may surface later and complicate the adoption procedures.

There are two types of fathers, "presumed" and "alleged" as set forth in the California Uniform Parentage Law. A man who has lived with the mother, is married to her when the baby is born, or was married to her 300 days or less before the birth he is considered the presumed father. If the mother does not wish to keep the child, he has a right to custody. Before the child can be placed for adoption both must sign relinquishment forms or court action must terminate parental rights. California Civil Code 7004(a)(4) states a man may be presumed to be the father if "he receives the child into his home and openly holds out the child as his natural child."

If a man does not meet the requirements of the presumed father, he may be considered the "alleged" father. This happens if the mother names him on the birth certificate.
The child can not be released for adoption until the alleged father either denies he is the father, waives in writing his rights to notice of the adoption hearing, or signs relinquishment for adoption. A presumed father has legal rights; an alleged father's rights are determined by the court unless he waives his rights for that determination. The court action is called a 7017.

Grieving after Adoption Placement

Although a birth mother may have thoughtfully decided that adoption was best, she still has lost a child and needs to grieve that loss. During pregnancy the birth mother receives much attention from the adopting parents. Yet, after relinquishment the adoptive family has begun a new life which typically does not include her. The birth mother finds herself returning to a situation where those around her don't provide the opportunity for her to talk through her painful emotions. Birth fathers also experience this grief, but it may come much later than that of the birth mothers. It is recommended that the birth mother write out all the reasons for choosing adoption before she delivers and to pack this in her bag to the hospital for her to look at and review. This list can reassure her despite various emotions after delivery, that it is the best decision for both child and mother. It is also recommended that she hold the child after delivery or at least see it before it is in
his or her new home. By doing so, this helps gives closure to the adoption. It is considered emotionally healthy to see the baby and helps complete the adoption in a positive way. The baby is not a stranger, and it helps reinforce whatever decision has already been made (Warren, 1988, p.129). Yet, it is ultimately up to the birth mother to decide.

It is also recommended by Warren (1988) that the birth mother make a scrap book of the baby momentos she receives, press the flowers people send her, and save the birth bracelet and anything else received for the birth or for herself. Parents and friends of the birth mother are encouraged to send cards, gifts, and flowers to the birth mother and support her now that her decision is made. Otherwise, this can be too overwhelming for her. She may begin to doubt that adoption was the best decision despite all her reasons. If family and friends are unable to talk with her about the grief she feels, it would be wise for her to seek out a pregnancy counselor, post-adoptive mother, or therapist to walk with through the grief process. Although the grief is painful, it does not mean the decision was bad or wrong, just that the birth mother has lost the child to whom she had given birth.
APPENDIX A

Exercise During Pregnancy Guidelines

Adapted from "Can I be excused from gym? I'm pregnant" (Solberg, 1988).

1. Seek medical care as soon as possible. Make sure the doctor verifies it is alright to exercise.
2. Maintain good posture during exercise, thereby reducing back and abdominal pain.
3. Weight management: Eat healthy. Appropriate weight gain is 25–35 pounds. Any more or less and you may be jeopardizing your health and your child’s. Be careful—soon enough you’ll get your body back.
4. Exercise: Do non-weight bearing or low impact aerobic exercises such as low-impact aerobics, walking, swimming or cycling.
5. Exercise three times per week. Rest. If you need more time take it. Don’t risk injury, and be sure to listen to your body.
6. Keep your heart rate at 70% of your maximum heart rate; 140 or lower beats per minute.
7. Do 5–10 minutes of warm-up, 20–30 minutes of aerobic workout and 5–10 minutes of cool down. Make sure to stretch well. Not stretching is the major reason for pain and injuries.
8. Do muscular strength exercises, especially for the legs,
abdominal and lower back areas.

9. Post partum exercises: Concentrate on regaining strength, especially in the abdominal and pelvic regions.

10. Post-partum weight loss: Don’t rush this. It took nine months to gain the weight. It may take nine months to lose it. Concentrate on good nutrition, strength building exercises and recovery. It will come off, just give yourself time to recover, get adjusted to your baby and the new schedule. Then deal with your weight.
APPENDIX B

Infant and Child Nutrition

Newborn to 3 months:

Newborns need only breast milk or formula. The baby will cry or fuss if she is hungry. It is commonly figured that babies should have about three ounces of formula for every pound of their bodyweight during a 24 hour period. Roughly 21 ounces for a 7 lb baby to 27 ounces for a 9 lb baby. Yet, allow the child to tell you what it needs. It is not recommended to give newborns to 3-month olds any solid food, cereal, juice or fruit. Never sweeten a bottle with honey as it can cause botulism and death in infants. They are unable to digest honey, and their bodies fight against bacteria found in it.

An important note regarding newborn infants: it is not good for them to sleep through the night until they are about 2 months old or older. The reason is that their stomachs can only hold about 3 ounces of milk at a time and their bodies will use all of it’s calories after four hours from the time of feeding. Yet, it is more important to look at the child’s overall health, growth and development. If these are within range, don’t worry about the baby’s feedings.

Breast milk is best. Yet, if you choose a formula, read the labels. The contents of many formulas are almost
identical; only the prices are different. The author recommends Gerber Infant formula.

4 to 6 Months:

Once your child is drinking the maximum his stomach can hold, which is roughly 7-8 ounces at a time, and has doubled his birthweight, he is probably ready for first foods. Introduce one food at a time for a 3-7 day period to make sure he is not allergic to it and that he likes it.

First foods generally are:
- rice cereal with formula
- rice cereal with blended vegetables (peas, green beans, sweet potatoes, squash)
- rice cereal with blended fruit (applesauce, pears, peaches, bananas)

Do not force feed a child. They need to learn that it is an enjoyable experience.

Tips on spoonfeeding

Hold a tiny spoon to baby’s lips and let her suck off the contents. If she likes it, she will continue to eat.

If you are putting too much food on the spoon or putting the spoon too far back in her mouth, she may gag, or you may force her to swallow thereby not giving her time to taste and decide whether she likes it or not.

If you put the food on the front of the baby’s tongue, it will just dribble out. She cannot get it back far enough
to taste or swallow.

Place the food on the spoon and in the middle of her tongue allowing her to suck the food off. When done properly, it is much cleaner and easier for both parent and child.

6 Month to 1 Year - Solid Foods:

Baby cereals should include rice and oatmeal cereals. Until baby can chew, mash or blend food so she will not choke. You can also start introducing table food into her diet.

1 to 2 1/2 Years (Toddlers):

Most table foods are fine now. Make sure the food is cut into bite-size pieces, so the toddler can pick it up and chew it. It should be a balanced diet. Stay away from extra sugars and fats.
Table 5: INFANT FEEDING CHART

<table>
<thead>
<tr>
<th>Foods</th>
<th>0-3 months</th>
<th>4-7 months</th>
<th>8-12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Milk or Formula for 0-12 Months</td>
<td>Breastfeed frequently (eg, every 2-4 hours), up to 32 fl oz a day.</td>
<td>Breastfeed on demand 27-40 fl oz a day.</td>
<td>Breastfeed on demand 24-32 fl oz a day.</td>
</tr>
<tr>
<td>Cereals and Breads</td>
<td>none</td>
<td>Iron-fortified single grain cereal (starting w/rice) at 4-5 months, mixed with formula, breast milk, or water. Feed with a spoon. Wait until baby can sit up before feeding teething biscuits.</td>
<td>Oatmeal, wheat, mixed cereal, crackers, toast, oat rings, rice, pasta.</td>
</tr>
<tr>
<td>Fruit Juice</td>
<td>none</td>
<td>Infant 100% fruit juice (apple, pear, etc). No citrus or tomato. Offer juices from a cup.</td>
<td>100% fruit juices. Tomato and orange may be included.</td>
</tr>
<tr>
<td>Fruits and Vegetables</td>
<td>none</td>
<td>Wait until 5th month. Offer cooked, strained, or mashed mild-tasting vegetables: squash, carrots, green beans, peas. Both vegetables and strained or mashed fruits should be given daily. No added salt or sugar.</td>
<td>May begin soft raw fruits and soft cooked vegetables or potatoes. No added salt or sugar.</td>
</tr>
<tr>
<td>Foods</td>
<td>0-3 months</td>
<td>4-7 months</td>
<td>8-12 months</td>
</tr>
<tr>
<td>-----------------</td>
<td>------------</td>
<td>------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Protein Foods</td>
<td>none</td>
<td>none</td>
<td>Ground or finely cut meat, or poultry. Use lean, no fat or bones.</td>
</tr>
</tbody>
</table>

(MeadJohnson Nutritionals, 1991)
## APPENDIX C

### Table 6: Child Development

<table>
<thead>
<tr>
<th>Age</th>
<th>Gross Motor</th>
<th>Personal Social</th>
<th>Fine Motor</th>
<th>Language</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 mo</td>
<td>Lifts head from prone (lying on stomach)</td>
<td>Smiles responsively</td>
<td>Hands tightly held</td>
<td>Throaty sounds</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Follows to midline</td>
<td>Responds to noise</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Regards face or toy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2mos</td>
<td>Prone: head up 45 periodically</td>
<td>Smiles without prompting</td>
<td>Follows past midline</td>
<td>Vowel sounds</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3mos</td>
<td>Prone: head up 45 sustained</td>
<td>Gets excited</td>
<td>Hands open or closed</td>
<td>Coos</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>loosely</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Follows 180</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4mos</td>
<td>Prone: head up 90 sustained</td>
<td>Recognizes bottle on sight</td>
<td>Hands together in midline</td>
<td>Laughs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Head steady sitting</td>
<td></td>
<td>Reaches for toy, takes to mouth</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5mos</td>
<td>Prone: Chest up Supine*: grasps foot Rolls prone to supine</td>
<td>Smiles at self in mirror</td>
<td>Prone: scratches bed or table</td>
<td>Squeals</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Picks up toy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Takes toy with both hands</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6mos</td>
<td>Sits leaning on hands Rolls supine to prone (back to stomach) Takes foot to mouth</td>
<td>Talks to self in mirror</td>
<td>Rakes object Bangs toy up and down</td>
<td>Same vowel sounds</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Knows stranger from family</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Resist pull toy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7mos</td>
<td>Sits without support Pivots in circles</td>
<td>Works for toy out of reach Feeds self crackers Bites and chews toys</td>
<td>Transfers picks up two toys at a time</td>
<td>Single consonant sounds</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Responds to &quot;NO&quot;</td>
<td></td>
</tr>
</tbody>
</table>

104
<table>
<thead>
<tr>
<th>Age</th>
<th>Gross Motor</th>
<th>Personal Social</th>
<th>Fine Motor</th>
<th>Language</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>8mos</td>
<td>Pulls to stand/Sits holding on</td>
<td>Holds own bottle</td>
<td>Thumb-finger grasp</td>
<td>Imitates speech/sounds/same</td>
<td></td>
</tr>
<tr>
<td>9mos</td>
<td>Crawls/Sitting to prone</td>
<td>Initially shy with/strangers/Waves bye</td>
<td>Bangs toys together/Pokes with/index finger</td>
<td>Mama,Dada non-specific/one other word</td>
<td></td>
</tr>
<tr>
<td>10mos</td>
<td>Creeps</td>
<td>Plays pat-a-cake</td>
<td>Supported pincer grasp</td>
<td>Mama, Dada, specific</td>
<td></td>
</tr>
<tr>
<td>11mos</td>
<td>Cruises-stands momentarily/Sitting: pivots in circles</td>
<td>Unsupported pincer grasp</td>
<td>Shakes head &quot;no&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12mos</td>
<td>Stands alone well/Takes a few steps/Walks with 1 hand held</td>
<td>Helps in dressing/Points/Kisses on request</td>
<td></td>
<td>Mama, Dada plus two other words</td>
<td></td>
</tr>
</tbody>
</table>

*Supine: lying on back. (Pediatric Medical Group, 1994).
APPENDIX D

Immunization Plan

Recommended by the American Academy of Pediatrics:

2 months - DPT, oral polio vaccine
4 months - DPT, oral polio vaccine
6 months - DPT, (oral polio vaccine optional)
12 months - tuberculin tests
15 months - measles mumps rubella
   (MMR-given as a one shot)
18 months - DPT, polio boosters
4-6 years - DPT, polio boosters

Hepatitis B vaccine (HIB) is now given in many doctors offices. Ask your healthcare provider if it is available for your child (Kiester, E.J. and Kiester, S.V., 1990).

Check with your local county department of health for free or low cost immunizations. Riverside County provides free immunizations. San Bernardino County provides immunizations for five dollars for each child, however, one will not be turned away if payment can not be made.
APPENDIX E

Child Safety and Prevention

Prevention is key! You may think it will never happen to your child, but it may. So, please be prepared and alert.

Automobile Safety:

Always use a car safety seat which is approved by the Federal Transportation Committee. Infants weighing 20 lbs or less should be in a safety seat that faces toward the rear. Follow the manufacturer's instructions carefully on how to properly install the safety seat. Read the car owner's manual for any special instructions. Infants should ride in the back seat, in the middle if possible.

Fire Safety:

Smoke detectors should be used on each level of your home, located between bedrooms or in each bedroom. Test detectors monthly. Change the batteries on your child's birthday. Keep two fire extinguishers in your home, one in the kitchen, the other in your bedroom. Make sure the fire extinguishers have a rating of "A B C". This type will put out all kinds of fires (grease, electrical, wood).

Flame Resistant Sleepwear - Wash the product carefully, as soap tends to wash out the flame retardant in the material. Wash in phosphate detergent. Do not use bleach or fabric softener. Do not iron. Borax is a flame
retardant and may be used to restore protection. Make sure crib matress meets fire safety requirements (Varansky, 1994).

Burns:

Never carry a child and hot liquids (coffee, tea) at the same time. Don’t allow children near you while cooking. Use back burners first, and turn the handles of the pots to the side, out of the child’s reach. Set the water heater temperature at 108 degrees farenheit.

When wall or floor heaters are in use, place child in playpen or crib away from the heaters.

Other Burn Prevention:

Use outlet covers for all electric outlets not in use.

Unplug appliances when not in use! Make sure appliance cords are out of reach.

Use cold water vaporizers. Hot vaporizers if spilt may cause burns.

Keep all cleaning chemicals, medicine or hazardous substances in a locked storage area and out of child’s reach.

Don’t allow child to chew on electrical cords.

Falls:

Never leave a child unattended, no matter how small, on a changing table, bed, high chair or other high place. Even infants have enough strength to push with their feet and
overturn themselves in a highchair. Also, when children are older they can climb up to high places but not down.

Make sure stairs are clear of clutter and toys. Use security gates at top and bottom of stairs for children under three years of age. Do not use accordion style gates because some will pinch their fingers. Make sure bannister posts are no more than six inches apart so the child doesn’t fall through them.

**Cribs:**

Make sure the crib mattress is set at the lowest point once the child can roll over. There should be no more than 2 3/8 inches between slats; a coke can should not be able to fit through the slats. If the space is larger, a child’s body may squeeze through the slats while the child’s head remains inside the crib causing the child to suffocate by hanging. Remove any corner post extensions on the crib, because if a child climbs out, his shirt may get caught on it and hang the child. Remove bumper pads and toys when the child is able to stand. Many children have used these as stepping blocks out of their cribs. Use a foam mattress instead of a spring mattress. This cuts down on the amount of height a child will get if he jumps in his crib. Also, place a piece of plywood between a spring mattress and spring box frame to prevent falling out of the crib. There should be two finger widths or less between the side of the
crib and the mattress. Stuff the space with towels or a blanket until there is no more gap. Many children have become stuck resulting in injury and death (Varansky, 1994; Vogel & Manhoff, 1993).

*Infants should be placed on their left side preferably, or on their backs while sleeping to reduce the risk of SIDS (Sudden Infant Death Syndrome).

**Shopping Carts:**

Place the child only in the seat provided. Never leave the child unattended as the child may climb out or the cart may tip over.

**Choking:**

Never prop a bottle while feeding an infant. Liquid will continue to come out even if the child stops drinking.

Keep the child seated while eating. Children should not run, walk or play while eating. Do not give a child food in the car; if they were to choke you may not be able to stop in time. Food should be cut into very small pieces. A child's throat is the size of their little finger. Children under four should not be given peanut butter (it may glue their throat shut); raisins, popcorn, peanuts, grapes, or carrots (if swallowed whole the child may choke); and hot dogs (they can choke on the skin).

Small objects or toys that can pass through a tube of toilet paper are too small for young children. Put small
objects out of reach of children or throw them away. A child should not run or walk while eating a sucker or brushing their teeth.

Balloons should not be given to young children. Uninflated or parts of a balloon are the number one non-food item children choke on and die from. Children may bite or burst a balloon; part of it may go down the trachea (windpipe) causing them to choke. Obstructed airway manoeuvres DO NOT work for balloons, often times resulting in death. Also, if a balloon bursts while the child is holding it, it may cause eye damage such as blindness or burns.

Water Safety

Never leave child unattended in the bath for even a few seconds. Children can drown in just a few inches of water very quickly. Toilet lids should be kept down and if possible locked with a safety clip. Children like to play in water but are top heavy and if they fall in they are unable to get out. Also, any buckets used for washing cars, or floors should be emptied as soon as possible when done. When at a pool or lake, always designate one person to watch your child if you are unable to do so. More children die when they are being watched by more than one person because the one person assumes the other is watching. Most children who drown do so in residential pools. Most fall in by riding a toy into the pool or playing too close to the edge. Invest
in putting a fence around the pool with a gate-key entry lock. Do not use water wings as a safety device. Empty small wading pools after use.

**General Safety**

An infant can suffocate on a waterbed or pillow because the sides may cover the infant’s nose and mouth. Infants can easily become entangled in bedspreads and comforters, and may strangle or suffocate. Therefore, dress the child warmly in flame retardant pajamas and cover with a light blanket (receiving blanket or crib blanket). Plastic bags should be kept out of reach. After use tie a knot in the bag and throw away. A child may suffocate or choke on a plastic bag.

Baby walkers are illegal in daycare centers. This is because of too many injuries, most are head injuries. The author does not recommend buying or using a walker. There are companies that specifically make safety furniture for kids. One the author recommends is Babee Tenda. Play pens should have the sides locked in place and cover over the hinge to prevent injury. Highchairs should be used with caution as well, do not place near a counter, stove, table or wall since a child can push it over using his legs. Highchairs are one of the leading causes of head injuries. Also remove the safety strap from the high chair, it causes more harm than help. Children can slide down out of their
highchair and get entangled in the strap, or if they are crawling under the chair the strap can act like a noose. Therefore, throw away the strap.

Cabinets and drawers should have safety latches installed properly. This is especially true for the bathroom and kitchen where most hazardous chemicals and medicines are kept. Buy a locking medicine cabinet or store cleaning supplies and medicines up high and out of reach (i.e. in the cabinet above the refrigerator). Older children’s toys should be kept away from small children and infants since these toys often contain small parts, which may result in choking (Vogel & Manhoff, 1993).

Teach your child how to dial 911 or the emergency phone number. Learn CPR; it may save your child’s life. Teach your child how to do CPR. Instruct your child how to stop, drop and roll to put out a fire on himself. Locate the Poison Control phone number near your telephone (1-800-544-4401). Never leave your child unattended for any reason unless they are placed in a crib or playpen.

A B C’s of C.P.R.

Airway- lie infant on its back. Position its head. LOOK in its mouth for obstruction. If an object is caught in the throat do not place your finger in the child’s throat because it will cause it to constrict. Listen for breathing. If the object is in the mouth clean it out, being careful
not to lodge it in the throat. If there is no breathing, go to the next step.

Breathing—cover the child’s nose and mouth with your mouth. Give two small, quick breaths. Watch for the child’s chest rising. Continue giving one breath every three seconds until the child starts breathing on her own or until medical help arrives. Have someone call 911 while you are doing C.P.R. Make sure the breathes are small, if they are too forceful they may rupture or explode the baby’s lungs.

Circulation—Check the child’s pulse. If a pulse is present, give one breath every three seconds. If NO pulse is present, start giving five compressions below the sternum using your index and middle finger. After five compressions, give one breath until the pulse comes back, and the child starts breathing. Even if you can’t remember the ratio of compressions to breaths, anything is better than nothing. If you are unsure if a pulse is present, continue with C.P.R. until medical help arrives or the child awakens.
Appendix F

Sexual Abuse Prevention and Intervention

Safety Tips

1. Know your child’s friends and their parents.
2. Never leave a child unattended for any reason.
3. Be involved in your child’s activities.
4. Listen when your child tells you he or she is afraid or does not want to be with someone.
5. Pay attention when someone shows greater than normal interest in your child.
6. Have your child fingerprinted and know where to locate dental records.
7. Be sensitive to changes in your child’s behavior or attitudes.
8. Take a photograph of your child each year. If the child is under age two, take photographs four times each year (every third month).
9. Be prepared to describe your child accurately; including clothing, birthmarks, or special characteristics.
10. Devlope a plan with your child should you be separated while away from home (i.e. go to lost and found, tell an adult who the child knows, tell a worker at a store, find a policeman or security guard).
11. Do not buy items that visibly show your child’s name.
12. Be sure your child’s school or daycare center will not
release your child to anyone other than yourself or someone you officially designate.

13. Instruct the school to contact you immediately if your child is absent or if someone other than you arrives to pick up him or her without advance notice from you.

Symptoms to Watch For

1. Explicit sexual knowledge, (it sometimes is bizarre).
2. Precocious sexually related speech or sexual experimentation.
3. Toilet training relapses.
4. Smearing feces or urine.
5. Gagging or unexplained vomiting.
7. Regressive behavior.
8. Masturbation.
10. Stomache and head pains.
12. Suicidal depression and/or self destructive tendencies.
13. Excessive fear of selected individuals or locations.
15. Unexplained bruises or injuries in genital areas.
16. Blood spotting or unexplained substances on underwear.
17. Abrupt or radical attitude or behavior changes.
19. Stress related disorders: ulcers, colitis, or anorexia.
20. Alcohol or drug use.
21. Frequent nightmares.
22. Excessive passivity.
23. Vaginal or urinary tract infections.
24. Infections of the mouth, gums, throat or rectum.
25. Unexplained gifts, extra money, or the presence of pornography in the child’s possession.
Appendix G

Suggested Reading List


Appendix H

Resources Available

The following is a list of businesses that can provide help, information or resources. The company names will be listed under the subheadings along with their phone numbers. The addresses will be listed in the back.
ABUSE

Christian Counseling Service
(909) 793-1078

D.O.V.E.S. of Big Bear Valley, Inc.
Attn: Janet Trott
(primarily for victims of domestic violence)
(909) 866-1546

Family Service Agency
(909) 886-6737

Family Service Association
Attn: Amy Casil
(909) 793-2673

Fathers of America
Attn: Vertner Vergon
(310) 305-1762

Florence Crittenton Service of Orange County
Attn: Mary Xavier
(714) 680-8200

High Desert Domestic Violence/ Self Esteem House
(619) 242-1468

House of Ruth
(domestic violence)
(909) 988-5559 24 hr. Hotline
(909) 623-4364

Life Network
Attn: Matt Neal or Ronda Perea
(805) 569-3050

Sexual Assault
Attn: Candy Stallings, Executive Director
(909) 885-8884

Southern California Alcohol and Drugs Program, Inc.
(310) 923-4545
ABORTION

Alternative Pregnancy Counseling
Attn: Laura Oliver
(909) 845-6650 24 hr. Hotline

Crisis Pregnancy Center
(818) 830-1200

Life Network
Attn: Matt Neal or Ronda Perea
(805) 569-3050

Loving Options
(909) 799-3994

Pregnancy Counseling Center
Attn: Kimberely Davison
(909) 889-4182
(909) 825-6656 24 hr. hotline
ADOPTION

Alternative Pregnancy Counseling
Attn: Laura Oliver
(909) 845-6650 24 hr. Hotline

Bethany Christian Services
Attn: Jan Viss
(209) 522-5121

Crisis Pregnancy Center
(818) 830-1200

Fathers of America
Attn: Vertner Vergon
(310) 836-1997

Life Network
Attn: Matt Neal or Ronda Perea
(805) 560-3050

Pregnancy Counseling Center
Attn: Kimberely Davison
(909) 889-4182
(909) 825-6656 24 hr. hotline

St. Anne’s
(213) 381-2931

San Bernardino County Adoptions
Attn: Peggy Thomas (San Bernardino)
(909) 387-5253
or
Attn: Anita Blake (Rancho Cucamonga)
(909) 945-3820

Yucaipa CPC
Attn: Deborah
(909) 797-6769
BREAST FEEDING

Ameda/ Egnell Corp.
Attn: Julie Stock
1-800-323-8750
(708) 639-2900

La Leche League—Inland Empire
(909) 783-9081

La Leche League International
1-800-LA-LECHE
(708) 519-7730
Loving Options
(909) 799-3994

CHILD BIRTH CLASSES
CHILD CARE

Buena Vista High School
Attn: Mary Ferguson
(909) 628-9903

Crisis Pregnancy Center
(818) 830-1200

Colton High School
School Age Parenting & Infant Development Program
Attn: Terry Yanez
(909) 876-4183

Family Service Association
Attn: Amy Casil
(909) 793-2673

Florence Crittenton Services of Orange County
Attn: Mary Xavier
(714) 680-8200

Heigh Ho Daycare Center (YWCA)
(909) 884-8157

Provisional Accelerated Learning (PAL) Center
Attn: Dr. Mildred D. Henry
(909) 887-7002

San Bernardino County Schools
Child Development Services
(909) 478-5700
CHILD DEVELOPMENT

Alternative Pregnancy Counseling
Attn: Laura Oliver
(909) 845-6650 24 hr. Hotline

Buena Vista High School
Attn: Mary Ferguson
(909) 628-9903

Colton High School
Infant Development Program
(909) 876-4183

Family Service Association
Attn: Amy Casil
(909) 793-2673

Florence Crittenton Services of Orange County
Attn: Mary Xavier
(714) 680-8200

Inland Counties Regional Center
(for young parents if their child was at risk or suspected of having a developmental disability).
Attn: Carol Cooper
(909) 370-0902

Provisional Accelerated Learning (PAL) Center
Attn: Dr. Mildred D. Henry
(909) 887-7002

St. Anne’s
(213) 381-2931

San Bernardino County Schools
Child Development Services
(909) 478-5700
CHILD SAFETY

Family Service Association
Attn: Amy Casil
(909) 793-2673

Sexual Assault
Attn: Candy Stallings, Executive Director
(909) 885-8884
CHILD SUPPORT

Fathers of America
Attn: Vertner Vergon
(310) 836-1997

Family Service Association
Attn: Amy Casil
(909) 793-2673

Legal Aid
(Family Law matters only)
(909) 889-7328
COUNSELING

Alternative Avenues
Attn: Janet Trenda
(909) 467-2188

Alternative Pregnancy Counseling
Attn: Laura Oliver
(909) 845-6650 24 hr. Hotline

Bethany Christian Services
Attn: Jan Viss
(209) 522-5121

Christian Counseling Service
(909) 793-1078

Crisis Pregnancy Center
(818) 830-1200

D.O.V.E.S. of Big Bear Valley, Inc.
Attn: Janet Trott
(for victims of domestic violence)
(909) 866-1546

Fathers of America
Attn: Vertner Vergon
(310) 836-1997

Family Planning Program
(909) 383-3020

Family Service Agency
(909) 886-6737

Family Service Association
Attn: Amy Casil
(909) 793-2673

Florence Crittenton of Orange County
Attn: Mary Xavier
(714) 680-8200

Inland Mediation Board
(housing)
(909) 984-2254
Counseling continued

Life Network
Attn: Matt Neal or Ronda Perea
(805) 569-3050

Loving Options
(909) 799-3994

Pregnancy Counseling Center
Attn: Kimberley Davison
(909) 825-6656 24 hr. Hotline
(909) 889-4182

Provisional Accelerated Learning (PAL) Center
Attn: Dr. Mildred D. Henry
(909) 887-7002

St. Anne's
(213) 381-2931

St. Anne's Outreach
Attn: Linda Lower
(805) 383-7277

Sexual Assault
Attn: Candy Stallings, Executive Director
(909) 885-8884

Villa Majella
Attn: Carole Boom
(805) 683-2838

Yucaipa CPC
Attn: Deborah
(909) 797-6769
HEALTH

Department of Public Health (C.H.D.P.)
Child Health and Disability Prevention Program
Attn: Vergia Slade
(909) 387-6499

Family Service Association
Attn: Amy Casil
(909) 793-2673

Florence Crittenton Service of Orange county
Attn: Mary Xavier
(714) 680-8200

Inland AIDS Project
Fontana: (909) 428-3720
Riverside: (909) 784-2437
1-800-499-2439

La Leche League International
1-800-LA-LECHE Hotline
(708) 519-7730

San Bernardino Medical Society
Tel-Med Health Library
(909) 825-6526
IMMUNIZATIONS

Department of Public Health (C.H.D.P.)
Child Health and Disability Prevention Program
Attn: Vergia Slade
(909) 387-6499

Family Service Association
Attn: Amy Casil
(909) 793-2673

San Bernardino County
Immunization Program
1-800-722-4794

Call your local Department of Public Health and ask for the nearest location for immunizations and the days they are provided on.
LEGAL AID

Alternative Pregnancy Counseling
Attn: Laura Oliver
(referrals)
(909) 845-6650 24hr. Hotline

Crisis Pregnancy Center
(818) 830-1200

D.O.V.E.S. of Big Bear Valley
Attn: Janet Trott
(for victims of domestic violence)
(909) 866-1546

Family Service Association
Attn: Amy Casil
(909) 793-2673

Inland Mediation Board
(housing mediation)
(909) 984-2254

Legal Action for Women
(for abortion injured women)
(904) 474-1091

Legal Aid
(Family Law matters only)
(909) 889-7328

Loving Options
(909) 799-3994
MATERNAL HEALTH

Family Planning Program
(909) 383-3020

Florence Crittenton Services of Orange County
Attn: Mary Xavier
(714) 680-8200

La Leche League International
1-800-LA-LECHE
(708) 519-7730

Loving Options
(909) 799-3994

Maternal Health
Attn: Dianne Rice
(909) 383-3033

Pregnancy Counseling Center
Attn: Kimberly Davison
(909) 825-6656 24 hr. Hotline
(909) 889-4182

St. Anne’s Outreach
Attn: Linda Lower
(805) 383-7277

Villa Majella
Attn: Carole Boom
(805) 683-2838
MATERNITY HOMES

Alternative Pregnancy Counseling
Attn: Laura Oliver
(909) 845-6650 24hr. Hotline

Angels Way Maternity Home
Attn: Mrs. Barbara Klinkhammer, Executive Director
(818) 346-2229

Baby Steps Inn
(for pregnant women addicted to drugs or alcohol)
(310) 986-5525

Bethany Christian Services
Attn: Jan Viss
(209) 522-5121

Casa de los Angelitos
Attn: Lorell Rutherford
(310) 325-8208

Choix de Vie
Attn: Program Director
(707) 258-0260

Florence Crittenton Services of Orange County
Attn: Mary Xavier
(714) 680-8200

Foley House
(for women addicted to drugs or alcohol)
(310) 944-7953

Heritage House
(for women addicted to drugs or alcohol)
(714) 646-2271

Life Network
Attn: Matt Neal or Ronda Perea
(805) 569-3050

Precious Life Shelter
Attn: Theresa Sherrin
(310) 431-5025

Pregnancy Counseling Center
Attn: Kimberley Davison
(909) 825-6656 24 hr. Hotline
(909) 889-4182
Maternity homes continued

St. Anne's
(213) 381-2931

St. Anne's Outreach
Attn: Linda Lower
(805) 383-7277

Salvation Army
(909) 792-6868

Villa Majella
Attn: Carole Boom
(805) 683-2838

Yucaipa CPC
Attn: Deborah
(909) 797-6769
Ameda/Egnell Corp.
Attn: Julie Stock
1-800-323-8750
(708) 639-2900

Crisis Pregnancy Center
(818) 830-1200

Family Service Association
Attn: Amy Casil
(909) 793-2673

Florence Crittenton Services of Orange County
Attn: Mary Xavier
(714) 680-8200

La Leche League—Inland Empire
(909) 783-9081

La Leche League International
1-800-LA-LECHE
(708) 519-7730

Maternal Health
Attn: Dianne Rice
(909) 383-3033

Villa Majella
Attn: Carole Boom
(805) 683-2838

St. Anne’s Outreach
Attn: Linda Lower
(805) 383-7277
PREGNANCY

Alternative Avenues
Attn: Janet Trenda
(909) 467-2188

Alternative Pregnancy Counseling
Attn: Laura Oliver
(909) 845-6650 24 hr. Hotline

Bethany Christian Services
Attn: Jan Viss
(209) 522-5121

Crisis Pregnancy Center
(818) 830-1200

Family Service Association
Attn: Amy Casil
(909) 793-2673

Florence Crittenton Services of Orange County
Attn: Mary Xavier
(714) 680-8200

La Leche League
(909) 783-9081

Loving Options
(909) 799-3994

Maternal Health
Attn: Dianne Rice
(909) 383-3033

Pregnancy Counseling Center
Attn: Kimberley Davison
(909) 825-6656 24 hr. Hotline
(909) 889-4182

St. Anne’s Outreach
Attn: Linda Lower
(805) 383-7277

San Bernardino County Adoptions
Attn: Peggy Thomas (San Bernardino)
(909) 387-5253
or
Attn: Anita Blake (Rancho Cucamonga)
(909) 945-3820
Pregnancy continued

Villa Majella
Attn: Carole Boom
(805) 683-2838

Yucaipa CPC
Attn: Deborah
(909) 797-6769
PREGNANT MINOR PROGRAM

Barstow Teen Mother Program
(619) 252-2279

Buena Vista High School
Attn: Mary Ferguson
(909) 628-9903

Colton High School
Attn: Mary Ferguson
(909) 628-9903
REFERRALS

Alternative Avenues
Attn: Janet Trenda
(909) 467-2188

Alternative Pregnancy Counseling
Attn: Laura Oliver
(909) 845-6650 24 hr. Hotline

Crisis Pregnancy Center
(818) 830-1200

Loving Options
(909) 799-3994

Pregnancy Counseling Center
Attn: Kimberley Davison
(909) 825-6656 24 hr. Hotline
(909) 889-4182

St. Anne’s Outreach
Attn: Linda Lower
(805) 383-7277

San Bernardino County Medical Society
Physician Referral
(909) 825-6526
SELF DEFENSE

Sexual Assualt
Attn: Candy Stallings, Executive Director
(909) 885-8884
SHELTERS

Casa de los Angelitos
Attn: Lorell Rutherford
(310) 325-8208

D.O.V.E.S. of Big Bear Valley, Inc.
Attn: Janet Trott
(domestic violence)
(909) 866-1546

Family Service Association
Attn: Amy Casil
(909) 793-2673

High Desert Domestic Violence/ Self Esteem House
(619) 242-1468

Pregnancy Counseling Center
(909) 825-6656 24 hr. Hotline
(909) 889-4182
TEEN FATHERS

Alternative Avenues
Attn: Janet Trenda
(909) 467-2188

Christian Counseling Service
(909) 793-1078

Colton High School
School Age Parenting Program
Attn: Terry Yanez
(909) 876-4183

Fathers of America
Attn: Vertner Vergon
(310) 836-1997

Pregnancy Counseling Center
Attn: Kimberley Davison
(909) 825-6656 24 hr. Hotline
(909) 889-4182

St. Anne's
(213) 381-2931

YWCA of Greater San Bernardino
Attn: Teen Parents as Teachers
(909) 889-9536
TEEN PARENTING

Alternative Avenues
Attn: Janet Trenda
(909) 467-2188

Bethany Christian Services
Attn: Jann Viss
(209) 522-5121

Chino Unified School District
Attn: Mary Ferguson
(909) 628-9903

Christian Counseling Service
(909) 793-1078

Colton High School
Attn: Terry Yanez
(909) 876-4183

Family Service Association
Attn: Amy Casil
(909) 793-2673

Florence Crittenton Services of Orange County
Attn: Mary Xavier
(714) 680-8200

Inland Counties Regional Center
(resource for young parents only if their children were at risk or suspected of having a developmental disability)
Attn: Carol Cooper
(909) 370-0902

La Leche League-Inland Empire
(909) 783-9081

Life Network
Attn: Matt Neal or Ronda Perea
(805) 569-3050

Pregnancy Counseling Center
Attn: Kimberley Davison
(909) 825-6656 24 hr. Hotline
(909) 889-4182

St. Anne's
(213) 381-2931
Teen parenting continued

YWCA of Greater San Bernardino
Attn: Teen Parents as Teachers
(909) 889-9536
TEEN PREGNANCY

Alternative Avenues
Attn: Janet Trenda
(909) 467-2188

Alternative Pregnancy Counseling
Attn: Laura Oliver
(909) 845-6650 24 hr. Hotline

Bethany Christian Services
Attn: Jan Viss
(209) 522-5121

Christian Counseling Service
(909) 793-1078

Family Service Association
Attn: Amy Casil
(909) 793-2673

Florence Crittenton Services of Orange County
Attn: Mary Xavier
(714) 680-8200

La Leche League-Inland Empire
(909) 783-9081

Life Network
Attn: Matt Neal or Ronda Perea
(805) 569-3050

Loving Options
(909) 799-3994

Maternal Health
Attn: Dianne Rice
(909) 383-3033

Pregnancy Counseling Center
Attn: Kimberley Davison
(909) 825-6656 24 hr. Hotline
(909) 889-4182

St. Anne’s
(213) 381-2931

Salvation Army
(909) 792-6868
Teen pregnancy continued

Yucaipa CPC
Attn: Deborah
(909) 797-6769
TRAINING-JOB

Bethune Youth Employment Center
NCNW, Inc.
Attn: Sandra J. Doyle
(909) 874-6000

Family Service Association
Attn: Amy Casil
(909) 793-2673

Florence Crittenton Services of Orange County
Attn: Mary Xavier
(714) 680-8200

High Desert Domestic Violence
(619) 242-1468

Provisional Accelerated Learning (PAL) Center
Attn: Dr. Mildred D. Henry
(909) 887-7002
WELFARE

For any and all benefits for Welfare, Food stamps, and Medi-Cal one must apply at the Office of Public Social Services that serves that city.

San Bernardino Office. (Services: San Bernardino, Highland, Crestline, and Twin Peaks).
494 North E St.
San Bernardino, CA
General Information 387-5040
Social Security/Welfare Information 383-2011
DPSS 1-800-952-5253

Fontana Office. (Services: Fontana, Colton, Bloomington, & Etiwanda).
7977 N. Sierra Avenue
Fontana, CA
General Information: 356-3150 \ 10:00 a.m.-4:00 p.m.

Redlands Office. (Services: Redlands, Loma Linda, Yucaipa)
881 W. Redlands Blvd.
Redlands, CA
General Information: 335-3200 \ 10:00 a.m.-4:00 p.m.

Women, Infants, and Children Program (WIC): 1-800-852-5770
Access for Infants and Mothers (AIM) information and application: 1-800-433-2611
Program Referral Information: 1-800-BABY-999
Addresses

Alternative Avenues  
125 W."F" St., Ste. 102  
Ontario, CA 91762  
(909) 467-2188

Alternative Pregnancy Counseling Center  
650 E. 14th St.  
Beaumont, CA 92223  
(909) 845-1179  
(909) 845-6650 hotline

Ameda\Engell Corp.  
755 Industrial Dr.  
Cary, ILL. 60056  
(708) 639-2900  
(800) 323-8750

Angels Way Maternity Home  
P.O. Box 1305  
Woodland Hills, CA 91365  
(818) 346-2229

Baby Steps Inn  
1755 Freeman Ave.  
Long Beach, CA 90804  
(310) 986-5525

Barstow Teen Mother Program  
405 North Second Ave.  
Barstow, CA 92311  
(619) 252-2279

Bethany Christian Services  
3048 Hahn Drive  
Modesto, CA 95350  
(209) 522-5121

Bethune Youth Employment Center  
NCNW, Inc.  
649 E. Foothill Blvd. Ste. D.  
Rialto, CA 92376  
(909) 874-6000

Buena Vista High School  
13509 Ramona  
Chino, CA 91740  
(909) 628-9903
Casa de los Angelitos
954 Koleeta Dr.
Harbor City, CA 90710
(310) 325-8208

Chino Unified School District
School Age Parenting, Infant\Toddler Development
Pregnant Minor Program
(909) 628-9903

Christian Counseling Service
51 W. Olive Ave.
Redlands, CA 92374
(909) 793-1078

Choix de Vie, Inc.
1209 Jefferson St.
Napa, CA 94558
(707) 258-0260

Colton Joint Unified School District
School Age Parenting, Infant Development Program
777 Valley Blvd.
Colton, CA 92324
(909) 876-4183

Crisis Pregnancy Center
16909 Parthenia #301
North Hills, CA 91343
(818) 830-1200

Department of Public Health C.H.D.P.
Child Health and Disability Prevention Program
351 North Mountain View Room 305
San Bernardino, CA 92415-0010
(909) 387-6499

D.O.V.E.S of Big Bear Valley, Inc.
P.O. Box 3646
Big Bear Lake, CA 92315
(909) 866-1546

Fathers of America
415 Washington Blvd. #1102
Marina Del Rey, CA 90292
(310) 836-1997
Family Service Agency
1669 N. "E" St.
San Bernardino, CA 92405
(909) 886-6737

Family Service Association
402 W. Colton Ave.
Redlands, CA 92374
(909) 793-2673

Family Planning Program
799 E. Rialto Ave.
San Bernardino, CA 92415

Florence Crittenton Services of Orange County
P.O. Box 919
Fullerton, CA 92632
(714) 680-8200

Foley House
1054 Mills Ave.
Whittier, CA 90604
(310) 944-7953

Heigh Ho Daycare Center/YWCA
561 N. Sierra Way
San Bernardino, CA 92410
(909) 884-8157

Heritage House
2212 Placentia Ave.
Costa Mesa, CA 92627
(714) 646-2271

High Desert Domestic Violence
(619) 242-1468

House of Ruth
Domestic Violence
(909) 623-4364 Pomona
(909) 944-8167 Rancho Cucamonga
(909) 988-5559 24 hr. hotline

Inland AIDS Project
1240 Palmyrita Ave., Ste. E.
Riverside, CA 92507
(800) 499-2439
Inland AIDS Project
17662 San Bernardino Ave.
Fontana, CA 92335
(909) 428-3720

Inland Counties Regional Center
1020 Cooley Dr.
Colton, CA 92324
(909) 370-0902

Inland Mediation Board
420 North Lemon Ave.
Ontario, CA 91764
(909) 984-2254

La Leche League Inland Empire
710 Robinhood Lane
Redlands, CA 92373
(909) 783-9081

La Leche League International
1400 N. Meacham Road
P.O. Box 4079
Schaumburg, ILL. 60173
(708) 519-7730
(800) LA-LECHE

Legal Action for Women
P.O. Box 11061
Pensacola, FL. 32524-1061
(904) 474-1091

Legal Aid
354 West Sixth
San Bernardino, CA
(909) 889-7328

Life Network
P.O. Box 3668
Santa Barbara, CA 93130
(805) 569-3050

Loving Options
24769 Redlands Blvd., Ste. E
San Bernardino, CA 92408
(909) 799-3994
Maternal Health
799 E. Rialto Avenue
San Bernardino, CA 92414-0011
(909) 383-3033

Precious Life Shelter
P.O. Box 414
Los Alamitos, CA 90720
(310) 431-5025

Pregnancy Counseling Center
570 W. La Habra Blvd.
La Habra, CA 90631
(310) 696-8401

Pregnancy Counseling Center
165 W. Hospitality Ln., Ste. 22
San Bernardino, CA 92408
(909) 889-4182
(909) 825-6656 hotline

Provisional Accelerated Learning (PAL) Center
2097 W. Highland Ave.
P.O. Box 7100
San Bernardino, CA 92411
(909) 887-7002

St. Anne’s
155 N. Occidental Blvd.
Los Angeles, CA 90026
(213) 381-2931

St. Anne’s Outreach
2301 Daily Drive #202
Camarillo, CA 93010
(805) 383-7277

Salvation Army
P.O. Box 26
Redlands, CA 92373
(909) 792-6868

San Bernardino County Adoptions
494 N. "E" St.
San Bernardino, CA 92415
(909) 387-5253
San Bernardino County Adoptions
9638 7th St.
Rancho Cucamonga, CA 91730
(909) 945-3820

San Bernardino County Public Health\ Immunization Program
799 E. Rialto Ave.
San Bernardino, CA 92415-0011
(800) 722-4794

San Bernardino County Medical Society
(Tel-Med Health Library, Physician referrals)
(909) 825-6526

San Bernardino County Schools
Child Development Services
10568 California Street
Redlands, CA 92373
(909) 478-5700

Sexual Assault
536 W. 11th Street, Suite A
San Bernardino, CA 92410
(909) 885-8884

Southern California Alcohol and Drug Program, Inc.
(310) 923-4545

YWCA Of Greater San Bernardino
567 N. Sierra Way
San Bernardino, CA 92410
(909) 889-9536

Villa Majella Maternity Home
202 W. Valerio St.
Santa Barbara, CA 93101
(805) 683-2838

Yucaipa Crisis Pregnancy Center
P.O. Box 563
Yucaipa, CA 92399
(909) 797-6769
References Cited


California Civil Code. Section 7004(a)(4).


Freedman, J. (1990). Seeking Success: Educating pregnant and


Hanson, R. (1990). Initial parenting attitudes of pregnant adolescents and a comparison with the decision about adoption. Adolescence. XXV(99), 630-643.


Harris v. McRae, 448 U.S. 297 (1980).


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