Evaluation of the State of Louisiana TANF Initiatives Teen Pregnancy Prevention Program

Final Report

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Foreword

Under the Temporary Assistance for Needy Families (TANF) program, states are allowed to use federal TANF block grant funds to support a variety of programs targeting needy families beyond the traditional welfare-eligible population. Availing itself of the flexibility allowed under TANF, the Louisiana State Legislature allocated a sizable amount of the state's unspent federal TANF funds, starting in Federal Fiscal Year (FFY) 2002, to a variety of programs known collectively as the TANF Initiatives. The total allocations amounted to $105 million in FFY 2002 and $160 million in FFY 2003. In its third year (FFY 2004), the TANF Initiatives consist of over twenty programs administered by eleven state agencies with a total budget of $127 million.

For the past three years, Berkeley Policy Associates (BPA), a social policy research and consulting firm in Oakland, California, has conducted a comprehensive evaluation of the state TANF-funded programs under contract with the Division of Administration. Included in this evaluation are the state welfare programs administered by the Department of Social Services (the Family Independence Temporary Assistance Program and Strategies to Empower People Program) as well as selected programs under the TANF Initiatives Program. The third year evaluation of the TANF Initiatives includes a comprehensive evaluation of the statewide Teen Pregnancy Prevention Program administered by the Louisiana Department of Education. The current report represents one in a series of the Year 3 TANF Initiatives Evaluation Reports.

Chapter 1
Teen Pregnancy Prevention Program

Key Findings

- A total of thirty-six different contractors received TANF Initiatives funding for Teen Pregnancy Prevention (TPP) programs in FY 2004[1]; 69 percent of contractors reported operating TPP programs in previous years as part of the TANF Initiatives. Programs were operated by community-based organizations (CBOs) (55 percent), faith-based organizations (26 percent), school-related organizations (15 percent), and municipalities (4 percent).

- As of August 2004, 16,000 participants had enrolled in TPP programs over the course of the contract year. Not all of these participants remained in the programs for a substantial number of classes.

- Eighty-five percent of contractors reported that all or most program participants are eligible for free or reduced lunch through the National School Lunch Program that requires that family income be below 185 percent of the federal poverty level.

- Contractor survey respondents indicated that many TPP program participants are involved in risk behaviors associated with teen sexual activity, childbearing, and STD infection. For instance, 37 percent of contractors reported that some participants use alcohol and 46 percent indicated that a few participants use illegal drugs. Sixty-three percent of contractors reported that at least some program participants are sexually active and 60 percent reported that a few participants have been pregnant.

- Only 15 percent of contractors reported not needing any outreach or recruiting in order to meet participation targets. Most contractors used a variety of recruitment methods including: word of mouth (85 percent); distribution of flyers, signs, and posters (82 percent); presentations (74 percent); promotion of TPP program to other programs (70 percent); and announcements through local media (52 percent).

[1] Thirty-four contractors operated through the contract year as projected, and two contractors ended services early. One contractor decided to forego its contract without starting services; another was closed for nonperformance half way through the contract year.

- The DOE-administered TPP program offers increased support for contractors who include curriculum-based and best practice trainings, announced and unannounced monitoring visits, and ongoing technical assistance. All TPP contractor survey respondents reported receiving best practices training and DOE monitoring visits. Ninety-four percent of contractors reported having received curriculum training; Seventy-seven percent of contractors reported that curriculum training was more effective than in previous years.

- In order to assure that contractors had the capacity to implement the mandated TPP curricula effectively, DOE offered on-site curriculum coaching. According to DOE, a total of seventeen contractors received curriculum coaching; 65 percent received three or more visits. Curriculum coaching is designed to increase the effectiveness of curriculum implementation by improving teacher/student communication and student involvement; encouraging participation and discussion of sensitive topics; and raising student and teacher comfort level with TPP issues. Approximately half of contractors rated coaching as more effective than similar services received in previous years.

- All contractors reported utilizing at least one of the DOE-mandated, research-based TPP curricula. This is a significant improvement given that in the previous year BPA found that only half of the surveyed contractors were using one of the five approved TPP curricula (Magill and LaPointe 2003).

- Many of the DOE-mandated curricula[2] are mentioned in the literature as having positive effects on reducing teen pregnancy and its associated risk factors. Most contractors use more than one curriculum. The most common teen pregnancy prevention curricula include Be Proud! Be Responsible!, Becoming a Responsible Teen (BART), Focus on Kids, and Making a Difference; each of these curricula are used by 22 percent of contractors. Other popular curricula include Reducing the Risk (19 percent), and Choosing the Best and Wise Guys (15 percent each).

- The TPP RFP indicated that all staff interacting with participants in curricula components must be able to document attendance at DOE trainings. However, in many cases those attending training were program administrators, who were less likely to implement curricula with participants. In some of these cases, contractors reported providing in-house training to disseminate the information from the DOE training to direct service staff. While this could be an effective way to distribute the information, it is clear that DOE's goal of training all staff interacting with participants in curricula components was not achieved.

[2] For instance, Be Proud! Be Responsible!, Becoming a Responsible Teen, Focus on Kids, Get Real About AIDS, Making Proud Choices, Reducing the Risk, Making a Difference, Postponing Sexual Involvement, and Teen Outreach Program have been shown to have positive impacts on teen pregnancy and risk factors associated with teen sexual activity.

- All contractors visited by BPA researchers reported implementing the required Personal Social Skills (PSS) curriculum and at least one of the DOE-approved research-based teen pregnancy prevention curricula. However, in a survey of all programs, only 66 percent of contractors reported utilizing the PSS curricula.

- All contractor survey respondents reported receiving best practices training and 61 percent reported that this training was more effective than in previous years.

- Despite DOE's attempts to increase providers' capacity to adopt best practices, there appeared to be significant variation in knowledge of and ability to implement best practices. One contractor noted that while best practices were mentioned during the RFP process and in the curriculum training, they were never clearly defined or stressed by the program's DOE contract officer. The degree to which contractors experienced DOE discussion and instruction on best practices appears to be dependent upon the DOE contract officer providing the information and whether or not the program was involved in ongoing curriculum coaching.

- Many TPP contractors mentioned the need for additional technical assistance and direction in implementing their curricula. Some particular areas of concern included information on integrating the various curricula into a more holistic program, suggestions on how to integrate the TPP curricula with the skills-based PSS curriculum, and ideas on additional curricula that might be used to supplement the program.

- Many contractors reported a need for training on topics other than curriculum. For instance, several contractors noted a need for budget design and administration training, effective classroom discipline, teen developmental phases, sustaining participant attention, and background on the theory behind the curriculum.

- Although contractors indicated a need for technical assistance in many areas, the overriding message was that the TPP Program has improved significantly under DOE administration. Previously, TPP contractors received neither curriculum training nor coaching. As mentioned, in FY 2004 94 percent received curriculum training and 56 received coaching.

- According to DOE respondents, the primary performance measures utilized to assess contractor progress are the 80 percent participation rate and the 50 percent retention rate benchmarks, which were monitored using data entered into ASSIST, DOE's online database. Many contractors, however, expressed confusion about the DOE participation and retention rate performance measures.

- The contract officer monitoring process primarily served as a way for DOE to make sure that contractors were utilizing required curricula on the day of the monitoring visit, rather than as a way to provide assistance and monitoring of curriculum implementation. Several contractors mentioned an interest in receiving increased feedback and assistance with curricula implementation during the DOE monitoring visits.

- Findings from participant surveys in CBOs show that about a quarter of all participants are already sexually active when they enter the TPP programs. Boys are more likely to be sexually active than girls.

- Most (75 percent) participants are middle school students and about a quarter of participants are in high school. Increases in knowledge and attitude changes were most significant for middle school students.

- Analyses comparing knowledge, behavior, and attitudes for program participants at two points in time do not find significant program effects on participants' sexual activity and use of contraceptives. They do show, however, that participants have greater knowledge of STDs, HIV, and preventing pregnancy. Participants (especially boys) also report less discomfort discussing sex and relationships with parents.

- Pre-post differences in participant knowledge and attitudes might have been larger if more teens had participated in the programs for significant amounts of time and if there had been more time between pre- and post assessments. Also, most participants were not sexually active and did not approve of teens having sex when they joined the programs. As such, one might not expect to see changes in attitudes and behavior for these teens.

Exhibit 1.1
TANF Initiatives Program Summary
Teen Pregnancy Prevention (TPP) Program

Contract Agency:	Louisiana Department of Education (DOE)
Initiative Grant Amount:	$6.5 million
Expenditures to Date:	$5,375,000 (as of 8/25/04)
Program Background and Services:	The TPP TANF Initiatives grant called for community-based and school-based programs to employ the following prevention education strategies: • Primary intervention services for adolescents who are not yet parents and are not yet sexually active; • Interventions for adolescents who may be sexually active or who engage in other risk behaviors; • Accountability strategies to assist teen parents in preventing additional pregnancies and provide core skills (e.g. parenting, child development, diploma/GED) to assist parents in providing for their child.
Contractors:	DOE issued 36 contracts, 34 contractors provided services throughout the contract year.
Initiative Locations:	Statewide
Eligibility:	No eligibility requirements
Total Number of Youth Served:	16,000 enrolled

Introduction

The teen birth rate in Louisiana is among the highest in the United States.[3] To address this problem, for the past several years the state has funded Teen Pregnancy Prevention (TPP) programs with Temporary Assistance to Needy Families (TANF) funds. A primary focus of this initiative is to reduce teen pregnancy through community-based services designed to provide life skills, mentoring, social skills, and parenting education with a strong message of abstinence, to at-risk teens in high need areas of the state. In FY 2004, the Louisiana legislature allocated $6.5 million in TANF Initiatives funds to the state's Department of

[3] See, for example, the 2000 Vital Statistics report of the Centers for Disease Control and Prevention (CDC 2002).

Education (DOE) to serve as the primary administering agency of the statewide TPP TANF Initiative. In past years, these initiatives were delivered through the Department of Social Services. This shift was made to support program improvements, but also to ensure a more streamlined approach to serving youth. DOE has experience administering programs similar to TPP through their administration of TANF-funded after school enrichment services and school-based HIV-AIDS prevention through grants from the Centers for Disease Control and Prevention (CDC).

TANF Initiatives funds require that community- and school-based contractors providing TANF-funded TPP services focus their efforts on prevention education programs that employ at least one of the following strategies:

- Primary intervention services for adolescents who are not yet parents and are not yet sexually active;
- Interventions for adolescents who may be sexually active or who engage in other risk behaviors; and
- Accountability for teen parents to assist them in preventing additional pregnancies and to provide them with core skills (e.g., parenting, child development, diploma/GED) necessary to support a child.

The specific objectives of the TPP TANF Initiative are detailed in the Memorandum of Understanding (MOU) between the Department of Social Services (DSS) and the Louisiana Department of Education as well as in the DOE Request for Proposals. The overall goal of this Initiative is to reduce teen pregnancy through community-based services designed to provide life skills, mentoring, social skills, and parenting education with a strong message of abstinence to at-risk teens in high need areas of the state.

Evaluation of the TPP: PY 03-04

Berkeley Policy Associates (BPA), a social policy research and consulting firm in Oakland, California, is under contract with the State of Louisiana's Division of Administration (DOA) to evaluate the state's TANF programs. BPA's evaluation has two parts, a study of the FITAP and STEP programs offered by the Office of Family Support (OFS) in the Louisiana Department of Social Services and a study of selected TANF Initiatives programs. This report presents findings from our evaluation of the Teen Pregnancy Prevention program administered by DOE. It provides an overview of the TPP program, including the history of the teen pregnancy problem in Louisiana and of the TPP program under the TANF Initiatives grant. It reports on implementation findings under the administration of DOE, and includes a description of the TPP contractors, program participants, services, and self-reported outcomes for the program. As DOE will be administering another year of the TPP program in the coming year, the report also highlights issues to be attended to by DOE.

The findings presented in this report are based on multiple data collection efforts including:

- An extensive literature review of various approaches utilized in preventing teen pregnancy, including abstinence-only-until-marriage, abstinence-plus, abstinence-based, and comprehensive approaches;
- In-depth site visit interviews with Louisiana Department of Education staff and curriculum coaches;
- Site visits to eight faith- and community-based TPP contractors, including comprehensive interviews with staff from ten individual TPP sites;
- Wide-ranging contractor survey[4], including data collection on program design and implementation; and
- Implementation of a pre- and post-program participant survey for all eligible[5] TPP contractors.

The pre- and post-program participant survey gauges the TPP programs' impact on participants' knowledge of sex, contraception, and pregnancy prevention; participants' choices and risk behaviors; and describes positive and negative influences in participants' lives. In total, sixteen TPP contractors and approximately 900 teens in programs not affiliated with schools participated in both the pre and post survey, with an overlap of 166 participants in both groups. The first wave of surveys was administered in February and March 2004 and the second wave of surveys in June and July 2004.

A Closer Look at Teen Pregnancy in Louisiana

While the teen birth rate in Louisiana continues to be among the highest in the U.S., since the early 1990s[6] there has been a steady decline in the teen birth rate in the state. Although the decline in teen birth rates (18 percent) in Louisiana between 1991 and 2000 is less than the U.S. average, it is the highest rate of decline among neighboring Southern states including Texas, Arkansas, Mississippi, and Alabama. When looking at the subgroup of Louisiana teens ages 15 to 17, the rate of decline increases to 29 percent.

Louisiana Vital Statistics Data provide a more recent comparison of teen birth rates for women aged 15 to 19 between 1995 and 2002, as highlighted in Exhibit 1-2 (Louisiana State Center Statistics at the Office of Public Health, 2004). The states' teen birth rate has fallen from a rate of seventy to fifty births per 1000 teenagers, a decline of nearly 15 percent.

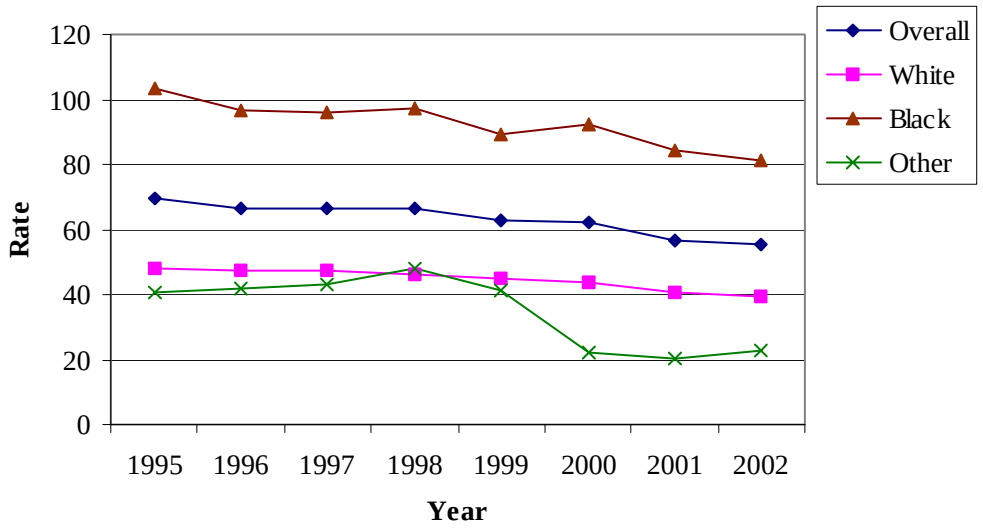
[4] Of the thirty-three currently active TPP contractors, twenty-seven completed the survey, a response rate of 82 percent.

[5] To comply with state regulations that disallow surveying students in school-based programs about their personal or family beliefs or practices in sex, morality, or religion, we only administered the student pre- and post surveys in programs that 1) operate in locations other than school sites, 2) do not use public school buses, and 3) do not accept any federal or state Department of Education funds.

[6] See, for example, the 2000 Vital Statistics report of the Centers for Disease Control and Prevention (CDC 2002).

Although the decline was greater among African American teens than among white teens, the birth rate among African American teens remains higher than that of white teens in the state. The white teen birth rate dropped from forty-eight to forty births per 1000 teenagers in 2002, a decline of 9 percent. While the 1995 African American teen birth rate dropped 23 percent between 1995 and 2002, the birth rate for African American teens remained eighty-one births per 1000, 26 percent higher than the state average.

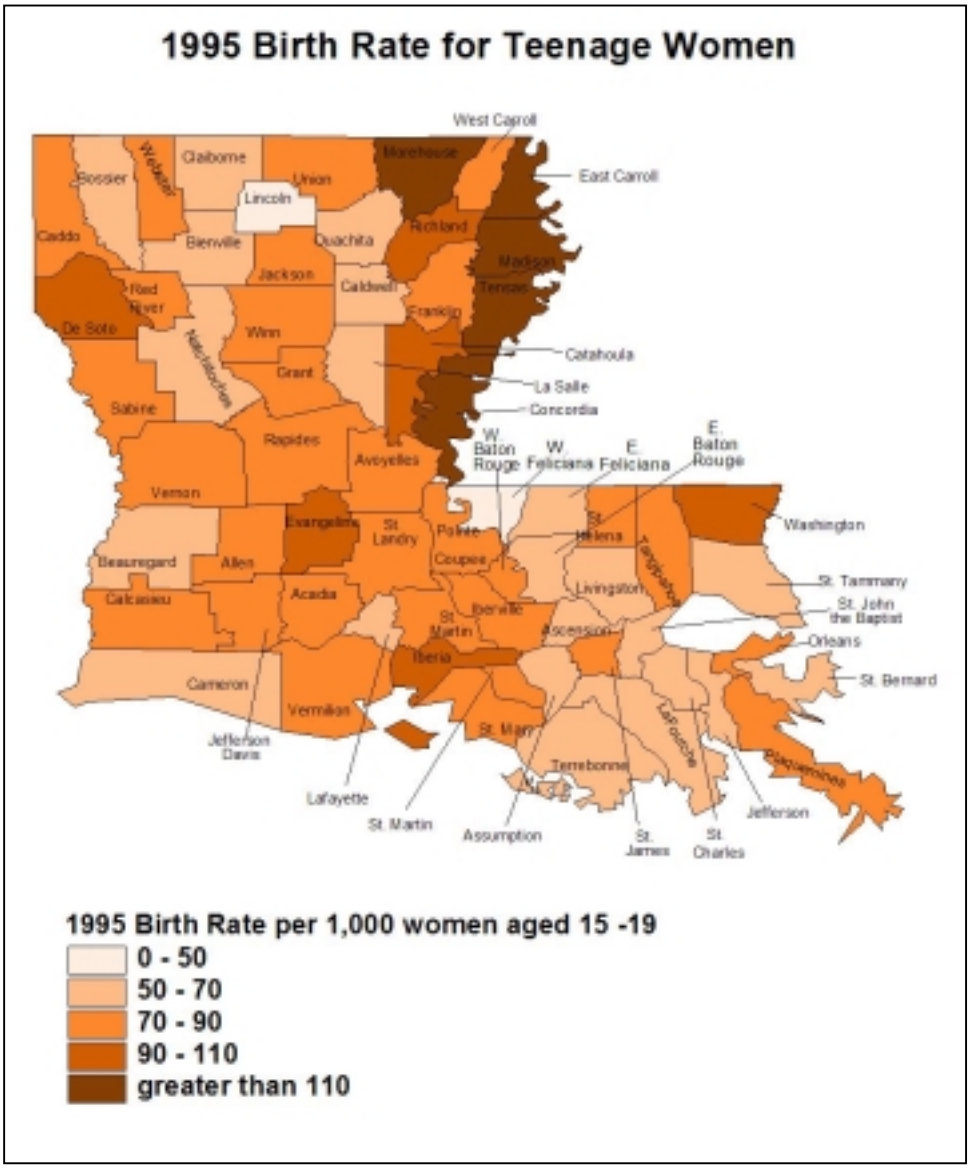
Exhibit 1.2
Louisiana Birth Rate
Per 1000 for Teens Ages 15-19



Source: Department of Health and Hospitals, Office of Public Health, State Center Statistics: Louisiana Vital Statistics Data Tables 1995 – 2002.

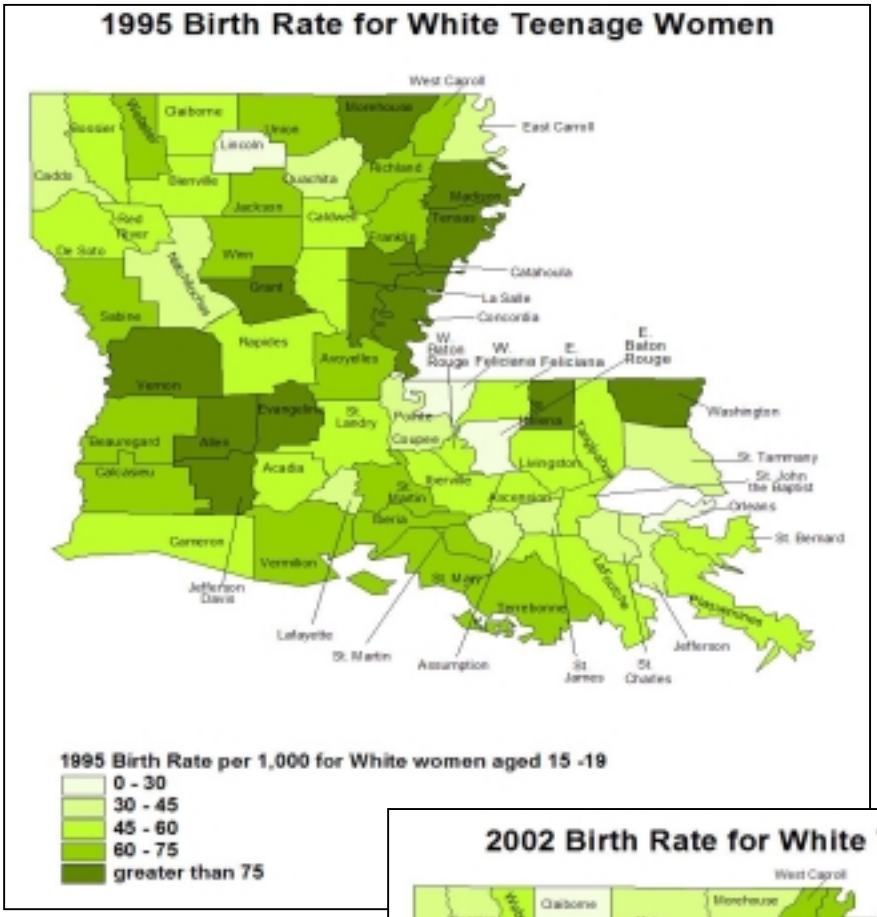
The following exhibit visually illustrates the decline of teen birth rates among all teens ages 15 to 19 throughout each Louisiana parish between 1995 and 2002. While eight parishes did not experience any reduction in teen birth rates (Allen, Avoyelles, Franklin, Jackson, La Salle, Lincoln, Vernon, and W. Feliciana), all other parishes experienced significant reductions in these rates. Forty-two parishes experienced reductions of between 10 and 40 percent; eight parishes experienced reductions of more than 40 percent; and seven parishes experienced a 10 percent or less reduction in teen birth rates during this period.

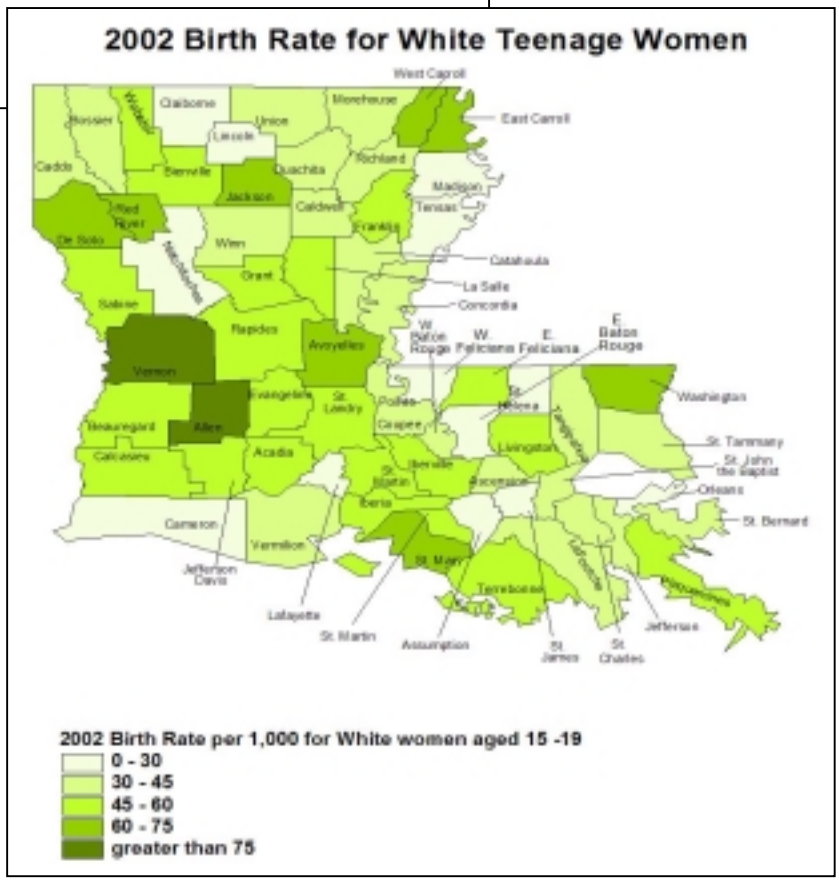
Exhibit 1.3



As shown in the exhibits below, the birth rate is declining among white teens. In 1995, twenty-eight parishes had a teen birth rate of sixty or more per 1,000 white teens. By 2002, only ten parishes had teen birth rates among white teens of sixty or more per 1,000.

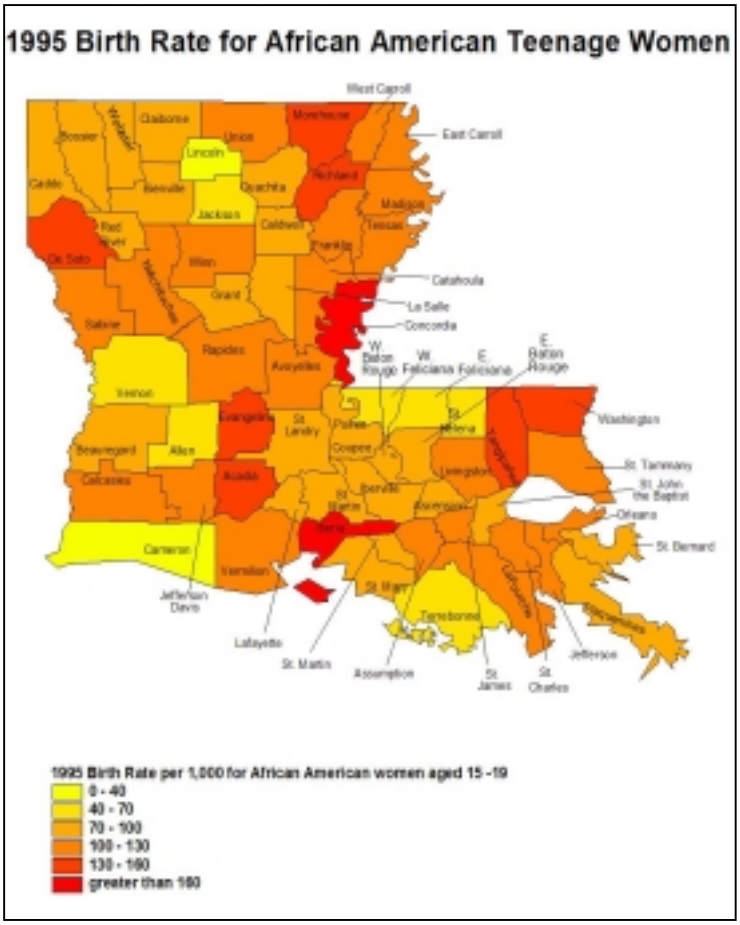
Exhibit 1.4

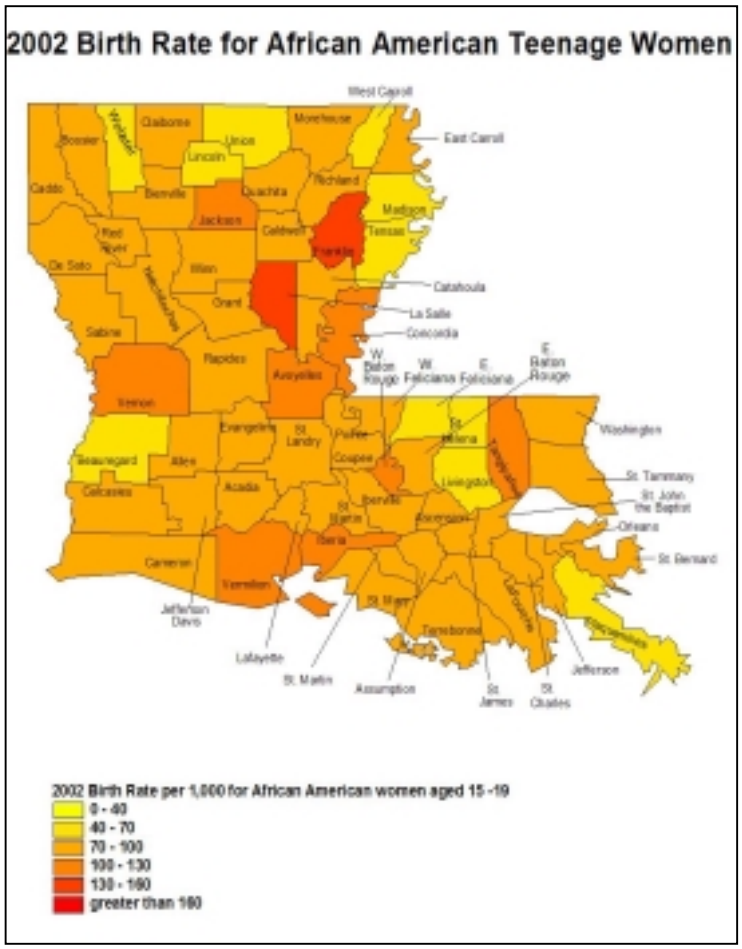

1995 Birth Rate for White Teenage Women
West Carroll
East Carroll
Morehouse
Union
Lincoln
Richland
Ouachita
Jackson
Caldwell
Franklin
Tensas
Madison
Claiborne
Bossier
Webster
Caddo
Bienville
Red River
De Soto
Winn
Grant
Natchitoches
Sabine
Rapides
Avoyelles
Catahoula
La Salle
Concordia
W. Baton Rouge
W. Feliciana
E. Feliciana
E. Baton Rouge
Vernon
Evangeline
St. Landry
Pointe Coupee
Iberia
Iberville
Livingston
Ascension
Orleans
Washington
St. Tammany
St. John the Baptist
St. Bernard
Beauregard
Allen
Calcasieu
Acadia
St. Martin
Cameron
Vermilion
St. Mary
Terrebonne
Lafourche
Plaquemines
Jefferson Davis
Lafayette
St. Martin
Assumption
St. James
St. Charles
Jefferson
1995 Birth Rate per 1,000 for White women aged 15 -19
0 - 30
30 - 45
45 - 60
60 - 75
greater than 75


2002 Birth Rate for White Teenage Women
West Carroll
East Carroll
Morehouse
Union
Lincoln
Richland
Ouachita
Jackson
Caldwell
Franklin
Tensas
Madison
Claiborne
Bossier
Webster
Caddo
Bienville
Red River
De Soto
Winn
Grant
Natchitoches
Sabine
Rapides
Avoyelles
Catahoula
La Salle
Concordia
W. Baton Rouge
W. Feliciana
E. Feliciana
E. Baton Rouge
Vernon
Evangeline
St. Landry
Pointe Coupee
Iberia
Iberville
Livingston
Ascension
Orleans
Washington
St. Tammany
St. John the Baptist
St. Bernard
Beauregard
Allen
Calcasieu
Acadia
St. Martin
Cameron
Vermilion
St. Mary
Terrebonne
Lafourche
Plaquemines
Jefferson Davis
Lafayette
St. Martin
Assumption
St. James
St. Charles
Jefferson
2002 Birth Rate per 1,000 for White women aged 15 -19
0 - 30
30 - 45
45 - 60
60 - 75
greater than 75

As the exhibits below illustrate, the birth rate is also declining among African American teens. In 1995, nine parishes had an African American teen birth rate of 130 or more per 1,000 teens. By 2002, only two parishes had an African American teen birth rate of 130 or more per 1,000 teens. In 1995, twenty-three parishes had an African American teen birth rate of between 100 and 130 births per 1,000 teens. In 2002, only eight parishes had an African American teen birth rate of between 100 and 130 births per 1,000 teens.[7]

Exhibit 1.5



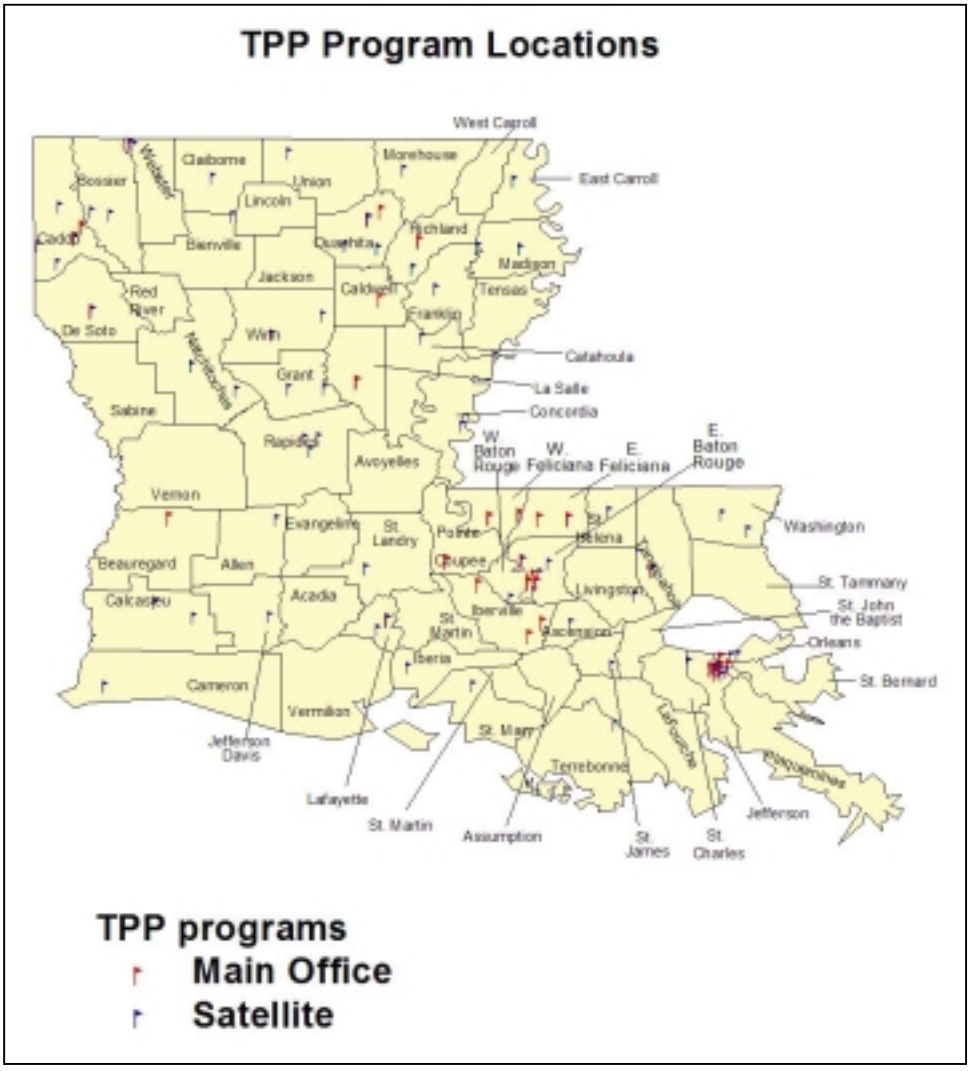


[7] Please note each set of exhibits use different scales to measure the rate of teen pregnancy among teen women ages 15 to 19. The different scales are necessary because of the variation in the rate of pregnancy among the different subgroups.

Distribution of TANF TPP Programs in Louisiana

As the following exhibit shows, DOE TPP programs are located across Louisiana. Services take place at main as well as satellite offices. While many contractors had service locations in rural areas, the majority of programs are located in more densely populated parishes that include major cities in Bossier, Caddo, East Baton Rouge, Orleans, Ouachita and Rapides parishes.

Exhibit 1.6



The Organization of This Report

The following six chapters present findings on the current literature of TPP programs (Chapter 2), on the design and implementation of the DOE TPP program (Chapter 3), and on participant characteristics and outcomes (Chapter 4). In Chapters 5 and 6, we summarize our conclusions and policy recommendations.

Chapter 2

Review of the Literature on Teen Pregnancy Prevention Programs

Types of Teen Pregnancy Prevention Programs

There are many different labels for the types of teen pregnancy prevention (TPP) programs in use in the research literature. The most commonly used include abstinence-only, abstinence-plus or abstinence-based, and comprehensive.[1] Some authors prefer the term 'safe sex' to refer to programs that include information about contraception or that they believe "encourages teens to use contraception, especially condoms" (Martin et al 2004). Most authors do not distinguish between abstinence-plus and comprehensive programs, although some suggest that the latter concentrate more heavily on contraception (Hutchins 1999; Martin et al 2004):

- abstinence-only: sexual abstinence until marriage as the only option for teenagers (Hutchins 1999); "focuses on delaying the onset of sexual activity, teaches the harm of casual sexual activity, and encourages students to view sexuality as part of a process of developing intimacy and lifelong commitment" (Martin et al 2004); sole message is the avoidance of sexual activity until a specified time, such as after high school graduation or until marriage. If contraception is mentioned, it is within the context of possible failures and health risks (Besharov and Gardiner 2000).

- abstinence-plus: strong abstinence messages, especially for younger teens, include information about contraception and recognize that teens become sexually active in later adolescence; offers a combined message: abstaining from sexual activity is the best course of action, but if one becomes sexually active, use contraception (Besharov and Gardiner 2000).

[1] Section 501(b) of Title V of the Social Security Act, P.L. 104-193 defines 'abstinence education' as a program that teaches: a) as its exclusive purpose the social, psychological, and health gains to be realized by abstaining from sexual activity; abstinence from sexual activity outside marriage as the expected standard for all school-age children; that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems; that a mutually faithful monogamous relationship in the context of marriage is the expected standard of sexual activity; that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects; that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society; young people how to reject sexual advances and how alcohol and drug use increase vulnerability to sexual advances, and; the importance of attaining self-sufficiency before engaging in sexual activity.

- comprehensive: encourages abstinence as the best choice for teens and provides information about correct condom and contraceptive use (Hutchins 1999; Hoff et al 2002; Martin et al 2004)

Most Americans support a more comprehensive approach to TPP:

- 81 percent say schools should both teach abstinence and give teens enough information to help them prevent unplanned pregnancies and the spread of STDs;

- 18 percent support teaching only abstinence until marriage (Hoff et al 2002).

Abstinence-based and Abstinence-only Teen Pregnancy Prevention Programs

While, as discussed above, there are many different categorizations for TPP programs, the literature seems in practice to divide fundamentally between abstinence-based/comprehensive and abstinence-only programs. Supporters of abstinence-based programs contend that participants, especially young teens, should be taught that abstinence is the best choice for teens to prevent pregnancy, STDs, and HIV infection.

According to the CDC, however, almost 50 percent of teens are sexually active by the time they finish high school (Martin et al 2004; Solomon and Card 2004). Because 42 percent of sexually active high school students did not use a condom the last time they had sex, more comprehensive sex education seems necessary to reduce pregnancy among these teens (Advocates/SIECUS 2001; Devaney et al 2002).

Comprehensive sexuality education emphasizes the benefits of abstinence while also providing information about contraception and disease prevention. It takes the approach that in grades K-12, TPP programs should provide developmentally appropriate information on sexual development, reproductive health, interpersonal relationships, affection, intimacy, body image, and gender roles as well as providing opportunities to develop communication, decision-making, and other personal skills (Advocates/SIECUS 2001).

Abstinence-only TPP programs teach abstinence from all sexual activity as the only morally correct option for unmarried young people; do not include information on contraception for the prevention of STDs and unintended pregnancies; limit discussion to STDs, unplanned pregnancies, contraceptive failure rates, and need to refrain from sexual activity outside of marriage; often do not mention basic sexual health information on puberty and reproduction; and contain no information about pregnancy and disease-prevention methods other than abstinence (Advocates/SIECUS 2001).

Supporters of an abstinence-only approach assert that TPP programs that provide students with information about sexuality, abstinence, and contraceptives send a mixed message. If teens learn that they should remain abstinent but that if they do have sex, they need to practice it safely, they may feel encouraged to engage in sexual activity. Abstinence-only advocates thus conclude that only their approach can provide a consistent message to adolescents (Devaney et al 2002).

It is worth noting that one relevant study suggests that focusing on youth of middle school age or younger has helped some communities to resolve the debate between abstinence-only and abstinence-based programs. There is some research that suggests national agreement on middle school as an appropriate time to offer abstinence-only interventions. This can then serve as an important foundation for all efforts at youth risk avoidance and pregnancy prevention (Devaney et al 2002).

Funding For Teen Pregnancy Prevention Programs

Funding for TPP programs comes from federal, state, and local sources. At the federal level, in 2001 family planning programs that serve adolescents received an estimated $135 million in funding (Hoff et al 2002). Since 1988, the CDC has provided funding for teen HIV education (Hoff et al 2002). The Title X clinic program provides contraceptive services to low-income and young women (Besharov and Gardiner 2000). Per the TANF legislation, states are "expected to give 'special emphasis' to teen pregnancy prevention" while the federal government is required to provide TPP programs to at least one-fourth of the nation's communities (Shore 2003). In FY 1996, the federal government spent $38 billion to help families that began with a birth to a teenager, including families in which that teenager has since become an adult, but spent only $138.1 million to help adolescents delay or prevent pregnancy (Feijoo 1999).[2]

In the past ten years, abstinence-only education has received the most significant increases in federal funding under the following programs:

- The Adolescent Family Life Act of 1981 (AFLA): funding has varied from $6 to $18 million/year;

- Title V of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996: $250 million in federal funds to the states over a five-year period; Congressionally reauthorized unchanged each year since then; states must match every four dollars in federal funds with three dollars of state money; and

- Special Projects of Regional and National Significance Community-Based Abstinence Education (SPRANS-CBAE): a separate abstinence-only 'set aside' as part of the maternal and child health block grants from 2000; funds are awarded directly by a federal agency and do not require local matching funds (Hoff et al 2002; Devaney et al 2002). SPRANS-CBAE received an initial $50 million allocation over a two-year period. HHS awards the funds directly to individual public and private entities and requires that they comply with all eight points of the Title V definition of an abstinence-only program (Hoff et al 2002). For FY 2005, President Bush has

[2] These include $71.1 million in family planning funds from Medicaid; $1.3 million in health education funds from HSHC; $0.9 million in HHS block grants to reduce teen pregnancy; $0.2 million for health education and TPP from CHC funds; $3.3 million in CCPPPTP funds for TPP programs administered by the CDC; $57.8 million from the National Family Planning Program for family planning clinics and comprehensive family planning services; $1.0 million Maternal and Child Health Services Block Grant including funds for SPRANS abstinence-only programs; $2.5 million in AFL funds for TPP. Note that these figures are from 1996 and do not include additional funds from welfare reform and the Bush administration for abstinence-only education, as discussed below (Feijoo 1999).

moved the administration of SPRANS-CBAE funds to the Administration for Children and Families and has requested it receive $186 million in funding (Hoff et al 2002).

In 2003, Louisiana received $2,643,972 in federal funding for abstinence-only-until-marriage programs. $1.6 million of this was Title V Abstinence-Only-Until-Marriage funds (SIECUS 2004; Hoff et al 2002). The state of Louisiana matches federal funds with $1.2 million. These funds are controlled by the Governor's Program on Abstinence (GPA). There is one SPRANS-CBAE grantee in Louisiana: Inner Reflections Too (IRT). IRT is based in Baton Rouge and receives both Title V and SPRANS-CBAE funding. This program works with youth between the ages of 10 to 16 who live in the inner city and are considered "high risk." There are no AFLA grantees in Louisiana.

Evidence on Program Effectiveness

Research on TPP program effectiveness indicates that some comprehensive programs have had a consistent, positive impact on teen sexual risk behaviors. Although there is some disagreement in the literature, the majority of research on abstinence-only programs suggests, at best, that there does not yet exist definitive research that can link abstinence education with downward trends in teen pregnancy rates. It remains to be seen to what extent abstinence-only programs are able to persuade youth to change their sexual behavior and remain/become abstinent. Mathematica Policy Research Inc. is currently engaged in a multi-year, Department of Health and Human Services (HHS) evaluation of Abstinence Education Programs funded under Title V Section 510, due out summer 2005.

When the CDC, Child Trends, and the National Campaign to Prevent Teen Pregnancy joined together to assess the impact of TPP programs, they focused their definition of effectiveness on the ability of programs to delay sexual initiation, reduce sexual activity among experienced teens, improve consistency and effectiveness of contraceptive use for pregnancy prevention, and/or increase condom use for disease prevention (Manlove et al 2004b). In other words, while TPP programs may have positive effects beyond these specific measures – building self-esteem or knowledge of HIV infection methods, for example – effectiveness refers to the ability of the TPP program to influence teen sexual risk-taking behavior. Most simply, Advocates for Youth deemed a TPP program effective when it demonstrated a "significant" reduction in primary pregnancy and STD/HIV rates in treatment vs. control groups (Alford et al 2003).

Another key issue vis-à-vis program effectiveness involves measuring outcomes. Solomon and Card point out that because most program evaluations involve only limited follow up and small sample sizes, it remains difficult to achieve statistically significant changes in health outcomes (2004). Furthermore, pregnancy, abortion, and rates of STD/HIV infection are consistently underreported. Given these limitations in accessing good health outcome data, "significant changes in risky sexual behaviors (e.g., frequency of sex, consistency of contraceptive use, number of sexual partners)" should be "treated as strong evidence of program effectiveness," especially where a particular program has been replicated at other sites and produced similar positive outcomes (Solomon and Card 2004). Successful replication corroborates that the program – rather than some other non-transferable factor –

has produced the positive results. According to Kirby (2001), however, very few replication studies have been completed.

Positive Impacts of Comprehensive Programs

Numerous studies and evaluations published in peer-reviewed literature suggest that comprehensive sexuality education is an effective strategy to help young people delay sexual involvement (Advocates/SIECUS 2001). A 2001 National Campaign to Prevent Teen Pregnancy analysis of impact evaluations of more than 100 TPP programs, for example, finds that comprehensive programs can assist in preventing teen pregnancy (Hoff et al 2002). One HHS-funded study contends that some comprehensive programs can delay the onset and reduce the frequency of sex, as well as reduce the number of partners among teens (Hutchins 1999). Certain HIV programs also appear to delay sex and increase the use of condoms and contraception (Hutchins 1999).

An Advocates for Youth literature review identified over 160 evaluations of TPP programs. They found nineteen programs proven, "by rigorous evaluation," to lead to "at least *two beneficial changes in sexual behavior* among program youth (Alford et al 2003).[3] Of these nineteen programs, sixteen are sex education programs that include information about abstinence and contraception; of the remaining three, two are early childhood interventions and one is a service-learning program:

- Twelve of these programs demonstrate a statistically significant delay in first sex among participants, relative to a control group.
- Eleven of these programs include information about abstinence and contraception within the context of sex education.
- Seventeen programs demonstrate reductions in other sexual risk-taking behaviors, in one or more of the following areas: increased condom use (11), other contraceptive use (8) and reduced number of sexual partners (6), frequency of sex (6), and incidence of unprotected sex (4).
- Eight programs produce a statistically significant decline in teen pregnancy, births, HIV, or other STD rates.
- Seven programs demonstrate a statistically significant impact on teenage pregnancy/ births among participants, and one, a reduced trend in STDs (Alford et al 2003).

[3] These nineteen programs include the following school-based sex education programs: Reducing the Risk**;** Postponing Sexual Involvement (Augmenting a Five-Session Human Sexuality Curriculum)**;** Postponing Sexual Involvement, Human Sexuality & Health Screening; Safer Choices**;** Reach for Health Community Youth Service**;** AIDS Prevention for Adolescents in School**;** Get Real about AIDS**;** School / Community Program for Sexual Risk Reduction among Teens. They also include the following community-based sex education programs: Self Center (School-Linked Reproductive Health Services)**;** California's Adolescent Sibling Pregnancy Prevention Program**;** Adolescents Living Safely: AIDS Awareness, Attitudes & Actions; Becoming a Responsible Teen**;** Children's Aid Society—Carrera Program**;** Be Proud! Be Responsible! A Safer Sex Curriculum**;** Making Proud Choices! and Poder Latino: A Community AIDS Prevention Program for Inner-City Latino Youth.

In sum, each of the nineteen effective programs reduce the incidence of pregnancy or STDs and/or positively impact ***two or more*** of the following behaviors:

1. the initiation of sex;
2. the frequency of sexual intercourse;
3. the number of sexual partners or increasing monogamy;
4. the use, or consistency of use, of effective methods of contraception and/or condoms; and/or
5. the incidence of unprotected sex (Alford et al 2003).

Even though they all encourage abstinence**,** none of the nineteen effective programs is abstinence-only.

A National Network for Health review of studies concludes that sexuality/HIV education Youth Education Programs can delay the onset of teen sexual involvement, reduce the frequency of intercourse, and reduce the number of partners in some situations (Bower 2002). A Child Trends study finds that "sex education programs that actively engage teenagers in role-playing to learn to negotiate contraceptive use have shown positive results" (Manlove et al 2003). This study also found that "teenagers who discussed contraception with their partners … had twice the odds" of using some form of contraception. TPP programs that have teens talk about issues and engage in role-playing with negotiation and refusal skills are "particularly effective in reducing sexual risk-taking," as well as improving contraceptive use consistency (Manlove et al 2003 and 2004b).

Research also supports the positive impact of some curricula-based sex and HIV education programs in delaying the onset of sex, reducing the frequency of sex; and/or reducing the number of partners (Kirby 2001). Two independent studies have found that Reducing the Risk both delays the onset of intercourse and increases the use of condoms or contraceptives for some youth. This is the first time that research on replication of a sex education program has confirmed initial findings of effectiveness (Kirby 2001; Cloninger and Pagliaro 2002).

At least twelve of twenty-five comprehensive programs evaluated show strong evidence of increased condom and contraceptive use among sexually active participants (Cloninger and Pagliaro 2002). The aforementioned HHS study also suggests that Reducing the Risk and Postponing Sexual Involvement (PSI), which are "more focused behavioral-skills types of sex education," show some positive impact (Moore et al 1995). Skills-oriented TPP programs "combine the traditional informational approach with skill building activities" (Moore et al 1995).

In practice, both abstinence-based and comprehensive TPP programs that include "skill-building to practice refusal of sex and negotiate contraceptive or condom use" (Making a Difference; Making Proud Choices; Focus on Kids; Be Proud! Be Responsible!; Becoming a Responsible Teen), when utilized for African-American youth in inner-city locations, "had some positive effect on sexual behavior and/or contraceptive use" (Manlove et al 2004a). Be Proud! Be Responsible!; Becoming a Responsible Teen; and Safer Choices (HIV education

programs) reduced sexual risk behavior; decreased frequency of sexual intercourse; increased condom use; reduced incidence of unprotected intercourse; and decreased numbers of new sexual partners in comparison to non-participants (Cloninger and Pagliaro 2002). Other studies have shown that a number of other sex and HIV education programs (Safer Choices; both the abstinence approach and safer sex approach versions of Making a Difference) can delay sex or increase condom or other contraceptive use and thereby decrease unprotected sex substantially. Importantly, studies substantiate these positive behavioral effects for at least twelve to thirty-one months after the intervention (Kirby 2001).

The CDC identifies these sex and HIV education curricula as "having strong evidence of success" (Kirby 2001). Indeed, most studies find that "balanced, realistic sexuality education" that "includes information on *both* abstinence *and* contraception" can delay teens' onset of sexual activity, increase the use of contraception by sexually active teens, and reduce the number of their sexual partners (Feijoo 1999). Moore et al also cite research evidence of the positive impact of dual message programs that encourage both delaying sex but using contraception if and when they do have sex as "more effective than approaches that focus solely on abstinence or solely on contraception" (1995).

Manlove et al find that, in practice, a multiplicity of comprehensive programs, from short, curriculum-based sex education to intensive multi-year youth development, can have some positive outcome – delayed sexual initiation, improved contraceptive use or condom use, and/or reduced pregnancy/childbearing (2004a). In fact, any type of after-school TPP program appears to **"**have a positive influence on teen pregnancy risk even if they do not have a strong sex education focus" (Manlove et al 2004a).

The U.S. Surgeon General recommends providing TPP programs that include information about "optimal protection from sexually transmitted diseases and unintended pregnancy . . . while also stressing that there are no infallible methods of protection, except abstinence" (Hoff et al 2002). Furthermore, the American Medical Association, the American Academy of Pediatrics, the National Institutes of Health, the Institute of Medicine, and the Office of National AIDS Policy have each recently issued reports highlighting scientific research in support of comprehensive sexuality education (Howell and Feijoo 2001; Advocates/SIECUS 2001).

Cloninger and Pagliaro also refer to the American Academy of Pediatrics, American Medical Association, Centers for Disease Control and Prevention, Institute of Medicine (IOM), Office of National AIDS Policy, National Institutes of Health, Society for Adolescent Medicine, and the Surgeon General of the United States publications of research analyses that support comprehensive sex education effectiveness (2002). In other words, the most substantial evidence of TPP program effectiveness supports comprehensive programs (Cloninger and Pagliaro 2002): "These programs promote abstinence as the most effective way to prevent pregnancy and STDs while also providing medically accurate facts and clear messages about condoms and contraceptive use," plus age-appropriate activities that address peer pressure and engender communication, negotiation, and refusal skills (Cloninger and Pagliaro 2002).

Kirby's review of comprehensive TPP programs shows abstinence-based programs that position abstinence as the first and best choice for teens, but also encourage youth to use condoms and contraceptives if they do have sex, as the most effective for teens (2002). Many

rigorous studies reviewed by Kirby demonstrate that specific comprehensive TPP programs can delay teen sexual intercourse and reduce its frequency as well as increase condom and/or contraceptive use, both of which are linked to reducing adolescent pregnancy and STDs (Kirby 2002).

Comprehensive Education: Effective for Whom?

Research continually correlates demographic differences with teen sexual risk behaviors: evaluations suggest that different TPP programs have different levels of effectiveness for different groups. Differences in age appear to be the most consistently important factors in terms of program effectiveness – for example, certain curricula and programs are more effective for older vs. younger teens. There is also research that suggests that gender, race/ethnicity, and socioeconomic status play a significant role in determining risk-taking behavior and program impact. These differences highlight the importance of considering and focusing on a specific group when choosing and implementing a TPP program (Manlove et al 2004b). For example,

- boys age 14 and younger are much more likely to have sex than girls of the same age;
- 34 percent of African Americans report having sex before age 15;
- 19-21 percent of Hispanics have sex before age 15;
- 14-16 percent of European Americans have sex before 15;
- teens from families with higher incomes and educational levels are less likely to be sexually experienced than those from lower incomes and educational levels (Manlove et al 2004b);
- the likelihood of sexual intercourse increases with age;
- STDs are disproportionately present among teens aged 15 to 19 and young adults 20 to 24 (Manlove et al 2001).

Using a set of stringent criteria for inclusion and an extensive literature review, Alford et al compiled a set of rigorously evaluated TPP programs that have demonstrated effectiveness in reducing adolescents' risk for primary pregnancy, STDs, and HIV (2003).[4] The following sample of evaluated programs suggests the specificity of their effectiveness for various demographic groups. Most evaluations show that age, location, and race/ethnicity are the most important factors to consider when choosing a program:

- Reducing the Risk, designed for high school students, especially those in grades nine and 10; low risk; sexually inexperienced; urban, suburban, and rural; European American, Latino, Asian, and African American youth, led to an increase in parent-

[4] Criteria for effectiveness included**:** published in peer-reviewed journals; used an experimental or quasi-experimental evaluation design; involved at least 100 subjects; continued to collect data from both groups at three months or later after intervention; and demonstrated that the program led to at least two positive behavior changes among program youth, relative to controls: showed program effectiveness in reducing rates of pregnancy, STIs, or HIV in intervention youth, relative to controls.

child communication about abstinence and contraception; delayed initiation of sexual intercourse; and reduced incidence of unprotected sex among lower risk youth.

- PSI plus a five session human sexuality curriculum, targeted at eighth grade; African American; sexually inexperienced; high-risk youth delayed initiation of sex, reduced frequency of sex, and increased contraceptive use. When replicated in a different state without the human sexuality curriculum supplement, however, it led to no significant changes in participants' sexual behavior.

- Safer Choices, targeted for ninth and tenth grade; multiethnic; sexually experienced; urban and suburban youth, increased contraception and condom use and reduced the number of partners without the use of condoms.

- Making Proud Choices!, designed for African American youth, ages 11 to 13; middle school students / sixth and seventh graders; and urban youth, delayed initiation of sexual intercourse; reduced frequency of sex; reduced incidence of unprotected sex; and increased condom use (Alford et al 2003).

These key demographic differences, coupled with differences in program effectiveness for various groups, recommend that communities choose both their target audience and their TPP program as specifically as possible to increase potential program effectiveness. Program design and selection should be based on research that has shown programs to be effective with similar populations of teens. These programs should then be 'replicated with fidelity' (Kirby 2001).

Negative Impacts of Comprehensive Programs

Some studies contend that comprehensive programs have not been effective and may even lead to an increase in teen sexual risk taking. Besharov and Gardiner, for example, find a "lack of solid evidence" that sex education programs have been successful in affecting teen sexual risk behaviors (2000). Kirby and Coyle, writing for the American Enterprise Institute, reviewed evaluations of thirty-five school-based programs and found that sex and HIV education programs seem to have no *consistent* impact on behaviors (1997).[5] While the programs increased knowledge about sexual matters, they were not found to have an impact on sexual activity or number of partners. Some did however lead to greater condom and contraceptive use (Besharov and Gardiner 2000).

The Kirby and Coyle study refers to the oft-cited, popular conception that because they expose teens to information about sex and sexuality, sex and HIV education programs may encourage teen sexuality and lead to an increase in teen sexual activity, hasten the onset of sex, increase the frequency of sex, and/or increase the number of sexual partners (Kirby 1997; Kirby and Coyle 1997; Kirby 2001). Martin et al, for example, claim that comprehensive programs' "overwhelming focus on teen condom use creates the impression

[5] Their criteria for inclusion of an evaluation in their review were: the evaluation employed an experimental or quasi-experimental design, measured program impact on specified behaviors, and was published in a peer-reviewed journal (Kirby and Coyle 1997).

that nearly all teens either are or soon will be sexually active" (2004). They assert that comprehensive TPP programs fail to "provide convincing reasons for teens to resist physical passions or risk the apparent unpopularity and social 'isolation'" that might ensue from choosing abstinence. Abstinence-only advocates argue that because TPP programs present teen sex "as commonplace, healthy, and largely unproblematic," these programs "do not really discourage" teens from engaging in sexual activity. The result is an "underlying message that pervades each of the curricula reviewed that it is okay for teens to engage in sex as long as 'protection' is used" (Martin et al. 2004).

The Surgeon General, however, contends that according to recent research, comprehensive TPP programs do not increase adolescent sexual activity (Hoff et al. 2002; Hutchins 1999). The National Campaign to Prevent Teen Pregnancy also finds that TPP programs that promote abstinence and provide contraceptive information do not increase the frequency of sex or number of partners, nor do they lower the age at which teenagers first have intercourse (Hoff et al. 2002). A third study cites research that clearly shows that sex and HIV education programs do not increase sexual activity, hasten the onset of sex, increase frequency of sex, or increase number of sexual partners among teens (Kirby 2001). According to an HHS study, the "most consistent and clear finding is that sex education does not cause adolescents to initiate sex when they would not otherwise have done so" (Moore et al. 1995).

A separate evaluation of twenty-five studies of comprehensive TPP programs found that such programs neither accelerate the initiation of intercourse nor increase the number of partners among teens. Moreover, some of the comprehensive programs delay the initiation of sex and at least three of these programs decrease the frequency of intercourse and number of partners among sexually experienced teens (Cloninger and Pagliaro 2002; Advocates/SIECUS 2001). While raising an important caveat regarding the lack of methodological rigor in some of these evaluations, some sexuality and HIV education programs have been shown to significantly delay sexual activity or increase contraceptive use (Kirby 1997).

As Kirby warns and HHS corroborates, most TPP programs have not been subject to "a scientifically rigorous evaluation plan" and as such, it is unclear whether they are effective. The research that does exist on "traditional sex education" shows increased teen sexual knowledge but "little or no effect on whether or not teens initiate sex or use contraception" (Moore et al 1995). More skills-oriented TPP programs, however (Reducing the Risk, PSI), "have been shown to result in short delays in onset of sexual intercourse among some groups, and to have moderate effects on improving contraceptive protection among those who are sexually active" (Moore et al 1995). This National Campaign to Prevent Teen Pregnancy study also finds that where teens do become sexually active, these programs increase the likelihood that they will use contraception (Hoff et al 2002).

Impact of Abstinence-only Programs

Abstinence-only advocates claim that that abstinence-only TPP programs "are effective in reducing teen sexual activity" and "dramatically reduce out-of-wedlock childbearing" (Rector 2004). They report that "numerous evaluations show that abstinence programs are effective in encouraging young people to delay sexual activity" (Martin et al 2004). Authors writing on behalf of the American Enterprise Institute found one program, positioned as

abstinence-only although it did include information about contraception, to show modest results in delaying first sex, as well as increasing contraceptive use among those that did become sexually active (Besharov and Gardiner 2000).

More specifically, Rector cites ten evaluations, half of which were published in peer-reviewed journals, that demonstrate the ability of abstinence education to reduce teen sexual activity (2004). He mentions, in particular, Not Me, Not Now and virginity pledge programs (Rector 2004). Reviewing these same ten evaluations, however, Kirby finds that nine out of the ten studies "failed to provide credible evidence, consistent with rigorous standards, that these abstinence-only programs delayed the initiation of sex or reduced the frequency of sex" (2002).

Not Me, Not Now did seem to delay the initiation of sex among youth 15 and younger and may reduce pregnancy rates for youth 15 to 17. While this is encouraging, Kirby does not believe that this constitutes evidence that abstinence-only mass communications campaigns can produce these declines over time. Furthermore, while taking an abstinence pledge might delay initiation of sex among some groups under certain conditions, it might equally decrease their use of contraception when they do have sex. In general, Kirby does not find these studies representative of all studies of abstinence-only programs; other studies have less encouraging and even negative results (2002). Kirby therefore concludes that there do not currently exist any abstinence-only programs with strong evidence that they either delay sex or reduce teen pregnancy, and provide too little evidence to know whether they delay the initiation of sex (2002).

Other evaluations of abstinence-only programs seem similarly inconclusive. Feijoo, for example, finds little research that seems to indicate that abstinence-only programs "are effective at reducing rates of teen pregnancy or birth" (Feijoo 1999). The National Campaign to Prevent Teen Pregnancy evaluation of three abstinence-only programs found that none of them had an overall impact on sexual behavior or an effect on contraceptive use; they conclude that there is not yet enough evidence to assess effectiveness of abstinence-only programs (Hoff et al 2002; see also Besharov and Gardiner 2000). In another case, after reviewing the evaluation of federally-funded abstinence-only programs, a team of researchers was "unable to find studies that demonstrate the effectiveness of curricula that teach abstinence as the only effective means of preventing teen pregnancy" (Feijoo 1999). They then conclude that "there is mounting evidence suggesting that [abstinence-only] programs are generally ineffective" (Wilcox BL, Limber SP, O'Bierne H, Bartels CL cited in Feijoo 1999). A separate review of studies suggests that program participants who learn that "abstinence is the 'only certain way' to avoid pregnancy and diseases and that condoms and contraceptive methods are not reliable" but who do then become sexually active are less likely to practice prevention techniques (Advocates/SIECUS 2001).

A review of six major studies of abstinence-only Youth Education Programs finds that none have had consistent and significant effects on delaying the onset of intercourse (Bower 2002). Advocates for Youth and SIECUS review a number of studies and conclude that no "published studies in the professional literature" demonstrate that abstinence-only programs result in teens delaying the initiation of sex (2001). Another review of abstinence-only programs found no overall effects on sexual behavior and no evidence that any was effective in delaying first intercourse or in reducing the frequency of intercourse (Cloninger and

Pagliaro 2002). Even the American Enterprise Institute concurs that "there have been even fewer rigorous evaluations of abstinence programs, but like those of sex education programs, they have shown only mixed results" (Besharov and Gardiner 2000). In general, current evidence indicates that abstinence-only programs do not delay the onset of intercourse. This evidence remains inconclusive because the majority of evaluations have had, according to Kirby, "significant methodological limitations" (1997). This then suggests the need for further research on the impact of abstinence-only programs.

Collecting "definitive and rigorous evidence on program impacts is a complicated, long-term process;" at this point it appears that statistically significant evidence of the impact of abstinence-only education is not yet available (Devaney et al 2002). As aforementioned, Mathematica Policy Research Inc. is currently evaluating Abstinence Education Programs funded under Title V Section 510 for HHS; this report is due summer 2005. Their early results, however, corroborate the above conclusion that there does not yet exist definitive research that can link abstinence-only education with downward trends in teen pregnancy rates. It remains to be seen to what extent abstinence-only programs are able to persuade youth to change their sexual behavior and remain/become abstinent. While the "few rigorous studies of abstinence-only curricula that have been completed to date do not show any overall effect on sexual behavior or contraceptive use," this does not mean that they have no value or should be abandoned (Kirby 2001).

The Annie E. Casey Foundation recommends that in the face of the lack of evidence to date that abstinence-only programs do not decrease teen sexual risk-taking, the U.S. should "rethink the focus of abstinence-only programs" (Shore 2003). The Institute of Medicine has called upon Congress to rescind funding for abstinence-only-until-marriage education because there is no evidence supporting its effectiveness (Cloninger and Pagliaro 2002).

Given lack of evidence at this time, the Surgeon General recommends more research on abstinence-only TPP programs in order to assess their effectiveness (Hoff et al 2002). In the interim, sexuality education should stress "benefits of remaining abstinent until involved in a committed, enduring, and mutually monogamous relationship," while providing "awareness" of how to protect against STDs and pregnancy, and "stressing that there are no infallible methods of protection, except abstinence" (Satcher 2004).

Teen Pregnancy Prevention Programs Best Practices

Most research on TPP has sought to locate best practices to consider when designing and/or selecting an appropriate program (Moore et al 1995; Kirby 1997; Kirby 2001; Bower 2002; Hoff et al 2002; Shore 2003). In general, the most effective TPP programs are "comprehensive, flexible, responsive, and persevering" (Bower 2002). Thinking holistically, the Annie E. Casey Foundation recommends "teaching adolescents the skills necessary to handle relationships, resist peer pressure, and negotiate difficult situations" (Shore 2003). After that, TPP programs should be directed to both males and females; focus on a wide spectrum of risk-taking behaviors, not just sex; begin prevention efforts well before the teen years; and seek to prevent both first-time and subsequent pregnancies (Shore 2003; see also Bernard and Knitzer 1999). Bower corroborates the importance of focusing on risk behaviors while also stressing the importance of being age- and culturally-appropriate, providing

accurate information, and introducing specific models and practices (2002). In general, one intervention strategy cannot meet the needs of all teens and therefore providers should choose programs targeted to their specific audience.

When considering program concentration, research recommends beginning with clear, concrete, and attainable objectives (Moore et al 1995). Programs should then focus on a wide spectrum of risk-taking behaviors, not just sex (Bower 2002; Shore 2003). Focus should then be on *both* boys and girls (both separately and together), early, and well before the teen years, while simultaneously maintaining an age-appropriate perspective (Kirby 1997; Bernard and Knitzer 1999; Hutchins 1999; Besharov and Gardiner 2000; Kirby 2001; Shore 2003). Programs should be research-based, that is, established on the foundation of previous research and theory, with special attention to the social learning theory paradigm (Moore et al 1995; Kirby 2001; Bower 2002).

Ultimately, the majority of research has found that both abstinence and safer sex messages are appropriate for younger and older teens. Programs should provide information about abstaining from sex as the safest choice for teens as well as the benefits of abstinence at the best protection against pregnancy and STDs. Programs are then most effective when they provide specific and accurate information about sexual behavior and contraceptive use (Moore et al 1995; Kirby 2001; Shore 2003; Manlove et al 2004b). The longer, more intensive, multi-component, and comprehensive a program, the more effective it will be – with added emphasis on the effectiveness of longer programs (Hutchins 1999; Kirby 2001; Bower 2002; Hoff et al 2002; Manlove et al 2004a and 2004b).[6]

When considering particular components to include, research recommends interactive activities and active rather than passive strategies, that help adolescents to personalize sexual issues including discussion and role-playing activities (Moore et al 1995; Hutchins 1999; Kirby 2001; Manlove et al 2004b). These activities should focus on skills-building in a number of areas, especially communication, negotiation, refusal, and goal-setting, while engendering a sense of the future (Moore et al 1995; Feijoo 1999; Hutchins 1999; Shore 2003; Manlove et al 2004b). A key and concomitant focus of these activities should be to directly address peer and social – especially media-based – pressure surrounding teen sexuality (Moore et al 1995; Kirby 1997 and 2001; Bower 2002; Shore 2003). Of course a well-trained staff is essential (Bower 2002). So too is carefully following – and not altering in any way – the curriculum. Altering the content of the curriculum runs the risk of reducing the program's effectiveness; as such, programs must "replicate with fidelity" (Kirby 2001; Manlove et al 2004b). Programs should also incorporate a scientifically rigorous evaluation plan in order to measure their own effectiveness (Moore et al 1995). For further, targeted best practices in TPP, see the research-based lists in Appendix A.

[6] Here, comprehensive meant that sex education was one of many components, including individual tutoring, sports, arts, work-related activities, health care services; it was also a very expensive program (Hoff et al 2002).

Chapter 3

Program Design and Implementation

Program Design

DOE contracted with school-, community-, and faith-based organizations to implement the TANF Initiatives TPP program. While the program allowed contractors considerable flexibility in developing a program tailored to their own specific community needs and organizational capabilities, DOE required the use of research-based curricula, promoted the implementation of best practices, and increased overall attention to quality, accountability, and outcomes. The RFP required that contractors implement program activities that included a combination of the following: life skills training, mentoring, social interventions, community service, parental involvement, responsible parenting, and male involvement. DOE encouraged use of curriculum-based TPP best practices by requiring that contractors address how they would include best practices in their programs and discussing best practices in curriculum trainings. Best practices DOE expected contractors to use include:

Exhibit 3.1

Teen Pregnancy Prevention Best Practices

- Reducing one or more of the sexual behaviors that lead to unintended pregnancy or HIV/STD infection by focusing on a small number of behavioral goals, such as delaying initiation of intercourse
- Influence decisions regarding risky behaviors through changing individual and group values and perceptions and building responsible social skills that lead to a voluntary change in behavior
- Consistently reinforce a clear message about abstaining from sexual activity and/or that unprotected sex is clearly an undesirable choice
- Provide basic, accurate information about the risks of teen sexual activity and ways to avoid intercourse
- Modeling and practice with communication, negotiation, and refusal skills (role-playing, verbal tools to say no to sex, reinforced body language, etc.)
- Appropriate staff, with sound teaching methods appropriate for the targeted population, with whom the participants can identify
- Age-, experience-, and culturally-appropriate curricula and program activities
- Program operation for an amount of time and offering a variety of activities so as to have a real influence on behavior

Source: Louisiana Department of Education, FY 03 -04 Teen Pregnancy Prevention Request for Proposals and contracts.

In the proposals for TANF Initiative TPP Programs, contractors were required to select at least one of the fourteen DOE-approved teen pregnancy prevention curricula. In addition, contractors were required to include Personal Social Skills (PSS), a skills-based curriculum focusing on building decision-making, communication, and self-management skills. The TPP RFP indicated that all staff interacting with participants in curricula components must be able to document attendance at DOE-provided trainings. Additionally, contractors were encouraged to specify in their proposals the overall strategy and planned program components.

As mentioned in the literature review of this report, many of the DOE-mandated curricula[1] have been shown to have a positive impact on teen risk-taking behaviors. While our review did not include analysis of all DOE-mandated curricula[2], DOE hired an experienced professional to identify TPP curricula proven to have a positive impact on teen sexual risk-taking. The list of curricula included those that demonstrated positive outcomes for groups with similar demographics of students at risk for early sexual activity, pregnancy, and STD infection; had multiple evaluations, showing positive impacts on youth; had been evaluated in peer-reviewed journals; and had been evaluated by entities not associated with the publisher. Ultimately, those chosen by DOE were identified by multiple sources as effective curricula recommended by experts in the field.

Overall, in comparison to the DSS program, the design of the DOE TPP program offered increased support for contractors, including trainings and ongoing technical assistance. DOE ensured the capacity of providers to implement their chosen curricula effectively by mandating that each staff person from all contractors attend curriculum trainings. Of the fourteen mandated curricula, DOE provided at least one full day of training for eight of the mandated curricula including: Be Proud! Be Responsible!, Becoming a Responsible Teen (BART), Can We Talk, Focus on Kids, Human Sexuality Values and Choices, Making a Difference, PSS, and Reducing the Risk in the fall of 2003. The majority of curriculum trainings were offered in Alexandria, as it is centrally located in the middle of the state. Professional STD and HIV/AIDS prevention education trainers hired by DOE conducted all curriculum training.

In addition to curriculum-based training, DOE also offered a number of other trainings geared toward improving the overall capacity of contractors. Topics included utilizing the DOE on-line participant tracking system; selecting the best curriculum; teen pregnancy prevention best practices; non-profit accountability and fiscal management; grant writing; and research-based programming. These trainings occurred over the course of the contract year and were conducted by a variety of professionals, including DOE staff, representatives from the Louisiana Association of Nonprofit Organizations (LANO), representatives from the Southwest Educational Development Laboratory (SEDL), and professors from the University of Louisiana at Monroe.

[1] For instance, Be Proud! Be Responsible!, Becoming a Responsible Teen, Focus on Kids, Get Real About AIDS, Making Proud Choices, Reducing the Risk, Making a Difference, Postponing Sexual Involvement (PSI), and Teen Outreach Program have been shown to have positive impacts on teen pregnancy and risk factors associated with teen sexual activity.

[2] Curricula that were not examined in our literature review include Human Sexuality and Choices: A Value Based Curriculum, Wise Guys, Can We Talk, and Choosing the Best.

Exhibit 3.2
Required Curricula for TPP Programs

Curriculum	Age or Grade Level	Focus
Be Proud! Be Responsible!	Ages 12-19	African American males. HIV prevention; and communication skills.
Becoming a Responsible Teen (BART)	Ages 14 - 18	African American males and females. Abstinence; group discussions, role-play.
Focus on Kids	Ages 9-15	African American males and females. Abstinence; group discussions; role-play; and decision-making skills.
Get Real About AIDS	Grades 4-6 and 6-9	Ethnicity/gender not specified. Abstinence; group discussions, role-play.
Making Proud Choices	Ages 11-13	African American males and females; abstinence; and STD, HIV, and pregnancy prevention.
Reducing the Risk	Grades 9-10	Abstinence; risk of teen parenthood; and HIV and STD infection.
Making a Difference!	Ages 11-13	Abstinence; HIV, STD, and pregnancy knowledge; refusal, negotiation skills, and self-efficacy.
Postponing Sexual Involvement	Grades 6-7 and 11-12	Abstinence focus; risks of early sexual involvement; societal pressures; and nature of relationships.
Human Sexuality Values and Choices: A Value Based Curriculum	Grades 7 and 8	Abstinence and parent/adolescent communication; promotes seven core values.
Wise Guys	Ages 11-19	Abstinence; male responsibility; goal setting, decision making and resisting peer pressure; communication with parents and peers.
Personal Social Skills (PSS)	Grades 6-12	Skills-based curriculum focusing on decision-making, communication, and self-management.
Can We Talk	Grades 4 - 8	Abstinence; parent/adolescent communication.
Choosing the Best	Grades 6 - 12	Abstinence-only curriculum; parent survey; student lessons and group activities.
The Teen Outreach Program (TOP)	Ages 12 - 17	Abstinence; youth development; service learning and community involvement.
Safer Choices	Grades 9-10	Abstinence; safer sex; increasing knowledge of STDs/HIV.

Source: Louisiana Department of Education, Teen Pregnancy Prevention Research-based Models.

To reinforce curricula training, DOE organized "curricula coaching," or on-site assistance for contractors. In this component, the plan was for each contractor's program director to select one site and instructor to receive a series of at least five on-site visits. According to DOE, a total of seventeen contractors received between one and five curricula coaching visits and more than half of these (65 percent) received three or more visits. DOE's curricula coaches worked individually with instructors on curricular implementation; teacher/student communication skills; student involvement; participation and discussion of sensitive topics; and student and teacher comfort level with the TPP material.

RFP and Reimbursement Process

According to the RFP, DOE expected to award $5.5 million to TPP contractors through a competitive bidding process that took place in August 2003. Contracts were awarded and services began in September 2003. A total of thirty-six different organizations received TANF Initiatives funding for TPP programs in FY 2004.

The RFP specified that funds were available for both community- and school-based interventions. In cases where contractors proposed to serve males, the RFP required contractors to address how to target the unique needs of this group. Additionally, contractors proposing to serve multiple age groups were to provide detail on how services would target the needs of these groups. As in past years, DOE based funding decisions on a scoring rubric and provided extra points based on the percent of live births to teenage mothers in the contractor's Parish in 2000.

As Exhibit 3.3 shows, under DOE there have been significant changes in the accountability system of the TPP program. One primary change has been the way that contractors bill and are reimbursed for providing TPP services. In previous years, TPP contractors submitted receipts for all expenditures and received direct reimbursement from DSS. DOE requires that contractors submit monthly calendars of proposed services for each site of operation, including the target number of student contact hours for the contract year. Each contractor's annual TPP budget is based upon reimbursement of seven dollars per contact hour as projected in the proposed monthly calendars. All TPP contractors were required to track student contact hours and report them to DOE. Contractors were also required to report participation, retention rates, and staff training. All data were submitted via ASSIST, the on-line DOE database. Contractors' monthly reimbursement was based on the actual number of contact hours reported. Contractors were required to deliver 80 percent of the projected contact hours in order to receive full reimbursement each month. Basing reimbursement upon actual number of students and contact hours delivered represents a significant change from previous TANF Initiative-funded TPP programs.

In another departure from the DSS TPP program, the RFP noted that contractors were not able to receive TPP reimbursement for providing after-school tutoring, academic assistance, or job training. Contractors were, however, encouraged to partner with providers of these services so that academic and job related activities would be available to program participants. The RFP also stipulated that contractors were required to use an electronic, web-based tracking system for monthly reporting and reimbursement, and that social security numbers had to be entered into the ASSIST database.

Exhibit 3.3
Teen Pregnancy Prevention Changes in Program Design and Administration

	DOE	DSS
Best Practices outlined in RFP	√	√
RFP requires life skills training and social interventions	√	√
Reimbursement based upon number of participants served	√	
Cost reimbursement		√
RFP suggests primary prevention, intervention, or accountability strategies	√	√
Contractors required to report enrollment and participation data using on-line database	√	
RFP requires curriculum-based approach	√	√
Programs consistently utilizing approved curriculum	√	
Clear monthly reporting requirements	√	
Curricula training	√	
Curricula coaching	√	
Funds after-school tutoring or academic assistance		√
Funds job development or training assistance		√
All contractors and sites receive programmatic and fiscal monitoring visits	√	

Source: Louisiana Department of Education, FY 03-04 Teen Pregnancy Prevention Request for Proposals and contracts; Louisiana Department of Social Services, FY 02-03 Teen Pregnancy Prevention Request for Proposals; and BPA, Year 2 Evaluation of the TANF Initiatives, Teen Pregnancy Prevention Program, September 2003.

Emphasis on TPP Program Outcomes

In contrast to DSS policy, DOE emphasized that TPP contractors be held accountable for meeting performance targets and goals. One section of the RFP stated that contractors were expected to document the following: achievement of 50 percent of projected enrollment; a decrease in participant risk behaviors; a 20 percent increase in knowledge of preventing pregnancy; a 20 percent increase in parenting skills/knowledge based on a pre/post survey; and a 50 percent completion rate of contractor's program or program cycles.

Another section of the RFP provided direction on performance measures, stating that contractors were expected to track and report participation and retention rates, student contact hours, staff training, and program components. The RFP explained that contractors must meet performance targets of 50 percent attendance and 50 percent retention. This part of the RFP also stated that contractors must enroll at least 80 percent of projected participants, rather than 50 percent as noted above, in order to receive full reimbursement.

According to DOE respondents, the primary performance measures utilized to assess contractors' progress are the monthly goals of an 80 percent participation rate and a 50 percent retention rate. These measures were monitored using data entered into the ASSIST database by individual contractors. Decreases in risk behaviors and gains in knowledge performance targets were to be measured by the pre/post participant survey administered to all eligible community-based contractors during winter and spring 2004 by BPA.

Program Implementation

Overview

BPA gathered information about the TPP program implementation from four primary sources: a contractor survey; in-depth site visits and interviews with staff from nine TPP service delivery locations representing eight TPP contractors; interviews with DOE staff administering the program; and a review of TPP background materials. The contractor survey was administered in May and June 2004. Contractor site visits took place in April through June 2004. Initial interviews with DOE staff took place in February 2004.

A total of thirty-six contractors received TPP funding for the 2003–2004 contract year; thirty-four contractors continued providing TPP services through the end of the contract year. Most contractors offered services at multiple sites. Among the twenty-seven contractors that completed the TPP contractor survey, the majority of programs were operated by community-based organizations (56 percent); the rest were operated by faith-based organizations (26 percent), school-related organizations (15 percent), or municipalities (4 percent). Many contractors (69 percent) receiving DOE TPP funding in FY 2004 had operated TPP programs in previous years as a part of the TANF Initiatives.

The majority (96 percent) of TPP programs that completed the contractor survey operated year-round. Most TPP contractors operated during after-school hours (89 percent) and during summer weekends (85 percent). A few contractors also offered services during school hours

(37 percent). Contractors provided services for varying lengths of time ranging from a minimum of ten weeks to a maximum of fifty-two weeks. Seventy-seven percent of contractors offered services for forty or more weeks. Contractors served participants between two and fifty-five hours per week, with ten out of twenty-seven contractors offering services for more than twenty hours. These reported hours seem very high and may reflect misunderstanding on the part of the survey respondents as to what constitutes service hours.

TPP contractors varied greatly in the number of participants they anticipated serving during the FY 2004 contract year from a low of twenty-four to a high of 3,000. This large variance is related to the range in the number of sites – from one to seventeen – operated by contractors.

The majority of TPP programs that completed the contractor survey provided services on a school campus (63 percent) and/or at a community or family center (52 percent). Other common service delivery-facilities included church sites (41 percent), non-profit organizations (26 percent), and office or business establishment meeting space (22 percent).

Outreach and Recruitment

Most TPP contractors reported a need for ongoing outreach and recruitment activities in order to meet monthly participation targets. Indeed, only 15 percent of contractors indicated not needing any outreach or recruiting to meet targets. Word of mouth was the most common recruitment tool utilized (85 percent), followed by distribution of flyers, signs, and posters (81 percent); presentations at community groups (74 percent); promotion of TPP program to other programs (70 percent); and announcements through local media (52 percent). All site visit contractors combined multiple outreach and recruiting methods.

Among TPP programs at which BPA conducted site visits, many contractors reported recruitment challenges. Two contractors, well established in their communities, reported not needing DOE technical assistance in this area. The majority of contractors reported receiving suggestions and technical assistance on recruitment/retention strategies from their assigned DOE contract officer once it was apparent the contractor was experiencing difficulties. Overall, newly established programs as well as those without school-based sites were more likely to experience recruitment challenges.

Among site visit contractors, the most common recruitment challenges involved community resistance to the discussion of teen pregnancy and sexual activity. Transportation and access issues constituted two other important challenges. Three contractors cited specific issues including community discomfort with discussion of sexual activity outside of the home and denial about the potential for teen sexual activity. For the most part, contractors reported overcoming community resistance to their programs and/or finding creative methods to mitigate the impact of this community resistance. In one case, the youth services arm of a faith-based contractor avoided referring to the program as “teen pregnancy prevention” and instead called the TPP program “Operation Blessed.” Additionally, the contractor moved the location of the program’s service delivery sites to another church-owned building, in an effort to circumvent the congregation’s concerns about providing TPP services in-house.

Contractors reported a number of other barriers to achieving full program participation. Transportation challenges were prevalent among contractors not operating at school sites, especially in rural and remote parts of the state that lack public transportation. One contractor indicated difficulty recruiting junior high and high school teens when elementary school-age children were also enrolled. Another contractor referred to ongoing challenges related to gaining sufficient trust of youth and their parents so that they will provide social security numbers, required by DOE for reimbursement. Respondents explained that recent public awareness campaigns regarding "identity theft" are strong factors in dissuading parents from sharing such important, private information.

The majority of contractors reported developing outreach and retention strategies to raise enrollment to the level originally proposed. In order to maintain participation, survey respondents utilized a range of retention strategies. The retention strategies rated most helpful included using staff or other adults as role models (100 percent); providing a safe place to discuss sensitive issues (100 percent); including program field trips (96 percent); providing activities or opportunities to spend time with peers (96 percent); and working with parents (92 percent). Other important retention strategies included scheduling the TPP program at a time less likely to conflict with school or employment-related activities (89 percent) and providing meals or snacks (85 percent). Interestingly, in terms of maintaining youth participation, formal service provision to parents (i.e. curricula-based work with parents) was rated less helpful (63 percent) by survey respondents than including parents or guardians in program activities (85 percent).

Contractors visited by BPA reported regular field trips, cultural and arts activities, guest speakers, and other extracurricular activities as important retention strategies. Many contractors included regularly providing snacks or activities that include food, such as pizza parties. Additionally, many contractors incorporated peer mentors or educators, often former program participants, as assistants to help with service provision. Two contractors also encouraged parental interaction with staff as a way to ensure continued participation of their children. One program provided weekly calls to parents to update them on their child's progress; another required parents to go into the facility daily to sign their children in and out.

Two site-visit contractors reported particular success at improving retention by incorporating mechanisms for participant input into the rules, activities, and services of the program. In one case, each TPP group elected "student officers" who were charged with meeting with program staff once a week to assist in program planning. The second practice encouraged participants to provide feedback into the design and administration of the program, and promoted participant collaboration by having participants join the organization's board of directors.

Staffing

All contractor survey respondents reported the selection of teachers who care about the goal of reducing teen pregnancy as a major focus of their TPP program. On site visits, there was a clear focus on hiring teachers who possess the background, skills, and experience necessary

to make the programs a success. For instance, three contractors used certified classroom teachers to work with participants. Additionally, several contractors had strict educational and work experience requirements. One program, for example, required TPP instructors to have a Bachelor's Degree and significant relevant work experience, and required program supervisors to have a relevant Master's Degree.

Several contractors noted barriers to hiring qualified staff. Hiring was particularly difficult in rural areas where contractors reported a lack of qualified applicants and a lack of comfort with the curricula subject matter. Additionally, several of the well-established contractors noted a need for increased funding to support hiring of additional instructors, making it possible to extend services to new sites in order to reach all potential participants and more effectively serve the youth in their area.

Several site visit contractors noted that difficulties recruiting qualified instructors were exacerbated by the impression that DOE would only allow contractors to hire part-time TPP staff. DOE respondents reported that contractors' proposals had to include a justification for each staff line item as well as adhere to a 10 percent cap on administrative expenditures, including funds allocated to pay administrative salaries. While the RFP and contracts do not specifically disallow contractors from hiring full-time staff, part-time staffing often became the default, as contractors operated on a less than full-time basis and did not have funds to pay instructors' salaries beyond the TPP program.

Curricula and Training

An integral component of the design and implementation of the TANF Initiatives TPP program was the emphasis on increasing the quality of TPP programs and provider capacity to implement research-based curricula. As mentioned above, in prior years the TPP TANF Initiative suggested that grantees use specific curricula but paid little attention to ensuring that grantees had the capacity to implement them. Lacking training and support, some contractors opted to deliver curricula in one or two sessions. These short-term workshops are generally considered less effective than longer-term, curricula-based interventions (Kirby 2001).

Under DOE administration, contractors were required to implement at least one of the DOE-approved, research-based teen pregnancy prevention curricula in tandem with the Personal Social Skills (PSS) curriculum. In an effort to improve provider ability to implement the TPP curriculum, DOE conducted curriculum-based and best practices training during the course of the contract year; announced and unannounced fiscal and programmatic monitoring visits to all grantees and many of the service sites; and ongoing technical assistance and communication via phone and e-mail. Each grantee was assigned a DOE contract officer (also referred to as the Education Program Coordinator) responsible for providing information to and fielding questions from grantees about best practices, curricula implementation, and reporting requirements. Contract officers were also responsible for conducting fiscal and programmatic monitoring visits. Some contractors also participated in curricula coaching. The coaching component was separate and distinct from contract compliance oversight, although there was communication among the various staff to ensure that programs were running effectively.

All contractors surveyed reported utilizing at least one TPP curriculum. As shown in Exhibit 3.4, the most common curricula included Be Proud! Be Responsible!, Becoming a Responsible Teen (BART), Focus on Kids, and Making a Difference; each of these curricula were used by 22 percent of contractors. Other popular curricula included Reducing the Risk (19 percent), and Choosing the Best and Wise Guys, both used by 15 percent of contractors.[3] Most contractors (93 percent) reported that their chosen curricula met or exceeded their expectations and all contractors (100 percent) reported that the curricula were somewhat or very appropriate.

Exhibit 3.4
Teen Pregnancy Prevention Programs Curricula Use

Curriculum	Range of Weeks Utilized	Number of Programs Using	Percent of Programs Using
Be Proud! Be Responsible!	10 - 32 weeks	6	22%
Becoming a Responsible Teen (BART)	12 - 16 weeks	6	22%
Focus on Kids	10 - 50 weeks	6	22%
Get Real About AIDS		1	4%
Making Proud Choices	10 - 16 weeks	4	15%
Reducing the Risk (RTR)	25 - 48 weeks	5	19%
Safer Choices		1	4%
Making A Difference!	20 - 40 weeks	6	22%
Postponing Sexual Involvement (PSI)	6 weeks	2	7%
Wise Guys	12 - 16 weeks	4	15%
Personal Social Skills (PSS)	2 - 42 weeks	18	66%
Can We Talk	1 - 32 weeks	7	26%
Choosing the Best	32 - 36 weeks	4	15%
Teen Outreach Program (TOP)	0 - 12 weeks	3	11%
Sample size		*27*	

Source: BPA TPP Contractor Survey, June 2004.

[3] As mentioned in the literature review section of this report, Be Proud! Be Responsible!, BART, Making a Difference; and Reducing the Risk are all TPP curricula that have been shown to have positive impacts on reducing risk factors associated with teen pregnancy.

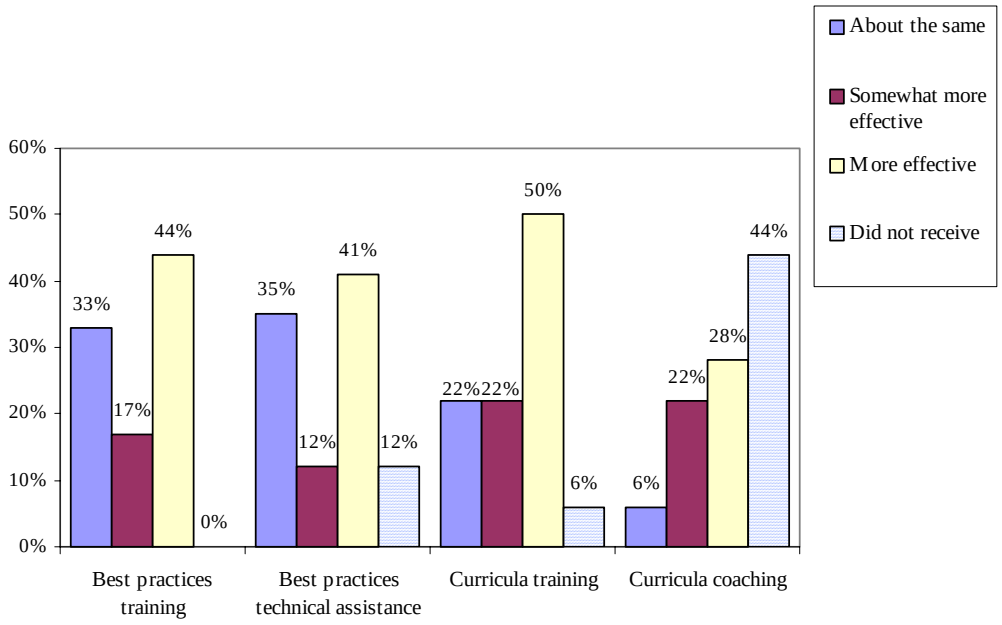
All contractors visited on site reported implementing the PSS curriculum and at least one of the DOE-approved research-based curricula. For the most part, they found the curricula easy to work with and effective at conveying abstinence-based messages that are simple to understand. Many respondents mentioned that using the curricula added value to their programs. Since DOE instituted more stringent curricula requirements, two site visit contractors changed their format from a short-term workshop-based program to a curriculum-based program. Both contractors perceived the change in format to be positive overall, stating that the curriculum-based format is more effective at teaching individual participants the skills needed to prevent teen pregnancy.

As shown in Exhibit 3.5, survey respondents indicated that the assistance, coaching, and training in curriculum and program implementation has been more effective than that received under DSS administration. All survey respondents reported receiving best practices training and 61 percent reported that the training was more effective than in previous years. Most respondents indicated receiving best practices technical assistance (88 percent) and 53 percent reported that best practices training was more effective than in previous years. Nearly all respondents indicated that their program received curricula training (94 percent). Fifty-six percent of contractors indicated receiving curricula coaching. Among those who received coaching, 50 percent rated it more effective than similar services received in previous years. Only two contractors at which BPA conducted site visits participated in the DOE coaching component, although several others mentioned an interest in and need for such services. One of these contractors mentioned specifically that the DOE coaching component was "very helpful"; coaches provided important instruction on the most effective methods of incorporating the curricula. These findings are corroborated by DOE TPP process evaluation findings[4] which demonstrate that 57 percent of respondents agreed or strongly agreed that the curricula coaching component was beneficial. Only 5 percent of respondents did not agree with the statement and 39 percent of respondents reported that the question did not apply. Despite the seemingly favorable response to curricula coaching, DOE respondents noted that they have decided not to use curricula coaching next year, citing perceived lack of contractor benefit from curricula coaching.

While the coaching component seems to have been a success overall, there were some challenges. For instance, one site visit contractor described curricula coaches as disorganized and "combative." In this case, the contractor made an appointment with a DOE coach but the coach did not keep the appointment and never called to reschedule. Additionally, despite the fact that DOE's original goal was for all TPP contractors to participate in coaching, only 56 percent of contractors actually received ongoing, on-site coaching. According to DOE respondents, a few of the curricula coaches that DOE hired did not fulfill their contracts. As a result, some contractors were ultimately unable to benefit from coaching. This was unfortunate given that several site visit contractors indicated they would have benefited from more guidance on the best ways to implement curricula.

[4] In the Spring 2004, DOE undertook a process evaluation, which sought to provide DOE with feedback about the FY 2004 TPP RFP process. DOE utilized the process evaluation to make changes in the RFP process for the FY 2005 TPP Program.

Exhibit 3.5
Effectiveness of DOE Training



Source: BPA TPP Contractor Survey, June 2004.

Despite ongoing emphasis on empowering contractors to utilize their chosen curricula, curricula-related challenges remain. While all site visit contractors implemented PSS and at least one of the DOE-approved research-based TPP curricula, only 66 percent of contractors surveyed reported utilizing the PSS curriculum. In addition, although the TPP RFP indicated that all staff interacting with participants in curricula components must be able to document attendance at DOE trainings, in many cases contractors sent only program administrators to them. TPP teachers and instructors, the staff most likely to implement curricula, often did not attend the trainings. In some of these cases, contractors reported providing in-house training to disseminate information from the training to direct service staff. While this could be an effective way to distribute the information, DOE's goal of training all instructional staff was not fully achieved.

Contractors visited by BPA identified some shortcomings in the training and additional topics they would have liked trainings to cover. These included a need for training on integrating the various curricula into a more holistic program, integrating the teen pregnancy prevention curricula with the skills-based PSS curricula, and additional curricula to supplement the curricula already being used. Several contractors reported a need for additional materials including visuals, information on peer pressure, STDs, and human biology.

A few contractors raised concerns about the timing of the DOE trainings. The majority of the curricula trainings occurred in November, two months after contractors began providing services. This was particularly challenging for newer TPP contractors or those working with new instructors. Further, a few contractors indicated that curricula trainings were often scheduled too close together and sometimes on the same day, forcing individual staff to forego some trainings in order to participate in others. Finally, one contractor noted registration challenges, never receiving any confirmation of registration or any additional information on the content to help the contractor assess whether the training would be beneficial. This contractor suggested that DOE send confirmations as contractors register and provide more specific information on the training content in advance of the training.

Many of the visited contractors appeared to need technical assistance on implementing their chosen TPP curricula. One contractor noted that they integrated parts of other curricula, including Making a Difference and Making Proud Choices, in order to address specific issues that were not covered in the abstinence-only curricula they had chosen. This is somewhat disconcerting, given that Making a Difference and Making Proud Choices are two of the three curricula that the National Campaign to Prevent Teen Pregnancy specifically designates as curricula that should be adhered to as written and which should not be modified by instructors in any way (Manlove et al. 2004a). Additionally, several contractors reported they did not receive direction from DOE with respect to the concepts that should be covered or a timeframe for covering the concepts. As previously mentioned, several site visit contractors noted they were either never offered or never received DOE coaching services, even though they wanted to participate and felt it would be beneficial to their program.

Many contractors reported a need for training on topics other than curricula, as well as networking opportunities that would improve their capacity to provide seamless services. Three contractors expressed an interest in attending regionally-focused, DOE-sponsored networking events that would provide a chance for contractors to exchange ideas and solutions unique to TPP programs in their area. Several contractors mentioned a need for budget design and administration training; such training should cover specific topics including allowable costs, payment requisitions, and spending history. Three contractors noted a need for training on effective classroom discipline as well as the developmental phases of teens in order to help contractors work more effectively with the population. Several contractors mentioned a need for training on how to capture and sustain participant attention to specific issues. One program mentioned a need for training on why they are teaching the teen pregnancy prevention material so that they can gain insight into how to best reach participants. This specific request seems to be for more background on the theory behind the curriculum in order to better prepare TPP instructors to effectively convey the material.

Many contractors also had specific feedback about the mandated curricula. A few mentioned that the abstinence-based curriculum is “not enough” and must be supplemented with other information on safer sex. Three contractors indicated that Making a Difference (which targets ages 11 to 13) and Wise Guys (which targets ages 11 to 19) curricula were too advanced for the participants being served. Similarly, other contractors noted a need to add explanatory aids to the curricula to help instructors simplify material that is too advanced for some

younger participants. It appeared that some contractors may have chosen curricula not intended for the age group they served.

Finally, even as contractors experienced difficulties and indicated an ongoing need for technical assistance in many areas, the overriding message is that the TPP program improved significantly under DOE administration. In previous years, contractors did not receive any curriculum training; under DOE, 94 percent of contractor survey respondents reported receiving curricula training. In the previous year, curricula coaching did not occur at all; this contract year 56 percent reported participating in curricula coaching. As mentioned, last year many contractors utilized very short-term interventions, such as Baby Think It Over retreats,[5] with only 51 percent of contractors utilizing approved TPP curricula. This year, however, contractors utilized longer-term curricula-based interventions and nearly all contractor survey respondents indicated using the DOE-approved TPP curricula.

Participants Served

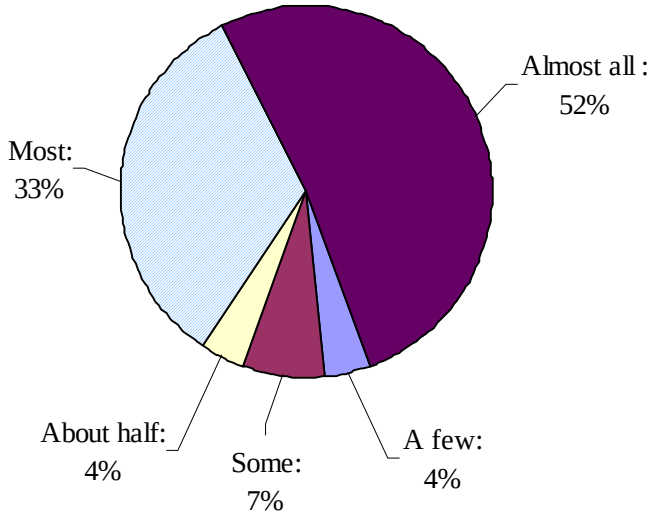
The DOE TPP TANF Initiative targeted youth ages 8 to 20 and all contractors indicated serving youth in this age range. More than a quarter of contractors served youth younger than age 9 (26 percent). A majority of contractors reported serving youth ages 10 to 13 (93 percent) and ages 14 to 16 (96 percent). Sixty-three percent of contractors indicated serving youth ages 17 and older. More than half of contractors served predominately African American youth (63 percent). Twenty-two percent served youth from a variety of ethnic backgrounds and 15 percent of contractors served youth who are either white or African American. Most contractors served both boys and girls (67 percent). However, 11 percent exclusively focused their efforts on girls. The remaining contractors either served mostly boys (11 percent) or mostly girls (11 percent).

As mentioned, the DOE TPP Initiative was designed to target youth in areas with high teen pregnancy rates. In addition, even though there are no particular income eligibility requirements, many of the visited contractors primarily served youth from low-income backgrounds. Several contractors also targeted children who were more likely to experience risk factors associated with teen pregnancy, including being from a single-family household or having difficulty in school. Contractor survey data corroborate the finding that many TPP participants are from low-income families. As detailed in Exhibit 3.6, 52 percent reported that almost all program participants were eligible for the free or reduced lunch program, while 33 percent reported that most participants were eligible for free or reduced lunch.[6]

[5] Baby Think It Over (BTIO) infant simulators are lifelike, life-size baby dolls with realistic computerized responses, which allow teens to experience some of the demands of infant care. Under DOE some contractors elected to use BTIO "weekend retreats" to help teens better understand and appreciate the responsibilities of parenthood.

[6] The number of children who qualify for free or reduced price school lunches in public schools as a part of the National School Lunch Program is a commonly used indicator of childhood poverty in a community. Although the standard for enrollment in free or subsidized school lunch programs changes from year to year, this measure remains a useful barometer of childhood poverty rates. Children from families with incomes at or below 130 percent of the poverty level are eligible for free meals. Those with incomes between 130 percent and 185 percent of the poverty level are eligible for reduced-price meals. For the period July 1, 2003, through June 30, 2004, 130 percent of the poverty level is $23,920 for a family of

Exhibit 3.6
Free and Reduced Lunch Eligibility

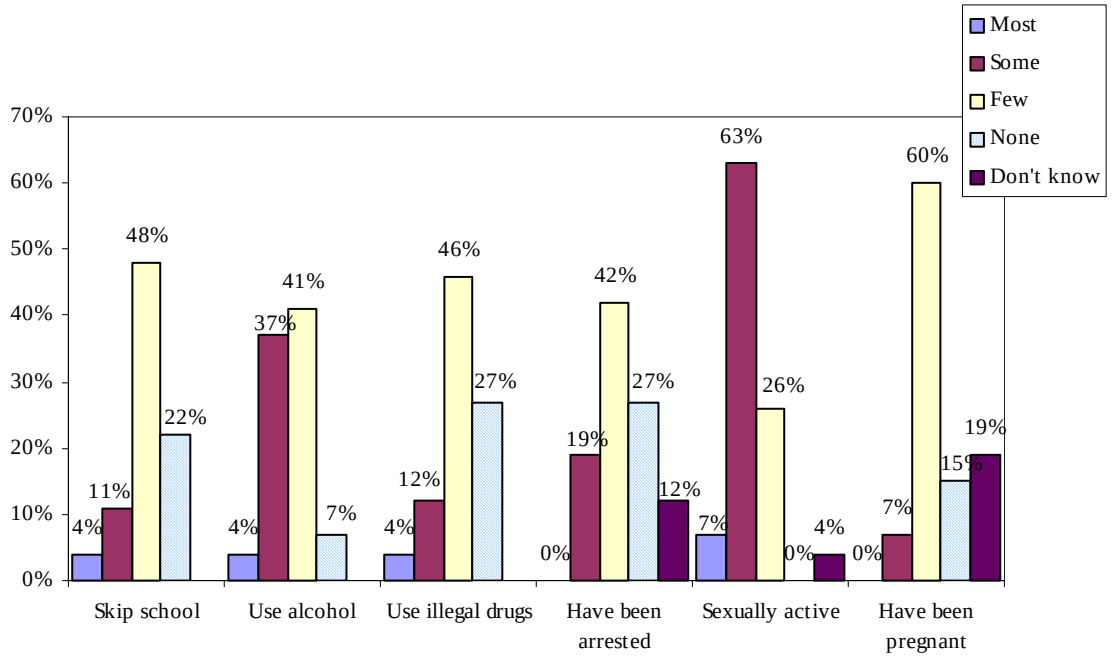


Source: BPA TPP Contractor Survey, June 2004.

Experts in the TPP field explain that there are a number of "antecedents" or risk factors to teen sexual activity, pregnancy and childbearing, including "community disadvantage, family structure, and economic disadvantage; family, peer and partner attitudes and behaviors; and characteristics of the teens themselves" (Kirby 2001). Contractor survey respondents indicated that many TPP program participants are involved in specific risk behaviors associated with teen sexual activity, childbearing, and STD infection. According to contractors survey respondents, 78 percent reported that "few" or "some" of their program participants used alcohol; forty-six percent reported that "few" participants used illegal drugs, and 42 percent reported that "few" participants had been arrested. Finally, 63 percent reported that "some" program participants were sexually active; 60 percent reported that "few" participants had been pregnant.

four; 185 percent is $34,040. See http://www.fns.usda.gov/cnd/lunch/AboutLunch/NSLPFactSheet.htm for more information.

Exhibit 3.7
Participant Risk Behaviors



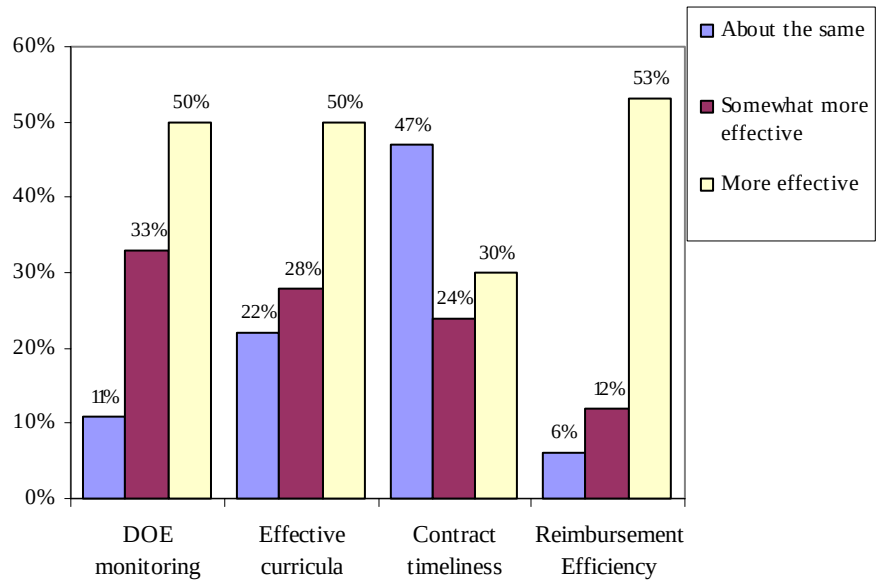
Source: BPA TPP Contractor Survey, June 2004.

DOE Administration

As mentioned earlier, in FY 2004 DOE implemented a number of new program supports and monitoring practices. DOE conducted, for example, announced and unannounced fiscal and programmatic monitoring visits to all grantees and provided technical assistance and communication via phone and e-mail. Each contractor was assigned a DOE contract officer who was responsible for ensuring that grantees understood DOE's expectations, as well as provided information about best practices, curriculum implementation, and reporting requirements.

On the whole, survey respondents indicated that DOE administration of the TANF Initiative TPP program was more effective than in previous years. Indeed, 83 percent of respondents reported that the DOE monitoring process was more effective than it was under DSS administration. In addition, 78 percent of respondents indicated that the curricula DOE chose were more effective than those utilized in previous years. Fifty-three percent reported that the contract awarding process occurred in a more timely manner. Site visit data also indicate that most contractors found DOE administration of the program to be efficient and effective. In general, DOE contract officers were described as accessible, helpful, and knowledgeable.

Exhibit 3.8
Effectiveness of DOE Administration



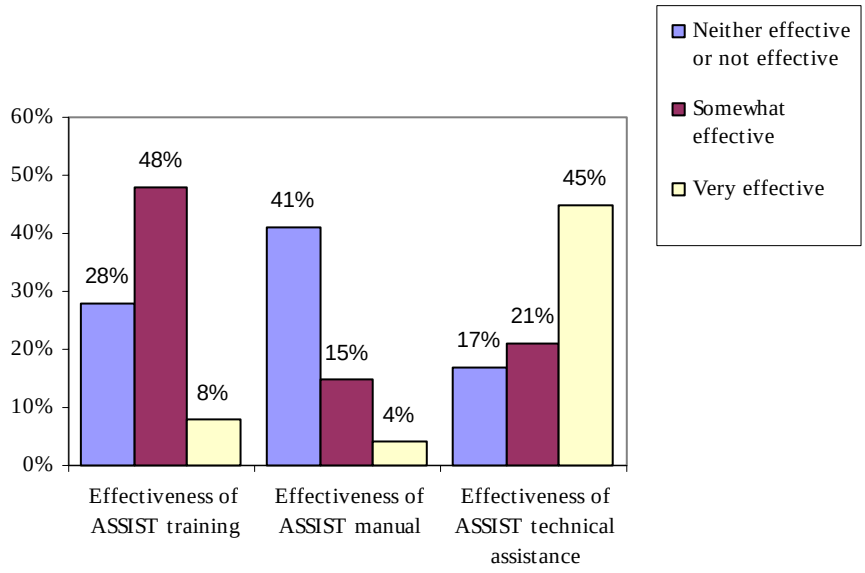
Source: BPA TPP Contractor Survey, June 2004.

One contractor described DOE as "more responsive and professional," explaining that in previous years, the program received little feedback, site visits, or phone contact from DSS staff. Another noted that the switch to DOE administration resulted in more central oversight. Respondents perceived this as a positive change because when an issue or question arose, they found it could be quickly and directly addressed by DOE.

As previously mentioned, under DOE administration TPP contractors were required to submit calendars with their proposals, including projected hours of service, number of participants to be served, and contact hours. These calendars were considered a part of each contract and were used as contact hour goals on which contractors' reimbursement was based. All contractors reported monthly contact hours to DOE using ASSIST. Contractors received the maximum monthly allocation when delivering 80 percent of the contact hours projected on the calendars submitted with their proposal. Contractors were also required to enter each individual participant's social security number into ASSIST in order to receive reimbursement for the participant. More than half (65 percent) of contractor survey respondents indicated that the DOE reimbursement process was more efficient than under DSS.

While some TPP contractors were already familiar with the ASSIST database through their work on other DOE-administered TANF Initiatives, some grantees were new to working with DOE and needed training on utilizing ASSIST. In response, DOE provided training on using the ASSIST database, an ASSIST user manual, and ongoing technical assistance from DOE staff familiar with ASSIST.

Exhibit 3.9
ASSIST Training



Source: TPP Contractor Survey, June 2004.

The majority (96 percent) of contractors surveyed reported receiving formal ASSIST training; 56 percent of survey respondents reported that the ASSIST training was somewhat or very effective. Fewer contractors surveyed (89 percent) reported receiving the ASSIST manual and only 19 percent of survey respondents indicated that the ASSIST manual was somewhat or very effective. Eighty-five percent of respondents indicated having access to ASSIST technical assistance and 66 percent of respondents reported that the ongoing technical assistance provided by DOE was somewhat or very effective.

Despite these successes, TPP contractors faced multiple challenges with the ASSIST database.

Exhibit 3.10
Barriers to Utilizing ASSIST

Difficulties collecting program data	30%
Lack of internet access	4%
Lack of staff to enter data	15%
ASSIST website unavailable	41%
Unable to log onto ASSIST	44%
Unable to change data	26%
Unable to save data	7%
Unable to enter data at each program site	7%
Need more timely ASSIST technical assistance	30%
Other	44%
No ASSIST barriers	11%
Sample size	*27*

Source: BPA TPP Contractor Survey, June 2004.

Among site visit contractors, the most common ASSIST challenge was the length of time it took to enter all of the necessary data. This finding is corroborated by contractor survey data that indicated that 59 percent of contractors spent between five to ten hours per week and 19 percent spent more than ten hours per week entering data into ASSIST. The length of time required for data entry caused serious difficulties, especially among contractors that were understaffed. For the past year DOE has been developing a new on-line database system that reportedly will be easier to use. The new system, called STARS, is expected to be operational for the FY 2005 contract year. Respondents reported that many rural TPP sites lack familiarity with the technology necessary to use an on-line database. Some contractors suggested that DOE should provide computer literacy training in order to facilitate program administration.

TPP Contractors' Ability to Replicate Best Practices

DOE focused their attention on helping TPP contractors incorporate best practices into service delivery, outlining them in the RFP and highlighting them at curricula training. As mentioned previously, all survey respondents reported receiving best practices training and 61 percent reported that this training was more effective than in previous years. In addition, curricula coaches reminded sites visited of best practices. Despite DOE's attempts to inform providers about and increase providers' capacity to adopt best practices, among site visit respondents there appeared to be variation in knowledge of and ability to implement best practices. For instance, one program specifically mentioned attempts to incorporate best

practices. Many others, however, were unaware of best practices. One program noted that while best practices were mentioned during the RFP process and in the curriculum training, they were never clearly defined or stressed as being of particular importance by DOE. The degree to which contractors experienced DOE discussion and instruction on best practices seems to have been dependent upon the DOE contract officer assigned and involvement in curricula coaching.

TPP Program Outcomes

DOE increased emphasis on meeting performance measures and goals among TPP contractors. DOE required that contractors report number of participants and contact hours monthly. Despite this increased emphasis, site visit data indicated that contractor confusion about performance targets remains. For instance, seven months into their contract, one contractor reported they were not sure what the 80 percent target was or how it was calculated using ASSIST. This contractor explained that the DOE contract officer also did not seem to understand how the 80 percent target worked. Several other contractors also noted confusion about DOE's performance measures, especially with regard to calculation of the retention rate.

Part of this confusion could be the result of unclear information about performance measures, as outlined in the RFP and TPP contracts. As mentioned above, the RFP included conflicting information about the percent of projected participants that must be enrolled. In one section, the RFP stated that contractors must achieve 50 percent of projected enrollment, while in another, the RFP stated that contractors must enroll at least 80 percent of projected participants in order to receive full reimbursement. In addition, the RFP noted that contractors must document a 50 percent completion rate for their program or program cycles. Despite the fact that DOE respondents indicated that they were "periodically tracking completion of curricula," only one of the contractors interviewed had any mechanism for tracking program completion that would ensure accurate reporting of this information to DOE.

According to DOE respondents, the primary performance measures utilized to measure contractors' progress were the 80 percent participation rate and the 50 percent retention rate, monitored using ASSIST data. For the most part, decreases in risk behaviors and gains in knowledge were being measured and reported utilizing BPA's pre/post participant survey administered to all eligible community-based contractors. In addition, a few contractors were utilizing pre/post tests included in their curricula to measure gains in curricula-related knowledge. There was, however, no formal mechanism for contractors to report this information to DOE. Detail on the outcomes measured utilizing BPA's pre/post survey will be discussed in Chapter 4 of this report.

Although DOE implemented efforts to evaluate TPP program success, it is unclear how effective the performance measures and targets outlined in the RFP and contracts were in determining the effects of TPP contractors. For example, experts suggest that it is difficult to achieve statistically significant changes in health outcomes among teen pregnancy prevention programs, due to the limited period of follow-up and the small sample sizes that usually characterize such programs (Kirby 2001). Given these limitations and given our findings on

program outcomes (reported in Chapter 4), it might be a good idea for DOE to focus on changes in knowledge, attitudes, and communication between teens and their parents as key indicators of program success. Such changes are more likely to be documented successfully with pre- and post-assessments administered a relatively short time apart.

DOE Monitoring of TPP Contractors

Under DOE administration, the monitoring process for TPP contractors has improved significantly. In previous years, DSS conducted monitoring site visits only to new programs and those identified as experiencing difficulties. In contrast, under DOE each contractor was assigned a DOE contract officer who provided ongoing technical assistance and communication via phone, mail, and e-mail, and monitored performance targets. In addition to these supports, DOE contract officers conducted announced and unannounced fiscal and programmatic monitoring visits to all grantees and to many of the service sites. During these visits, contract officers interviewed staff, observed services, and sometimes offered suggestions for improvement. As previously mentioned, 83 percent of respondents indicated that the DOE monitoring process was more effective than it was under DSS administration. This finding is corroborated by site visit data that indicated that all contractors received fiscal and programmatic site visits and that DOE monitoring and technical assistance was more effective and useful than interactions with the previous administering agency.

While the contract officer monitoring process was beneficial overall, it resulted, however, in little assistance with curriculum implementation. The visits served as a way for DOE to make sure that on the day of the monitoring visit, contractors were utilizing the curricula. Monitoring visits were not a tool by which contractors were able to obtain assessments of their curricula implementation. Further, while one contractor felt that curricula monitoring was informally taking place during the DOE monitoring visits, the majority of contractors were not aware of any particular methods or ways that DOE contract officers were monitoring curricula implementation. Four contractors specifically mentioned an interest in receiving feedback and assistance with curricula implementation during the DOE monitoring visits.

Improving Program Implementation

Many site visit contractors provided valuable feedback regarding ways to improve the TPP program. Some common concerns were expressed that may provide insight into how to improve the TPP programs in the future. Four contractors mentioned a need for multiple year contracts, citing that one year is often not enough time to work out all of the challenges related to effectively providing teen pregnancy prevention services. Several contractors noted that the restriction in the FY 2004 TPP program design on including academic, job training, and development services was a serious handicap to those contractors who previously used these components as a tool for recruitment and retention. The restriction on including academic, job training, and development services was especially debilitating for those contractors who historically offered tutoring for standardized testing and who relied on the tutoring as an effective way to obtain parental support for their children's regular attendance. These challenges highlight a potential area for DOE improvement. While it may be beyond DOE's purview to advocate for multiple year TANF-funded TPP contracts, it might be

possible for DOE to assist TPP contractors in accessing grants to provide other services that are not allowable under TANF funding, such as academic assistance and job training and/or to expand such services for multiple years.

Site visit data also revealed a need for more and early discussion of TPP contract requirements. The experiences of two of the site visit contractors who had not previously worked with DOE highlight this challenge: One new TPP contractor expected to receive start up funds to assist with changing their existing tutorial services to a more comprehensive TPP program, but never received such funds. Another contractor did not realize until several months into the contract year that they needed to submit social security numbers of participants in order to be reimbursed. This same contractor's proposal included a detailed description of work with parents for which they expected to receive TPP reimbursement. In part because the contractor did not fully understand the reimbursement structure of the DOE TPP program, the contractor did not learn until several months into the contract period that the program would not be eligible for reimbursement for services to parents. The contractor was in part responsible for the lack of understanding on these issues, as the RFP clearly stated that enrollment was limited to youth ages eight through twenty and that social security numbers had to be submitted to DOE. However, the lack of clarity on these important issues point to a need for more clearly defined contract requirements and early communication to try to ensure that contractors understand their exact contract requirements. This need for clear and early communication about contract requirements is corroborated by a contractor survey respondent who noted receiving "bits and pieces of information about curriculum, paperwork and enrollment requirements" over the course of the contract year, resulting in confusion about the actual requirements for which the contractor would be held accountable.

Program Design and Implementation Conclusions

In summary, DOE has made great strides in improving the overall design and implementation of the TPP program. Indeed, contractors indicated that the DOE contract awarding and monitoring process was more effective than it was under DSS administration. Contractor staff describe DOE contract officers as accessible, helpful, and knowledgeable. Under DOE each contractor was assigned a DOE contract officer who provided ongoing technical assistance and communication, and conducted announced and unannounced fiscal and programmatic monitoring visits to all grantees. DOE administration also resulted in increased emphasis on meeting performance measures and goals among TPP contractors. For instance, contractors regularly reported the number, name, and social security number of participants and contact hours to DOE. This system improved the accountability of TPP contractors and helped ensure that contractors only received reimbursement for participants they actually served.

DOE also improved contractor capacity to effectively implement TPP curriculum by providing curricula-based and best practices training and curricula coaching over the course of the contract year. Earlier TPP TANF Initiative programs did not offer curricula-based or best practices training or curricula coaching. DOE offered contractors expanded choices of department-approved curricula with which to work. Importantly, all contractors utilized at least one of the DOE-mandated, research-based TPP curricula. Under DSS administration, BPA found that only about one-half of the surveyed contractors indicated they had been

using one of the five approved TPP curricula (Magill and LaPointe 2003). Finally, DOE focused on helping TPP contractors incorporate best practices into service delivery by highlighting best practices in the RFP, curricula training, and during coaching sessions. The finding that 61 percent of contractors reported that this training was more effective than in previous years highlights improvement in dissemination of best practices training.

Even as DOE administration resulted in significant improvements in the ability of contractors to implement TPP curricula effectively, there remain a few areas that it would be beneficial to address. The DOE TPP RFP indicated that all staff interacting with participants in curricula components must be able to document attendance at trainings provided by DOE. However, in many cases, TPP teachers and instructors did not always attend the trainings. This is unfortunate because, in general, TPP instructors interviewed during site visits reported benefiting from curriculum trainings whereas TPP administrators more often reported that the curriculum trainings did not result in significant learning opportunities. In addition, TPP teachers and instructors were the staff most likely to implement curricula with participants. Therefore, it is of the utmost importance that these staff receive curriculum training. Some contractors reported providing in-house training to disseminate lessons learned to TPP teachers and instructors. However, TPP instructors working for contractors who reported providing in-house training, in some cases, did not result in TPP instructors reporting that they received any training. In the future, DOE might consider closer monitoring of the goal of having all staff interacting with participants in curricula components trained in those components, in order to assure that all instructors have the training necessary to effectively implement TPP curricula.

An additional area for improvement relates to dissemination and assistance with effectively implementing the mandated TPP curriculum. While DOE made advances in improving training, coaching, and monitoring opportunities for contractors, several site visit contractors indicated that monitoring visits themselves were not opportunities for contractors to learn about best practices or the most effective ways to implement mandated curriculum. Indeed, several contractors specifically mentioned that they would have liked to have feedback on curriculum implementation from DOE contract officers during monitoring visits. For the most part, site visit contractors, especially those not involved in the curricula coaching, reported that monitoring visits did not include such feedback. Further, several contractors who did not receive curricula coaching reported feeling they would benefit from the opportunity. These requests for more feedback from DOE and for opportunities to participate in curricula coaching point to a need for more universal access to curricula coaching or similar activities to further enhance contractors' ability to effectively implement TPP curricula.

Chapter 4

Participant Characteristics and Outcomes

Introduction

Responses to both student survey waves and a survey of TPP providers provide a demographic profile of teens participating in Louisiana TPP programs. These findings update data presented in our Interim Report on the First Wave of the Participant Survey.

The student surveys specifically address the following program objectives:

- Reduce participants' sexual activity and risk of pregnancy.
- Increase participants' knowledge of reproductive health, risks of STDs and AIDS, and ways to prevent pregnancy or postpone sex.
- Encourage participants to become more cautious about engaging in sexual activity and more comfortable discussing sex and relationships with parents and other responsible adults.

Comparisons of student responses at the beginning and toward the end of their programs help capture program effectiveness. The following discussion describes participant characteristics and program outcomes in each of the above three areas.

Participant Characteristics

Exhibit 4.1 presents background characteristics of participants surveyed in either survey wave.[1] In its demographic composition, this larger student sample closely mirrors the much smaller sample of the Interim Report. Overall, approximately equal numbers of boys and girls participated in the TPP programs. Participants were, on average, a little over 13 years old, and 75 percent were in middle school (grades 6-8). This is consistent with reports from the TPP programs, which, in the TPP contractor survey, overwhelmingly reported serving students ages 10 to 16. More than 90 percent of participants were African American. Students reported an average GPA of 2.7.

[1] Because of the timing of the surveys, many participants surveyed in the second wave were not yet participating in their TPP program at the time we administered the first wave of the survey. In describing the demographic and other characteristics of the teenagers who participated in the TPP program, we count each individual participant as one, regardless of whether they completed the first survey, the second survey, or both.

Exhibit 4.1
Participant Background Characteristics

Characteristic	Percent or Average
Gender (%)	
Male	49.1
Female	50.9
Age (%)	
12 or younger	46.4
13	16.7
14	12.6
15 or older	24.3
Average age	13.1
Grade (%)	
6th	40.6
7th	19.4
8th	15.1
9th	10.3
10th or higher	14.6
Ethnicity (%)	
African American	93.6
Other	6.4
GPA in school	2.7
Sample size	*1669*

Source: TPP Participant Survey, April-July 2004.

Family Characteristics

Family characteristics of program participants are very consistent with results reported in the Interim Report. As shown in Exhibit 4.2, just over one-third of participants (36 percent) have parents who are married, and a slightly smaller group, 34 percent, report that they live with both parents. Of those not living with both parents, 25 percent see each of their parents at least once a week, while 16 percent never see his/her non-resident parent. Very few participants—2 percent—report that they already have a child of their own.

Exhibit 4.2

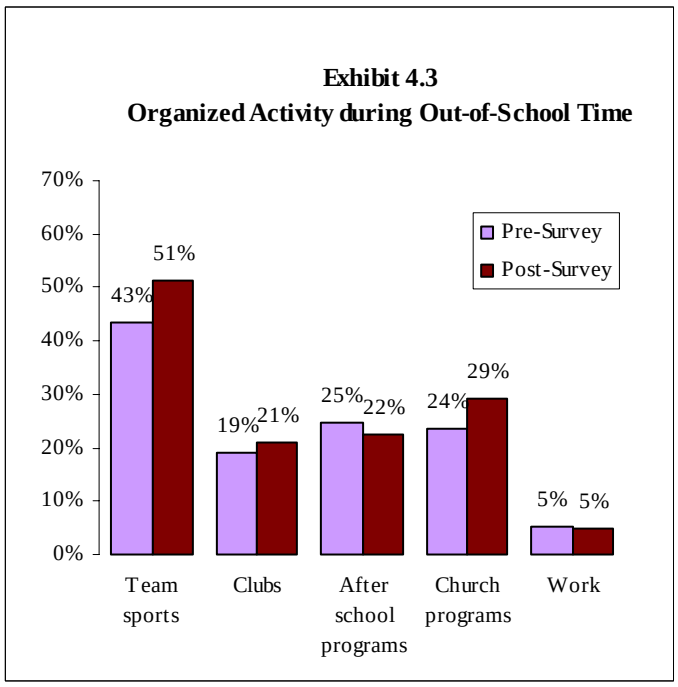
Family Background Characteristics of Participants

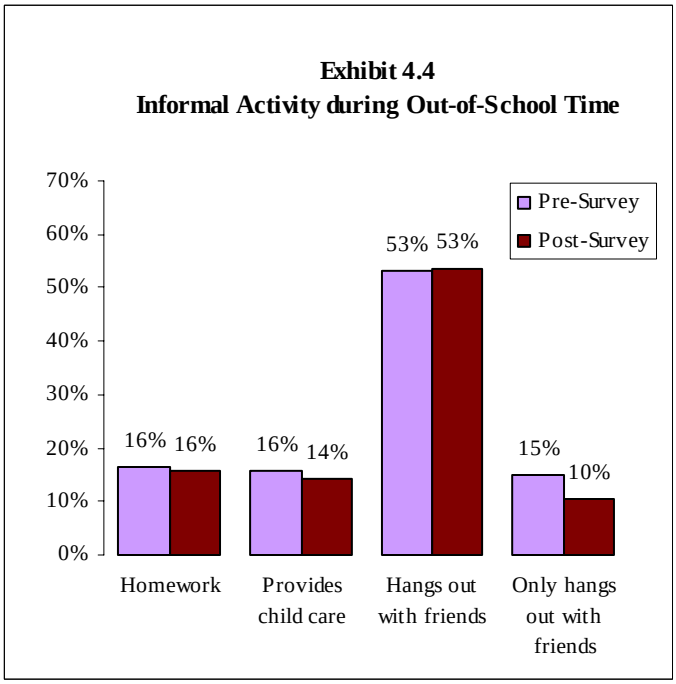
Characteristic	Percent or Average
Parenthood	
Participant has a child (%)	2.2
Family status (%)	
Parents are married	36.4
Lives with both parents	34.0
Sees non-resident parent	
Every day	11.0
1-3 times per week	14.1
Twice a month	5.4
Once a month	2.8
A couple of times a year	17.0
Never	15.8
Has a sibling who is a teen parent	26.1
Has a sister who is a teen parent	15.8
Has a brother who is a teen parent	14.7
Sample size	*1669*

Source: TPP Participant Survey, April-July 2004.

About one in four participants (26 percent) reports having a sibling who is a teen parent. Similar proportions of participants report having a sister who is a teen parent (16 percent) or a brother who is a teen parent (15 percent).[2] As discussed in the Interim Report, living with only one parent, being a survivor of sexual abuse, and having a sibling who is a teen parent are all risk factors associated with teenage pregnancy (Miller, et al. 2001). For teenage girls, having a sister who is a teen parent is especially considered to increase her risk of a pregnancy (East, 1996). In our sample 14 percent of all girls reported having a sister who had a child while in her teens.

[2] This distinction between brothers and sisters who are teen parents was available only for participants who completed the second survey.





Source: TPP Participant Surveys; February-April 2004. The pre- and post-surveys cover different groups of participants, although 166 participants completed both surveys.

Participant Out-of-School Activities

As shown in Exhibits 4.3 and 4.4, participants were more likely to participate in team sports at the time of the post-survey, as well as somewhat more likely to be in church programs. In the post-survey, fewer participants reported no organized or informal activities other than hanging out with friends. In the pre-survey, 15 percent of participants fell into this group as compared to 10 percent in the post-survey. This is a positive finding, as students who are engaged in organized and positive activities after school are less likely to engage in early sexual activity and less at risk for teen pregnancy (Manlove et al 2004a).

Risk Factors for Teen Pregnancy

These surveys attempted to identify students that exhibited both structural and behavioral risk factors that could lead to early sexual activity and pregnancy. Structural risk factors refer to environmental and family structures associated with a higher incidence of teen pregnancy. They include living with one parent, poverty, and a sibling who is a teen parent. As shown in Exhibit 4.5, two-thirds of respondents live in a single parent household, and about one-quarter have a sibling who is a teen parent. While students were not asked about family income, 85 percent of TPP providers indicate that “most” or “almost all” participants were eligible for free or reduced lunch, a federal nutrition program for students from low-income

families. The majority of participants thus seem to have at least one or more structural risk factors associated with a higher rate of teen pregnancy.

Participants also answered questions about specific behaviors that are often related to higher rates of teen pregnancy. As shown in Exhibit 4.6, a large majority of participants (73 percent) knew someone who had been arrested or had themselves been arrested. Twenty-one percent reported drinking or using drugs, and 25 percent have skipped school. Across the two surveys, another 14 percent reported engaging in no out-of-school activities other than hanging out with friends, another risk factor for teen pregnancy.

Exhibit 4.5
Structural Risk Factors for Participants

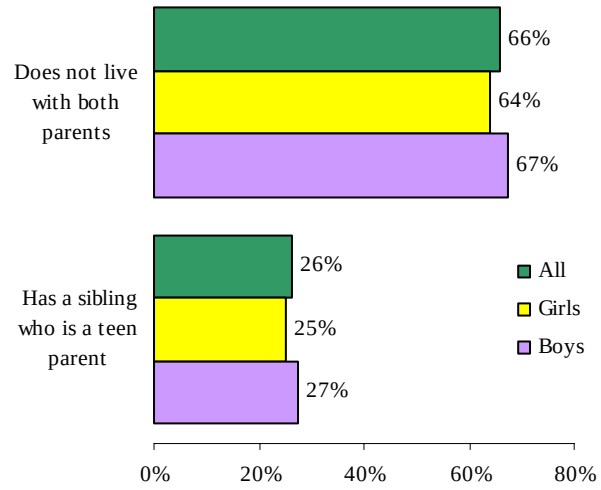
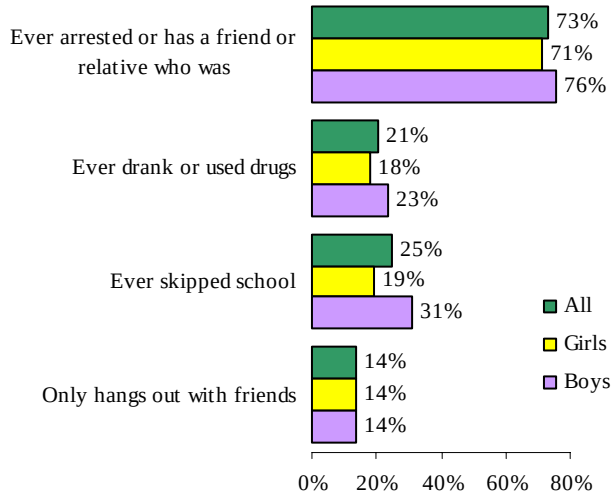


Exhibit 4.6
Behavioral Risk Factors for Participants

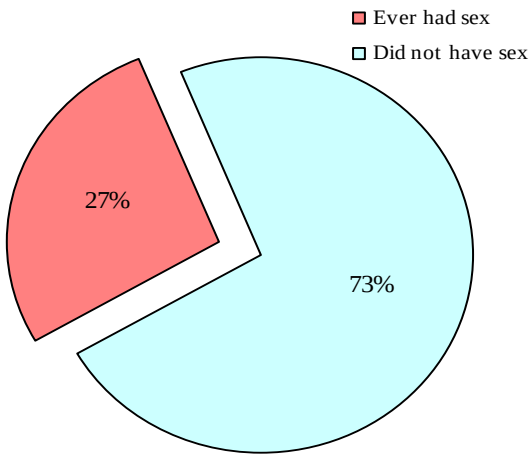


Source: TPP Participant Surveys; February-April 2004.

Prior Sexual Activity

As shown in Exhibit 4.7, over one-quarter of all participants reported ever having had sex. This proportion is much smaller than we found for the cohort of participants on whom we reported in the Interim Report. We found no net increase in sexual activity between the first and second waves of the survey, neither for the sample as a whole nor for those whom we surveyed twice. This suggests that during the four to six month period between the surveys very few participants became sexually active. While we cannot know how many participants would have become sexually active in the

Exhibit 4.7
Percent of Participants Who Have Had Sex



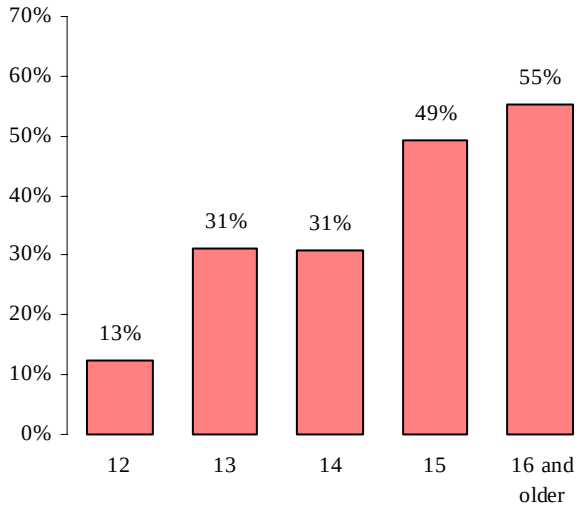
Source: TPP Participant Surveys; February-April 2004.

absence of the TPP programs, the programs may have slowed down the rate at which participating teens became sexually active.

Boys were more likely to be sexually active than girls. Of boys, 40 percent reported having had sex, compared to 15 percent of girls. There were no significant pre-post differences in this outcome for either gender.

Exhibit 4.8 shows the percent of participants who have had sex, broken down by age at the time of the survey. While half of 15 and16 year olds reported ever having sex (49 and 55 percent respectively), this proportion is much smaller for younger participants: i.e., 31 percent for 14 and 13 year olds and 13 percent for 12 year olds.

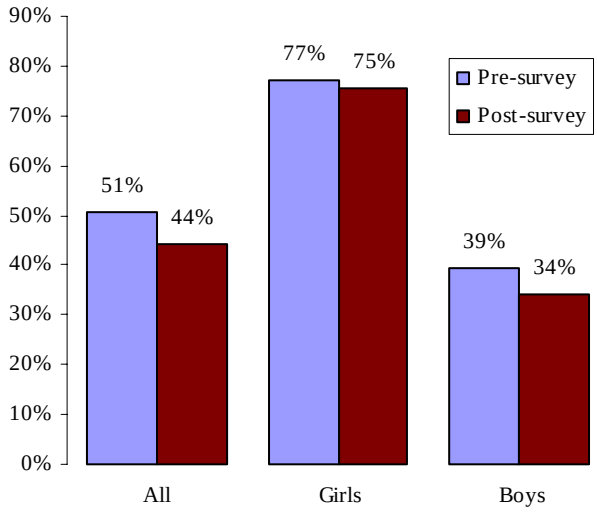
Exhibit 4.8
Percent of Participants Who Have Had Sex, by Age



Source: TPP Participant Surveys; February-April 2004.

Approximately half of all sexually active participants reported wishing that they had waited to have sex. As shown in Exhibit 4.9, this proportion decreased somewhat between the pre and post assessment. Of sexually active participants in the post survey, 44 percent reported wishing they had waited, compared to 51 percent at the pre-survey. This finding is counterintuitive because the TPP programs might be expected to make sexually active teens think twice about their decisions to have sex.

Exhibit 4.9
Percent of Participants Who Had Sex Who Said They Wished They Had Waited



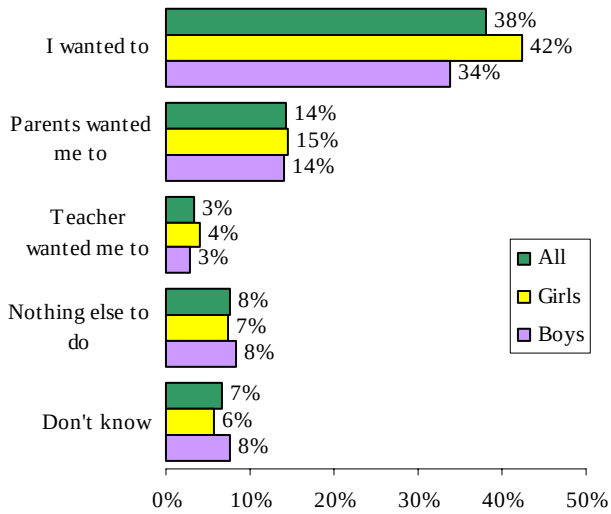
Source: TPP Participant Surveys; February-April 2004. The pre- and post-surveys cover different groups of participants, although 166 participants completed both surveys.

As reported in the Interim Report, sexually active girls were much more likely to report wishing they had waited to have sex than sexually active boys. As shown in Exhibit 4.9, more than three out of four girls report that they wished they had waited, compared to less than 40 percent of sexually active boys.

Reasons for Program Participation

Students reported a range of reasons for their program participation. Exhibit 4.10 shows that 38 percent reported wanting to participate in the TPP program. More girls (42 percent) than boys (34 percent) were likely to choose this as a reason for program participation. Fourteen percent of participants joined programs because their parents wanted them to be involved.

Exhibit 4.10
Participants' Reason for Participating in TPP Program



Source: TPP Participant Surveys; February-April 2004.

Changes in Participants' Sexual Activity

The most direct way to reduce teens' risk of pregnancy is to help them postpone having sex and to reduce the frequency of their sexual activity when they have had sex already. These outcomes are not easy to accomplish in the six months between two relatively closely spaced survey waves.

As reported previously, very few participants became sexually active during their time in the program. Twenty-eight percent of participants completing a second wave survey reported having had sex. This is only one percentage point higher than students surveyed in February.

Not all sexually active participants have sex on a regular basis. Exhibits 4.11 and 4.12 show the frequency of sex in the last six months for sexually active participants. As indicated by the graphs, there were only limited differences in participants' frequency of sex between the pre- and post-survey. On each of the two surveys, a significant proportion of sexually active participants reported not having had sex in the last six months and close to half had sex only once or twice during the past six months. Exhibit 4.12 shows that fewer teens had sex on a more or less regular basis (more than five times in the past six month) at the time of the post-survey than at the time of the pre-survey.

Exhibit 4.11
Sexually Active Teens Who Did Not Have Sex in Last 6 Months

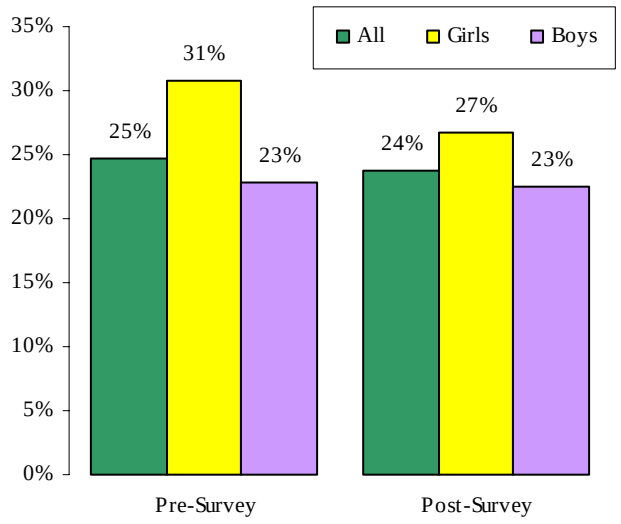
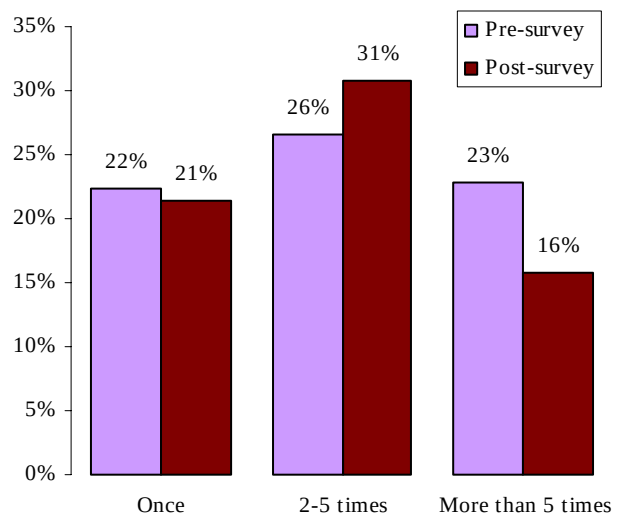


Exhibit 4.12
Frequency of Sex in Last 6 Months



Source: TPP Participant Surveys; February-April 2004. The pre- and post-surveys cover different groups of participants, although 166 participants completed both surveys.

Practices to Prevent Pregnancy and STDs

For sexually active participants, both surveys collected information about their use of contraceptives. Exhibit 4.13 and 4.14 summarize this information for both waves of the survey. While there were few overall differences in the reported use of contraception when participants last had sex, there is a disturbing reduction in the percent of participants who reported using a condom, from 80 percent at the pre-survey to 73 percent at the post-survey. While this difference may be due to any number of factors, including the fact that condom use often declines as relationships mature, the mixed messages about condoms prevalent in many TPP programs may have contributed as well. On the one hand, programs teach participants that condoms can help prevent sexually transmitted diseases, but on the other hand, programs stress the fallibility of condoms and their unreliability relative to abstinence. That latter message may cause some participants who also use other forms of birth control to question the usefulness of condoms.

Another somewhat disturbing finding concerning contraception is shown in Exhibit 4.14. It shows that the number of sexually active teens who report being comfortable discussing protection with their partner declined over time. Boys were less likely to be comfortable with this than girls at both points in time, but even for girls their comfort with this issue eroded. It may be that the strong emphasis on abstinence in most TPP programs reduces participants' comfort levels with discussions of actually having sex, or teens responding to the post-survey may simply be more aware of their discomfort with discussing these topics. In any case, a failure to discuss contraception with one's partner is an important risk factor for teen pregnancy that TPP programs ought to address.

Exhibit 4.13
Sexually Active Participants' Use of Contraception

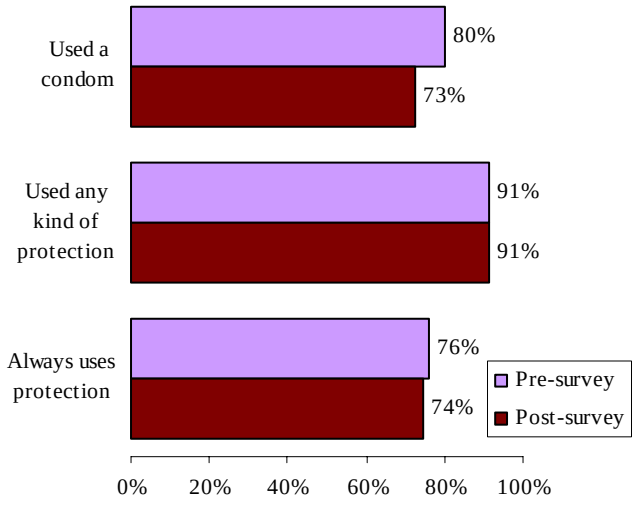
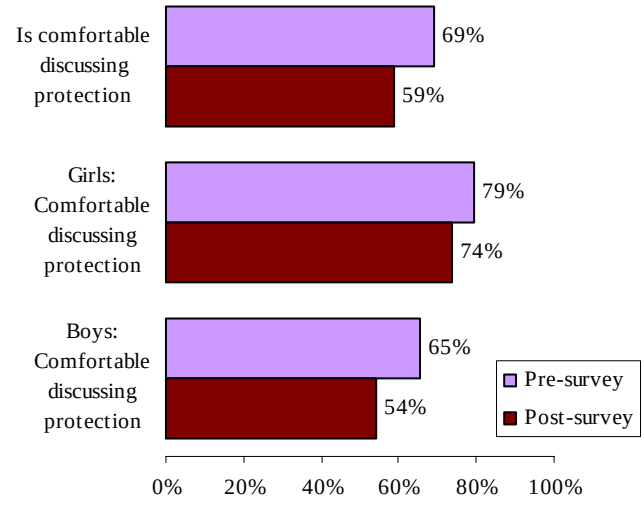


Exhibit 4.14
Sexually Active Participants' Comfort Discussing Contraception

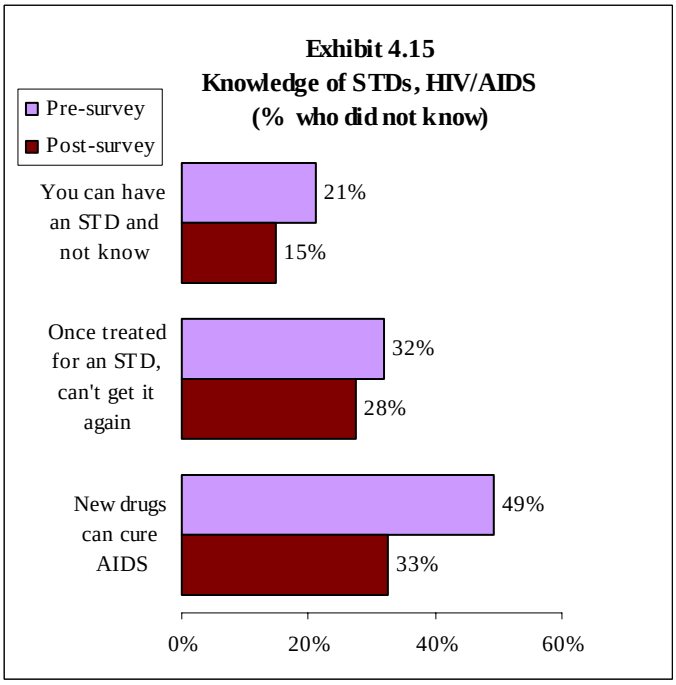


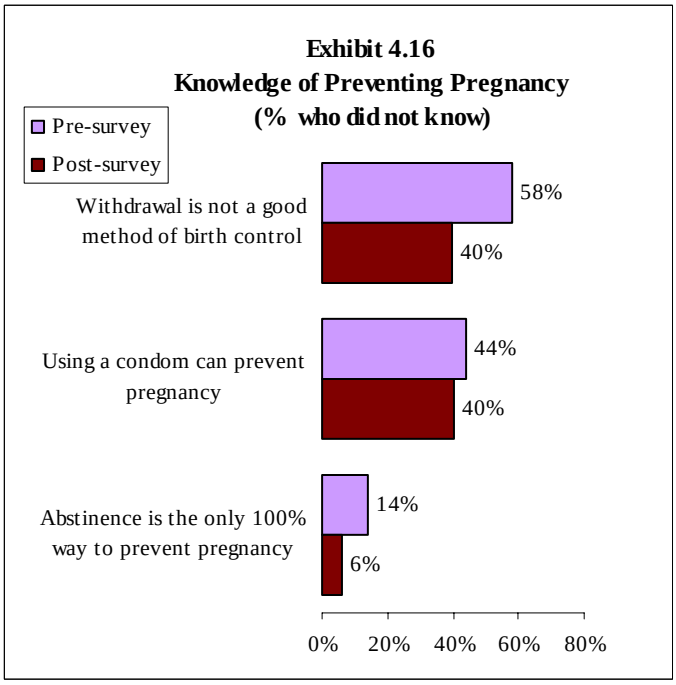
Source: TPP Participant Surveys; February-April 2004. The pre- and post-surveys cover different groups of participants, although 166 participants completed both surveys.

Knowledge of Sex, HIV/AIDS, and Contraception

An important objective of the TPP programs is to increase participants' understanding of reproductive health, risks of STDs and AIDS, and ways to postpone sex or prevent pregnancy. This includes dispelling myths and inaccurate information that may otherwise guide participants' decisions. For assessing the extent to which the programs met this objective, the best measure is to compare participants' knowledge at the beginning and end of their program experience. Because of this, we focused our analysis for this section of the report on findings for participants who completed both pre- and post-surveys. Exhibits 4.15 and 4.16 present the results, showing an increase in the percent of participants who correctly identified answers. Exhibit 4.15 focuses on participants' knowledge of STDs and HIV/AIDS, and Exhibit 4.16 focuses on knowledge related to preventing pregnancy.

Both exhibits show significant increases in participant knowledge across the board. Increases were strongest for questions that many participants did not answer correctly on the first survey, suggesting that the programs successfully targeted these areas of greater concern.

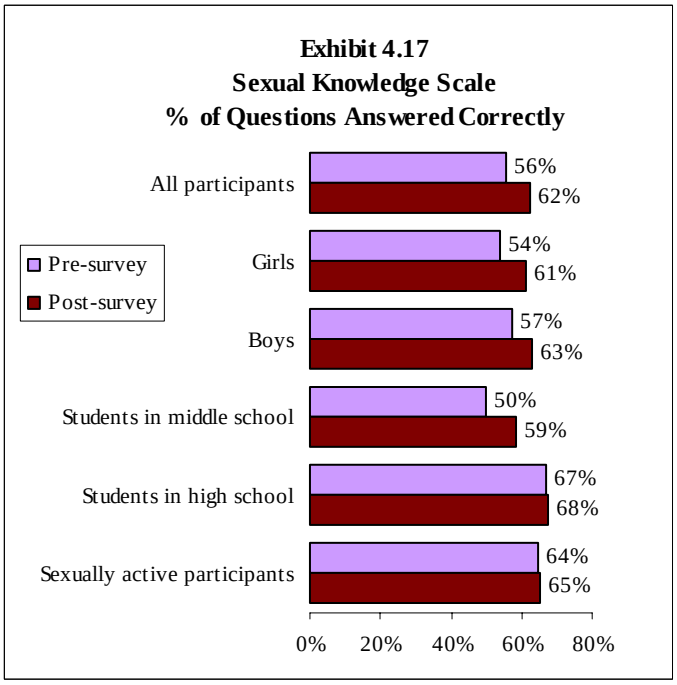




Source: TPP Participant Surveys; February-April 2004. The sample for this figure is limited to 166 participants who completed both pre- and post-surveys.

Exhibit 4.17 shows changes in sexual knowledge summarized in a single scale, which combines all the various questions. The numbers shown represent the percentage of questions answered correctly by participants.[3] Participants' average score at the pre-test was 56 percent, which increased to 62 percent on the post-test. Boys and girls had similar levels of knowledge at both time points and recorded comparable gains in knowledge over time.

Gains in sexual knowledge were higher for some groups of participants than for others. Participants in middle school knew less when they started and experienced greater gains in their sexual knowledge during their participation, a finding commensurate with recommendations in the literature that programs are most effective for this age group. On the other hand, we found only limited



Source: TPP Participant Surveys; February-April 2004. The sample for this figure is limited to 166 participants who completed both pre- and post-surveys.

[3] Chronbach's alpha for this scale was 0.63 for the pre-test and 0.61 for the post-test, showing that this was a reliable measure of participant knowledge at both time points

learning gains among older participants and those already sexually active. This may point to an important limitation of the TPP programs as they are currently operated, especially since sexually active participants still answered 35 percent of all follow-up questions incorrectly.

Influences and Attitudes about Sex

Participants learn about sex and are supported in their decisions about sex and about postponing sexual activity by a range of different influences, including their parents, their peers, church, and trusted adults such as teachers and family members. One of the roles of the TPP programs is to expand the information and positive guidance available to participants and to improve communication about sex and pregnancy prevention between participants and their parents.

The pre-survey asked participants whether they had learned about STDs and pregnancy prevention. As indicated in the Interim Report and Exhibit 4.18, most participants reported having learned about these topics, but many did not. Focusing on preventing pregnancy as a key outcome area, Exhibit 4.19 shows that middle school participants were more likely to report not having learned about pregnancy prevention from anyone.

Exhibit 4.18
Percent of Participants Who Reported Not Having Learned about HIV, STDs, and Preventing Pregnancy

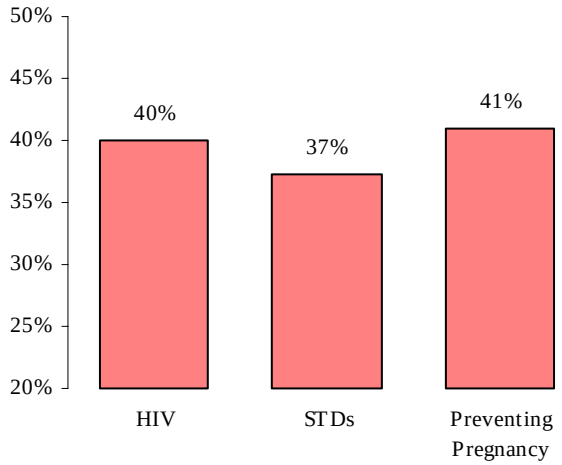
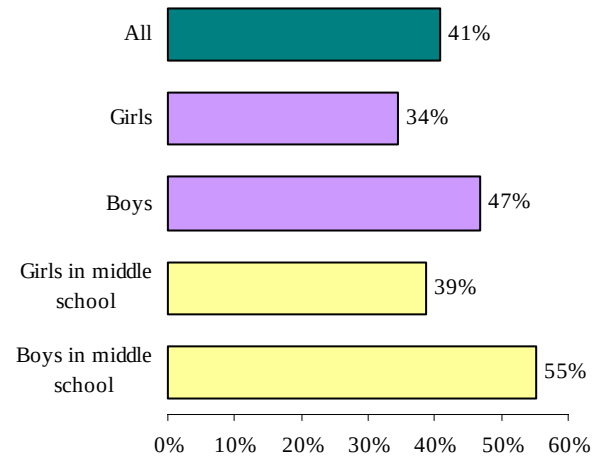


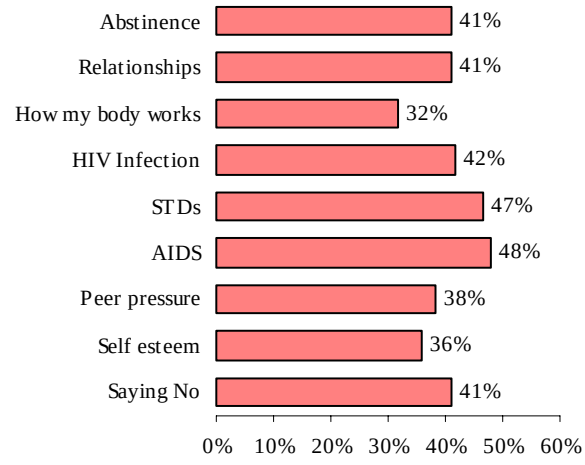
Exhibit 4.19
Percent of Participants in Selected Subgroups Who Reported Not Having Learned about Preventing Pregnancy



Source: TPP Participant Surveys; February-April 2004.

In the post-survey we included some follow-up questions to assess whether the TPP program helped to fill this void. As Exhibit 4.20 demonstrates, this was indeed the case, with 42 percent of participants reporting having learned about HIV through the program, 47 percent reporting having learned about STDs, and 41 percent having been taught how to prevent pregnancy through abstinence.

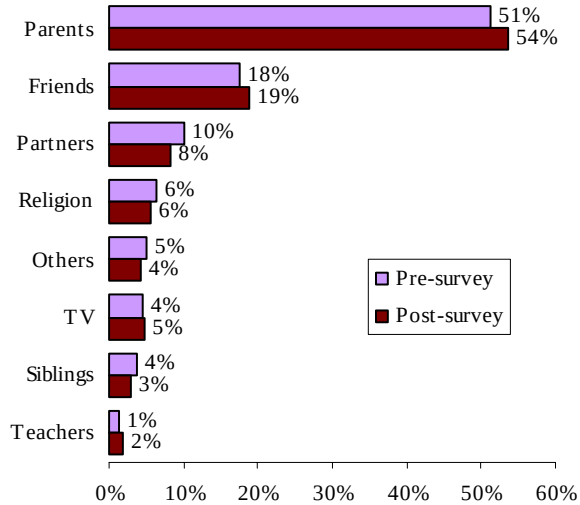
Exhibit 4.20
What Participants Report Learning in the TPP Programs



Source: TPP Participant Surveys; February-April 2004.

As discussed in the Interim Report, participants reported that parents were the most important influence on decisions about sex for most teens at the time of the first survey. This was also the case at the time of the second survey. As shown in Exhibit 4.21, the influence of parents increased somewhat between the two surveys, but so did the influence of friends.

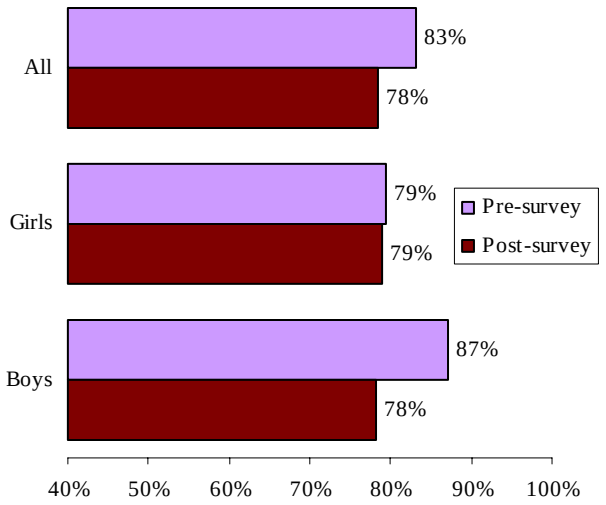
Exhibit 4.21
Primary Influence in Decisions about Sex and Relationships



Source: TPP Participant Surveys; February-April 2004. The pre- and post-surveys cover different groups of participants, although 166 participants completed both surveys.

Given how important the influence of parents is for teens' decisions about sex, the number of participants who report having difficulty talking to their parents about sex and relationships is of great concern. As shown in Exhibit 4.22, on the pre-survey 83 percent of participants reported this difficulty, a figure that the programs improved somewhat, to 78 percent on the post-survey. The figure shows that this improvement was concentrated among boys, who were more likely to report being uncomfortable at the time of the pre-survey, but comparable to girls by the time of the second survey.

Exhibit 4.22
Participants Reporting Difficulty Talking with Parents about Sex and Relationships



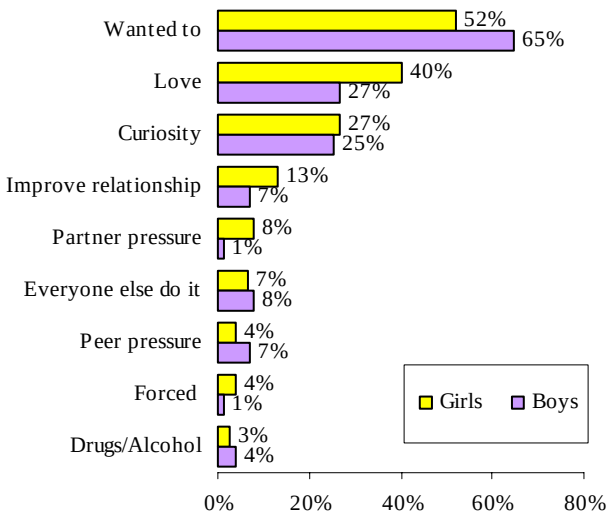
Source: TPP Participant Surveys; February-April 2004. The pre- and post-surveys cover different groups of participants, although 166 participants completed both surveys.

In spite of these positive results, this is an area in which the programs might be able to do better. Research on best practices in pregnancy prevention has found that the involvement of parents is very important and that programs that improve parents' understanding of sexuality and ability to communicate accurate information about sex and relationships help teens postpone sex and prevent unwanted pregnancies (Shore 2003).

Reasons Teens Decided to Have Sex

To help teens postpone sexual activity, it is important to understand why teens decide to have sex and what they consider reasons for not having sex. Exhibit 4.23 uses data from the pre-survey to describe (for sexually active teens) why they first decided to have sex. Boys and girls answer this question differently, although the majority of teens in both groups reported that they decided to have sex simply because they "wanted to." Large proportions of sexually active boys and girls also reported being "curious." Girls were more likely than boys to report being in love or wanting to improve their relationship as a motivation for having sex. This is consistent with other studies that suggest sex is often viewed as a "transaction" for teens, something they do as part of a relationship (National Campaign to Prevent Teen Pregnancy 2004).

Exhibit 4.23
Reasons Participants First Decided to Have Sex



Source: TPP Participant Surveys; February-April 2004.

In the pre/post survey, participants reported that peer pressure is not a significant reason for becoming sexually active. In fact, fewer than 10 percent of sexually active teens report that pressure from friends or from their partner contributed to their decision to have sex. Nevertheless, most participants (and the vast majority of sexually active girls) reported that they wished they had waited longer before having sex for the first time. Participants' reporting that peer pressure is not a significant contributing factor to their becoming sexually active is contrary to site visit data suggesting that peer pressure is an important contributing factor for early sexual activity.

Participant Ideas about Sexual Activity

Another goal of TPP programs is to change participants' attitudes about early sexual activity. If teens become less accepting of sex among their peers, they themselves may decide to remain abstinent when faced with the decision. Teens may also decide that sex is acceptable only under certain narrowly defined circumstances. TPP programs use group discussions and role-playing exercises to change how participants approach these decisions.

The surveys included a number of different questions concerning participant ideas about sexual activity. As early indicators for subsequent sexual activity, this outcome would be a good place to look for early impacts of the TPP programs.

As indicated in Exhibits 4.24 and 4.25, the TPP programs appear to have changed participant attitudes about the acceptability of early sexual activity. Changes were generally modest, but in several cases, were more substantial. For example, among sexually active teens, the percent that reports that sexual activity among teens is acceptable declined from more than 25 percent to 20 percent. Similarly, the percentage of boys who said that sex among teens is not

Exhibit 4.24
Reasons It Is Not OK for Teens to Have Sex

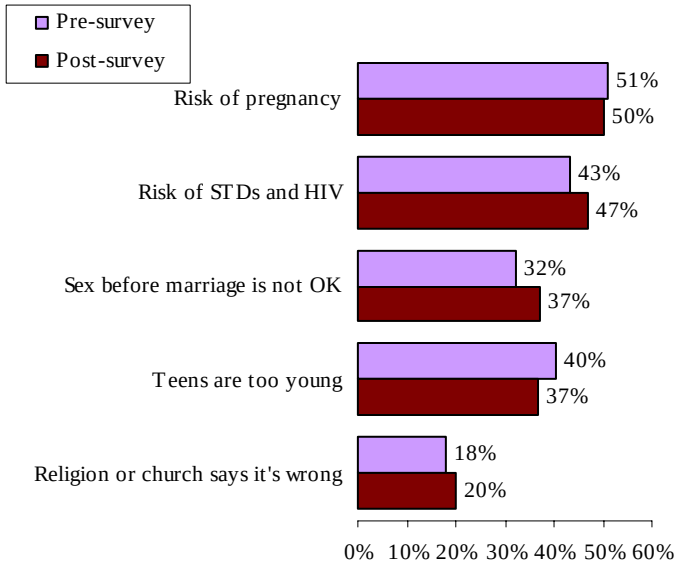
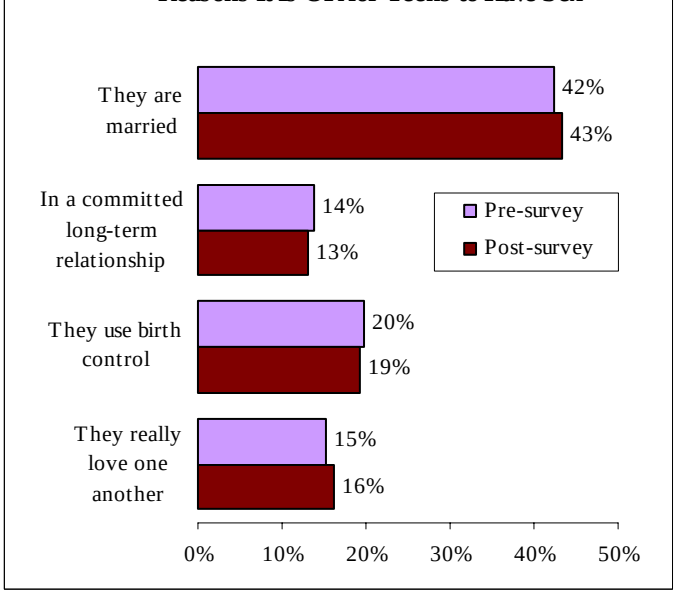


Exhibit 4.25
Reasons It Is OK for Teens to Have Sex



Source: TPP Participant Surveys; February-April 2004. The sample for this figure is limited to 166 participants who completed both pre- and post-surveys.

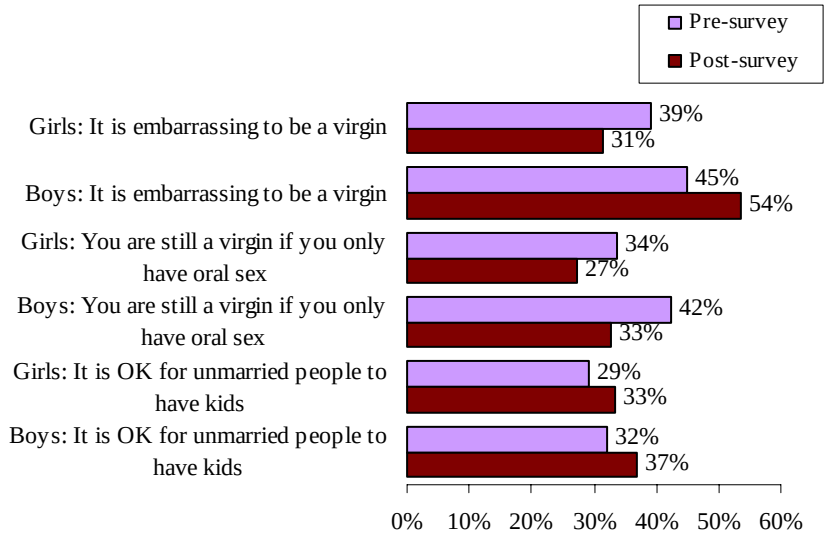
acceptable under any circumstances increased from 24 to 30 percent. (Among girls this percentage remained significantly higher, but increased less strongly, from 42 to 45 percent).

Overall, these changes in participants' attitudes did not amount to a major shift in the attitudes of participating teens. This may be because most teens entered the programs feeling that sex is not appropriate for teens under most conditions. For them, the TPP programs merely reinforced those beliefs, showing no net change. Also, as teens get older and are more likely to engage in sexual activity, their attitudes about the acceptability of early sex tend to weaken. Thus, the lack of a change in participants' attitudes in a more permissive direction may itself signal that the programs are successful in their attempts to increase participants' mindfulness about their decisions regarding sex.

Views about Virginity and Childbearing

The survey also asked teens to comment on their views of virginity and teen child birth. This was done with three questions, for which results are presented in Exhibit 4.26. Teens were asked: (a) whether it is embarrassing to be a virgin (a possible indication of peer pressure to have sex); (b) whether they consider oral sex sufficient to lose one's virginity; and (c) whether they think it is acceptable for unmarried people to have children. As Exhibit 4.26 shows, the results of these questions show surprising shifts in teens' attitudes over the course of their program experience. One might expect TPP programs to reduce the potential embarrassment of virginity, to increase the percent of participants who consider oral sex a real threshold, and to reduce participants' tolerance of unmarried people who have children. Instead, with one important exception, the exhibit shows the reverse: boys are more embarrassed about being virgins, are less likely to see oral sex as "real" sex, and are more accepting of unmarried parents. All these differences are significant. For girls, the exception to this pattern is that they are significantly *less* likely to be embarrassed about being virgins.

Exhibit 4.26
Opinions about Virginity and Parenthood



Source: TPP Participant Surveys; February-April 2004. The pre- and post-surveys cover different groups of participants, although 166 participants completed both surveys.

While it is important and encouraging that teen girls are made to feel more comfortable with their virginity, the other results concerning these three questions are disappointing. In this regard it seems, at this point, that the programs did not change participants' attitudes.

Chapter 5

Conclusions

Program Administration and Implementation

DOE's Administration of the TPP program significantly increased the support and oversight of the TPP programs. This contributed to an overall improvement in the quality of the programs. DOE required that the programs use research-based curricula and offered training and coaching to help programs implement them. As a result, all contractors used at least one research-based teen pregnancy prevention curriculum, a significant improvement over only half of contractors reported use the previous year. All TPP contractor survey respondents also reported receiving best practices training and monitoring visits, with 94 percent receiving curricula training.

Although there is room for improvement in program outcomes, DOE's administration of the TPP program resulted in more reliable data on the number of participants and contact hours served, as well as a better understanding of the retention rates, a factor strongly linked to improved program outcomes. The data gathered in this first year of DOE administration can be used for continued improvement of the TPP programs.

A number of challenges related to program outcomes were revealed during the evaluation. One important challenge arose from lack of clarity about performance targets. While the TPP RFP and contracts mention program objectives and performance targets, the items included were often dissimilar and not clearly defined and there was no clear process for monitoring and reporting adherence to performance targets.

Performance targets included changes in participant risk behavior, parenting skills, and knowledge. Generally, however, contractors did not have a clear sense of how these performance targets would be measured nor a formal way of measuring, tracking, and reporting findings to DOE.

Experts recommend that the best way to measure program effectiveness among TPP programs is to focus on measuring significant changes in such risk behaviors, sexual debut, frequency of sex, and consistency of contraceptive use. The use of a pre/post participant survey among community-based programs represents this type of measure. Further improvements can be made to streamline the testing process. For instance, some site visit contractors did not follow explicit instruction about survey confidentiality. One contractor even reported reviewing the surveys before sending them to BPA. Other contractors simply never administered the survey. In some cases, contractors either feared or experienced

parental unease with the pre/post survey, which, may have contributed to their failure to conduct the surveys. Other challenges involve the late notice (November 2003) of legislation prohibiting survey administration to the survey in programs affiliated with schools. This led to the need to ask "triage questions" of each contractor in order to properly identify which program sites were eligible for the pre/post test. Taken together, these challenges resulted in late distribution of the pre/post participant survey, four months into the contract year. This delay could contribute to less differentiation of pre/post-survey results than there would have been had the first survey been administered at the start of programs.

Implementing Curriculum with Fidelity

According to the literature, curriculum-based teen pregnancy prevention programs must last a significant amount of time, incorporate a number of interactive activities, and be replicated "with fidelity" to achieve positive results similar to those found in the research (Kirby 2001). DOE respondents and site visit contractors indicated, however, that participant retention is an ongoing challenge for TPP programs. The relatively low number of TPP participants included in both the pre- and the post-survey also indicates this is a program challenge.

During FY 2004, here were no processes in place to ensure that all participants enrolled in a program remained involved in each curriculum component. Some contractors reported policies requiring that participants attend "regularly" in order to participate in extra-curricular activities. However, the focus of such policies was primarily on ensuring the participants did not solely attend when activities, such as field trips, were scheduled. Less attention was paid to guaranteeing that all participants were exposed to all facets of each curriculum component. Several contractors also noted that TPP instructors often skipped around within a curriculum and used parts of one curriculum to supplement another.

Another issue related to program fidelity involved the fact that many programs are serving participants in a wide range of age groups. This makes it difficult for programs to address all participants at a level appropriate to their intellectual and emotional development. Contractors sometimes noted that specific curricula, such as *Making a Difference* and *Wise Guys*, were too advanced for their participants, indicating that the contractors may have been using the curriculum with an inappropriate age group. Given that the relevant literature emphasizes the importance of age-appropriate programs, the fact that the majority of TPP programs target a very wide range of ages may be cause for concern.

Use of Curriculum, Training, and Best Practices

While DOE's attention and focus on curricula training and coaching was a very important improvement in the overall administration of the TPP program, it is clear that some of the goals DOE set were not achieved. For instance, all staff interacting with participants in curricula components did not attend DOE trainings. Indeed, many site visit contractors reported that program administrators were the staff most likely to attend the trainings. This is unfortunate given that program administrators were less likely than TPP instructor staff to interact with participants during curricula implementation.

TPP instructors often reported that the DOE curricula training resulted in significant learning opportunities. Several contractors, however, reported challenges related to the timing of the curricula training, especially that they took place too late in the contract year. They would have preferred to have the training take place before or as soon as contracts were signed. Other contractors mentioned a need for additional curricula training dates, as several of the trainings in FY 2004 took place at the same time, making it difficult for contractors to benefit from all trainings offered.

Many contractors noted a need for additional training on how to integrate the TPP and PSS curricula. Other contractors reported a need for training on topics other than curricula, such as background on the underlying theory of TPP curricula, effective classroom discipline, teen developmental phases, and budget design.

Another area of concern was the plan to have all contractors offer the PSS curricula. Only 66 percent of contractors surveyed reported utilizing the PSS curricula. Many site visit contractors lacked information on the best way to incorporate the PSS with their other mandated TPP curricula.

Best practices implementation also presents a challenge to many contractors. Despite DOE's attempts to increase contractors' capacity to adopt best practices, among site visit contractors there was variation in knowledge of and ability to implement them. DOE put particular emphasis on best practices during the RFP process and in the curricula training. The degree to which contractors had knowledge of TPP best practices, however, tended to depend on their DOE contract officer and whether or not the program was involved in curricula coaching.

TPP Program Monitoring

DOE has clearly made advances in improving the process of monitoring TPP contractors. The system of conducting monitoring visits to each TPP contractor was much more comprehensive than it was under DSS. Despite these improvements, site visits revealed that some contractors felt that monitoring visits were missed opportunities to receive increased feedback on best practices or on the most effective ways to implement mandated curriculum. Monitoring visits included observation of services, review of staff and participant sign-in sheets and comparison with data entered into ASSIST, and brief, informal staff interviews. Some contractors reported receiving suggestions for improvement. Several contractors mentioned, however, that monitoring could be improved if contract officers offered increased direction on curricula implementation and best practices.

Curricula Coaching

The curricula coaching component offered by DOE resulted in unprecedented attention to improving contractors' capacity to provide effective services. Contractors who experienced it found curricula coaching very effective. Despite the gains resulting from curricula coaching, however, DOE respondents reported that curricula coaching would not be used in the coming year due to a perceived lack of effectiveness. This decision is unfortunate, especially given

that 50 percent of contractors rated curricula coaching as more effective than services received in the past. Given that only 56 percent contractors reported receiving curricula coaching, it seems as though the component actually had high perceived effectiveness among contractors. Among site visit contractors, only two of which received curricula coaching, most reported an interest in and need for feedback on curricula implementation and best practices. For these reasons, the continuation of services similar to those received through curricula coaching might be a good idea.

Student Outcomes

Although there were some areas of meaningful improvement, program effects on student outcomes as measured with the pre- and post-survey were limited. Participants increased their knowledge of STDs, HIV, and pregnancy prevention. These gains were strongest for younger participants and for those who were not yet sexually active. The overall size of the knowledge gains was a little over 10 percent (an increase from 56 to 62 points on a 100-point scale).

Participants also increased their level of comfort discussing sex and relationships with their parents. This is an important outcome, which was especially strong for boys. Parents constitute an important influence on teens' decision making about sex and relationships. As such, it is important that teens feel comfortable discussing these issues with their parents.

Approximately 25 percent of participants had already had sex at the time of their entry into the TPP programs. Boys were much more likely to report being sexually active than girls. Between the pre- and post-survey, very few participants became sexually active, which may indicate a positive effect of the program. We do not know how many participants would have begun having sex if they had not been in a TPP program. Among those who were sexually active, there was some evidence of reduced sexual activity. In the post-survey, fewer sexually active teens reported having sex frequently (more than five times in the past six months) than had been the case in the pre-survey.

A major concern among participant outcomes is the consistent use of contraception when having sex. Although the majority of sexually active teens use condoms to prevent pregnancy and STDs, according to the pre/post survey, condom use actually went down from 80 to 73 percent of sexually active teens. Sexually active teens also reported being less comfortable discussing contraception with their partners at the time of the post-survey than they had been at the time of the pre-survey. This is especially true, and of particular concern, for sexually active boys, of whom only 54 percent were comfortable discussing contraception at the post-test survey. Given the importance of communication in preventing teen pregnancy, this is an area in which the programs can and should do better.

Chapter 6

Specific Recommendations for the Teen Pregnancy Prevention Program

The previous chapter provided conclusions of BPA's evaluation of the Teen Pregnancy Prevention (TPP) program. The following concise overview of specific policy and programmatic recommendations are drawn from these conclusions, in an effort to improve future TPP programs. The recommendations are designed to aid DOE administration of TPP program; to render the DOE/TPP service provider partnership more efficient, and to improve overall program effectiveness.

Training:

- Provide training on TPP curricula choice, best practices, and budgeting, and schedule them as early as possible during the contract year.

- Schedule TPP curricula trainings four to six weeks in advance of contract commencement; notify contractors of scheduled trainings at least four weeks in advance; replicate trainings in multiple locations; and make sure that trainings on different curricula are not scheduled for the same day.

- Produce other topical trainings – teaching to particular demographic groups, for example – throughout the contract period but do not schedule them too close together or too far from the providers who would like to attend.

Start-up Funds:

- Create and disseminate a consistent policy statement about start-up funds in order to facilitate program acquisition of the resources necessary to receive participants and deliver services at the beginning of the contract period.

Staffing:

- Encourage contractors to structure their programs so that they can hire full-time TPP direct services staff.

- Encourage providers to recruit and retain the most qualified staff available in their area.

Performance measures and targets:

- Create a clear policy statement about performance measures, performance targets, and data used to track these targets.

- Disseminate this policy statement among all contractors and include the policy statement in all future RFPs and contracts. This policy statement should be consistent throughout the contract year, identify the specific data that will be required for the on-line database, and clarify how programs should monitor and track their participants.

- Clarify with contractors the difference between attendance, contact hours, and completion rates; require that contractors track completion rates; and provide a mechanism by which they can consistently collect this data across contractors and sites.

- Arrange DOE contract officer meetings with their programs early in the contract period to explain performance target requirements and ensure that the contractors are fully aware of the requirements necessary to meet their individual performance targets.

Participant Program Involvement:

- Encourage contractors, where appropriate, to incorporate teen program participants into program design and guidance in order to increase participant involvement and help with program retention.

Attendance Policies:

- Develop a set of best practices related to program attendance to help service providers apply the policy consistently and in a manner appropriate for their population.

Upfront direction regarding recruitment and retention:

- Increase DOE contract officers' contact with contractors on recruitment and retention issues.

- Initiate discussions with contractors early in the contract year to review recruitment and retention plans, make recommendations for their improvement, and eliminate any incongruence between DOE policy and program proposals.

Best Practices: Improving program targeting:

- Work closely with contractors to ensure that the chosen TPP curricula are appropriate for the targeted age groups and populations served.

- Encourage service providers, where possible, to consider dividing participants into age- and/or gender-appropriate groups.

Best Practices: Age Groups:

- Develop a set of best practices related to provision of age-appropriate services.
- Help service providers to develop programs, recruit, and retain participants that appeal to the age groups they deem most in need of services in their area.

Best Practices: Replicate Curricula with Fidelity:

- Work with contractors and individual instructors to make certain they have the capacity to replicate their chosen curricula with fidelity.
- Stress the importance of using curricula as they are written, especially where research emphasizes its paramount importance.
- Work with program instructors to ensure they have the ability and willingness to discuss all curriculum components with their program participants, even if topics are sensitive and/or challenging.

Best Practices: Comprehensive Youth Development or Educational Model:

- Encourage contractors to incorporate TPP curricula into well-rounded youth development or educational programs that are holistic.
- Encourage program design that can teach youth the skills necessary to withstand peer pressure, manage relationships, and navigate difficult situations.

Sexually Active Teens:

- Remain aware that contractors are serving some participants who are already sexually active.
- Encourage contractors to incorporate activities specifically beneficial to this as well as to all groups of teens.
- Specifically include negotiation, refusal, and self-esteem skills-building activities into their programs.

Curricula Coaching:

- Provide a service similar to the curricula coaching offered FY 2004.

- Require every TPP instructor who will interact with participants in curricula implementation to participate in at least one session.

- Offer additional coaching sessions, on-site, to instructors whom coaches identify as in need of further coaching or to programs that request it.

- Coordinate and integrate the coaching, monitoring, and technical assistance efforts of DOE contract officers and curricula coaches so that contract officers can review curricula coaches' notes and follow up when areas of concern arise.

Improving Pre/Post Participant Survey Process:

- Contract officers should work closely with contractors to identify an optimal pre/post program survey timeframe for each site.

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Appendix A

Best Practices for Teen Pregnancy Prevention

Youth Matters Best Practices for Preventing Teen Pregnancy (1999):

1. combine messages: about abstinence and contraception – both may have a role in declining teen pregnancy rates;
2. combine approaches: appropriate instruction and increasing access to contraceptives appears to be more successful in reducing TP and unprotected sex than either approach alone;
3. create school-based health centers;
4. don't forget the big picture: programs that focus exclusively on sexuality may be less effective than those that also address education, employment and life options;
5. add community involvement;
6. start young, before teens become sexually active;
7. shape the program to fit the audience;
8. don't beat around the bush – provide teens with clear information about how they might get pregnant or infected with an STD and how they can protect themselves;
9. make sessions interactive – practice communication, negotiation and refusal skills and allow for discussion of personal experiences;
10. allow plenty of time for the message to take hold – a single session is not enough; programs should consist of several sessions to permit teens to understand and think about the message, practice new skills, and change their attitudes.

National Campaign to Prevent Teen Pregnancy Best Practices for TPP programs (Kirby 2001):

1. focus narrowly on reducing one or more sexual behaviors that lead to unintended pregnancy or STD/HIV infection;
2. based on theoretical approaches that have been successful in influencing other health-related risky behaviors;
3. give a clear message by continually reinforcing a clear stance on particular behaviors;
4. provide basic, accurate information about the risks of unprotected intercourse and methods of avoiding unprotected intercourse;
5. include activities that address social pressures associated with sexual behavior;
6. provide modeling and the practice of communication, negotiation, and refusal skills;
7. incorporate behavioral goals, teaching methods, and material that are appropriate to the age, sexual experience, and culture of the students;
8. last a sufficient length of time to complete important activities adequately;

9. select teachers or peers who believe in the program they are implementing and then provide training for those individuals.

Schorr's Research-based Strategies for Application (2002)

1. distinguish between replication and local adaptation: some programs that are successful locally do not translate well to large-scale replication;
2. tame bureaucracies: most successful local program managers learn to bend bureaucratic policies in the interest of program effectiveness;
3. reach agreement on outcomes;
4. forget the silver bullet: various adolescent risk-taking behaviors, such as drug abuse, school failure, delinquency, and sexual involvement, are usually linked.; programming that addresses only one behavior is less effective than more comprehensive approaches;
5. get in for the long haul;
6. create necessary intensity: effective programs begin with necessary levels of intensity and maintain them; effectiveness will generally decline if budgets are cut or outreach is broadened without proportionate funding;
7. balance direction from bottom and top: effective interventions match large-scale program findings with unique local assets and needs; both ends of this scale should be included and balanced (Bower 2002).

Annie E. Casey Foundation strategies that can contribute to preventing teen pregnancy (Shore 2003):

1. address the underlying causes of teen pregnancy;
2. help parents succeed in their role as sex educators by providing community-based adult education about sexuality;
3. broaden the scope of pregnancy prevention efforts;
4. provide accurate, clear and consistent information about how to reduce risk-taking behaviors;
5. create community-wide plans of action for teen pregnancy prevention including adolescent reproductive health services;
6. give young people a real vision of a positive future by investing time and resources to help them acquire good decision-making, communication, and work skills that prepare them for the adult world (Shore 2003).

National Campaign to Prevent Teen Pregnancy Criteria for Choosing an Appropriate TPP Program (Solomon and Card 2004)

1. choose programs with evidence of effectiveness in achieving behavioral and health-related objectives relevant for and acceptable to their community;
2. look for programs that were effective with a population similar to the new target population;
3. consider the fit of the program with available agency resources, such as setting, staffing, and funding;
4. determine the availability of replication kits or program materials.

HHS and National Campaign to Prevent Teen Pregnancy Promising Abstinence Education Strategies (Hutchins **1999)**

1. start early;
2. talk about values – responsibility, self-control, self-respect, respect of others;
3. do not be fear-based;
4. include youth development components;
5. address sexual abuse.

HHS and National Campaign to Prevent Teen Pregnancy Basic Principles for which All Successful TPP Programs Should Strive (Hutchins 1999)

1. maintain a long-term, intense effort – of at least five years, if possible;
2. avoid one-shot programs;
3. involve the community;
4. start young;
5. tailor programs to teens' age level;
6. use peer leaders;
7. be flexible – different groups of teens need different types of intervention at various degrees of intensity and time;
8. understand the audience – respect and reflect the cultural, religious, and social traditions;
9. deal with drugs and alcohol – sexual risk-taking by teens is often related to other risky behaviors;
10. include boys and young men;
11. get outside the classroom;
12. help teens postpone sex;
13. encourage teens who are sexually active to use contraception consistently and correctly;
14. teach sexual decision-making skills – give teens specific skills to avoid pregnancy through abstinence and responsible contraceptive use;
15. support and motivate teens;
16. support parents in their roles as strong and loving influences on their teen children.

Appendix B

Implementation of Effective Teen Pregnancy Prevention Curricula

Curriculum	Percent of TPP Programs Utilizing	Range of Weeks Utilized Among TPP Programs	DOE Implementation Notes	Urban Institute and National Campaign Suggested Use	Urban Institute and National Campaign Findings and Outcomes	Urban Institute and National Campaign Key Challenges and Lessons Learned
Be Proud! Be Responsible!	22%	10 - 32	Six 50-minute sessions; optimal number of students is 6-12 per group; tested in classrooms of 25 students with success.	**National Campaign:** 5 hours; **Urban Institute:** 16 hours over two days.	**Urban Institute:** Program participants reported significantly more consistent condom use than control group at 3-month follow-up and a higher frequency of condom use at all follow-up intervals (3, 6 and 12 months). Among those participants who were sexually active at the program's onset, program participants reported less sexual activity at the 6- and 12-month follow ups than the control group.	**National Campaign:** It is important that facilitators adhere to curriculum as changes can affect the program's outcomes; Need to take time to explain the program to adults to increase community support.
Becoming a Responsible Teen (BART)	22%	12 - 16	Eight, 2-hour interactive weekly sessions including group discussions and role play.	**National Campaign:** 12 - 16 hours (1 session for 8 weeks); **Urban Institute:** 8 weeks	**National Campaign:** Participants are more likely to use condoms immediately after intervention than control group; Female participants more likely to use condoms after one year than control group; participants who were not sexually active at program outset were more likely to have delayed sexual intercourse than control group; sexually active participants reported lowered rate of sexual activity than control group.	**Urban Institute:** Suggest combining with behavioral skills training.

Curriculum	Percent of TPP Programs Utilizing	Range of Weeks Utilized Among TPP Programs	DOE Implementation Notes	Urban Institute and National Campaign Suggested Use	Urban Institute and National Campaign Findings and Outcomes	Urban Institute and National Campaign Key Challenges and Lessons Learned
Focus on Kids	22%	10 - 50	Eight weekly sessions including interactive games, role play, discussion, booster sessions, field trips, and community service.	**National Campaign:** 1 session for 8 wks (each session 90 min**); Urban Institute:** 8 wk meetings	**Urban Institute:** Intervention youth significantly more likely than comparison group to use effective birth control methods at the 6-month follow-up. At 12-month follow-up, all differences between the control and intervention group disappeared.	**National Campaign:** "Booster" sessions can be used to sustain intervention impacts; important to explain to community members why HIV prevention should be a priority and to engage kids and make it enjoyable; suggest implementing parent education component to summarize sexuality/HIV prevention information being delivered to kids.
Get Real About AIDS	4%	Not reported	Fourteen sessions including interactive activities, discussion, role play, simulations and videos.	**Urban Institute**: 15 sessions	**Urban Institute**: At 6-month follow-up, participants who were sexually active at program onset reported fewer sexual partners within the last two months and greater frequency of condom use.	**Urban Institute**: Encourages the use of activities designed to reinforce the themes of the lessons, such as HIV posters and info cards.

Curriculum	Percent of TPP Programs Utilizing	Range of Weeks Utilized Among TPP Programs	DOE Implementation Notes	Urban Institute and National Campaign Suggested Use	Urban Institute and National Campaign Findings and Outcomes	Urban Institute and National Campaign Key Challenges and Lessons Learned
Making Proud Choices	15%	10 - 16	Eight 1-hour sessions that can be divided according to site circumstances. Integrates STD, HIV, and pregnancy prevention. Optimal 6-12 per group; tested in classrooms of 25 participants with success.	**National Campaign**: 2 four hour sessions or eight hourly sessions	**National Campaign**: At 12-month follow-up, those participants who were sexually active at program onset reported higher frequency of condom use and lower frequency of unprotected intercourse when compared with the control group; those participants who were not sexually active at program onset did not differ on any outcomes when compared to the non-sexually active control group.	**National Campaign:** It is important that facilitators adhere to curriculum as it's written and not try to modify in any way; to sustain effects supplement with "booster" sessions that include one-on-one sessions with original facilitator**.**
Reducing the Risk (RTR)	19%	25 - 48	Sixteen 45-mintue sessions emphasizing refusal, delay, and alternative action statements.	**Urban Institute**: Sixteen 45 minutes sessions (each session can be expanded to fill two class periods for a total of 90 minutes each).	**Urban Institute**: Among participants who were not sexually active at program outset, program reduced the likelihood of becoming sexually active at the 1-month follow-up; sexually active program participants are more likely to use contraception consistently than the control group at the 18-month follow-up; among students who were already sexually active at baseline and for those at high-risk, there were no differences in contraceptive use between the participant and the control group.	**Urban Institute:** Program requires one- or two-day workshops to prepare school teams to use curriculum; three-day skills based educator training enables experienced teachers to train others to implement curriculum.

Curriculum	Percent of TPP Programs Utilizing	Range of Weeks Utilized Among TPP Programs	DOE Implementation Notes	Urban Institute and National Campaign Suggested Use	Urban Institute and National Campaign Findings and Outcomes	Urban Institute and National Campaign Key Challenges and Lessons Learned
Safer Choices	4%	Not reported	Twenty sessions focusing on abstinence, knowledge of sex, STIs and HIV, refusal and negotiation skills, reducing risk taking behaviors. Emphasis on improving school climate.	**Urban Institute**: 10 lessons.	**Urban Institute**: Program participants were less likely to have unprotected sex, were more likely to use an effective method of contraception at last intercourse and had marginally fewer partners than those in the control group.	
Making A Difference!	22%	20 - 40	Eight 60-minute sessions. Used in schools or community centers with small groups (6-12) or classrooms. Uses interactive sessions in a flexible format.	**National Campaign**: two 4-hour sessions or 8 one-hour sessions	**National Campaign**: At 3-month follow-up participants who were not sexually active at outset were more likely to remain non-sexually active than those in the control group (2.9 percent of participants vs. 10.3 percent of control group); at 12-month follow-up sexually active program participants reported a higher frequency of condom use than the control group. However, there were no other variances on other measures of sexual behavior and contraceptive use and no difference in the likelihood of having sex between control and participants.	**National Campaign**: It is important to adhere to curriculum as it is written and not try to modify in any way; because this is a short-term program it is important to incorporate "booster" sessions to sustain effects over time.

Curriculum	Percent of TPP Programs Utilizing	Range of Weeks Utilized Among TPP Programs	DOE Implementation Notes	Urban Institute and National Campaign Suggested Use	Urban Institute and National Campaign Findings and Outcomes	Urban Institute and National Campaign Key Challenges and Lessons Learned
Postponing Sexual Involvement (PSI)	7%	6	High school juniors and seniors are selected by school counselors to serve as teen leaders to 6th and 7th graders. Teen leaders required to attend twenty hours of training.	**Urban Institute**: A teen and pre-teen component both of which consist of five 50-minute sessions; two educational series for parents of teens and pre-teens	**Urban Institute:** Participants who were not sexually active at onset were more likely to continue postponing sexual activity through the end of ninth grade than were similar students who did not participate. There were fewer pregnancies among program participants than students who did not participate in the program.	**Urban Institute**: Program is led by older teens for teens (7th and 8th graders) and pre-teens (5th and 6th graders). Requires 30 hours of training for peer leaders.
The Teen Outreach Program (TOP)	11%	0 - 12	Participants attend weekly discussion groups on volunteer experience and life skills. Curricula include multiple levels to ensure age-appropriate lessons. Incorporates strong emphasis on service learning and community involvement.	**National Campaign**: Lasts a year and requires meeting once a week for classroom discussion and a minimum of 20 hours of community service.	**National Campaign**: Program participants less likely to experience or cause pregnancy, or be suspended or fail a course than those in the control group. Control group experienced twice the percent of pregnancies than did program participants. TOP had a similar effect for all racial/ethnic groups, socioeconomic groups, household composition and grade levels. There was a greater effect on reducing the percent of girls who became pregnant than the percent of boys who caused pregnancy.	**National Campaign**: As TOP is not a sexuality education program some facilitators may not be comfortable with material. Facilitators are encouraged to have outside speakers address such topics. TOP works best when added to an ongoing program. TOP requires a trained classroom facilitator, a site coordinator and adult supervisor for volunteer work.

Curriculum	Percent of TPP Programs Utilizing	Range of Weeks Utilized Among TPP Programs	DOE Implementation Notes	Urban Institute and National Campaign Suggested Use	Urban Institute and National Campaign Findings and Outcomes	Urban Institute and National Campaign Key Challenges and Lessons Learned
Human Sexuality Values and Choices: A Value Based Curriculum	none		Fifteen sessions for teens and three for adults including role-play, group discussions, and behavioral skills exercise. Strong emphasis on abstinence and parent/adolescent communication; promotes seven core values.			
Wise Guys	15%	12 – 16	Ten to twelve week curriculum designed to promote sexual responsibility of males and emphasizing communication with parents, peers, and others.			
Personal Social Skills (PSS)	66%	2 – 42	Skills based curricula, divided into three levels focusing on decision making, communication, and self-management skills.			

Curriculum	Percent of TPP Programs Utilizing	Range of Weeks Utilized Among TPP Programs	DOE Implementation Notes	Urban Institute and National Campaign Suggested Use	Urban Institute and National Campaign Findings and Outcomes	Urban Institute and National Campaign Key Challenges and Lessons Learned
Can We Talk	26%	1 – 32	Focus on parent/adolescent communication. The four lesson cornerstones are: self-esteem, puberty and sexuality, peer pressure, and mixed messages in the media.			
Choosing the Best	15%	32 – 36 weeks	Three different age-appropriate levels, all of which are focused on abstinence. Includes parent interviewing, student lessons, and hands-on activities for youth.			

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