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Adolescent pregnancy prevention: Choosing an effective program that fits

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ABSTRACT

Adolescent pregnancy prevention remains a high priority issue for communities, schools, and service agencies that work with adolescents. Since the early 1990s the United States has provided funding for pregnancy prevention programs with an emphasis on abstinence only education programs. Also during this time, prevention programs with youth development and service learning foundations have been developed and empirically studied. Current programs found to be effective through rigorous evaluation and that are included in best-practice lists by five research and advocacy groups are identified in the article. As well, strategies are discussed for program planning and implementation, and for strengthening goodness-of-fit between the program and the local community.

1. Introduction

Since 2005, teen pregnancy is once again on the rise in the United States (Centers for Disease Control and Prevention, 2007). With nearly 800,000 adolescents in the United States becoming pregnant each year, teen pregnancy continues to be a significant problem. The Department of Health and Human Services annual budget of some $33 million to fund adolescent pregnancy prevention programs, and the presence of programs in 2200 communities (http://www.hhs.gov/news/press/2002pres/teenpreg.html) provide evidence of ongoing concern. Mental health practitioners are frequently called upon to take the lead in selecting and implementing pregnancy prevention programs in schools and the community. In the current climate of limited resources and high accountability, selecting or developing a program that demonstrates visible results is critical. With hundreds of available programs that vary considerably in their approach and content, selecting one that produces visible results in the local community can be a daunting process. As teen pregnancy and sex education remain controversial topics, establishing program goodness-of-fit and community buy-in is essential to program success.

This article explores three broad categories of current adolescent pregnancy prevention programs. It identifies five best-practice program lists developed by recognized research and advocacy groups and briefly discusses the criteria for program inclusion among the five. Assessing program goodness-of-fit with the needs, resources, and values of the local community is discussed, as well as strategies based on the Communities That Care (CTC) prevention model (Hawkins et al., 2008) for collaborative planning, implementing, and evaluating programs in school- and community-based settings.

2. The problem

Between 1972 and 1990 births to teenage mothers in the United States increased by 27% to an all-time high (Alan Guttmacher Institute, 2004). According to statistics cited in a recent report by the Alan Guttmacher Institute (2006) adolescent pregnancy declined 36% between 1990 and 2005. Most experts agree that this substantial reduction was likely the result of several factors, including not only more pregnancy prevention programs but also growing concern about HIV and STD, and a decade of widespread financial well-being that provided youth with more life opportunities. Birth rates declined most for African American women (31%) and least (15%) for Hispanic adolescents (Alan Guttmacher Institute, 2004). In 2005 the rate leveled, and in 2006 began to rise once again (Centers for Disease Control, 2007). Currently, nearly 4 out of 10 adolescent girls in this country become pregnant at least once before they reach the age of 20 (Alan Guttmacher Institute, 2007). This is a higher adolescent pregnancy rate, by far, than in any other industrialized nation (Alan Guttmacher Institute, 2006).

The problem remains real and present. The elevated rate of school dropout among adolescent mothers remains at the forefront of concerns. Across the nation, more than 60% of adolescents who give birth before age 18 drop out of high school (National Campaign to Prevent Teen Pregnancy, 2007). Not completing high school or a GED by the age of 20 is a decisive indicator of future poverty.

Women who become mothers in adolescence, along with their children, are far more likely to live in poverty than women who postpone childbearing until their twenties. According to a compilation

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of risk factors by the National Campaign to Prevent Teen Pregnancy (2007), a child born to an unmarried adolescent mother without a high school diploma, is 9 times more likely to live in poverty than other children. Some 51% of all mothers receiving public assistance had their first child as a teenager. About one fourth of adolescent mothers have a second child within 24 month of the first birth, further contributing to economic dependency and poverty (National Campaign to Prevent Teen Pregnancy, 2002).

The penalties for children born to teenage mothers can be numerous and serious. As a group, these children are more likely to be born prematurely and at low birth weight, leading to a number of chronic medical and developmental problems. They are 50% more likely to fall behind academically and less likely to graduate from high school (Jaffee, Caspi, Moffitt, Belsky, & Silva, 2001; Terry-Humen, Manlove, & Moore, 2005). Sons are 13% more likely to become involved with the law and to be incarcerated (Haeman, Wolfe, & Peterson, 1997). Daughters are 22% more likely to become teen mothers themselves (Terry & Manlove, 2000). These children are more restricted by factors that limit their resources and life options than children born to mothers age 20 and older.

3. Pregnancy prevention programs

The growing presence of teen pregnancy caught national attention in the mid-1980s with the continuing rise in non-marital births and welfare dependency among adolescent mothers. This pattern placed teen pregnancy at the center of policy debates and national program initiatives, launching a large-scale initiative to prevent adolescent pregnancy. The effort was first fueled with relatively small grants and more recently with $250 million for abstinence education programs provided by the 1996 Welfare Reform Law. By 2001 more than 700 public-funded pregnancy prevention programs have been established in 47% of urban communities across the United States, in community agencies and churches, medical facilities, and schools (Jindal, 2001).

Since the early 1990s adolescent pregnancy prevention programs have mushroomed into the hundreds, some focused on primary prevention and others on preventing subsequent pregnancies (Franklin & Corcoran, 2000). Current programs can be categorized according to distinctive features and special emphases. This article focuses on programs demonstrated effective in schools and community-based organizations in which the primary goal is to prevent first-time pregnancies.

The format and focus of programs that have been evaluated and demonstrated effective in changing sexual behavior and preventing pregnancy fall into three broad categories: (1) sex education with or without contraception, (2) youth development or life options programs, and (3) service-learning programs (Manlove, Franzetta, McKinney, Papillo, & Terry-Humen, 2004). Abstinence-only program goals can be found in all three of these categories, as well as program goals for reducing sexual behavior or risks related to sexual behavior. An important distinction is whether skills building is a central goal of the program (Franklin & Corcoran, 2000). Skills building has become an especially important component in the success of prevention programs, as discussed in the next sections.

3.1. Sex education programs

These programs focus on delaying or reducing sexual activity. They range from short courses of fewer than 10 h to comprehensive courses of more than 40 h. The focus of sex education prevention programs varies. Some programs include contraceptive information and distribution, while others exclude this content. Although a survey of school-based health clinics in the mid-1990s indicated that communities are becoming more comfortable with programs that include contraception knowledge building (Schlitt, Rickitt, Montgomery, & Lear, 1994), this can still be a controversial issue. Regardless of contraception as a program feature, most sex education prevention programs contain components such as decision-making and assertiveness skills, relevant information, values clarification, peer education, computer-assisted instruction for parents and adolescents, day-long conferences and training, and theater projects where dramatic scenes launch discussions.

3.2. Current evidence on the abstinence-only approach

Abstinence-only sex education programs increased in number and received federal government sanction as part of the Personal Responsibility and Work Opportunity Act of 1996. Mathematica Inc., conducted a ten-year evaluation of abstinence only education programs, commissioned by the Department of Health and Human Services, and published in April 2007. The conclusion of this study is that abstinence-only programs are no more effective in preventing school-age pregnancy and sexual activity than having no sex education program (Trenholm, Devany, Fortson, Quay, Wheeler, & Clark, 2007). While abstinence is seen as "a healthy choice for teenagers, as they face considerable risk to their reproductive health from unintended pregnancy and sexually transmitted infections" (Santelli, Ott, Lyon, Rogers, & Summers, 2006), current empirical research does not support the effectiveness of stand-alone abstinence-only sex education programs.

While recent research (Rosenbaum, 2008) indicates that adolescents who have strong religious faith tend to delay becoming sexually active for 3 years longer than other youth, the Abstinence Pledge intervention, where teens pledge in a ceremony to remain abstinent until marriage, was demonstrated ineffective with 934 adolescents (Rosenbaum, 2008). Five years after the pledge those in the study who had pledged (289) did not differ from those who had not pledged (645) in premarital sex, STDs, anal, and oral sex. As well, this study and an earlier one with data from 14,000 adolescents (Bearman & Bruckner, 2001), found that fewer pledgers than non-pledgers had used birth control and condoms in the past year, or birth control at last sex, putting them at higher risk for pregnancy, STDs, and HIV.

3.3. Life options/youth development programs

Life options and youth development programs focus on changing sexual behaviors and reducing pregnancies through enhancing life skills and increasing options for disadvantaged youths (Philliber & Allen, 1992). The core assumption, based on research evidence (Afexentiou & Hawley, 1997; Allen, Philliber, Herrling, & Kuperminc, 1997), is that youth who have higher educational aspirations and greater opportunities are more likely to delay sexual intercourse and childbearing. Life options programs target teenagers' educational and earnings opportunities, such as postsecondary education, job training programs, and guaranteed student loans. Target populations are male and female multiracial junior high and high school students, similar to target populations for other pregnancy prevention programs. A number of studies have examined the effectiveness of life options/youth development programs in preventing pregnancy (e.g., Allen et al., 1997; Philliber, Williams Kaye, Herding, & West, 2002), and the results are promising.

Youth development programs with a number of components that target both sexuality and youth development are demonstrated in a number of program evaluation studies to be the most effective interventions for pregnancy prevention (Kirby, 2001). For example, the Carrera Program, a multi-component program offered by the Children's Aid Society, was demonstrated to prevent pregnancies for as long as 3 years. This program includes interventions common to many youth development and life options programs that focus on sexuality as well as youth development, offered in combination over time. Core components of the Carrera Program are (1) family life and sex education, (2) individual academic assessment and preparation for standardized tests and college prep exams, (3) tutoring, (4) self-