Communities Responding to the Challenge of Adolescent Pregnancy Prevention

Designing Effective Family Life Education Programs

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Advocates for Youth

Volume III

Designing Effective Family Life Education Programs

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Preface

Welcome to a new resource, ***Communities Responding to the Challenge of Adolescent Pregnancy Prevention***, for program planners, service providers, health and sexuality educators, community leaders, and youth advocates. This series provides resources and information to address the multifaceted nature of teenage pregnancy, using lessons learned from research and promising programs across the United States.

The adolescent pregnancy rate in the United States continues to be among the highest of all industrialized countries, and its reduction is a primary concern for policy makers and community members alike. Early pregnancy affects not only adolescents but also families, communities, and the nation as a whole. Factors linked to teenage pregnancy are complex and range from poverty, school failure, and behavioral problems to family distress and restricted access to health services. Preventing these pregnancies, therefore, is no easy task.

All pregnancy prevention programs need to take into account that teens exhibit different levels of risk. Some teens need fewer or less intensive interventions, while others need more comprehensive and sustained services. At a minimum, all teens require accurate, age-appropriate, balanced, and on-going sexuality education. For teens who are sexually active, access to contraceptive services is necessary to prevent pregnancy or sexually transmitted diseases (STDs). For teens who have had one or more births, extensive family planning counseling and services are needed to help delay or reduce subsequent teenage births. However, for most teens, family life education and health services must be linked with programs which help motivate teens to delay pregnancy and early childbearing.

In addition, it is important to recognize that individual teens need different interventions at different points during adolescence. Thus, during the early years of puberty, teens are most likely to benefit from clear and consistent messages about abstinence. As they progress through adolescence, teens are more likely to become sexually active and will need clear, consistent, and medically accurate messages about effective contraceptive use and protection from STDs and HIV infection as well as information on the benefits of abstinence. For those who become pregnant, a range of interventions, from pregnancy options counseling to abortion, adoption, and prenatal care services, are necessary. Teen parents require yet another set of interventions, including child care, social services, and job training.

Given the strong personal beliefs and political sensitivities surrounding the issues both of teen sexual activity and teen pregnancy, many communities focus their pregnancy prevention efforts either on abstinence or on services for pregnant and parenting teens. These narrow approaches ignore the needs of many teens. Abstinence-only education ignores the information and service needs of sexually active teens as well as of abstinent teens who will almost certainly become sexually active at some point in their lives. Services for pregnant and parenting teens ignore the needs of all teens who are not already pregnant and/or parenting.

These volumes encourage communities to address adolescent sexuality in a balanced and realistic manner. The series outlines new strategies for reaching youth, especially those at highest risk for early pregnancy. These strategies challenge traditional efforts that have often been too late, too little, too narrow, and too confusing. The series sheds light on why young

people are at risk and addresses the complex components of implementing or expanding teen pregnancy prevention programs. The series is organized as follows:

Volume I. Mobilizing for Action examines ways to increase public awareness and generate support for community-wide pregnancy prevention initiatives. The volume reviews recent research on adolescent pregnancy; examines key ingredients for organizing and operating a community-wide coalition; outlines steps for planning, conducting, and evaluating advocacy and public education campaigns; and provides tips for working with the media, policy makers, and other key stakeholders.

Volume II. Building Strong Foundations, Ensuring the Future provides step-by-step guidance on how to assess the needs and assets of youth in the community, how to develop a strong funding base for programs, and how to plan for evaluation of pregnancy prevention programs.

Volume III. Designing Effective Family Life Education Programs explains the components of effective family life education and provides guidance in planning and implementing family life and sexuality education programs. This volume relies on knowledge amassed from existing, effective efforts.

Volume IV. Improving Contraceptive Access for Teens examines the barriers and obstacles which restrict contraceptive use among young people. The volume discusses key strategies for planning and implementing contraceptive availability programs, based on models that have been shown to be effective.

Volume V. Linking Pregnancy Prevention to Youth Development addresses the value of motivating teens to delay childbearing and expand their educational and economic goals. The volume explores critical components of these programs and identifies successful strategies. Models demonstrate linking adolescent health programs and services, including family life education and contraceptive services, to youth development.

Program effectiveness does not rest solely on content. The design, development, delivery, quality, and evaluation of a program are equally vital for achieving success. Also important are the people providing the programs. Principles underlying the foundation of successful adolescent pregnancy prevention efforts are identified below.

Principles for Successful Pregnancy Prevention Programs

1) Acknowledge that teen sexual behavior is a complex issue that is often uncomfortable and difficult for adults to deal with.
2) Create strategies based on the latest research in teen pregnancy.
3) Start programs at early ages and provide interventions that reach young people through childhood, adolescence, and young adulthood.
4) Emphasize primary pregnancy prevention for both males and females.
5) Recognize that preventing first pregnancies requires different strategies than does reducing subsequent pregnancies.
6) Assess the effectiveness and quality of programs and build on existing foundations.
7) Ensure that programs are comprehensive, integrated, and multi-faceted.
8) Involve community members and teens in program planning, service delivery, and evaluation.
9) Collaborate with other community sectors, including business, religious organizations, and the media.
10) Set realistic goals based on available resources, definite time frames, and reachable objectives.
11) Realize that effective pregnancy prevention involves a sequential, though not necessarily linear, developmental process.
12) Recognize that long-term sustainability requires a significant investment of time, money, and committed individuals.
13) Acknowledge that effective pregnancy prevention efforts involve major challenges and require taking calculated risks.

A discussion of these principles is included in Volume I, *Mobilizing for Action,* of this series.

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INTRODUCTION

Juanita is a 10th grade biology teacher in a small, rural southwestern school. She has had primary responsibility for teaching the "home-grown" 7th to 12th grade family life education program for the last 10 years. The students have always enjoyed the course, but she has never been sure if it "works." Knowing that many students continue to have unprotected sex, she is concerned about the increasing number of teen mothers and fathers at her school. At a recent conference, she learned of several evaluated curricula which have shown some success in helping inner city kids delay sexual intercourse or use contraception more effectively. She wants to use one of the curricula, but feels it must be adapted for her rural, Latino population.

Pierre is a 7th grade teacher in an inner city school. He is well aware that many of his students begin having sexual intercourse by 9th grade. He wants to implement an effective curricula, but knows that the curriculum committee will only approve of its use for 10th graders. He feels like he is in for an uphill battle.

Dani recently joined the staff of the local YWCA. Part of her job responsibilities include teaching a six-week family life education course. She does not feel that the "dosage and intensity" are sufficient for the young participants, given all the mixed messages they hear from their parents, friends, and the media.

These three scenarios are familiar to today's sexuality educators who want to help young people who often do not have the necessary information, motivation, and skills to reduce sexual risk-taking behavior. "What works?" is the question foremost on sexuality educators' minds. They often are concerned about choosing the most appropriate curriculum, adapting a "model" curriculum for use, or incorporating school-based sexuality education programs into larger, community-wide efforts.

Volume I, *Mobilizing for Action*, provides an overview of the individual, social, and political factors that contribute to adolescent pregnancy risk. The facts below underscore the importance of providing young people with balanced, realistic, and responsible family life education to help them deal with behaviors that place them at risk of pregnancy and sexually transmitted diseases (STDs). Statistics pointing to early age of sexual initiation among many youth clearly indicate the need to reach teens at earlier ages with prevention messages. Programs must provide accurate information and help teens develop solid decision-making skills and the motivation to protect themselves. Such programs will help them consciously to select abstinence or to use contraception to prevent unintended pregnancy and STD infection.

FACTS

Adolescent Sexual Behavior

- Fifty percent of young women, ages 15 to 19, have had sexual intercourse according to the 1995 National Survey of Family Growth (NSFG). (National Center for Health Statistics, 1997) The 1995 Youth Risk Behavior Survey found that 66 percent of women and 67 percent of men have had intercourse by 12th grade. (Kann, Warren, Harris, et al., 1996)
- While the 1995 NSFG shows that sexual activity rates among young women have declined slightly since the 1980's, the current figure is significantly more than in the early 1970's and twice as high as in the late 1950's (50, 35, and 27 percent, respectively). (National Center for Health Statistics, 1997)
- In 1995, 66 percent of high school seniors reported having had sex. (Kann, Warren, Harris, et al., 1996) compared to 53 percent of those 18 years of age and older in the early 1970's and 46 percent in the late 1950's. (Alan Guttmacher Institute, 1994)
- Although most sexually active teens are older than 15 years, teens are initiating sexual intercourse at earlier ages than did teens in previous decades. Nine percent of males and two percent of females have initiated sexual intercourse by age 13. By age 15, 27 percent of males and 10 percent of females have had sexual intercourse. (Alan Guttmacher Institute, 1994) Teens who initiate intercourse at early ages frequently have more partners and have intercourse more often than those who initiate sex later. (Moore, Miller, Glei, et al., 1995)
- When teens become sexually active, they often lack the appropriate knowledge and skills to protect themselves. (Moore, Miller, Glei, et al., 1995) Many adolescents lack the cognitive skills to understand the connection between their actions and long-term consequences. (Brindis, 1990)
- Many teens do not plan their first intercourse. (Moore, Miller, Glei, et al., 1995) Many report that they had intercourse because they felt "swept away." (Institute of Medicine, 1995)

This third volume of the series, *Responding to the Challenge of Adolescent Pregnancy Prevention,* examines the history and role of family life education programs in reducing sexual risk-taking, reviews key components of successful programs, and discusses planning and implementing a balanced, realistic, K through 12th grade sexuality education program that adapts and incorporates promising strategies. Family life education is only one important component of a comprehensive pregnancy prevention strategy which should link education and access to contraceptive services to youth development strategies.

Section I
Family Life Education: An Overview

Section I

Family Life Education: An Overview

Family life education programs — also called sexuality education, health education, health promotion, human development, and family living — are curricula designed to provide information that will help young people make healthy decisions and choices about their sexuality. (Brindis, Pittman, Reyes, et al., 1991) Family life education is a principal strategy to influence adolescent risk behaviors that may lead to early pregnancy. In addition, these courses help young people become sexually healthy, responsible adults.

Family life education has changed over time, and the history of sexuality education in the United States provides a number of important lessons that can be applied to current efforts. Over the past 20 years, hundreds of sexuality education curricula have been designed and implemented in junior and senior high schools with the intent of reducing adolescent pregnancy and STD infection. (Kirby, 1997) Evaluations of some of these curricula provide clues about what works and does not work in helping young people reduce sexual risk taking.

Sexuality education programs in the 1970's focused on increasing knowledge about sexual behavior and raising awareness about the risks and negative consequences of pregnancy. The premise was that "if youth had greater knowledge about sexual intercourse, pregnancy, methods of birth control, the probability of pregnancy, and the consequences of childbearing, then they would rationally choose to avoid unprotected intercourse." (Kirby, 1992) However, over time educators learned that knowledge alone was insufficient to change behavior.

The second generation of programs, implemented during the late 1970's and early 1980's, sought to supplement knowledge with values clarification and skills in applying the knowledge (skills building). The premise of this approach was that "if students' values became more clear and their decision-making skills improved, then they would become more likely to decide to avoid risk-taking behavior, and, if their communication skills improved, then they would be more apt to communicate effectively their decisions to their partners." (Kirby, 1992) Evaluations of this approach show mixed results. Participants are more likely to experience changes in sexual attitudes than changes in sexual behavior, contraceptive use, or pregnancy.

During the 1980's and into the 1990's, another set of programs developed. Directing youth to wait until marriage to engage in sexual intercourse, these programs present abstinence as the only acceptable way for adolescents to prevent pregnancy and disease. Abstinence-only programs do not teach young people about effective use of contraception, arguing that providing contraceptive information sends a double, or mixed, message to teens. Evaluations of these programs show limited, short-term effects. (Kirby, 1997) The following provides definitions of commonly used sexuality education terms and discusses evaluation findings of these types of programs.

Terms, Definitions, and Evaluation of Sexuality Education Programs

- **Abstinence-only** (also referred to as abstinence-centered): Some curricula advocate abstinence as the only appropriate choice for adolescents. These programs offer inaccurate and/or incomplete information, especially about contraceptives. Educational strategies range from skill-based to fear-based.
- **Abstinence-until-marriage:** Some curricula advocate that sexual activity belongs only within marriage. Abstinence-until-marriage programs offer inaccurate and incomplete information, especially about contraceptives. Educational strategies range from skill-based to fear-based.

  Evaluations of **abstinence-only** and **abstinence-until-marriage** programs have shown limited success. While they may have short-term effects on attitudes regarding premarital intercourse, there is no evidence of effects on the timing of sexual initiation, the frequency of sexual intercourse, other behavioral outcomes, or attitudes in the long run. (Kirby, 1992; Kirby, 1997)
- **Abstinence-based** (also known as **comprehensive or balanced, realistic sexuality education**): Curricula that advocate **both** abstinence **and** responsible, healthy sexual behavior, these programs build skills in communication, negotiation, and refusal. **Abstinence-based** programs offer complete contraceptive information.

  A number of **comprehensive or balanced, realistic sexuality education** programs have been shown to help young people delay the onset of intercourse, decrease the frequency of intercourse, increase the use of protection against pregnancy or STDs and HIV, and/or reduce the number of sexual partners. The most promising programs are skill based, theory driven curricula which send clear, consistent messages about sexual risk reduction. (Kirby, 1997) There is no evidence that programs that include information on condoms and other contraceptive methods encourage teens to engage in earlier or increased sexual activity.

Source: Hoffman, 1997

A recent, thorough review of sexuality education programs and their evaluations reveals that balanced, realistic sexuality education has a positive impact on the sexual behavior of young people. (Kirby, 1997) The evaluations offer insights into which types of programs, interventions, and strategies work best. Key resources for evaluation and research findings are included in Appendices B and G.

In this volume, the terms "effective" and "model programs" both refer to evaluated sexuality education curricula or programs which have demonstrated some success in reducing pregnancy-related risk behaviors. The terms "promising" and "innovative" refer to programs which may or may not have been evaluated or did not have strong outcomes but offer interesting and creative approaches. The term "comprehensive" refers to sexuality education programs which span kindergarten through grade twelve (K-12). "Balanced, realistic" refers to curriculum content which teaches about both abstinence and contraception and provides **both** communication **and** decision making skills.

Section II
Key Components of Effective Family Life Education Programs

Section II

Key Components of Effective Family Life Education Programs

Lessons learned from previously evaluated curricula form a foundation for today's program planners, educators, and youth-serving professionals. The following section summarizes key components of effective (evaluated) sexuality education curricula. Consider the needs of youth in the community and how to apply these "keys to success".

Ensure that the family life education program is based on a solid theoretical model.

Effective programs, such as Reducing the Risk and Teen Talk, use a variety of theoretical approaches, including the health belief model, cognitive behavioral model, social inoculation, stages of change model, and social learning theory. (Kirby, 1997) These theories focus on personal or psychological characteristics, including knowledge, attitudes, beliefs, motivation, self concept, past experiences, skills and abilities, and developmental concerns. The following discussion demonstrates how these models are applied to sexuality education programs.

Stages of Change Model. When applied to pregnancy prevention, this model focuses on education and skills building to increase young people's awareness of the potential consequences of sexual activity and to motivate them to plan and move toward preventive behavior. This model recognizes that people often must move through a sequence of readiness steps before they can adopt consistent behaviors. The following chart illustrates the sequential steps of the stages of change model and their application to changing risk behavior among teens.

Stages of Change Model

Concept and Definition	Applications
Stage 1. Pre-Contemplation Adolescents are often unaware of sexual risks and consider themselves invulnerable. They must become aware of risks before they can protect themselves.	Increase awareness of the need for risk reduction. Personalize information on risks and on benefits of postponement and protection.
Stage 2. Contemplation Adolescents must contemplate potential risk-reduction steps and consider how to take these steps in the near future.	Motivate and encourage teens to make specific plans regarding risk reduction. Help them to make a concerted effort to delay sexual intercourse or take active steps to use contraception if already sexually active).
Stage 3. Decision/Determination Adolescents must develop an action plan to guide them in making the desired behavior changes.	Assist in developing concrete action plans, setting goals for postponement or protection.
Stage 4. Action The adolescent implements his/her action plan and makes the desired change.	Assist with feedback, problem solving, social support, and reinforcement of teens' risk reduction measures.
Stage 5. Maintenance For the adolescent to continue taking the desirable actions, she/he needs repeated periodic reinforcement.	Remind and assist in coping, finding alternatives, and avoiding slips. If a slip occurs, provide reinforcement to return to the desired behavior.

Source: Glanz, Rimer, 1995.

> ***Reducing the Risk** is a curricula based, in part, on the stages of change model. A school-based approach to pregnancy prevention for 10th graders, **Reducing the Risk** emphasizes avoiding unprotected sex either through abstinence or through contraceptive use for those who choose to be sexually active. Discussion of sexuality, reproduction, and contraception is made relevant to each individual, while role playing allows participants to model and practice healthy behaviors. Participants discuss social pressures, negotiation skills, and pregnancy prevention. Students are asked to talk with their parents about abstinence and contraception as well as go to stores and clinics to obtain information on contraceptives. The curriculum reduced the rate of unprotected intercourse by 40 percent among "lower risk" youth and among students who had not yet initiated intercourse at the time of the pre-test.* (Note: Lower risk was defined as youth who lived with both parents, whose mother finished high school, who received grades mostly of C or better, and who drank alcohol infrequently and in limited quantities.) (Kirby, Barth, Leland, et al., 1991)
>
> ***Reducing the Risk*** did not significantly influence the frequency of intercourse or use of contraception among sexually active teens. This finding suggests that it may be difficult to alter already established patterns of sexual intercourse and contraceptive use. Further, it underscores the importance of reaching teens with messages about abstinence and sexual risk reduction before they become sexually active.

Health Belief Model. This model promotes the ability to weigh benefits and make changes when confronting a health risk. An example of this model would be a young woman having unprotected intercourse who must perceive first that sexual activity involves consequences such as an unintended pregnancy (susceptibility). Then she must perceive that the consequences can be negative, such as having a child and dropping out of school to support her child (severity). Finally, she must see that the prescribed interventions, such as using contraception and finishing school before becoming a parent, are useful (benefits) and outweigh potential negative side effects, such as weight gain from contraceptive use or potential loss of social status by delaying parenthood.

The following chart illustrates the various elements of the health belief model and its application to contraceptive use among teens.

Health Belief Model

Concept and Definition	Applications
Perceived Susceptibility Before an adolescent can take active self-protective steps, the teen must believe that she/he is susceptible to pregnancy, STD infection or, parenting a child.	Personalize the level of risk based on a young person's characteristics or behavior. If the adolescent considers his/her susceptibility to be low, heighten the perceived susceptibility.
Perceived Severity An adolescent must believe that the consequences of unprotected sexual activity or parenthood are severe enough to warrant prevention and protection. For example, she/he must believe that the consequences of unprotected sexual activity will have a negative impact now in her/his life.	Specify the risks and consequences of the behavior.
Perceived Benefits An adolescent must believe in the efficacy and benefits of the alternatives, such as the positive aspects of delaying sexual activity, using contraception, and/or completing school.	Define actions to take: how, where, when. Clarify the positive effects to be expected if actions are taken.
Perceived Barriers An adolescent must be able to meet the costs of the advised action. For example, a teen who delays sexual activity may face sexual pressure or fear loss of status among friends. A teen who decides to contracept may experience short-term side effects.	Identify and reduce barriers through reassurance, incentives, and assistance.
Cues to Action An adolescent needs strategies which will strengthen her/his readiness to make behavior changes.	Provide how-to information, promote awareness, and provide reminders and reinforcements.
Self-Efficacy An adolescent must be confident in his/her ability to take action.	Provide training, skills-building opportunities, and guidance.

Source: Glanz, Rimer, 1995.

The health belief model is an important part of *Teen Talk* which teaches teens, ages 13 to 19, to take responsibility for their actions and provides skills to remain abstinent and/or to use contraception. For more information on *Teen Talk*, see social learning and cognitive theory below.

Social Learning and Cognitive Theories. These theories assert that teens change their behavior when they acquire knowledge, skills, beliefs, and confidence through interactions with others in their own environment. Teens must have strong role models to reinforce positive behaviors. *Reducing the Risk* applies this model in schools to 10th graders by inviting role models to meet with students. Students are encouraged to learn about contraception by going to stores or visiting clinics. Peer education is another application of this model. Peer education programs aim to change the social attitudes and norms about sexuality by involving youth in educating other youth.

Social Learning or Social Cognitive Theory

Concept and Definition	Applications
Reciprocal Determinism Behavior change among adolescents results from the interaction between a person and his/her environment.	Involve the individual and relevant others in deciding what actions are needed. If warranted, work to change the environment through media messages, peer education training, etc.
Behavioral Capability Adolescents need appropriate knowledge and skills to make a behavior change.	Provide information and training.
Expectations Adolescents must believe that their actions will produce positive change.	Incorporate information about probable results of actions in advance and provide scenarios of likely results.
Self-Efficacy Adolescents must have confidence in their ability to act and must persist in taking the action.	Affirm a teen's individual strengths and ability to implement new behaviors. Use persuasion and encouragement. Approach behavior change in small incremental steps that build self-confidence.
Observational Learning Adolescents make changes most effectively when they can observe others like themselves doing so and see visible, tangible results from their actions.	Demonstrate the relevant experience of others. Identify role models.
Reinforcement Adolescents need reinforcement in order to sustain behavior changes.	Provide incentives, rewards, and praise and encourage self-reward. Decrease possibility of negative reactions that deter positive changes.

Source: Glanz, Rimer, 1995

Teen Talk is a contraceptive educational initiative based on social learning and cognitive theories. A school-based and community-based approach to pregnancy prevention for teens ages 13-19, *Teen Talk* presents information on reproduction, physiology, and contraceptive methods in large group settings. Additional sessions allow teens to participate in small group discussions. The goals of the small groups are to increase teens' understanding of the risks and consequences of teen pregnancy as well as to learn and practice refusal and negotiation skills. Games, role playing, and films provide the basis of work in the small groups and are designed to stimulate group discussion. Ideally, the program runs for two to three weeks for a total of 12 to 15 hours. Evaluation conducted in both urban and rural settings indicated that the program is especially beneficial in delaying intercourse for young males who are not yet sexually active. In addition, findings indicate that the program leads to more effective use of contraception among sexually active teens. (Philliber Research Associates, Child Trends, 1998)

Young people are choosing to become sexually active at increasingly early ages. In addition, many young people experience sexual abuse or forced sex. Family life education programs often offer students their first information about sexuality issues. Programs, therefore,

should start no later than the middle school years. Several program evaluations suggest that family life education should be implemented in elementary school. (Moore, Sugland, Blumenthal, et al, 1995; Girls Incorporated, 1991) For students 10- to 14-years-old, emphasis should be placed on decision-making, communication skills, and the reinforcement of positive self-esteem.

Implement age-appropriate curricula that meet the developmental needs and match the backgrounds and life experiences of adolescents.

> *A problem we face is that there are very few materials on sexuality designed for deaf and hearing impaired children and teens. At our school, we are not allowed to use models of sexual organs as teaching aids. These are important teaching tools for deaf children. I have been trying for eight years to get them into the classroom, with no luck.*
>
> *Maureen, Teacher*

> *In my school, we asked several bilingual teens to translate and adapt sexuality education materials as a class project.*
>
> *Jason, Coach*

Family life education programs are most effective when they match cognitive development, literacy levels, cultural backgrounds, and the special needs of adolescent participants. The chart in Appendix C reviews stages of adolescent development, including the special physical, cognitive, emotional, moral, and social characteristics of each stage. Programs should consider that in early adolescence (ages 11 to 14), teens experience rapid physical changes, think concretely, have difficulty seeing others' points of view, and are less likely than older teens to accept responsibility for their actions. Older teens are better able to think abstractly and exhibit better memory processes and problem-solving skills. While programs must take these age differences into account, programs must also allow for individual differences in maturity, literacy, and culture within each stage. (Jaccard, 1996)

Teach values and norms while focusing on reducing sexual risks.

Effective programs focus on specific behavioral goals, including postponing sexual intercourse and using contraception consistently, while emphasizing values and norms appropriate for the community and age group. (Kirby, Coyle, 1994) Programs for younger teens may emphasize the value of abstaining from and/or delaying sexual activity. Those for older, often sexually active, teens will emphasize the importance of protection and risk reduction.

A variety of strategies have been shown to change behavioral norms. Peer-led sessions, role playing, and exercises that clarify values can all reinforce the importance of postponing sexual intercourse, avoiding unprotected intercourse, using condoms, and avoiding partners who engage in high-risk behaviors. (Kirby, Coyle, 1994) *Reducing the Risk*, for example, clearly emphasizes the value of abstinence while also encouraging contraceptive use among sexually active adolescents. *Be Proud! Be Responsible!,* an AIDS risk reduction program, combines role playing, games, and other exercises to increase knowledge about HIV/AIDS and STDs and build skills to promote safer sexual behaviors.

Aim for a balanced, realistic program that covers a broad range of topics, including healthy sexuality, responsible sexual behavior, contraception, dating relationships, pregnancy, HIV, STD's, sexual abuse,and sexual orientation.

> *One of the students kept coming to my office for band-aids. He came seven times. He had a small cut on his finger that he kept bandaging up. We all wondered what was wrong. When he came for the eighth band-aid, he told me he was being sexually abused.*
>
> *School Nurse*

> *Many of the deaf students in our school have been sexually abused by a family member such as a father, brother, or uncle. Some men believe it's safe to rape them because the children won't talk about it to anyone. Our courses must address this issue.*
>
> *Maureen, teacher*

Differing opinions exist regarding whether a balanced, realistic approach to sexuality education is superior to a focused one. *The Guidelines for Comprehensive Sexuality Education* from the National Guidelines Task Force stress the value of teaching that sexuality is a natural part of being human. The Guidelines encourage schools to implement balanced, realistic sexuality education programs in grades K-12. (National Guidelines Task Force, 1991) Balanced, realistic, K-12 programs are not easy to implement or evaluate. Recent evaluations have measured the impact of specific curricula. The most successful programs for reducing unprotected sexual intercourse have a "particular emphasis on those specific facts, values, norms, and skills necessary to avoid sex or unprotected sex". (Kirby, Coyle, 1994)

Given the many factors associated with teen pregnancy as well as the time constraints faced by sexuality educators, the real question is how to help young people to abstain and to protect themselves at intercourse as well as teach them positively about sexuality. Two approaches address this dilemma. One makes pregnancy prevention a priority, using an evaluated curriculum for reducing pregnancy risk behaviors and adding other topics as appropriate. The other institutes a balanced, realistic curriculum focusing on healthy adolescent sexuality, but incorporating the key components of pregnancy prevention programs. (Kirby, Coyle, 1994) The authors of this series strongly support the guidelines of the National Guidelines Task Force and encourage implementation of a balanced, realistic, and responsible sexuality education program that, at minimum, includes an evaluated curriculum and covers a range of topics related to healthy sexual development. The chart below highlights characteristics of a sexually healthy adolescent.

Characteristics of a Sexually Healthy Adolescent

In 1994, the National Commission on Adolescent Sexual Health convened to identify characteristics and behaviors of sexually healthy adolescents to help teens understand and accept their evolving sexuality and make responsible sexual choices.

The Commission identified characteristics and behaviors of the sexually healthy adolescent in relationship to self, parents and other family members, peers, and romantic partners. Sexually healthy adolescents appreciate their own bodies, take responsibility for their own behaviors, communicate effectively within their families, communicate effectively with their peers of both genders in appropriate and respectful ways, and express love and intimacy in a developmentally appropriate manner. Sexual behaviors a teenager engages in or abstains from do not define sexual health. The Commission recognizes that the majority of adolescent attributes and behaviors relevant to self, family, peers, and partners also apply to sexually healthy adults and, in many cases, represent an ideal to strive toward.

Characteristics of a Sexually Healthy Adolescent

Self

Appreciates own body
- Understands pubertal change
- Views pubertal changes as normal
- Practices health promoting behaviors, such as abstaining from alcohol and other drugs and having regular check-ups.

Accepts responsibility for his/her own behaviors
- Identifies personal values
- Decides what is "right" for her/himself and acts on these values
- Understands the consequences of actions
- Understands that media messages can create unrealistic expectations related to sexuality and intimate relationships
- Is able to distinguish personal desires from desires of peers
- Understands how alcohol and other drugs can impair decision-making
- Recognizes behavior that may be self-destructive and can seek help

Is knowledgeable about sexuality issues
- Enjoys sexual feelings without necessarily acting upon them
- Understands the consequences of sexual behaviors
- Makes decisions about masturbation consistent with personal values
- Makes personal decisions about sexual behaviors with a partner
- Understands his/her own gender identity
- Understands effects of gender role stereotypes and makes choices about appropriate roles for her/himself
- Understands his/her own sexual orientation
- Seeks further information about sexuality as needed
- Understands peer and cultural pressure to become sexually involved
- Accepts that people have different values and experiences

Relationships with Parents and Family Members

Communicates effectively with family about issues including sexuality
* Maintains appropriate balance between family roles and responsibilities and growing need for independence
* Is able to negotiate with family on boundaries
* Respects the rights of others
* Demonstrates respect for adults

Understands and seeks information about parents' and family's values and considers those values in developing his/her own values
* Asks questions of parents and other trusted adults about sexual issues
* Can accept trusted adults' guidance about sexuality issues
* Works to understand parental point of view

Peers

Interacts with both genders in appropriate and respectful ways
- Communicates effectively with friends
- Has friendships with males and females
- Is able to form empathetic relationships
- Is able to identify and avoid exploitative relationships
- Understands and rejects sexually harassing behaviors
- Respects others' right to privacy
- Respects others' confidences

Acts on one's own values and beliefs when values conflict with those of peers
- Understands pressures to be popular and accepted
- Makes decisions consistent with own values

Romantic Partners

Expresses love and intimacy in developmentally appropriate ways
- Believes that males and females have equal rights and responsibilities in love and sexual relationships
- Communicates desires not to engage in sexual behaviors and accepts refusal to engage in sexual behaviors
- Is able to distinguish between love and sexual attraction
- Seeks to understand and empathize with partner

Has the skills to evaluate readiness for mature sexual relationships
- Talks with partner about sexual behaviors before they occur
- Is able to communicate and negotiate sexual limits
- Differentiates between low- and high-risk sexual behaviors
- Together with partner, makes sexual decisions and plans behaviors
- If having intercourse, protects both her/himself and partner from unintended pregnancy and diseases through effective use of contraception and condoms as well as other safer sex practices
- Knows how to access and use the health care system, community agencies, religious institutions, and schools
- Seeks advice, information, and services as needed

Source: National Commission on Adolescent Sexual Health, 1995

Provide sexuality-related information and activities to encourage skill development.

Programs should include both information and skill building. While information about anatomy, physiology, abstinence, and contraception is important, teens need skills to apply this knowledge. Therefore, knowledge should be combined with training in assertiveness, negotiation, decision making, and communication, life skills training, and goal setting. (Howard, McCabe, 1990; Kirby, Barth, Leland, et al., 1991)

The most effective programs provide information about skills, demonstrate effective use of skills and provide participants opportunities to practice these skills. (Kirby and Coyle, 1994) Participants should gain knowledge and skills through real activities, such as *Reducing the Risk's* family planning clinic visits, or through the active learning methods used by *Teen Talk,* such as games, videos, and role playing. (Kirby, Coyle, 1994)

Many successful programs teach young people how to communicate about sexuality with parents or other adults. *Reducing the Risk* encourages students to discuss abstinence and birth control with parents. *Wise Guys* focuses on positive parent-child relationships and teaches young men effective communication skills to use with parents.

> ***Wise Guys** is a male responsibility program for 10- to 15- year-olds that aims to prevent teen pregnancy. Developed in 1991 by the Family Life Council of Greater Greensboro in North Carolina, the curriculum has served more than 5,000 young men. Program objectives include: providing information about sexuality so that young men can make good decisions about sexuality, encouraging respect for oneself and for others, helping young men understand the importance of acting responsibly, and helping young men communicate effectively with their parents. The curriculum fosters positive self-image and includes lessons on values clarification, setting goals, good decision making, effective communication, and positive parent-child relationships.* (Family Life Council of Greater Greensboro, 1996)
>
> *Program evaluation showed a substantial increase in contraceptive use among participants. Upon entering the program, 60 percent of participants reported recent contraceptive use. Eighty-eight percent of program participants reported recent contraceptive use both at exit of the program and at six month follow-up (for the control group of students decreased from 82 percent at program entry to 69 percent at exit). The percentage of sexually active program participants who always used contraception increased from 41 percent at program entry to 49 percent at exit and 56 percent at follow-up, while the percentage who never used birth control decreased from 24 to 12 percent.* (Philliber Research Associates, 199?).

Provide information on both abstinence and contraception.

> *I am not a virgin. I was raped and molested for six years during my childhood. I hate these programs which only focus on abstinence until marriage. I had no choice.*
>
> *Monette, student*

For youth who are not yet sexually active, abstinence-based education may encourage the delay of intercourse. However, teaching all youth — those abstaining as well as those who are sexually active — about consistent, effective contraceptive use is as critical as is providing access to contraception. (Frost and Forrest, 1995)

A recent federal mandate will provide funds through the federal Maternal and Child Health Bureau for abstinence-only and abstinence-until-marriage programs despite research

demonstrating their ineffectiveness and inaccuracies. Some local programs intend to use the funds to implement mentoring programs for younger teens, conduct research and evaluations, or launch media campaigns, rather than apply it directly to education. Many states will respond by focusing on influencing adolescents ages 10 to 14 in an attempt at early intervention. At this writing, it is premature to assess the impact of the federal mandate, but the law presents challenges to program planners and advocates.

Involve both young women and young men in programs.

Programs should address the social pressures that both male and female teens experience regarding sexual behavior. Effective programs discuss media influences, common "lines" used by partners and peers to encourage sexual activity, and social barriers that prevent young people from using protection. (Kirby, Coyle, 1994) While some curricula are designed for both females and males, other curricula are specifically designed only for young women or young men. *Wise Guys* is one example of a curriculum for young men.

Given recent research on teen pregnancy and sexual victimization, programs must address the power dynamics in sexual relationships. All young people have rights and responsibilities regarding safe, consensual, and responsible sexual behavior.

Involve teens in programs as peer educators.

> *Our youth center serves teens who have mental and physical disabilities. They require extra time and attention when dealing with sexuality issues. Most of the 'model curricula' do not address these teens. We found that training peer educators was a great way to get the students to open up and discuss these issues.*
>
> *A Youth Worker*

Adolescents often say they engage in sexual activity as a result of peer pressure. Sometimes teens need the positive support of other teens to deal successfully with these pressures. Consider peer education, peer counseling, and peer leadership strategies as part of the sexuality education program. While adults often focus on the negative influence teens have on one another, it is important to remember that teens also play a positive role with one another.

FACTS

The Influence of Peers on Teen Sexual Decision Making

- Teens often feel pressured to become sexually active. One study shows that up to 30 percent of teenagers feel pressured by their peers to have sex. (Moore, Miller, Glei, et al., 1995)
- A Chicago study shows that low-income African-American teen women more often experience peer pressure to become pregnant, carry their pregnancies to term, and keep their children than do white and Hispanic teen women. (Musick, 1993) However, peer pressure affects all teens.
- Pregnant teens cite inability to resist pressure from boyfriends as the most common reason for initiating sexual activity. (Musick, 1993)
- Peer influence is a significant factor in teens' perceived ability to say no to sex. As peer influence increases, teens' confidence in their ability to say no to unwanted sexual advances decreases. (Zimmerman, Sprecher, Langer, et al., 1995)

- Trained teen peer educators may have an impact on other teen's sexual risk taking by influencing the timing of sexual activity as well as the decision to remain abstinent or to become sexually active. (Panel on Adolescent Pregnancy and Childbearing, 1987)

Unfortunately, few evaluations have demonstrated the impact of specific peer-based interventions. Thus far, peer-based programs are more likely to positively impact the peer educators themselves, rather than other participants.

Following are tips for a successful peer education program.

Tips for a Successful Peer Education Program

- Find someone who enjoys working with teens to coordinate the program.
- Involve young people in the design as well as the implementation of the peer education program.
- Set clearly defined goals, with realistic objectives and activities. One program cannot address all the issues facing teens, and peer educators may have their biggest impact on knowledge and attitudes rather than on behavior.
- Link the peer education program to other community agencies and health services so that peer educators know where to refer their peers.
- Train teens to facilitate activity-based learning rather than to give lectures.
- Provide on-going encouragement and support for peer educators, including opportunities for them to make suggestions about the program.
- Expect attrition and have a formal structure for recruiting and training new peer educators.

Source: Norman, 1998

Involving young people in the planning process of pregnancy prevention programs may be challenging but enriching. Following are tips for working with young people and involving them in program efforts. By and large, these are simply common-sense courtesies that make any group effort successful. Schools and other agencies in the community that work with young people can be resources for contacting involved and interested youth.

Tips for Working with Young People

Integrate young people into program efforts. Schedule meetings at times and locations convenient for teens. Keep young people informed about plans and meeting times. Enable young people to participate in group activities in meaningful ways. Youth should participate as much as possible in the planning group's decision making process, have equal voting rights, and hold leadership positions. Other planning group members must be clear that young people are equals in the effort.

Be open and non-judgmental about young people's insights and suggestions. Let youth know that their involvement is important. Guard against dismissing or otherwise reacting negatively to young people's suggestions. Many young

people are intimidated by adults and may not be accustomed to being included in planning or other strategy discussions. It may take time and effort to get young people to participate fully in the program. Work to help teens feel comfortable. Do not assume that a teen has no opinion if he/she does not speak up. Ask teens' ideas and opinions during meetings and discussions.

Take advantage of the expertise teens offer. Young people know about their peers. Encourage them to share their insights about a proposed program's potential positive or negative impact on young people. Affirm teens' input.

Keep expectations realistic. Be honest about expectations for the project, teens' contributions, and benefits of youth participation. Ensure that the needs of all planning group members are being met.

Be prepared to offer support for young people. Think about the kinds of support necessary to involve a broad variety of teens in the project. Support may include financial assistance, transportation, training, and information. Encourage planning group members to provide this support and maximize everyone's participation.

Make the work interactive and fun. Like adults, young people are more likely to become and remain active in projects that are interesting and fulfilling. Volunteer work should be pleasurable.

Help build teens' skills so they can become more involved. Young people may need information about adolescent health statistics, the overall political situation, or the community's need for a particular program. They may need training to become effective communicators and support to feel comfortable speaking with program directors, the media, or policy makers. Providing young people with opportunities to build their skills is crucial.

Source: Clark, Haughton-Denniston, Flinn, et al., 1993

Section III
Planning and Implementing Successful Family Life Education Programs

Section III

Planning and Implementing Successful Family Life Education Programs

Sexuality education programs can be implemented and adapted in a variety of settings. Schools are excellent settings because many young people can be reached at once and consistently. Other settings are equally important for reaching out-of-school youth and other underserved groups, such as pregnant and parenting teens, as well as youth in foster care, juvenile justice programs, or shelters for homeless youth. These youth may need more intensive, long-term, and individually-oriented approaches than do those in school. Religious organizations may also adapt a variety of programs for their own young members.

The planning process has similar phases regardless of the setting or target population. The following section discusses fundamental steps for planning a new family life education program or adapting an existing one and uses the school setting to demonstrate the planning process. Assessing existing family life education programs and their potential for expansion will help to determine if a new program is needed or an existing one should be strengthened, and whether the program can be linked with other youth services.

Chapter 1

Launching a New Family Life Education Program

If the school has no family life education, consider the following steps to get started:

1. **Convene a planning group with adult and teen stakeholders.** This planning group may include teachers (many schools have designated teachers who are responsible for family life education), the curriculum supervisor, principals, school nurses, guidance counselors, parents, health professionals, teen pregnancy prevention experts, and students. The planning group may even begin as a task force from a local pregnancy prevention coalition or network of agencies. The planning group will carry out the needs and assets assessment (see Volume II of this series) and assume responsibility for implementing the program.
2. **Conduct an assessment to identify the needs of youth and the existing information available to them.** Existing risk and demographic data, as described in Volume II, will help define the needs of young people in the school or community. Focus groups and surveys of both students and parents will identify the amount of sexuality-related information students currently receive. School health educators, biology teachers, home economics teachers, and coaches can assess current courses. Does the biology or health class cover anatomy, physiology, and other issues related to sexuality? Do students receive any information related to sexual health and pregnancy prevention, such as contraceptive information? Does the school use an evaluated sexuality education curriculum? At what grade level does sexuality education begin?

   Based on this review, ascertain what information gaps exist and identify possible strategies to introduce additional curricula. What information is needed to make a compelling case for either introducing or expanding family life education?
3. **Learn the school policy concerning sexuality education and identify existing guidelines for implementation.** Different school systems have different policies regarding sexuality education. Check whether the school system has a mandate requiring sexuality education. Is school board policy for or against it? What requirements exist regarding the contents of sexuality education and the grade level(s) to be targeted? Are there guidelines for parental involvement? What qualifications must teachers have? Investigate the school system's history related to sexuality education, whether there has been any controversy about teaching a balanced, realistic, and comprehensive program in the past, and if so, how it was resolved.
4. **Become familiar with evaluated curricula appropriate for your community.** Visit schools or other youth-serving organizations that can help in the selection process; observe programs in action. Many of the program models listed in this volume may be obtained from *Sociometrics' Program Archive on Sexuality, Health, and Adolescence.* (Refer to Appendix I and the program contact list in Appendix B.)

Once a curriculum is chosen, review all materials and resource requirements, including educational supplements, teaching tools, staffing requirements, and costs, to assure that it is well suited to the needs of the community, its youth, and available resources. A focus group of teens can review the curriculum to test its acceptability and relevance.

5. **With the planning group or coalition task force, design a draft plan based on the selected evaluated program.** The plan should include cost of acquiring materials as well as necessary strategies for adapting the model program, implementation procedures, training schedules, needed technical support, and evaluation plans and procedures.
6. **Get official approval for implementing the program, even when sexuality education policy restrictions do not exist.** Find supportive advocates in the school who are in favor of implementing the program, such as the health education or science chair, the school principal or vice principal, or the school superintendent. Ask them for help in securing approval. In some schools, the health teacher simply needs the approval of her/his supervisor; in others, the school board approves curricula for the entire school system.
7. **Be prepared for controversy.** Balanced, realistic sexuality programs are often controversial. Expect some opposition. Dealing with controversy is discussed in the first volume of this series. "Common Questions About Sexuality Education" (Appendix D), "Refuting the Myths and Misinformation" (Appendix E), and Advocates for Youth's *Advocacy Kit* (Flinn, 1997) provide help and strategies to deal effectively with controversy. Involving key school and community representatives as well as parents and teens throughout the planning process can make all the difference.
8. **Community action can result in solid support when a decision to implement a program is up to the school board.** Start by garnering school and community support for the curriculum. Generate media coverage of the teenage pregnancy problem in the community and the success of the selected program in other communities. Invite a teenage pregnancy prevention specialist from the health department, family planning clinic, or local university to meet with the PTA and groups of teachers. In addition, invite someone who has used the curriculum or is an expert in the field of adolescent sexual and reproductive health to discuss the program with key representatives of the planning group, community, and school. A state coalition or national organization, such as Advocates for Youth, can assist by conducting a series of advocacy trainings for program planners and advocates. (See also Volume I of this series.) The chart below provides tips for working with school boards.

Tips for Working with School Boards

- **Do your homework.** Learn how curriculum changes are usually and optimally handled. Consider school politics. Enlist key players, such as the curriculum committee chair, to help sort out school policies and procedures.
- **Garner the support of the principal.** Try to discern whether he/she supports balanced, realistic sexuality education. If so, enlist the principal's help to approach the superintendent and the school board. If the principal is not supportive, find ways to lobby for support.
- **Discover the history of balanced, realistic sexuality education at the school.** Have previous efforts failed? Who has introduced the issue in the past? What happened?
- **Sort out the best approach to school board members.** Ascertain who best can introduce the issue and who should make policy recommendations to the board. Approach school board members and the superintendent cautiously

and courteously. Conduct parent surveys and student polls to demonstrate support for the proposed changes.

- **Learn who on the board is influential and enlist their support.** Meet with board members who are sympathetic and explain the planning group's concerns and proposal. Seek advice on how to proceed.
- **Identify who on the board opposes balanced, realistic sexuality education.** Discover why and strategize ways to minimize opposition.
- **Make contacts with the presidents of the PTA and the student association.** PTA presidents often are familiar with members of the school board and can be influential in getting the message to them for consideration. Students can be excellent spokespeople for expressing the needs of the student population.
- **Offer to speak at forums and meetings.** Be prepared to summarize the research related to effective sex ed curriculum.
- **Offer to accompany school board members to community meetings relating to the issue.** Establishing relationships with school board members can help garner their support.
- **Demonstrate parent and student support.** For example, when presenting at a school board meeting, enlist parents and students to attend and visibly demonstrate their support.

Source: Clark, Haughton-Denniston, Flinn, et al., 1993.

Finally, develop an implementation strategy. Once the plan is approved, the planning group develops an implementation strategy including defined time lines, targeted age groups, training, evaluation, and funding support. Refer to the following sample program planning worksheet, "Action Steps for Identified Change," provided below.

Action Steps for Identified Change

(An Example)

Use this page to outline action steps for each identified change to be sought in each community sector.

Community Sector: Schools

Community Change to be Sought: By January 2000, provide the community with data on youths' view about sexuality, including availability of contraception, methods of contraceptive use, and sexual activity.

Actions	By Whom	By When	Resources/Support Needed/Available	Potential Barriers or Resistance	Communication
What needs to be done?	Who will take action?	By what date will the action be done?	By what date will the action be done?	What individuals and organizations might resist? How?	What individuals and organizations should be informed about these actions?
Secure support from school administrators and teachers to survey high school students on issues related to sexuality.	School Committee	August 1999	Committee Members	School administrators, teachers, and parents may resist by not permitting the survey.	Coalition Members/Network of Agencies, Parent Organizations
Prepare a survey to distribute to high school youth.	School Committee	August 1999	Committee Members, Teachers, Parents	School administrators, teachers, and parents may resist by not permitting the survey.	Coalition Members/Network of Agencies
Secure informed consent from parents and students to distribute the survey.	School Committee	Schools Committee	Committee Members, Teachers, Parents	Parents and students may refuse to complete the survey.	Staff, Committee Members, Evaluators
Teachers will distribute the survey to all high school youth.	Teachers with help from School Committee	October 1999	Teachers	Teachers, parents, and school administrators may resist by not distributing the survey.	Coalition Members/Network of Agencies
Summarize the results and prepare the report.	School Committee and Staff	December 1999	Staff, Committee Members, Evaluators		Coalition Members/Network of Agencies, School Administrators

Source: Fawcett, Paine-Andrews, Francisco, et al., 1994

Action Steps for Identified Change

Planning Page

Use this page to outline action steps for each identified change to be sought in each community sector.

Community Sector: ______________________________

Community Change to be Sought: ______________________________

Actions	By Whom	By When	Resources/Support Needed/Available	Potential Barriers or Resistance	Communication
What needs to be done?	Who will take action?	By what date will the action be done?	What financial, human, political, and other resources are needed? What resources are available?	What individuals and organizations might resist? How?	What individuals and organizations should be informed about these actions?

Source: Fawcett, Paine-Andrews, Francisco, et al., 1994.

Chapter 2

Strengthening Existing Family Life Education Programs

Family life education may already be available in local schools. However, increasing teen pregnancy and birth rates, limited information, and/or courses that do not provide appropriate information may motivate the community to seek new approaches. In this case, the goal of the planning group or coalition task force is to assess the quality and content of existing programs to determine whether they need to be strengthened or replaced with a more effective approach. Evaluations have shown that family life education alone is insufficient to have a measurable impact on teen pregnancy rates. However, well evaluated family life education programs are an important component in reducing sexual risk-taking behaviors which may lead to pregnancy. The following questions may help the coalition, network of agencies, or planning group to assess whether to strengthen or replace the current program.

Assess the quality and content of the existing program.

Assess its duration and content. Does the school have a comprehensive K-12 sexuality education program? If not, in what grade(s) is family life education taught? How many sessions do students receive over how many years?

Assess the quality of the course with regard to content and skill building. Has the curriculum been evaluated? Are the materials skills-based? Do they include role playing, negotiation, and assertiveness skills? Does the curriculum provide abstinence-based information to help adolescents postpone sexual activity? Does it address peer and social pressures? Does it provide contraceptive education for sexually active teens? Are the participants referred to contraceptive services, when needed?

Assess the relevance of the curriculum to youth participants. Is it tailored to the specific needs and life experiences of students? Is the intensity and duration of the program sufficient for participants, given their level of risk? Does the existing curriculum meet the developmental needs and reflect the cultural and ethnic background of the participants?

Assess the extent of teacher training.

What qualifications are necessary for teaching the course? Are the instructors comfortable teaching the course materials? Do they receive in-service training? Has the training been evaluated? Survey the teachers to assess their satisfaction with current training. What additional training do they need?

Identify gaps in the current program and develop a plan to address these gaps.

Ask if current curricula should be implemented at earlier ages. Can skill building components be added to the already existing family life education program? Can the curriculum be adapted to reflect the cultural background of participants? Does the teacher training program need to be expanded? Is an altogether new curriculum needed? In what ways can the community meet the information and education needs of its young people and reinforce messages of sexual responsibility?

The Family Life Education Program Assessment (Appendix F) can guide the analysis of current programming and help in the development of an implementation plan, which should include strategies for adapting and evaluating the existing program, obtaining resources, and providing additional teacher training.

With the approval of major decision makers, including the principal and teachers, the plan can be implemented. Implementation is similar to that for a new program, discussed in steps six through nine in the previous section. Test a new comprehensive family life education curriculum in a few school sites before full implementation. Use pre- and post- data to assess the effectiveness of the program before implementing it throughout the school district.

Chapter 3

Linking Family Life Education to Other Pregnancy Prevention Efforts

If an effective family life education program already exists in the school system, consider enhancing the program by linking it to other pregnancy prevention programs in the community. Perhaps the school system already has a strong commitment to sexuality education, has a curriculum committee, has completed a needs assessment, and has chosen a program based on a well-evaluated curriculum. Perhaps the school system has already evaluated its own program and knows that the curriculum increases the students' knowledge and skill levels. The program is well established and effective. The coalition or planning group may want to strengthen the program by providing increased opportunities for youth development to students and increasing contraceptive access for those who are sexually active. (See Volume IV, Improving Contraceptive Access for Teens and Volume V, Linking Pregnancy Prevention to Youth Development.) The following discussion highlights strategies and provides examples of combining family life education programs with youth development to enhance overall program effectiveness.

Link sexuality education and youth development programs.

Youth development is the ongoing growth process in which all youth are engaged in attempting 1) to meet their basic personal and social needs to be safe, feel cared for, be valued, be useful, and be spiritually grounded, and 2) to build skills and competencies that allow them to function and contribute in their daily lives. Source: Pittman, 1993

Sexuality education programs, especially those designed for under-served youth, can be greatly strengthened by linking them to youth development services, such as tutoring, mentoring, community service, and job training. Services that help youth build skills and competencies for their futures and assist them in meeting their basic personal and social needs also provide youth with important alternatives to early childbearing. The following examples indicate the possibilities to be provided by links with youth development programs.

Start a community service component as part of the family life education program. The *Teen Outreach Program* is a model approach which combines a developmentally appropriate, balanced, and realistic comprehensive family life education curriculum for students with community service volunteer opportunities.

> *Originally developed by the Association of Junior Leagues and now operated by Cornerstone Consulting, the* ***Teen Outreach Program*** *(TOP) is a junior high- and high school-based program combining life skills and adolescent reproductive health education with youth involvement in community service. (See Appendix B for program contact information.) The educational component occurs in small groups with a facilitator who also serves as a mentor. TOP's unique approach consists of two components: a newly revised classroom-based curriculum entitled "Changing Scenes" and community service experience. These components combine to fulfill the program's mission of helping teens develop self-esteem, good judgment, a sense of responsibility and cooperation, and life skills.*

Usually employed in school-based settings, the curriculum has also been successfully utilized in after-school programs. The program is divided into four age-appropriate modules to serve adolescents between the ages of 12 and 17. TOP is designed so that it can be easily integrated with other programmatic priorities, including service learning, career education, interdisciplinary teaching, community service requirements, prevention programs, and school reform. A five-year impact evaluation showed TOP students generally had fewer pregnancies, as well as fewer course failures and school suspensions than comparison students. (Philliber, Allen, 1992) The program appeared to be more effective in preventing these behavior problems with high school than with junior high school students. (Allen, Philliber, Hoggson, 1990)

Implement a mentoring program. Implementing mentoring programs, such as Big Brothers Big Sisters of America, for students enrolled in family life education classes encourages the development of on-going, close relationships with adults in addition to their parents or teachers. If mentors are also trained in the content of the sexuality education curricula, they can help youth develop the skills that promote sexual health.

Find ways to involve parents. Invite parents to be a part of the curriculum committee or to co-teach some of the educational sessions. Offer parent-child communication sessions to help parents talk more openly with their children, as exemplified in both *Reducing the Risk* and *Wise Guys.*

Reinforce the relationship between the family life education program and contraceptive access.

Contraceptive information and services are key components of successful pregnancy prevention programs. There are a number of ways to ensure that sexually active young people have access to appropriate referrals or services. Answering the following questions will provide a picture of assets and gaps in both the family life education program and existing reproductive health services for the teens.

Strengthen in-school referral systems to family planning clinics. Which school personnel are responsible for referring students to health services? Can these people also refer students for family planning services? Can the sexuality education teacher make referrals? Can the school nurse or guidance counselor offer brochures or referral cards to students? How can nurses or other personnel learn more about clinical services available in the community to improve the referral process? Can they conduct site visits to local clinics to become better informed about teen-friendly services available in the community?

Establish a condom availability program. These programs increase teen access to contraception by making condoms available on school grounds. Often, youth help initiate the program and educate their peers about the importance of condom use to prevent pregnancy and disease. (Information on condom availability programs may be found in Volume IV of this series and from Advocates for Youth, see Appendix A.)

Develop formal links between the school and the local family planning clinic. Can clinic staff conduct regular presentations as part of the curriculum's design? In some schools, for example, Planned Parenthood lead regular sessions on anatomy, reproduction, sexuality, and contraception, and refer young participants to clinics for contraceptive services, when appropriate.

Link the program to a school-based or school-linked health center that provides reproductive health services. These clinics offer accessible, youth-friendly services to adolescents.

For example, the *Self Center* in Baltimore, MD, provided students with reproductive and mental health services at a nearby store-front clinic. Clinic staff also had a designated room in the school where they provided health education and counseling. The *Teen Health Connection* in Charlotte, NC, offers comprehensive health services to adolescents and has special arrangements for serving youth in foster care and in juvenile justice programs.

*The **Self Center**, a school-linked program for 7th to12th graders in Baltimore, MD, linked students with reproductive health education and counseling services at a nearby clinic. A social worker and a nurse practitioner spent each morning working at the school site lecturing in homeroom classes, counseling individuals, conducting rap sessions, and leading educational discussions. The social worker and nurse then worked at the nearby clinic in the afternoon where they provided students with reproductive health care services, including contraceptives. They also referred students to other health services where indicated. The Self Center significantly delayed the initiation of sexual activity among 14- and 15-year-old female participants and increased contraceptive use at last intercourse among sexually active females by 20 percentage points.* (Zabin, Hirsch, Smith, et al., 1986)

*The **Teen Health Connection** is a private, non-profit health center which provides affordable, accessible, and comprehensive physical and mental health care for young men and women ages 11 to 22. Early in its history, clinic founders wanted to establish a school-based health clinic (SBHC). Although community support existed for the SBHC, there was insufficient support among school board members, teachers, and the PTA. Instead, the clinic developed strong linkages with school nurses, as well as a variety of other agencies which serve vulnerable populations. The clinic has formal contracts with social service agencies to be the primary health provider for youth in the juvenile justice system, foster care programs, and the school dropout prevention program.* (Davis, 1996)

Section IV
Pathways to Prevention

Section IV

Pathways to Prevention

Designing a new or adapted family life education program frequently entails a number of planning and management issues. The process is easier when the issues are planned for at the outset. Think about how to advocate for the program, especially in the face of controversy. Expect controversy. Consider how to conduct an asset and needs assessment. Develop an action plan outlining goals, objectives, a time line, and a budget. Plan how to fund and evaluate the program. These components should all be defined during the planning phase. This section addresses each of these components.

Chapter 1

Advocating for Family Life Education Programs

I never considered myself an advocate before. I don't even like public speaking. It's amazing to me to think that I am now speaking in front of hundreds of people! I started by preparing a speech for my daughter's principal about the importance of sexuality education.

Parent of a teen

My two daughters and I attended the last school board meeting together to learn about all the recent hoopla on sex education programs. After a very heated debate on the merits of abstinence-until-marriage education, I came home to find my daughter's Teen Magazine on the dining room table. In a column titled 'My Most Embarrassing Moment,' a teen wrote about her boyfriend 'going down' on her and how his bubble gum got stuck in her pubic hair. I thought, "My God, while we adults debate and debate and debate, our teens are out there in a very different world."

Parent of teens

Mobilizing for Action, the first volume of this series, identifies principal strategies to mobilize community support for pregnancy prevention programs. Topic areas include how to work with policy makers, the media, and the general public to garner support and raise community awareness. Appendices E and F may be helpful in preparing the task force or planning group to meet and answer potential opposition. Below are some specific ways to address the controversy and conflict which often surround family life education programs.

Controversy and Conflict

As mentioned earlier, comprehensive family life education programs are sometimes accompanied by heated debate, often focused on the value and purpose of teaching about sexuality in school settings. Topics related to abstinence, contraception, abortion, and sexual orientation cause the greatest controversy. Unfortunately, as a result of this opposition, many schools face content restrictions (for example, courses which emphasize only abstinence), lack of teacher training, and strict parental notification requirements.

Although most of the American public supports the teaching of balanced, realistic sexuality education in schools, opposition to such programs frequently arises. The facts below show the support and opposition that such programs have received across the country.

FACTS

The Politics of Family Life Education

Controversy affects the implementation of family life education programs.

- Only 22 states, the District of Columbia, and Puerto Rico require sexuality education through state law. Only 15 states, DC, and Puerto Rico monitor its implementation.(NARAL, 1995; SIECUS, 1995)
- Teacher certification for sexuality education is required by only twelve states, DC, and Puerto Rico. (SIECUS, 1995) In most states, sexuality education is taught by teachers of other subjects and often incorporated into the curriculum of another field, such as home economics, biology, or physical education.
- Of the 26 states that teach about abstinence, only 14 require instruction about contraception, pregnancy, and disease prevention. (NARAL, 1995)

Family life education has a great deal of public and teacher support.

- A 1996 study commissioned by Planned Parenthood Federation of America revealed that, of 1,000 registered voters, 79 percent favor requiring schools to teach sexuality education (62 percent are strongly in favor). (Planned Parenthood Federation of America, 1996)
- The majority of adolescents, parents of teens, and school administrators believe a responsible, balanced health education curriculum is of equal or greater importance as other school subjects. (Gallup Organization, 1994)
- In a study conducted in North Carolina, 90 percent of voters and 87 percent of fundamentalist voters believe that sexuality education should be taught in public schools. Sixty-seven percent believe contraceptives should be made available to high school students. (North Carolina Coalition on Adolescent Pregnancy, 1993)

Tips for addressing potential controversy are outlined below.

Tips for Dealing with Controversy

Carefully assess the perceptions of key stakeholders. Formulate strategies that are consistent with the perceptions of key stakeholders and that reflect research about effective programs. Use surveys, interviews, and focus groups to obtain information. Ask parents, teachers, students, and community leaders for their opinions about teen pregnancy in the community.

Summarize the issues of most importance to each set of stakeholders. Select several priority areas to address simultaneously. However recognize that, depending upon the political and social climate, available resources, and mechanisms in place to implement action, the planning group may need to prioritize the issues on which to focus their initial efforts.

Select interventions that are consistent with research-based strategies. Use what is known about effective and ineffective sexuality education programs. Use research findings to support the proposed program. Where gaps exist between the perceptions of key stakeholders and research findings, explore the following questions.

- Is the research on evaluated curricula consistent with the perceptions of key community members?
- If yes, how will the coalition involve stakeholders in supporting realistic and responsible sexuality education, which provides information on both abstinence and contraception?
- If not, how will the coalition educate stakeholders about the research findings? For example, if the perceptions of the school nurse, the health teacher, and teens are supportive of contraceptive referrals, while parents and school board members are opposed, how can the former be encouraged to vocalize their views and educate the latter group?
- How will the coalition ensure that supportive parents, teens, and religious leaders actively contribute to the development of viable, sustainable solutions?
- If general perceptions do not match research findings, why not? Has the community unique factors that should be further explored?
- How will the coalition educate unsupportive stakeholders or the community at large about research findings without invalidating personal experiences and beliefs? Can public education strategies or the media raise awareness?
- If community conflict is paralyzing, how will the coalition implement an advocacy campaign that strategically targets school board members or other key decision-makers to implement a pilot program?

Involve parents from the beginning. One of the goals of balanced, realistic sexuality education programs is to support families and to involve parents. Parental consent and/or notification is an important strategy that reduces controversy. Many schools have mechanisms that involve parents. Eighty-one percent of school-based comprehensive sexuality education programs require some kind of parental consent, either an opt-out provision for parents to sign a form if they do not want their child to participate in the course, or an opt-in provision for students to receive parental consent to participate in the course. The opt-out provision is less restrictive and less time-consuming, yet it gives every parent the opportunity to be involved. Nationally, few parents actually withdraw their children from family life education when it is offered.

Other ways to involve parents include providing opportunities for them to review materials at school open houses. Some communities ask parents to sit on curricula review committees along with teachers and administrators. Some community-based programs provide extensive training for parents to help prepare them to be the primary sexuality educators for their children.

> *We scheduled a community forum on sexuality education at the library. When we arrived, we learned that someone had canceled our meeting. Forty of us showed up, including a bunch of parents and three ministers. We held the program as scheduled in the parking lot.*
>
> *Parent*

Consider timing and potential for success. The needs assessment will help determine the potential for success or controversy of specific interventions. Remember that the success of the program today will set the tone for future projects. If strong opposition to sexuality education and contraceptive services exists in the schools and/or community, it may be unwise to choose an extremely controversial program strategy. Consider, instead, a range of strategies that will respond to the different needs documented by the assessment process. For example, if the needs assessment shows that many adolescents are sexually active in the middle school

grades, you may decide to implement both after-school and abstinence-based programs, as well as family planning counseling, thus providing a continuum of options to respond to the differing needs of teens in the community.

In one community in North Carolina, planners decided to implement *Postponing Sexual Involvement* during the first year of the project and *Reducing the Risk* during the second year. *Postponing Sexual Involvement's* message—delay sexual activity until you are ready—was acceptable to parents and paved the way for later acceptance of *Reducing the Risk's* message—it is best to delay sexual activity, but, plan to use contraception if you decide to engage in sexual activity. The school was able to implement both curricula for different age groups, *Postponing Sexual Involvement* for 7th and 8th graders and *Reducing the Risk* for 9th and 10th graders.

Start small and build a base of support if a strong network does not already exist. If the network exists, continue to build on it.

The Needs and Assets Assessment

Volume II of this series, provides a wealth of information on how to conduct a community-wide needs and assets assessment. Collecting information about existing family life education efforts is important. The following questions, at a minimum, will help to assess the extent and quality of current programs. (Brindis, Card, Niego, et al., 1996)

- What type of family life education is available in the schools?
- Is family life education mandated?
- Does family life education include (a) sexuality, (b) health, (c) contraception, (d) communication skills, (e) behavioral skills?
- Does the curriculum cover knowledge, attitudes, and beliefs?
- When is family life education provided? How long is the intervention?
- In what grade levels are courses taught and what types of community providers are involved?
- What types of referrals, if any, are made to community agencies?
- Have past family life education efforts been effective with this community population? How has this been measured?
- What results have been documented by the evaluations?
- What techniques have been most effective in reaching students?

The Program Plan

The needs assessment will be used as the basis for developing the program plan. The plan should include specific goals and objectives, activities, a time line, staff training plans, and a budget for implementing or enhancing family life education efforts and potential linkages to youth development programs.

Developing Goals and Objectives

Whether developing a community-wide plan or a site-specific, single component program, goals should reflect the needs of the population to be served and realistically correspond to anticipated program interventions.

Choosing Appropriate Goals

Carefully consider the goals when selecting program interventions. The family life education programs included in Sociometric's *Program Archive on Sexuality, Health, and Adolescence* are designed to influence a variety of pregnancy-related outcomes. Outcomes related to attitudes, skills, intentions, and beliefs include increasing refusal/negotiation skills, changing intentions and/or knowledge about engaging in sexual behavior, using contraception, or changing values and attitudes to support postponement, negotiation, and protection.

Behavioral outcomes include postponing sexual intercourse, decreasing the frequency of sexual intercourse, decreasing the number of sexual partners, increasing contraceptive use at first intercourse, increasing contraceptive use at most recent intercourse, and increasing consistent contraceptive use among the sexually active at every intercourse.

Source: Sociometrics, 1996.

Goals state the overall desired outcomes. Objectives are more concrete and specific than overall goals and help define how the goals will be achieved. Objectives are measurable and should include information about who will implement the program, how they will implement the program, the specific audience, the projected time line, and the location. Consider both process and outcome objectives as described in the following scenario:

The Jasper County High School has decided to implement *Reducing the Risk* for middle and high school students. The school will work with parents and teachers to implement the program.

Example of the program goal:

To delay sexual intercourse among teens who are not yet sexually active and to increase contraceptive use among those who have already initiated intercourse.

Examples of process objectives:

By July 1998, 175 parents in Jasper County High School will be sent permission slips for *Reducing the Risk* and 10 teachers will be selected to participate in the training.

By January 1999, 150 10th-grade youth at Jasper County High School will receive the 15-week sexuality education program, *Reducing the Risk*. Participants will understand basic information about social pressures to be sexually active, assertiveness techniques, and refusal skills.

By January 2000, the *Reducing the Risk* curricula will be incorporated into the regular curriculum at all 17 public high schools in Jasper County. In some of these schools, the program may be implemented in the eighth or ninth grade.

Examples of outcome objectives:

By June 1999, 30 percent of the youth participating in the *Reducing the Risk* curricula will have increased their knowledge about abstinence and contraception as measured by pre- and post-tests.

By June 1999, 30 percent of the youth participating in *Reducing the Risk* will improve their skills related to communication and negotiation.

Example of impact objectives:

By December 2000, 20 percent more of the youth who participated in the *Reducing the Risk* curriculum will have delayed sexual intercourse by at least nine months as compared to a control group.

By December 2000, 30 percent more of the sexually active youth who participated in *Reducing the Risk* will report contraceptive use at last intercourse as compared to the control group.

Designing Activities

Ultimately, the coalition or network of agencies will identify a few goals, a number of objectives and even more specific activities designed to meet and carry out the objectives. To achieve the objectives listed for Jasper High School, the following types of activities need to be accomplished.

- Develop support of key stakeholders.
- Review and select curriculum.
- Develop session outlines.
- Review supplemental materials.
- Prepare budget and finance plan.
- Gain approval from school administrators or curriculum committee.
- If resources are available, establish a system for tracking a subset of students to ascertain long-term outcomes.
- Develop student permission slips for parent(s) or guardian(s) of participants.
- Send student permission slips to parent(s) or guardian(s).
- Obtain materials for *Reducing the Risk*.
- Identify 10 teachers to lead sessions.
- Provide formal training to teachers.
- Make arrangements to gather teaching materials, video, and TV monitor.
- Develop formal system for referrals for contraceptive services in the community, including a referral list with specific contact names.
- Make arrangements to obtain incentives (refreshments, T-shirts, and certificates of completion).
- Conduct pre-test questionnaire on first day of course.
- Implement 15-session sexuality education program, three hours per week for five weeks.
- Conduct post-test questionnaire on last day of course. If resources available, establish a system of tracking a subset of students to ascertain long-term outcomes.
- Hold closing ceremony and distribute T-shirts and certificates.
- Write final report summarizing process of implementation and findings of pre-and post-test evaluations.
- Distribute report to school board and school administrators.

Developing the Time Line

The time line will help determine the activities to be accomplished to fulfill the program goals and objectives as well as direct the schedule of activities. The following questions should be asked.

1. What critical tasks need to be accomplished?
2. What are the critical dates? For example, when do the tasks have to be accomplished to meet the projected implementation plans?
3. What other interim tasks must be accomplished for the plan to be implemented?
4. What are concrete benchmarks that indicate the progress made towards meeting the goals and objectives?

Source: Brindis, Pittman, Reyes, et al., 1991

Hiring and Training the Staff

Staff training is an important part of program planning and implementation. The type and amount of training will depend on the comprehensiveness of the program but also should be flexible and accommodate the time and resource constraints of the school. It is important to include follow-up assistance for trained sexuality education teachers so they can discuss with a mentor or other sexuality education teachers problems or difficulties that have arisen. (Abbey, 1994)

Some sexuality educators recommend a minimum of three or four days of training. Sociometric's PASHA programs recommend two three-day training sessions. These sessions can be combined or separated depending on the school's resources and time constraints. Model programs have taken various approaches to training staff:

> *Reducing the Risk* provides a three-day training session for sexuality educators that focuses on practicing role playing and other hands-on activities. The training also includes three hours of instruction on obtaining parent and student consent and collecting program data. (Sociometrics, 1996)

> A two-day intensive workshop trains the group leaders of *Teen Talk* to conduct effective group discussion sessions and familiarizes them with the program format and content. (Sociometrics, 1996)

Training at intervals over a short period of time is advantageous because it allows participants to absorb concepts and try new strategies with students between training session. Successes and failures can then be shared at the next session. Periodic training can also relieve strain on the school budget and teacher substitute pool. (Abbey, 1994) Sexuality education teachers may also consider attending the Family Life Education Institute, a two-week graduate-level training course co-sponsored each summer by Advocates for Youth and the University of North Carolina at Charlotte.

Training should use a variety of approaches and be consistent. Adults learn best when training builds on life experiences, allows interaction between participants, and enables participants to apply the information to real life situations. (Dewitt Wallace, 1996)

Training must be incorporated as a regular part of the sexuality education program. Some youth-serving organizations have developed innovative ways to train their staff. *Girls Incorporated* uses a national training team to train counterparts in locations throughout the country. (Girls Incorporated, 1991) Other organizations use internships, job "shadowing", and train-the-trainer programs to ensure that educators learn from each other.

Training should provide participants an opportunity to gain knowledge, explore attitudes and beliefs and develop skills. Training should cover, at a minimum, the following (Teen Pregnancy Prevention Project, 1996):

- **Correct and up-to-date information:** Topics covered should include reproductive anatomy and physiology, adolescent sexual development, contraception, abstinence, sexually transmitted diseases, HIV/AIDS, sexual abuse, substance abuse, and related health, educational, and economic issues.
- **Knowledge about teen pregnancy:** Participants should learn antecedents to teen pregnancy, research on successful and comprehensive teen pregnancy prevention efforts, and strategies for involving adolescent and adult men, parents, and young people.
- **Values, attitudes and beliefs about teen sexuality and sexual behavior:** Teachers must be comfortable with their own views on sexuality (self-knowledge) and

recognize their own perspectives and biases before they can instruct teens in an open, respectful, supportive manner. Teachers should be given the opportunity to explore their own levels of comfort in discussing various issues or topics and learn ways to deal effectively with difficult questions and situations. (Drolet, 1994)

- **Skills in program delivery:** Sexuality educators and youth-serving professionals should be trained in presentation and group facilitation skills, such as role playing and other skills based, interactive, and experiential learning methods. Educators should be trained in developmentally appropriate counseling skills. When replicating and adapting specific program models, educators need the opportunity to learn about the goals and purpose of the program, as well as lessons learned from original program applications.
- **Skills in program planning and development:** As appropriate, sexuality education teachers should be trained to conduct the following: 1) assess individual and community needs, 2) plan and implement effective programs, 3) recruit, hire, supervise and train staff, 4) evaluate program effectiveness, 5) coordinate provision of services, and 6) arrange referrals. (Drolet, 1994) Often educators are asked to assume responsibilities that are not theirs and for which they do not have the requisite skills. For example, sexuality educators are often expected to conduct pre- and post-test evaluations. Program planners must ensure that all personnel receive appropriate direction, training, and oversight.
- **Skills in community planning and advocacy:** Educators should be trained on effective methods of collaboration, how to handle conflicts and opposition, how to facilitate and lead groups, and how to work effectively with the media, policy makers, funders, and the general public.

Adapting and Replicating Evaluated Programs

Family life education programs have been designed and implemented in widely varied places such as schools, youth organizations, religious settings, hospitals, and homeless shelters. Regardless of the setting, programs are most apt to be successful if they are carefully planned and based on model programs and approaches that have proven to have positive results. This section addresses the importance of replicating an evaluated model, adapted to fit the community.

> *It is difficult to replicate a curriculum which has been made for another group of teens. In our program, we only have males. Some of the exercises were designed as role plays to be used with both males and females. The boys are afraid to take on the role of a 'girl' out of fear of being labeled gay.*
>
> *Jeff, Sexuality Educator*

Many of the program models discussed in this volume have shown promise in influencing sexual risk-taking among youth. The needs assessment (see Volume II) and evaluations will provide clues about the potential application and impact of these models, whether starting a new program or strengthening an existing one.

Implement evaluated curricula in their entirety to maintain the integrity of the program and allow replication of the original evaluation results. However, because no two communities are alike, adaptation will probably be necessary. Adaptations help ensure ownership and applicability of the model but may dilute the impact found in the original research. The following principles will help guide decisions in selecting, replicating, or adapting model programs.

Select a model program which has already been evaluated. Although one program may already interest the planning group, it is important to learn whether the program has been rigorously evaluated before replicating it in schools and/or community. Sociometrics' *Program Archive on Sexuality, Health, and Adolescence* (PASHA) offers information and materials on evaluated teen pregnancy and STD/HIV/AIDS prevention programs. Each "program in a box" includes training manuals, a curriculum guidebook, workbooks, videos, and board games to help communities replicate, adapt, and evaluate the program.

Maintain fidelity to the model. When adapting an evaluated program, it is important that the changes do not compromise the goals or objectives of the original program. When it is necessary to supplement or adapt materials or alter time schedules to suit a specific audience, every effort should be made to preserve the original focus of the model curriculum. Some program planners have attempted to "transform" comprehensive curricula by replacing a contraceptive education with an abstinence-until-marriage unit. This strategy defeats the purpose of the comprehensive approach. Adapting the length or setting of the program should also be consistent with program goals. For instance, if a program cannot accommodate the ten prescribed one-hour per week sessions, consider covering the material during five, two-hour sessions. Keep in mind the importance of maintaining the strength and intensity of the program by offering it within an appropriate time-frame.

The chart below, "Criteria for Selecting Supplemental Curricula and Materials", provides additional guidance for choosing supplemental materials to enhance the already chosen curriculum.

Criteria for Selecting Supplemental Sexuality Education Materials

Are the goals and objectives of the supplemental curriculum clear? Are they realistic? Are the goals and objectives stated in measurable terms? Are the content and methods specifically outlined to ensure the desired outcome? Is the goal to control a student's sexual behavior or to promote sexual health?

Does the curriculum contain accurate information? Has the content been updated to reflect findings from clinical research and other studies? Is it free from provocative descriptions? Are the references cited in the text reputable and current?

Is the curriculum comprehensive? Is it balanced and realistic? Is the curriculum designed for kindergarten through grade 12? Is it developmentally appropriate? Does it cover biological, psychological, social, and ethical aspects of sexuality? Does it cover topics in sufficient depth and detail to meet the stated objectives? Does it include information on abstinence and contraception? Does it include the tough topics — masturbation, abortion, rape, incest, and sexual orientation?

Is the curriculum appropriate to the developmental state and learning needs of students? Does it approach learning about sexuality as a developmental process that occurs at every age and stage in life? Does it help students acquire knowledge, explore their attitudes and feelings, and examine their behavior? Does it enable students to develop problem solving and decision making skills? Will students be able to identify their options and the consequences of their choices? Is it sensitive to those students who have experienced exploitative relationships and/or forced sex, such as incest and rape?

Does the curriculum meaningfully involve parents and other family members? Does the curriculum promote family communication and learning about sexuality? Does it help family members recognize that different families may have different values and that individuals within families may have different values?

What will it cost to implement the curriculum? Consider the cost of the curriculum, teacher's guides, parent information, student workbooks, and related videos, etc. Will there be a need to replace materials with every class that takes the course (e.g., student workbooks)? How much training will be required for teachers, and how much will it cost?

Is the curriculum easy to use? Do the teacher and student workbooks correspond? Are the lessons laid out logically with an outline? Are lessons easy to read and to follow? Are materials easy to read?

Does the curriculum include lessons that help students develop and practice effective communication skills? Does it aim to reduce misinformation, help young people delay premature sexual intercourse, support safer sex, prevent drug abuse, and develop an understanding of and respect for differences? Will the curriculum help students understand their obligations and responsibilities to others?

Does the curriculum present clear messages about attitudes and values? Will the curriculum enable students to question, explore, and assess their values, attitudes, and feelings about sexuality? Will it support the development of the student's self-esteem?

Is the curriculum balanced? Does it present more than one interpretation of situations and issues, especially controversial ones? Does it clearly distinguish between a position, an opinion, and a fact? Does it validate the family and cultural values of the students while recognizing their diversity?

Is the curriculum inclusive and respectful of diversity? Does the curriculum reflect the demographics, including racial/ethnic groups, sexual orientation lifestyle, family structure, and the changing conditions of communities in the United States? Does the curriculum acknowledge the broad range of sexual attitudes, values, and behaviors that exist in a pluralistic society, or does it insist on a single approach or philosophy? Does it integrate information for and about people who are disabled and those who are gay, lesbian, or bisexual?

Source: Planned Parenthood Federation of America, 1993a. "Choosing a Sexuality Education Curriculum." New York, NY: The Federation, 1993.

Adapt programs to the unique needs of youth participants. Choose programs that closely reflect the needs of the population served. Use local needs assessment data to determine a match between program and participants. Once a program has been selected, consider how it may be applied most effectively to meet the background and experiences of youth participants. Conduct focus groups to test acceptability and relevance. Adaptations will permit tailoring the curriculum for the audience. For example, changing a scenario for a role play may provide cultural relevance while retaining the effectiveness of this teaching tool.

Address the values of the community. Choose a program that is consistent with principles valued by the community, but that also reflects the research about effective curricula. In many communities, debates on abstinence-only versus balanced, realistic sexuality education

have brought efforts to a standstill. To prevent this, carefully analyze the controversy that has arisen. If abstinence is a dominant value in the community, seek creative ways to emphasize postponement as a pregnancy prevention goal. Institute a successful, evaluated abstinence-based curricula for younger teens, offer parent-child communication classes, and strengthen mentoring and tutoring opportunities. Adults in the community may be willing fully to support contraceptive access as long as postponement remains a high priority.

However, some groups in the community may be opposed to any program that is not solely based on abstinence. In that case, a carefully implemented strategy should enable the coalition to deal with such conflicting values. Volume I of this series provides in-depth information on conducting an advocacy campaign and dealing with controversy.

Seek parental and community involvement. To reduce the potential for community controversy and to identify advocates, ask youth, supportive parents, community residents, and religious leaders to participate in program planning, implementation, and evaluation.

Consider resources and training. Ensure adequate resources for implementing the model, including funds for acquiring and adapting materials, evaluation, and staffing. Train the educators since most teachers and program planners do not have all the skills needed to implement model programs. Training will save money in the long run and contribute to more effective programs.

Seek outside assistance. Talk with people who have produced or used the curriculum in the past to learn about potential challenges or pitfalls; learn from their experiences. Many model programs, as well as national organizations, such as Advocates for Youth, Sociometrics Corporation, The National Campaign to Prevent Teen Pregnancy, ETR Associates, Planned Parenthood Federation of America, and SIECUS, can provide information about implementing programs. (Refer to "Selected Resource Organizations" in Appendix A for these and other resources.)

Start small and build a foundation. Start small by implementing the program in one classroom and monitoring the results. Consider a pilot test to see if the curriculum is effective with the young people in the community. Process data will measure the curriculum's acceptability as well as numbers of students reached. Pre- and post-test data will measure changes in knowledge and attitudes. Based on the experience and success of the program, regularly refine and expand to reach larger numbers of teens.

Replicate evaluation criteria. Try to replicate the evaluation criteria and procedures of the model programs so that the effectiveness of the program can be compared for different sites and populations. Use goals and objectives that are similar to the ones used in the model program, but be sure these meet the assessed needs of the community.

The following examples illustrate common barriers to program implementation and discuss various strategies for adaptation.

Example: The youth in our program are different than the youth in the original study (i.e., they differ by age, ethnicity, cultural background).

The program is **less likely** to work if planners:

- Ignore or gloss over the differences;
- Plop a curriculum down and expect it to work like the original;
- Fail to hire or train the appropriate staff ; or
- Translate the curriculum verbatim from English into another language.

The program is **more likely** to work if planners:

- Assess the differences carefully;
- Hire staff that are similar to the background of participants;
- Train the staff with regard to the unique needs of the participants;
- Research effective adaptations with others in the field;
- Make cultural adaptations, rather than simply translating curriculum (i.e., use supplemental materials that may be more relevant but do not compromise the original intent of the curricula);
- Conduct a focus group to test acceptability and relevance of the materials.

Example: Our community does not support the contraceptive component of the curricula and believes that an abstinence-until-marriage message will be more effective.

A curriculum is **less likely** to work if planners:

- Ignore the opposition to the curricula;
- Focus only on younger teens or on youth development strategies as a means to sidestep the controversy;
- Take out the contraceptive component and encourage sexually active youth to abstain.

A curriculum is **more likely** to work if planners:

- Create a small planning group composed of supportive parents, teens, and religious leaders;
- Use research-based findings to support recommendations to include contraceptive information;
- Offer a menu of effective, already-tested curricula from which to choose.
- Consider strategies for younger adolescents who may not be sexually active as well as for older teens who may or may not be sexually active.
- Consider non-school settings to provide contraceptive information.

Developing A Funding Strategy

Lastly, consider how to attain the pregnancy prevention-related goals already identified. Volume II provides information on how to tap into different funding sources. Below are tips specific to family life education programs. To develop the funding strategy, begin by exploring the following questions:

- What resources are needed to attain these goals?
- What components are already in place and what gaps exist?
- What resources could be tapped that might not have been incorporated in the past?

Tips for Obtaining Funding

Consider all potential costs. The cost to implement a sexuality education program will vary according to the length of the program, staff training costs, and program materials. Curricula incur costs, and adaptations for materials will also incur costs. In calculating costs, staff training, substitute teachers, and travel for training must be included. Stipends may be necessary to recruit and retain youth as peer educators.

Link funding strategies to the needs assessment. Use the needs and assets assessment as a guide to identify areas of need and resources. Consider funding needs in light of the proposed

goals and activities. Also think about the additional data needed to qualify for particular funding, such as "matching" funds.

Link funding proposals to pregnancy prevention research. Include the latest research on effective strategies in grant proposals. Innovative and cutting edge approaches to pregnancy prevention are most likely to attract funds. Be sure to demonstrate how the program has been used successfully or how it is designed to reach an underserved, at risk population.

> *In our community, we used Carl Perkins funding to cover the cost of a sexuality education course. These federal funds, channeled through the state vocational education program, were used to train 30 women machinists, ranging in ages from early- to mid-20's. The life management skills course, which focused on sexuality and relationships, met two hours per week for nine months.*
>
> *A vocational training specialist*

Be creative and responsive to the political winds of change. Funding often changes with current political priorities. Ascertain what these priorities are and adapt the program accordingly. Consider how the program can apply for available job training or "welfare-to-work" dollars. Use creative strategies to ensure the long-term viability of the program. Identify new resources from the private sector or through in-kind contributions; blend public and private dollars. Use or redeploy existing resources more efficiently by improving staffing, sharing funds, and locating services with other agencies.

> *The public school system in New York City found ways to maximize existing resources, rather than seek new funding for sexuality education and contraceptive access. In the schools, health education programs are dispersed throughout the central school system. One division is responsible for alcohol and drug education while other, distinctly separate divisions are each responsible for HIV/AIDS, teen pregnancy prevention and sex education and family living. Officials reexamined health education programs to provide a coordinated system, eliminate duplication, and establish links among related subject areas. They anticipate that this process will not only improve the quality of existing education programs, but will also make funds available to defray the costs of operating a condom availability program.* (Brindis, 1993)

Obtain strong leadership. Strong leadership can help guide the funding strategy, secure a strong funding base, and convince key decision-makers to place new priorities on family life education. The following example demonstrates how important it is to choose leadership carefully and obtain assistance as needed.

> *Dom is a youth worker in New York. After working directly with kids for many years, he felt he was ready to take on new challenges as director of the local adolescent pregnancy prevention coalition. He said, " I felt I could really represent the voices of students, especially when it came time to get family life programs instituted in the schools and youth-serving organizations. But I couldn't raise money. In particular, I realized that foundations didn't want to fund sexuality education given the potential for controversy. I also realized that I wasn't equipped to fulfill my role as accountant, finance director, fund raiser, and media spokesperson. I decided to get some training and then called in some parents to help raise funds and visit local foundations with me."*

The previous sections focus on advocacy, planning, and issues such as adapting or replicating sexuality education programs. Whether the planning group is establishing a new family life education program, enhancing an existing program, or linking the initiative to other pregnancy prevention efforts, program evaluation is essential. Evaluation will help measure whether the goals and objectives of the program being obtained, increase efficiency, and improve program operations. The next section reviews the basics of program evaluation. A detailed discussion of evaluation can be found in Volume II of this series.

Chapter 2

Planning for Evaluation of Family Life Education Programs

Conducting an evaluation of family life education efforts is crucial to determine whether short- and long-term objectives and goals are being attained. The findings of the evaluation will help determine what is working and what is not and factors contributing to the success or failure of the program. Additional resources in the field of program evaluation will provide more specific approaches for conducting a program evaluation. (See Appendix G selected evaluation resources; contact Sociometrics, listed in Appendix A, for information on a national network of pregnancy prevention program evaluators.)

The following section provides a brief overview of evaluation issues to consider when planning a family life education program. To conduct an evaluation successfully, plan the evaluation prior to implementation of the curriculum. Make decisions about evaluation resource allocation, evaluation design, baseline data collection, and evaluation indicators early in the planning process.

The previous volume discusses three primary types of evaluation: process, outcome, and impact. This section reviews them and provide examples of questions which each type of evaluation can answer.

A process evaluation examines the way a program has conformed to its original planned goals and objectives.

For example, if the program intends that over 1,000 students will receive a six-part curriculum, the process evaluation can help answer whether all 1,000 students participated, whether each one received the same level of program intervention, and whether all components of the program were in place. The process evaluation also assesses the barriers encountered in achieving the planned objectives and ways to overcome these factors. A process evaluation rarely requires a comparison group and is primarily aimed at measuring program implementation and the quality of the implementation. Without a strong process evaluation in place, it would be premature to move to outcome and impact evaluations because the program needs to be adequately in place before its impact can be measured.

In the case of Jasper County High School, a process evaluation would answer the following questions.

- Did 175 parents in the school district receive permission slips for their youth to participate in the *Reducing the Risk* program by July 1998?
- Did 150 10th graders receive the 15-week program by January 1999?
- Was the program incorporated into the regular curriculum at all seventeen public high schools in the County by January 2000?

An outcome evaluation helps determine whether the program has had an effect on participants as compared to a comparable group without access to the intervention. The emphasis is on the immediate results of program efforts and at six months following the intervention.

For example:

In the case of Jasper High School, did the 1,000 students increase their level of knowledge and behavioral intent by 30 percent in the area of reducing sexual risk-taking? What were the results as compared to a group who received a different kind of intervention or no intervention at all?

- Did the participating students demonstrate a 30 percent increase in knowledge about abstinence and contraception from pre- to post-test? Was there a corresponding increase in communication and negotiation skills? Were these findings significantly different from the comparison group?

By answering these questions, the outcome evaluation helps you explore the immediate results of the program.

An impact evaluation determines whether the program ultimately had the desired long-term effect on participants after an interval of 12 months when compared to a group that was not exposed to the intervention.

Two questions central to an **impact evaluation** are (1) did the program produced the desired effect? and (2) could the observed effect have occurred in the absence of the program?

In the case of the Jasper High School family life education program, an impact evaluation would measure whether significantly larger numbers of the students who participated in the *Reducing the Risk* curriculum delayed the onset of sexual initiation for nine months as compared to the control group. Another indicator would measure sustained increases in contraceptive use among sexually active youth who participated in the program, as compared to those who did not, 12 to 18 months after the intervention.

As discussed in Volume II of this series, the cost of an evaluation increases in moving from a process evaluation to outcome and impact evaluations. Each phase of the evaluation spectrum requires more time and expertise to provide an accurate picture of efforts evaluated. Review Volume II before planning the evaluation. Remember to seek professional help from an evaluation expert or university research group if outcome and/or impact evaluations are planned. An additional resource to use is a simulated comparison group identified through PASHA. (For contact information, see Sociometrics, in Appendix A.)

Conclusion

The growing number of family life education programs that have been well evaluated provide much information on how to direct responsible messages to teens. Programs must be planned carefully using evaluated approaches in order to best reach youth with pregnancy prevention messages. However, even the best programs have had mixed results when rigorously evaluated. The reasons for this are varied and involve the complexity of teen pregnancy and prevention itself, the changing profile and needs of youth, insufficient planning and resources, and the lack of sufficient evaluation results for improving and replicating existing strategies. To reach the target population with programs that are well designed and effective, all of these factors must be taken into account. Behavior changes among youth requires comprehensive programs with varied approaches, of which family life education is only one. This series addresses the other major intervention strategies, including contraceptive access (Volume IV), and youth development (Volume V), that increase the likelihood of improving the reproductive and sexual health of today's adolescents.

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Appendices

Appendix A**

Selected Resource Organizations

Advocates for Youth
2000 M Street, N.W., Suite 750
Washington, DC 20036
Telephone: (202) 419-3420
Fax: (202) 419-1448
E-mail: info@advocatesforyouth.org
Executive Director: James Wagoner, President
Contact Person: Susan Pagliaro, Pregnancy Prevention Associate

Advocates for Youth (formerly known as The Center for Population Options) seeks to enhance the quality of life for adolescents by working to prevent unintended pregnancy and high-risk sexual behavior. Advocates' national and international programs seek to improve adolescent decision making (through life planning and other educational programs), improve access to reproductive health care, promote the development of school-based clinics, and prevent the spread of HIV and other sexually transmitted diseases among adolescents. The organization houses the Teen Pregnancy Prevention Clearinghouse which provides a national database of public and private programs, a hotline for technical assistance in program planning, and information and guidance on policy issues. The organization publishes newsletters and provides trainings. A publications catalog is available.

Alan Guttmacher Institute
120 Wall Street, 21st Floor
New York, NY 10005
Telephone: (212) 248-1111
Fax: (212) 248-1951
E-mail: info@agi-usa.org
Executive Director: Jeannie I. Rosoff, President
Contact Person: Susan Tew, Deputy Director of Communications

The Alan Guttmacher Institute (AGI) is a nonprofit corporation for research, policy analysis, and public education in the field of reproductive health. The institute publishes two journals, *Family Planning Perspectives* and *International Family Planning Perspectives,* and a biweekly newsletter, Washington Memo. A publications catalog is available.

Association of Reproductive Health Professionals
National Adolescent Reproductive Health Partnership
2401 Pennsylvania Avenue, N.W., Suite 350
Washington, DC 20037
Telephone: (202) 466-3825
Fax: (202) 466-3826
E-mail: arhp@aol.com
World Wide Web site: www.arhp.org
Executive Director: Dennis J. Barbour, President
Contact: Johanna Chapin, Legislative Associate

***Adapted from Healthy Mothers Healthy Babies Coalition. Adolescent Pregnancy Prevention: a Compendium of Programs. Washington, DC: The Coalition, 1995.*

The Association of Reproductive Health Professionals (ARHP) National Adolescent Reproductive Health Partnership provides information on programs, strategies, and resources that work to effectively address the problems of adolescent pregnancy and sexually transmitted diseases. The clearinghouse provides information regarding primary prevention of adolescent pregnancy, pregnant and parenting adolescents, sexuality education, and research and evaluation in the field of adolescent pregnancy. Fact sheets, brochures (some in Spanish), and a publications catalog are available.

Child Trends
4301 Connecticut Avenue, N.W., Suite 100
Washington, DC 20008
Telephone: (202) 362-5580
Fax: (202) 362-5533
Executive Director: Kristin A. Moore, Ph.D.
Contact Person: Lauren Connon, Executive Research Assistant

Child Trends is a nonprofit charitable and educational organization that works to improve the quality, scope, and use of statistical information on children and adolescents. The research and public information activities of Child Trends are supported by grants from government agendas and foundations and by contributions from the public. Statistics regarding child and adolescent health indicators, including data on adolescent pregnancy and childbearing, are available on request. Publications include a newsletter, Facts at a Glance, that reports data on U.S. adolescent fertility.

ETR Associates (Education, Training, and Research)
P.O. Box 1830
Santa Cruz, CA 95061-1830
Telephone: (408) 438-4060, (800) 321-4407 (for publications)
Fax: (408) 438-3618
E-mail: bonnie@etr-associates.org (for training and technical assistance)
Contact Person: Nancy Calvin, Research

ETR Associates provides curricula, videotapes, pamphlets, and photo tabloids on a variety of health education topics including family life education, abstinence, birth control, reproductive health, sexual responsibility, self-esteem, drug use, and sexually transmitted diseases.

Girls Incorporated
30 East 33rd Street, Seventh Floor
New York, NY 10016
Telephone: (212) 689-3700, (317) 634-7546 Resource Center
Fax: (212) 683-1253
E-mail: HN3579@handsnet.org
Executive Director: Isabel Stewart, National Executive Director
Contact Person: Amy Sutnick Plotch, Director of Communications

Girls Incorporated has developed several programs and curricula to promote adolescent health, including *Friendly PEERsuasion* and *Preventing Adolescent Pregnancy.* The Girls Incorporated National Resource Center furnishes research materials to organizations, individuals, and the media. The resource center is located at 441West Michigan Street, Indianapolis, IN 46202.

Healthy Mothers, Healthy Babies Coalition
409 12th Street, SW
Washington, DC 20024-2188
Telephone: (202) 863-2458, (800) 673-8444, ext. 2458
Fax: (202) 554-4346
Executive Director: Lori Cooper
Contact Person: Leslie Dunne, Membership Director

The Healthy Mothers, Healthy Babies Coalition (HMHB) is an association of more than 100 national professional, voluntary and governmental organizations with a common interest in maternal, infant, and child health. The coalition fosters education efforts for pregnant women through collaborative activities and sharing of information and resources, conducts outreach and legislative advocacy activities, and sponsors a biennial fall conference. Publications include the quarterly newsletter *Healthy Mothers, Healthy Babies.*

Institute of Medicine
2101 Constitution Ave, NW
Washington, DC 20418
Telephone: (202) 334-2169
Fax: (202) 334-1412
Executive Director: Kenneth I. Shine, M.D., President
Contact Person: Mike Eddington, Managing Editor

The Institute of Medicine, a component of the National Academy of Sciences, is committed to the advancement of the health sciences and education and to the improvement of health care. Studies by the Institute of Medicine are conducted on contracts from government or grants from private organizations. The Institute has issued numerous studies, policy statements, and other publications. The report *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families* examines how unintended pregnancies—both mistimed and unwanted—affect the health and well-being of children, youth, and adults.

March of Dimes Birth Defects Foundation
1275 Mamaroneck Avenue
White Plains, NY 10605
Telephone: (914) 428-7100
Fax: (914) 428-8203
World Wide Web site: www.modimes.org
Executive Director: Jennifer L. Howse, Ph.D., President
Contact Person: Resource Center 888-MODIMES (888-663-4637)

The March of Dimes (MOD) works to prevent birth defects and infant mortality through its Campaign for Healthier Babies, which funds research, community service, education, and advocacy programs. The Birth Defects Foundation produces educational materials for health care professionals and the public; topics include genetics and gene therapy, birth defects, preconception education, prenatal and postnatal care, nutrition, healthy behaviors, and adolescent pregnancy. A publications catalog is available.

National Adolescent Health Information Center
Division of Adolescent Medicine and
Institute for Health Policy Studies
University of California, San Francisco
400 Parnassus Avenue, Room AC-01, Box 0503
San Francisco, CA 94143-0503
Telephone: (415) 476-2184
Fax: (415) 476-6106
Executive Director: Charles E. Irwin Jr., M.D., Center Director
Claire Brindis, Dr.P.H., Executive Director

The National Adolescent Health Information Center (NAHIC) was established to develop policy and programs in the area of adolescent health. The center works to improve the capacity of professionals, communities, states, and the nation to plan and improve the delivery of health care for adolescents. It also conducts policy analyses of legislative changes that will affect the adolescent population. The center helps to identify and disseminate information about exemplary adolescent health programs, research and evaluation findings, and related data profiles.

National Assembly on School-Based Health Care
1522 K Street, NW, Suite 600
Washington, DC 20005
Telephone: (202) 289-5400
Fax: (202) 289-0776

The National Assembly on School-Based Health Care provides technical assistance and support to program providers and advocates of school-based health care. A membership organization, the Assembly holds an annual conference for school-based health care professionals.

The National Campaign to Prevent Teen Pregnancy
2100 M St., N.W.
Suite 300
Washington, DC 20037
Telephone: (202) 857-8655
Fax: (202) 331-7735
Executive Director: Sarah Brown, Director
Contact Person: Tamara Kreinin, Director of State and Local Affairs

The National Campaign to Prevent Teen Pregnancy is a nonprofit, nonpartisan initiative, founded in 1996. The Campaign's goal is to reduce the teenage pregnancy rate by one-third by the year 2005. The work of the Campaign is being led by four task forces: Media Task Force, Religion and Public Values Task Force, State and Local Action Task Force, and Effective Programs and Research Task Force. Publications include *No Easy Answers: Research Findings on Programs to Reduce Teen Pregnancy, Partners in Prevention: How National Organizations Can Assist State and Local Pregnancy Prevention Efforts,* and *Using the Media to Reduce Teen Pregnancy: State Experience and Lessons from Research.*

National Coalition of Hispanic Health and Human Services Organizations
1501 16th Street, N.W.
Washington, DC 20036-1401
Telephone: (202) 387-5000, Maternal and Child Health Division (202) 797-4348
Fax: (202) 797-4353
Executive Director: Jane L. Delgado, Ph.D., President and CEO
Contact Person: Mary Thorngren, Director

The National Coalition of Hispanic Health and Human Services Organizations (COSSMHO) is a private nonprofit organization that works to improve the health and psychosocial well-being of the nation's Hispanic population. The coalition coordinates research, conducts national demonstration programs, contributes to the education and training of health professionals, and serves as a source of information, technical assistance, and policy analysis. Targets for national programs include alcohol and other substance abuse, juvenile delinquency, child abuse and sexual abuse, parenting, strengthening families, maternal and child health, adolescent pregnancy, AIDS, and chronic diseases. Publications include a quarterly newsletter, COSSMHO Reporter. A catalog of publications and products is available.

National Council for Adoption
1930 17th Street, N.W.
Washington, DC 20009-6207
Telephone: (202) 328-1200
Fax: (202) 332-0935
World Wide Web site: www.ncfa-usa.org
Executive Director: William Pierce, President
Contact Person: Mara Duffy, Director of Professional Practice

The National Council for Adoption (NCFA) represents voluntary agencies, adoptive parents, adoptees, and birth parents who wish to protect all parties involved in the adoption process as well as the institution of adoption itself. The council promotes ethical adoption practice to legislators, policymakers, human service agencies, and the public. A publications catalog is available.

National Council of La Raza
1111 19th Street, N.W., Suite 1000
Washington, DC 20036
Telephone: (202) 785-1670
Fax: (202) 776-1792
Executive Director: Raul Yzaguirre, President
Contact Person: Stephanie Avila, Health Specialist

The National Council of La Raza (NCLR), a nonprofit constituency-based Hispanic organization, brings together more than 200 formally affiliated community-based organizations. Activities include assistance to community-based Hispanic organizations, public information efforts to present accurate, positive images of Hispanics, and applied research, public policy analysis, and advocacy to influence policies and programs so that they equitably address the needs of the Hispanic community. The council's Center for Health Promotion manages Maternal and Child Health, the HIV/STD/TB Prevention Project, and the Hispanic Health Liaison Project. Publications include *Reducing Hispanic Teenage Pregnancy and Family Poverty*, a replication guide for community-based organizations interested in developing and implementing a teen pregnancy and/or parenting program targeted to Hispanic youth. A publications guide is available.

National Council on Family Relations
3989 Central Avenue NE, Suite 550
Minneapolis, MN 55421
Telephone: (612) 781-9331
Fax: (613) 781-9348
E-mail: ncfr3989@ncfr.com
Executive Director: Mary Jo Czaplewski

The National Council on Family Relations (NCFR) is a nonprofit organization of family professionals in education, social work, counseling, psychology, sociology, psychotherapy, home economics, anthropology, and health. It provides information on cross-cultural families, family violence, adolescent issues, working families, and other related concerns, sponsors a national program to certify family life educators, and holds an annual conference in late fall. Publications include *Family Relations, Journal of Marriage and the Family,* and *NCFR Newsletter.* A publications and products catalog is available.

National Family Planning and Reproductive Health Association
122 C Street, N.W., Suite 380
Washington, DC 20001-2109
Telephone: (202) 628-3535
Fax: (202) 737-2690
E-mail: info@nfprha@.org
Executive Director: Judith M. DeSarno, President
Contact Person: Marilyn Keefe, Director of Service Delivery

The National Family Planning and Reproductive Health Association (NFPRHA) is a coalition of more than 1,000 family planning providers, hospital-based and independent clinics, Planned Parenthood Federation of America affiliates, family planning councils, health care professionals, consumers, and state, county, and local health departments. The association works to improve and expand the delivery of family planning and reproductive health services and programs throughout the nation. Publications include *NFPRHA Alert* and *NFPRHA Report.*

National Organization on Adolescent Pregnancy, Parenting, and Prevention
1319 F St. N.W.
Suite 401
Washington, DC 20004
Telephone: (202) 783-5770
Fax: (202) 783-5775
E-mail: noappp@aol.com
President of the Board of Directors: Patricia Canessa
Coordinator: Regina W. Malatt

The National Organization on Adolescent Pregnancy, Parenting, and Prevention (NOAPPP) is a national resource network of individuals and organizations focused on solving problems related to adolescent pregnancy prevention, sexuality, pregnancy, and parenting. The organization serves as a resource sharing and communication network to inform service providers and others about available resources and successful program models. It publishes a quarterly newsletter, *NOAPPP Network.*

National Training Center for Adolescent Sexuality and Family Life Education
Children's Aid Society
350 East 88th Street
New York, NY 10128
Telephone: (212) 876-9716
Fax: (212) 876-1482
Executive Director: Philip Coltoff
Contact Person: Michael Carrera, M.D., Director

The National Training Center for Adolescent Sexuality and Family Life Education, sponsored by the Children's Aid Society with support from Bernice and Milton Stern, has developed a primary pregnancy prevention model designed to train community agencies and youth service providers in adolescent pregnancy prevention issues. Three times a year, the center publishes a newsletter for youth service providers, policymakers, and legislators on adolescent sexuality and family life issues.

Office of Population Affairs Clearinghouse
P.O. Box 30686
Bethesda, MD 20824-0686
Telephone: (301) 654-6190
Fax: (301) 215-7731
Executive Director: Mark Edwards, Project Director

The Office of Population Affairs Clearinghouse (formerly the Family Life Information Exchange) distributes various federal publications on family planning, contraception, adolescent pregnancy, and adoption through technical assistance, referrals, and online search services. Available materials include newsletters, directories, fact sheets, monographs, bibliographies, and pamphlets.

Philliber Research Associates
28 Main Street
Accord, NY 12404
Telephone: (914) 626-2126
Fax: (914) 626-3206
Contact: Susan or William Philliber, Senior Partners

Philliber Research Associates specializes in evaluation of human services programs and provides technical assistance and training.

Planned Parenthood Federation of America
810 Seventh Avenue
New York, NY 10019
Telephone: (212) 541-7800 or (800) 829-7732
Fax: (212) 245-1845
World Wide Web site: www.ppfa.prg/ppfa
Executive Director: Gloria Feldt, President
Contact Person: Gloria A. Roberts, Head Librarian

Planned Parenthood Federation of America (PPFA) is dedicated to the principle that every person has the fundamental right to choose whether or when to have children. The federation works to ensure access to sexuality education and family planning services. A computerized database includes more than 15,000 books, brochures, programs, curricula, and audiovisual materials on sexuality education. Publications include the bimonthly *Educator's Update*. A publications catalog is available.

Sexuality Information and Education Council of the United States
130 West 42nd Street, Suite 350
New York, NY 10036-7901
Telephone: (212) 819-9770
Fax: (212) 819-9776
E-mail: siecus@siecus.org
Executive Director: Debra Haffner, M.P.H., President
Contact Person: Monica Rodriguez, School Health Coordinator

The Sexuality Information and Education Council of the United States (SIECUS) believes that accurate information, comprehensive education, and positive attitudes toward sexuality enhance physical and mental health and promote greater communication and caring within society. Through services and programs, SIECUS works to promote the concept that sexuality is an important and natural part of life. The Mary S. Calderone Library houses an extensive collection of sexuality information and educational materials. Publications include SIECUS Report, a bimonthly journal of human sexuality, and *Guidelines for Comprehensive Sexuality Education, K-12.* A publications catalog is available.

Sociometrics Corporation
Data Archive on Adolescent Pregnancy and Pregnancy Prevention
170 State Street, Suite 260
Los Altos, CA 94022-2812
Telephone: (650) 949-3282
Fax: (650) 949-3299
E-mail: socio@socio.com
Executive Director: Josefina J. Card, Ph.D.
Contact Person: Jane Park, Research Associate

The Data Archive on Adolescent Pregnancy and Pregnancy Prevention (DAAPPP) at Sociometrics Corporation provides large-scale data on adolescent pregnancy, pregnancy prevention, and family planning to researchers, practitioners, and policy makers. Publications include *The DAAPPP Catalog* and a quarterly newsletter. The Program Archive on Sexuality, Health, and Adolescence (PASHA) is a collection of effective teen pregnancy and STD/HIV/AIDS prevention programs which may be replicated by program planners. See Appendix I of this volume.

Urban Institute
The Population Studies Center
2100 M St., N.W., 5th Floor
Washington, DC 20037
Telephone: (202) 833-7200
Fax: (202) 331-9747
E-mail: paffairs@ui.urban.org
Executive Director: Craig Coelen
Contact Person: Freya Sonenstein, Director of Population Studies Center

The Population Studies Center tracks U.S. social and economic trends. In the 1990's, this policy research center has focused on both the impact of increasing immigration and the changing composition of families. *Involving Males in Preventing Teen Pregnancy* is a guidebook for program planners which looks at male involvement in teen pregnancy prevention based on 25 male involvement programs.

Appendix B

Sources for Selected Family Life Education Programs

Effective family life education curricula include reproductive and anatomical facts, as well as practice in skills to resist pressure from either peers or partners and negotiate contraceptive use. The best sexuality education curricula offer opportunities for adolescents to clarify their beliefs, build values, and acquires skill in negotiation, compromise, assertiveness, and accessing services. (Kirby, 1997)

Reducing the Risk (RTR)

Reducing the Risk utilizes a school-based approach to pregnancy prevention for tenth graders, emphasizing avoiding unprotected sex through either abstinence or contraceptive use for those who choose to be sexually active.

Reducing the Risk
ETR Associates
P.O. Box 1830
Santa Cruz, CA 95061-1830
Telephone: (408) 438-4060, (800) 321-4407 (for publications)
Fax: (800) 438-3618
Contact: Douglas Kirby
or

Sociometrics Corporation
PASHA
170 State Street
Suite 260
Los Altos, CA 94022-2812
Telephone: (650) 949-3282
FAX: (650) 949-3299
Contact: Jane Park, Research Associate

The Teen Outreach Program (TOP)

Originally developed by the Association of Junior Leagues and now directed by Cornerstone Consulting, the **Teen Outreach Program** is a junior high and high school-based program which combines life skills and adolescent reproductive health education with youth involvement in community service.

Teen Outreach Program
Cornerstone Consulting Group
TOP National Project
P.O. Box 710082
Houston, TX 77271-0082
Telephone: (Office for TOP Dissemination and Replication Project) (215) 572-9463

Teen Talk

Teen Talk is a collaborative school- and community-based adolescent pregnancy prevention program for youth ages 13 to 19.

Teen Talk
Sociometrics Corporation
PASHA
170 State Street
Suite 260
Los Altos, CA 94022-2812
Telephone: (650) 949-3282
Fax: (650) 949-3299
Contact: Jane Park, Research Associate

Wise Guys

Wise Guys is a male responsibility program for 10- to 15-year-olds that aims to prevent teen pregnancy.

Wise Guys
Family Life Council of Greater Greensboro, Inc.
301 East Washington St.
Suite 204
Greensboro, NC 27401
Telephone: (910) 333-6890
Fax: (910) 333-6891
Contact: Cynthia Dorman, Executive Director of Family Life Council

Appendix C

Stages of Adolescent Development

Early Adolescence	Middle Adolescence	Late Adolescence
Females ages 9-13 Males ages 11-15	Females ages 13-16 Males ages 14-17	Females ages 16 and older Males ages 17 and older
• Puberty as a hallmark; • Adjustment to pubertal changes, such as secondary sexual characteristics; • Concern with body image; • Beginning of separation from family; increased parent-child conflict; • Presence of social group cliques; • Identification in reputation-based groups; • Concentration on relation-ships with peers; • Concrete thinking, beginning of new ability in abstract thinking.	• Increasing independence from family; • Increasing importance of peer group; • Experimentation with relation-ships and behaviors; • Increasing ability to think abstractly.	• Autonomy nearly secured; • Body image and gender role definition nearly secured; • Empathetic relationships; • Attainment of abstract think-ing; • Defining of adult roles; • Transition to adult roles; • Greater intimacy skills; • Sexual orientation nearly secured.

Source: National Commission on Adolescent Sexual Health, 1995

Appendix D

Common Questions About Sexuality Education

Here are some questions frequently raised by opponents of comprehensive sexuality education, along with responses used successfully in local communities. Other criticisms and questions may arise, and sexuality education proponents should decide in advance what response to make.

Shouldn't parents be the ones responsible for teaching their children about sexuality?

Open communication between parents and children is extremely valuable, and many young people say they want to be able to talk with their parents about sexuality. Unfortunately, most parents report that they do not know what to say and that they feel uncomfortable talking with young people about intimate issues. Sixty-seven percent of parents say it is hard for them to talk with their children about sexuality; 98 percent of parents say they need help in communicating better.

Supplementing education received from parents with sexuality education provided in the schools provides young people with the information and skills they need. School-based sexuality education helps parents with the difficulties they face when they are the sole providers of information and guidance. Sexuality educators work together with parents to promote healthy sexual development by adolescents. This cooperation between parents and schools can aid parents, schools, and young people.

What advantage is there in offering sexuality education in the schools?

The goal of sexuality education is to promote positive sexual health. Quality sexuality education focuses on both factual information and skills development. Skills building components address setting goals, communicating values, discussing abstinence or negotiating contraceptive use, resisting peer pressure, and other important abilities.

While sexuality is a normal, healthy part of being alive, too many parents are silent on the subject, giving young people the message that sexuality is bad or, at least, that talking about it is bad. In such a climate, teens cannot discuss important issues about abstinence, contraception, sexuality, and relationships, either with partners or with adults they trust. Left without guidance or education, they have a nearly impossible task making informed, responsible decisions.

School-based programs can play an important role in educating young people about sexual health and decision making. Age-appropriate, balanced, realistic sexuality education, from kindergarten through 12th grade, can reach young people before they start having sex and increase motivation to delay initiation of sexual intercourse and to use contraception correctly and consistently once intercourse is initiated.

Comprehensive sexuality education which includes information on both abstinence and contraception also allows students the opportunity to examine behavioral values and norms in order to weigh the consequences of their decisions. School-based education helps young people identify their own and their family's values, helping them make healthy choices throughout their lives.

What are the effects of sexuality education?

Sexuality education, combined with access to contraception, can help teens delay sexual intercourse and/or to use contraception better. Other industrialized countries that have balanced, realistic, and comprehensive (K through 12) education along with confidential access to contraceptives have much lower rates of teen pregnancy, childbearing, and abortion than does the United States. In fact, even though teen sexual activity is similar for U.S. and European teens, the European birth rates are two to seven times lower than U.S. rates.

Research shows that young people who receive sexuality education in the schools are more likely to talk with their parents about sexuality. Balanced, realistic sexuality education enhances young people's knowledge, clarifies their values, improves their communication skills, and encourages sexually active teens to use contraception. Research shows that balanced, realistic programs help teens delay having sex and improve their contraceptive use when they do become sexually active.

Sexuality education can decrease contraceptive failure since most contraceptive failure is due to error on the part of the user rather than to flaws in the product. For example, condoms, when used correctly and consistently, are highly effective. Comprehensive sexuality education helps reduce user error by improving people's communication about contraception as well as by educating them about correct, consistent use.

Doesn't sexuality education promote sex and lead to sexual experimentation?

No. Providing information about sexuality does not lead young people to experiment with sex. Age-appropriate, balanced, realistic sexuality education that begins early and is sustained through the developmental years helps teens **delay sex** and use more effective methods of birth control once they become sexually active.

In fact, a recent World Health Organization review of sexuality education programs from all over the world found that young participants engaged in neither earlier nor increased sexual activity. Studies consistently show that teens who receive quality sexuality education are more likely to report contraceptive use at first intercourse than teens without sexuality education.

What's wrong with teaching values?

Sexuality education programs **do** stress values. The values-based components help young people identify their own values as well as the cultural, family, and religious values with which they live. Comprehensive sexuality education programs attempt, not to replace family values, but rather to help young people identify those values so they consciously make decisions that are right for them. Education which explores differences in a multi-cultural society fosters respect for diversity while validating commonly held social values, such as honesty, dignity, and individual responsibility.

What's wrong with teaching abstinence?

All comprehensive sexuality education programs teach about abstinence and help teens build skills that will help them remain abstinent, if they choose to do so. These topics include decision making, negotiating contraceptive use, accessing health care, preventing infection, and avoiding peer pressure. Almost every adult is or has been sexually active, and, when abstinence is taught as the only option for young people, teens are denied information and skills that will be vitally important to them at some point in the future.

Furthermore, sexually active teens feel stigmatized by messages that **only** abstinence is safe or appropriate, and they are less likely to acquire and use contraception when they have intercourse. Withholding information does not help young people make informed and responsible choices.

How can you teach abstinence and contraception at the same time? Doesn't that send a mixed message?

Teaching abstinence along with contraception does not send a mixed message. Instead, it realistically acknowledges the complicated nature of sexual relationships and the important decisions that people must make about sexual behavior. Comprehensive sexuality education provides young people with facts about a wide range of behaviors and choices, including abstinence and contraception. This information empowers all teens to make healthy decisions based on knowledge and their personal values. Research indicates that school programs that promote both abstinence and protected sex are more effective in reaching teens and helping them make responsible decisions.

How can sexuality education be good if so many people oppose it?

Actually, most people (including most parents) support sexuality education. A recent study indicated that 85 percent of adults support comprehensive sexuality education in the schools, and 94 percent support HIV prevention education in the schools.

Most opposition to sexuality education comes from a small minority of people who are unusually conservative in their political and religious values. These critics usually fear that any discussion of sexuality will lead young people to have sex and/or that discussing homosexuality will somehow "recruit" teens into lesbian or gay relationships. Another misperception is that programs which only discuss abstinence can be effective. Not one of these beliefs is true. Educating the public about the real content and effects of sexuality education will help allay fears and make visible the overwhelming public support for comprehensive sexuality education.

Source: Flinn S, 1996

Appendix E

Refuting the Myths and Misinformation

Here are arguments against balanced, realistic sexuality education and the answers from scientific literature.

Argument	Response
• Abstinence-until-marriage curricula work.	→In five studies of abstinence-until-marriage curricula (under the abstinence-only Reagan Administration), Office of Adolescent Pregnancy Prevention (OAPP) evaluations failed to show that abstinence-only curricula increased abstinence among sexually active teens. [1 2 3]
• Abstinence-plus curricula that pays special attention to skills building and contraception education does not work.	→Three skills based, abstinence-plus programs, which were followed by lessons on protected sex, maintained abstinent behaviors in an intervention group one and two years later. [1 2 3 4]
• Researchers from the Institute for Research and Evaluation in Utah have shown that Sex Respect, an abstinence-until-marriage curriculum, works.	→While research on Sex Respect was performed in 1989 and 1991, researchers have not yet submitted their studies for peer review or for publication in professional journals. The Institute of Research and Evaluation's report to the OAPP showed Sex Respect made no significant or lasting differences in attitudes or behavior after one and two years. In a second study completed in 1991, researchers claimed a slight behavioral difference in favor of the program group, but the OAPP reported that the research methods were flawed and findings could not be concluded on the basis of the data. [5 6 7 8]
• Teen Aid has been a highly successful abstinence-until-marriage curriculum. In San Marcos, California, teen pregnancy was reduced 68 percent when Teen Aid was taught.	→To date, the Teen Aid curriculum has not been investigated in a scientifically rigorous study. The San Marcos report can not be substantiated by the school administration or counselors at the school. [7]
• Sexuality education encourages students to become sexually active at younger ages.	→The World Health Organization has reviewed the evaluations of 47 studies in the United States and abroad. Of these, 25 studies reported that sexuality and HIV/AIDS education neither increased nor decreased sexual activity and attendant rates of pregnancy and STDs. In fact, in 17 of the studies, HIV and/or sexuality education delayed the onset of sexual activity, reduced the number of sexual partners, or reduced unplanned pregnancy and STD rates. [1 9]
• Teaching students about contraception increases their likelihood of becoming pregnant.	→There is evidence to the contrary. Young women whose parents have discussed contraception with them are less likely to become pregnant. Europeans include contraception in family life education throughout middle and high school grades. A study of 36 countries found that while U.S. students initiated sexual intercourse at the same ages and with the same frequencies as European students, the rates of pregnancies are two to seven times higher in United States teens.[9]
• Contraceptives fail so frequently that we should just teach teenagers to abstain.	→The percentage of women experiencing an accidental pregnancy within the first year of perfect use of contraception is only .1 percent with the combined pill and .6 percent with the IUD Copper T 380A. Furthermore, the failure rate with typical use for the IUD Copper T 380 is only .8 percent.10 In other words, the success rate for all these contraceptives is more than 99 percent.
• Contraceptives do not protect against HIV and other sexually transmitted diseases.	→Other than total abstinence from risky behaviors, only condoms provide significant protection against STDs, including HIV. That is why good programs teach using condoms, as well as contraception to prevent pregnancy and STDs. [11, 12]

• Condoms have a failure rate of 12 - 40 percent.	→Condoms are the preferred contraceptive choice among teens. Condoms are very effective at preventing unintended pregnancy and STDs when used consistently and correctly. The failure rate among typical first-year users of condoms is approximately 12 percent and includes pregnancies resulting from condom slippage and breakage. [10]
• Condoms break frequently	→A study of condoms performed by Consumer Reports show that condoms do not break frequently even when subjected to air burst tests. In another study of condom users in eight countries, an average four percent of participants experienced breakage over a year's time, often due to improper use. [13, 14]
• Condoms are not effective in preventing the transmission of HIV.	→A study of HIV-serodiscordant couples in Europe (in which one is HIV infected and the other is not) has shown no transmission to the uninfected partner among the 124 couples who used a condom every time. Among those couples who were inconsistent users, 12 percent of the uninfected partners became infected with HIV. [11, 15]

Source: Berne, Huberman, 1994

1. Baldo M, Aggleton P, Slutkin G. Does Sex Education Lead to Earlier or Increased Sexual Activity in Youth? Presented at the Ninth International Conference on AIDS, Berlin, June 6 - 19, 1993. Geneva, Switzerland: World Health Organization, 1993.
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5. Weed S, Olsen J. Evaluation report of the Sex Respect Program: Results for the 1988-1989 School Year. Unpublished report, submitted to the Office of Adolescent Pregnancy Programs. Hyattsville, MD: The Office, 1990.
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7. Blake J. Sex Education in America: AIDS and Adolescence. [Video recording] Boston, MA: Media Works, 1993.
8. Roosa M. Comments on Weed S. Report on the Sex Education Pilot Project, Executive Summary. Tempe, AZ: Arizona State University, Program for Prevention Research, 1991.
9. Alan Guttmacher Institute. Sex and America's Teenagers. New York: The Institute, 1994.
10. Hatcher RA, Trussel J, Stewart F, et al. Contraceptive Technology. 16th ed. New York: Irvington, 1994.
11. Centers for Disease Control and Prevention. Update: barrier protection against HIV infection and other sexually transmitted diseases. Morbidity & Mortality Weekly Report 1993; 42:589-591.
12. _____. How effective are condoms at preventing STD's? Contraceptive Technology Update 1989; 10: 17-28.
13. Steiner M, Piedrahita C, Joanis C, et al. Condom breakage and slippage rate among study participants in eight countries. International Family Planning Perspectives 1994; 20:55 - 58.
14. _____. How reliable are condoms? Consumer Reports 1995; (May):320-325.
15. deVincenzi I, et al. A longitudinal study of human immunodeficiency virus transmission by heterosexual partners. New England Journal of Medicine 1994; 331:341-346.

Appendix F

Family Life Education Program Assessment

Use the following assessment tool to analyze the family life education curriculum currently in use. Note the questions that are difficult to answer. The assessment may indicate a need to strengthen the current curriculum, institute a teacher training program, expand topic areas, and/or devise an evaluation plan.

The following characteristics describe the family life education curriculum in our school (or youth-serving agency):

	Yes	No
The family life education curriculum:		
a) Is based on a program that is demonstrated to be effective at promoting sexual responsibility	❑	❑
b) Provides at least 50 hours of instruction	❑	❑
c) Is developmentally appropriate	❑	❑
d) Builds sequentially from one grade to another	❑	❑
e) Reflects the cultural background of participants	❑	❑
f) Gives equal emphasis to the responsibility of males and females regarding abstinence and contraceptive use	❑	❑
The family life education curriculum has a component to prepare parents to be the primary sexuality educators for their children.	❑	❑
The family life education curriculum is taught by professionals trained in human sexuality and includes in-service trainings for continuing professional development.	❑	❑
The family life education program has a strong peer leadership training component covering the following topics:	❑	❑
a) Reproductive health	❑	❑
b) Aspects of sexuality education beyond reproductive health	❑	❑
c) Peer support and assistance for sexuality education	❑	❑
d) Community resources for reproductive health and sexuality education	❑	❑
e) Decision making skills regarding sexual behavior	❑	❑
The following mechanisms are in place to assess the effectiveness of the curriculum:	❑	❑
a) Assessment of students' knowledge, attitudes, or behaviors related to sexuality	❑	❑
b) Feedback from students, parents, and school staff to improve the program	❑	❑
c) Monitoring of the quality of instruction by teachers	❑	❑

	Yes	No
The family life education curriculum in our school (or in our youth-serving agency) covers the following topics in an accurate, comprehensive manner:		
a) Consequences of unplanned pregnancy	❑	❑
b) Physical maturation and development	❑	❑
c) Communication and decision making skills related to sexual activity	❑	❑
d) Abstinence		
e) All contraceptive methods	❑	❑
f) Prevention of STDs and HIV infection	❑	❑
g) Sexual victimization including rape and incest	❑	❑
The family life education curriculum covers these topics by:		
a) Providing accurate information	❑	❑
b) Teaching clear and consistent values about responsible sexual activity	❑	❑
The curriculum adequately promotes the following behavioral skills:		
a) Sexual decision making	❑	❑
b) Assertiveness skills	❑	❑
c) Refusal and negotiation skills	❑	❑
d) Life skills training	❑	❑
e) Goal setting	❑	❑

Source: Brindis, Peterson, 1996

Appendix G

Selected Evaluation Resources: Learning about Effective Pregnancy Prevention Programs

This series provides information on a variety of evaluated pregnancy prevention programs. The sources listed below offer comparisons of various models, discuss evaluation methodologies and results, and provide important information needed for replication.

Card JJ, Brindis C, Peterson J, Niego S. *Guidebook: Evaluating Teen Pregnancy Prevention Programs.* Los Altos, CA: Sociometrics, forthcoming. For ordering information, contact Sociometrics Corporation, 170 State Street, Suite 260, Los Altos, CA 94022-2812, or call (650) 949-3282.

Card JJ, Niego S, Mallari A, et al. The program archive on sexuality, health and adolescence: promising "prevention programs in a box." *Family Planning Perspectives* 1996; 28:210-220.

Frost JJ, Forrest JD. Understanding the impact of effective teenage pregnancy prevention programs. *Family Planning Perspectives* 1995; 27:188-195.

Institute of Medicine, Committee on Unintended Pregnancy, Brown SS, Eisenberg L, ed. *The Best Intentions:Unintended Pregnancy and the Well-Being of Children and Families*. Washington, DC: National Academy Press, 1995.

Kirby D. *No Easy Answers: Research Findings on Programs to Reduce Teen Pregnancy.* Washington, DC: National Campaign to Prevent Teen Pregnancy, 1997.

Kirby D, Short L, Collins J, et al. School-based programs to reduce sexual risk behaviors: a review of effectiveness. *Public Health Reports* 1994; 109:339-360.

Moore KA, Sugland BW, Blumenthal C, et al. *Adolescent Pregnancy Prevention Programs: Interventions and Evaluations*. Washington, DC: Child Trends, 1995.

Philliber S, Namerow P. *Trying to Maximize the Odds: Using What We Know to Prevent Teen Pregnancy.* Prepared for a technical assistance workshop to support the Teen Pregnancy Prevention Program, Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, Atlanta, GA, December, 1995. Accord, NY: Philliber Research Associates, 1995.

In addition, you can receive evaluation information and program replication materials from Sociometrics' Program Archive on Sexuality, Health, and Adolescence, 170 State St. Suite 260 Los Altos, CA 94022-2812. Phone: 650-949-3282. Fax : 650-949-3299; and from Philliber Research Associates, 28 Main Street, Accord, NY 12404. Phone 914-626-2126; Fax 914-626-3206.

Appendix H

Advocates for Youth Publication Information

Exceptional resources for youth-serving professionals, policy makers, advocates and the media!

Open Up! Listen Up!

Family communication about sexual health

Open Up! Listen Up! is a packet of educational materials, pamphlets, resources, and activities which helps parents, care givers, and teachers answer children's questions about sexuality and use "teachable moments" to convey values and beliefs. One packet has been developed for parents of 8- to 13- year olds and another for parents of 14- to 18- year olds. Excellent resource for professionals, including members of faith communities, who plan and offer sexuality education for adults. (1997)

$30.00 each (Please specify age level.)

Advocacy Kit

Adolescent reproductive and sexual health

This publication provides in-depth information on how to improve adolescent reproductive and sexual health programs and policies by organizing at the state and local levels. The Advocacy Kit includes information on building coalitions, conducting needs assessments, planning public education campaigns, working with the media, educating policy makers, and responding to opposition. Specific sections address sexuality education, HIV prevention, school-based health, pregnancy prevention, and abortion. 100 pp. (1997)

$30.00 each

Guide to Programs for SBHC/SLHCs

A comprehensive, five-volume resource for advocates or administrators on planning or expanding SBHC/SLHCs

Volume I: Advocating for School-Based and School-Linked Health Centers. 58 pp. (1993)

Volume II: Designing and Implementing School-Based and School-Linked Health Centers. 96 pp. (1993)

Volume III: Potential Sources of Federal Support for School-Linked Health Services. 144 pp. (1993)

Volume IV: Assessing and Evaluating School-Based and School-Linked Health Centers. 100 pp. (1994)

Volume V: Introduction to Legal Issues. 35 pp. (1997)

$85.00 for five volume set; $20.00 for individual volumes.

When I'm Grown

This three-volume resource for young children offers an innovative approach to "lifeskills." It covers sexuality, HIV prevention, and health information within a comprehensive framework of self-esteem development, problem solving, healthy peer and family communications, values clarification, goals achievement, and career awareness. Nearly 300 activities mix large and small groups, hands-on discussion exercises, and role playing to stimulate self-reflection and critical thinking skills. Soft covers with perforated pages. Grades K-2, 170 pp. (1 993); Grades 3-4, 320 pp. (1 992); Grades 5-6, 390 pp. (1 992).

Individual volumes $45.00 each; two volume set $85.00; three volume set $125.00.

Order form on back

Let's Talk Month Planning Guidebook

October is Let's Talk Month (LTM). The purpose of Let's Talk Month is to encourage individuals, community organizations, and institutions to plan and implement special events, programs, and services which support adults in their efforts to give youth accurate and healthy information about sexuality. *The Let's Talk Month Planning Guidebook* contain organizing tips, selected innovative activities, funding ideas, a suggested time line, sample forms and materials, and much, much more to help you plan and implement Let's Talk Month in your community.

$30.00 each

National Teen Pregnancy Prevention Month Planning Guidebook

May is designated National Teen Pregnancy Prevention (NTPPM), and is designed to raise awareness about teen pregnancy so communities will commit to teen pregnancy prevention efforts. Advocates' planning guidebook helps local communities plan and coordinate public awareness activities. This "must have" manual contains strategic organizing tips and examples from NTPPM campaigns across the country, including sample proclamations, editorials, public service announcements, flyers, pamphlets, and forms to engage participation.

$30.00 each

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Appendix I

ORDER FORM—Primary Pregnancy Prevention Programs

Program Name	Qty.	Item Description	Price	Total
Human Sexuality—Values & Choices	_____	PASHA Program Package	$315.00	_______
	_____	User's Guide (if purchased separately)	$15.00	_______
	_____	Values Cards (set of 5, if purchased separately)	$1.25	_______
	_____	A Guide for Parents (set of 5, if purchased separately)	$17.50	_______
	_____	My Values, My Choices: A Student's Thoughtbook (set of 5, if purchased separately)	$14.95	_______
Project TAKING CHARGE	_____	PASHA Program Package	$960.00	_______
	_____	User's Guide (if purchased separately)	$15.00	_______
Reducing the Risk	_____	PASHA Program Package	$125.00	_______
	_____	User's Guide (if purchased separately)	$15.00	_______
Reproductive Health Counseling for Young Men	_____	PASHA Program Package	$195.00	_______
	_____	User's Guide (if purchased separately)	$15.00	_______
School/Community Program for Sexual Risk Reduction Among Teens	_____	PASHA Program Package	$195.00	_______
	_____	User's Guide (if purchased separately)	$15.00	_______
School-Linked Reproductive Health Services (The Self Center)	_____	PASHA Program Package	$195.00	_______
	_____	User's Guide (if purchased separately)	$15.00	_______
Tailoring Family Planning Services	_____	PASHA Program Package	$195.00	_______
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Teen Talk	_____	PASHA Program Package	$195.00	_______
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Queens Hospital Center's Teenage Program	_____	PASHA Program Package	$125.00	_______
	_____	User's Guide (if purchased separately)	$15.00	_______

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