THE
NATIONAL
CAMPAIGN TO
PREVENT TEEN PREGNANCY

Making the List:

1 Understanding, 2 Selecting, and Replicating 3 Effective Teen Pregnancy 4 Prevention Programs

By Julie Solomon, Ph.D. and
Josefina J. Card, Ph.D.

2004

PUTTING WHAT WORKS TO work
A PROJECT OF THE NATIONAL CAMPAIGN TO PREVENT TEEN PREGNANCY

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Note to Reader

Those interested in learning more about effective programs to prevent teen pregnancy are encouraged to consider the following resources from the National Campaign. All are available through our website — www.teenpregnancy.org.

- *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy,* by Douglas Kirby, Ph.D.
- *A Good Time: After-School Programs to Reduce Teen Pregnancy,* (published in partnership with Child Trends) by Jennifer Manlove, Ph.D, Kerry Franzetta, Krystal McKinney, Angela Romano Papillo, M.A., and Elizabeth Terry-Humen, M.P.P
- *No Time to Waste: Programs to Reduce Teen Pregnancy Among Middle School-Aged Youth,* (published in partnership with Child Trends) by Jennifer Manlove, Ph.D, Kerry Franzetta, Krystal McKinney, Angela Romano Papillo, M.A., and Elizabeth Terry-Humen, M.P.P
- *Another Chance: Preventing Additional Births to Teen Mothers,* by Lorraine Klerman, Dr.P.H.
- *Progress Pending: How to Sustain and Extend Recent Reductions in Teen Pregnancy Rates,* by Douglas Kirby, Ph.D., and Karen Troccoli, MPH.

1
Introduction

As anyone working to reduce the incidence of teen pregnancy knows, it can be difficult to sift through the research literature on prevention programs and figure out which are most effective and for which populations they work best. Many overlapping lists of programs are in existence, and each uses somewhat different criteria to define "effectiveness." Yet we do know that in communities across the country, innovative programs are successfully promoting responsible sexual behavior among teens, and many of them have been evaluated and captured on program lists. This report was developed to help those working with young people to navigate these lists of teen pregnancy prevention programs and make informed decisions about how to select the best one(s) for a particular community and population.

Teen Pregnancy

Teen pregnancy remains a serious problem in the United States. Although the nation's teen pregnancy and birth rates are declining, there is still plenty of room for improvement. According to the most recent data available from the Centers for Disease Control and Prevention (CDC, 2001), 46 percent of high school students have had sexual intercourse, 14 percent of high school students have had four or more sex partners during their lifetime, and 42 percent of sexually active high school students did not use a condom the last time they had sex (CDC, August, 2003). As a result, approximately 860,000 teenagers become pregnant each year in the United States, and approximately three million cases of sexually transmitted diseases (STDs) occur in this age group (CDC, August, 2003). These rates surpass those of all other industrialized nations (Panchaud, Singh, Feivelson, & Darroch, 2000; Singh & Darroch, 2000). Moreover, every year nearly one quarter of all new Human Immunodeficiency Virus (HIV) infections in the United States occur among teenagers (CDC, June, 2003).

Teen mothers and their children often face serious consequences. Too-early childbearing increases the likelihood that the mother will drop out of school and that she and her child will live in poverty (James-Traore, et al., 2001). Infection with an STD (including HIV) can cause health problems ranging from infertility to death. Society pays a price as well. In the mid-1990s it was estimated that the annual cost associated with childbearing prior to age 18 is $6.9 billion (Maynard, 1997).

Programs

Research, funding, and advocacy organizations that support teen pregnancy prevention efforts encourage those working with teens to put into place "programs that work," "promising programs," "programs with strong evidence of success," or "effective programs." They emphasize that such programs (hereafter referred to collectively as "effective programs") have many benefits: (1) they offer the best chance for positive results; (2) they are economical because curricula and materials are already developed and tested; and (3) they allow for additional testing of evaluated prevention strategies to see if they are equally successful in different locations and with teens of various backgrounds.

A quick search of the internet and print literature reveals that many lists of effective programs exist. But what does it mean for a program to be included in an "effective program" list (hereafter referred to as an "EPL")? In actuality, it means something slightly different from one list to the next. This raises questions such as:

- What credible EPLs are in existence?
- Why do these EPLs differ on which programs are effective?
- What specific criteria were used to select programs for each EPL?
- What are the implications of the different criteria for the EPLs and for practitioners' efforts to set-up effective programs in new communities?
- How should practitioners use EPLs to select programs for replication (operation and evaluation in a new setting)?

This Report

This report addresses the questions noted previously in order to help practitioners choose the best programs for their communities.

- **Section Two** provides a brief overview of existing credible lists of effective teen pregnancy and STD/HIV prevention programs. (EPLs of teen pregnancy prevention programs usually include STD/HIV prevention programs as well, since many sexual behaviors lead to pregnancy and infection with STDs, including HIV.)
- **Section Three** describes the program and evaluation criteria that have been used to identify effective programs for these lists.
- **Section Four** reviews the specific criteria the developers of each EPL used to identify effective programs.
- **Section Five** discusses the significance of such criteria to program selection and replication and highlights the programs that have been rated "effective" by the majority of the EPLs.
- **Section Six** offers guidelines for using EPLs.
- **Section Seven** provides some final thoughts on the roles of practitioners in merging science and practice to successfully promote responsible sexual behavior among teens.
- A **glossary** of terms used in this report appears at the end (defined terms are italicized in the text), followed by three appendices.
- **Appendix A** provides a table summarizing the criteria used to select programs for each EPL;
- **Appendix B** lists all the programs included in the EPLs; and
- **Appendix C** provides information on the programs that were included in a majority of the EPLs.

2

What Credible Effective Program Lists Are in Existence?

The best EPLs include programs with scientifically rigorous outcome evaluation studies. Such studies compare changes among teens in a program to a group of similar youth who were not in the program. Credible lists are not based on process evaluation data (that is, they do not simply assess client or staff satisfaction with the program, whether the program was delivered as planned, or attendance patterns);[1] intuition about program effects; faith in a particular approach or method; political or religious inclination; or rhetoric about what should or might work. Criteria for program selection should be based on the rigor of the evaluation design and methods, as well as the strength of the findings. Specific criteria are discussed in greater detail in Section Three.

Sources of credible EPLs include:[2]

- *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy* (Kirby, 2001), a report published by the National Campaign to Prevent Teen Pregnancy. In addition to reviewing the results of numerous studies, it contains a list of programs with "strong evidence of success" (p. 179). It is referred to in this report as **Kirby (2001).**

- *Background for Community-Level Work on Positive Reproductive Health in Adolescence: Reviewing the Literature on Contributing Factors* (Manlove et al., 2001) and *Preventing Teenage Pregnancy, Childbearing, and Sexually Transmitted Diseases: What the Research Shows* (Manlove et al., 2002), reports published by Child Trends. Both reports contain tables of "what works," that include general prevention approaches and specific programs. Their lists of effective programs overlap but are not identical. (Details on their differences are provided in Section Four.) The programs identified as

1 Process evaluation should always be a *component* of a rigorous outcome evaluation in order to shed light on its results. However, while high levels of client and staff satisfaction with the program, consistent program delivery, and consistent attendance by the target population are usually necessary to achieve desired outcomes, they are not sufficient to achieve these changes. Therefore, positive process evaluation results do not serve as a good proxy for positive outcome evaluation results.

2 ETR Associates' Resource Center for Adolescent Pregnancy Prevention (ReCAPP) website also contains a credible effective program list (see http://etr.org/recapp/programs/index.htm). This list is very similar to the list in Kirby (2001), and all of the programs on it are included in at least one of the other lists discussed in this report.

effective in either or both reports are referred to collectively as **Child Trends (2001, 2002).**

- *Program Archive on Sexuality, Health, and Adolescence (PASHA),* a collection of replication kits for effective programs that was developed by Sociometrics Corporation (Card, Niego, Mallari, and Farrell, 1996; Sociometrics Corporation, 2002). PASHA not only lists effective programs but, for many of them, also provides corresponding program and evaluation packages that can be purchased.[3] PASHA is updated with new programs on an on-going basis. The most recent update took place in 2002. This source is referred to in this report as **PASHA (2002)**.[4]

- *Science and Success: Sex Education and Other Programs that Work to Prevent Teen Pregnancy,* a report authored and published by Advocates for Youth. It is referred to in this report as **Advocates (2003).**

Until recently, CDC had a Programs-That-Work (PTW) list that focused on teen pregnancy and STD/HIV prevention, as well as on prevention of youth tobacco use (see Collins et al., 2002 for a description). CDC's PTW list has been discontinued and is no longer current. Therefore, it is not reviewed in this report. CDC is in the process of developing a new system to "assist communities in identifying effective and appropriate health risk reduction programs for youth" (CDC, 2002).

None of the above lists includes the same set of programs because different criteria were used to select the programs for each one. These criteria are discussed in greater detail in the next section.

3 Many of the original developers of programs selected for PASHA have agreed to have their programs distributed through the Archive.

4 It should be noted that the authors of this report, Julie Solomon, Ph.D., and Josefina J. Card, Ph.D., are the Director of Training Support and President (respectively) of Sociometrics (see the biographical sketches on inside back cover).

3

Why Do the Effective Program Lists Differ on Which Programs are Effective?

The differences between the EPLs cited previously hinge principally on two sets of criteria used to identify effective programs. The first set, *program criteria,* refers to the types of programs that could be included in the list. The second set, *evaluation criteria,* pertains to the rigor of the evaluation methodology and design and to the strength of the evaluation results.

Program Criteria

Program criteria identify the kinds of programs included in the EPL, such as pregnancy or STD/HIV prevention. These criteria do not address evaluation methods or outcomes. Three key program criteria differed between the four EPLs in this report.

Ultimate health outcome that the program aims to achieve

Programs that address teens' sexual and reproductive health have a range of goals. Principal among these are prevention of first pregnancies ("primary prevention"), prevention of subsequent pregnancies ("secondary prevention"), and prevention of STD infection, including HIV. Some EPLs include programs that address one or more of these three outcomes (Child Trends, 2001, 2002; PASHA, 2002), while others selected only programs that focus on prevention of first pregnancies and/or STDs/HIV (Advocates, 2003; Kirby 2001).

Prevention approach

The EPLs also vary in their programs' approaches. In particular, one EPL (Advocates, 2003) excluded programs that use one-on-one formats such as counseling and physical exam protocols and testing for pregnancy or STDs.

Age of the primary target population

Collectively, the EPLs in this report include programs that serve youth from early childhood to young adulthood. Individually, some lists specifically excluded programs targeting young children (PASHA, 2002), while others omitted those for college-age youth (Advocates, 2003; Kirby, 2001).

Evaluation Criteria

Evaluation criteria encompass the scientific rigor of the evaluation design and the methods used to collect and analyze the data. They also address the strength of the evaluation results. The specific evaluation criteria used by the EPLs discussed in this report are described below.

Evaluation design

Experimental and *quasi-experimental* evaluation designs use two groups of youth. One group, the *treatment group,* participates in the program being evaluated. The other group receives another program or no intervention at all. Those who are not in the treatment group are called the control group or comparison group, based on how they are assigned to their group (*random assignment* or *non-random assignment* — see below). Using an appropriate control or comparison group (i.e., one that is well-matched to the program youth in terms of gender, age, ethnicity, and other relevant features) makes it possible to attribute behavioral changes to the intervention itself.

An experimental design randomly assigns youth to treatment and control groups by using random number tables or other similar lottery-style procedures. This design can provide the strongest evidence for a causal link between a program and the changes observed in its participants. A quasi-experimental design uses non-random means, such as self-selection (volunteering), to create program and comparison groups. The disadvantage of this design is that the program and comparison groups are likely to end up differing in ways that could bias the results. For example, students who volunteer to participate in an after-school program may be inherently more motivated to learn from the program and avoid health risks than their peers in the comparison group who opted out of the program. Yet despite its advantages, an experimental design is often not possible due to ethical, legal, fiscal, and/or practical constraints. Therefore, it is common for evaluations to use a quasi-experimental design that tries to identify a well-matched, self-selected comparison group.

One EPL reviewed in this report (Child Trends, 2001, 2002) required that all program evaluations have an experimental design. The other EPLs included experimental or quasi-experimental designs, as long as quasi-experimental designs had a well-matched comparison group.

Length of follow-up

Although following-up with teens after a program ends can be challenging, it is crucial for assessing effects over time. Behavioral changes may not be immediately apparent, may last only briefly, or may endure for longer periods. Child Trends (2001, 2002) did not specify a minimum follow-up period for the selection of effective programs. The other EPLs set a minimum requirement, but it varied from one EPL to another and often within a single EPL, depending on what was being measured.

Sample size

An appropriate sample size is critical to a solid evaluation. If the sample size is too small, the results may be meaningful to the participants, but they may not be *statistically significant.* That is, they may not be detected by appropriate statistical analyses. Additionally, with very small sample sizes it is more likely that an apparently significant effect is due to chance. The minimum appropriate sample size depends upon many evaluation design factors, including the number of treatment and control/comparison groups; the number of categories of youth (e.g., African-American males, African-American females, Latino males, Latino females) for which outcomes are being measured; and the range of outcomes assessed across the groups. Also, the sample size at baseline (i.e., at the start of the program, also called *pre-test*) is almost always greater than sample size at follow-up (i.e., at the conclusion of the program and at points thereafter, also called *post-test*). This is due to *attrition,* which is the loss of participants over time. Therefore, programs must generally recruit more youth for a study than they actually need, under the assumption that some will not be available for follow-up data collection.

Two EPLs (Advocates, 2003 and Kirby, 2001) set minimum sample sizes for program inclusion. Another EPL (PASHA, 2002) let a scientific panel assess appropriateness of sample size in conjunction with other design and analysis factors (see "other aspects of evaluation methodology" below). Child Trends (2001, 2002), did not include a minimum sample size as a criterion.

Other aspects of evaluation methodology

Other factors that affect the scientific rigor of an outcome evaluation include the methods used to match treatment and comparison groups, the quality of the evaluation instruments, and the types of statistical analyses used. All the EPLs in this report referred to the importance of these evaluation features, but none was specific in defining them. Advocates (2003) used publication in a scientific, peer-reviewed journal as a proxy for use of appropriate methods. PASHA (2002) required a scientific panel to review and score programs based on an assessment of the rigor of the design and methods, as well as the significance of the results. Thus, although the broad notion of scientific rigor has been identified as important, not all the criteria that comprise it have been precisely defined or prioritized.

Evaluation results: behavioral or health effects

Assuming that an evaluation has been designed and executed with sufficient rigor, the ultimate test of the program's effectiveness is whether it has had a significant impact on the pregnancy, birth, or STD/HIV rates of participants, versus a control or comparison group. However, as Kirby (2001) points out, it is difficult to achieve statistically significant changes in these health outcomes, given the limited period of follow-up and small sample sizes that usually characterize these studies. In addition, pregnancies may be underreported because adolescent boys may not know about or acknowledge causing a pregnancy. There may also be reluctance to report abortions or STD/HIV infection. Because of these limitations on health outcome data, significant changes in risky sexual behaviors (e.g., frequency of sex, consistency of contraceptive use, number of sexual partners) are generally treated as strong evidence of program effectiveness.

All EPLs in this report required evidence of significant change in behavior or health status in the evaluation. One list (Advocates, 2003) required that behavioral effects be demonstrated for at least two key behaviors. PASHA required such effects for programs targeting older youth, but had less stringent criteria for younger adolescents (aged 15 or younger). These latter criteria included significant effects on fertility- or STD/HIV-related refusal or negotiation skills, values, and/or attitudes (towards risk-taking behavior), which are more practical to measure among young adolescents given the relatively low prevalence of sexual intercourse among this population.

Evidence of program effectiveness is even stronger if the program has been replicated in other sites and yielded positive outcomes. Successful replication helps confirm that the results are due to the program itself, rather than from an individual staff member or other factors that are not transferable between locations. However, scientific study of replication is relatively new and, therefore, few rigorous replication studies have been carried out (see Kirby, 2001 for some examples). None of the EPLs in this report used successful replication as a criterion for program inclusion.

Other Factors that Have Created Differences between EPLs

Various other factors have contributed to differences between EPLs. Timing is one example. Program evaluations are published regularly in journals and other media. Depending upon when an EPL is compiled, the studies that can be included will vary. Differences between lists also occur because researchers may overlook a published study and/or may not have access to unpublished manuscripts and reports. It is also true that, on occasion, a program falls within a "gray area" regarding program or evaluation criteria, and the

researchers must use their own best judgement as to whether the program merits inclusion.

Therefore, there are several factors that account for the overlapping (but not identical) sets of effective programs in the EPLs included in this report. Each EPL was compiled using a unique combination of program and evaluation criteria. Also, each was subject to constraints such as the timing of publications and the need for reviewers to make final judgments about whether or not to include programs of borderline eligibility.

4

What Specific Criteria Were Used to Select Programs for Each Effective Program List?

This section describes the set of program selection criteria each EPL used. It is presented in chronological order, according to the publication/latest revision date. A summary table appears in Appendix A.

Kirby (2001)

Kirby's (2001) *Emerging Answers,* a report published by the National Campaign to Prevent Teen Pregnancy, reviewed studies that met two key program criteria: the desired program outcome was the reduction of primary pregnancy and/or STD/HIV infection; and the primary target population was aged 18 or younger. Kirby reviewed studies with an experimental or quasi-experimental design; a sample size of at least 100 in the combined treatment and comparison groups in the statistical analysis; a measurement of behavioral and/or health status outcomes; and proper statistical analyses. Additionally, programs had to have either a follow-up period of at least six months if initiation of sex was measured, or a follow-up of two months after the program ended or four months after the pre-test (whichever was shorter) if other outcomes were measured. (For a fuller summary of criteria, see Appendix A or Kirby, 2001).

After summarizing and critiquing the chosen studies' results, Kirby identified eight programs with what he termed "strong evidence of success." These eight programs met even more rigorous evaluation criteria for selection, namely one of the following requirements: (1) evaluation with an experimental design, a large sample size, strong statistical analyses, and statistically significant and programmatically important behavioral effects for at least one year; or (2) two or more evaluation studies conducted by independent research teams, each with, at minimum, a quasi-experimental design (including intervention and comparison groups, and pre-test and follow-up data), acceptable sample size and statistical analyses, and statistically significant and programmatically important behavioral effects for at least one year (Kirby, 2001: 178-179). The eight programs chosen by Kirby using these criteria are listed in Appendix B.

Child Trends (2001, 2002)

Manlove and colleagues (2001, 2002) produced two reports for Child Trends in which they reviewed studies that focused on primary pregnancy, secondary pregnancy, and/or STD/HIV prevention. The programs could focus on youth of any

age. Evaluation criteria were described as "studies that are rigorously implemented, experimental evaluations of interventions, in which aspects of the environment are manipulated, and reproductive health outcomes are examined" (Manlove et al., 2001). The studies had to measure outcomes during adolescence, regardless of whether the programs targeted adolescents or younger children.

The first report (2001) includes seven tables, each of which presents information about the effectiveness of various prevention approaches on the following seven outcomes: initiation of sexual intercourse; frequency of sexual activity; number of sexual partners; use of condoms for protection; use of contraception; pregnancies and births; or contracting STDs. Each table classifies the prevention approaches (e.g., abstinence-only education, HIV education, clinic-based programs) according to the categories "what works," "what doesn't work," and "mixed reviews" with respect to a single outcome. An effective program may appear in the "what works" or "mixed reviews" category, depending on the classification of its approach. Some programs in the "mixed reviews" category showed statistically significant positive effects only for a subgroup of the treatment population (e.g., only one gender; only one ethnicity; only at one of several program sites), or differentially according to length of follow-up. The second report (2002) includes a subset of the tables presented in the first one. These tables are virtually identical to their 2001 counterparts, but have a few additional studies in the "mixed reviews" columns. Across these two reports (2001, 2002), a total of 20 programs were identified in the "what works" or "mixed reviews" categories as having shown a positive effect for at least one subgroup of youth on at least one of the seven key outcomes. They are listed in Appendix B.

PASHA (2002)

The Program Archive on Sexuality, Health, and Adolescence (PASHA) identifies effective, youth-focused primary pregnancy, secondary pregnancy, and STD/HIV prevention programs. With permission from original program developers, PASHA staff develop replication kits containing all the materials needed to operate and evaluate the program. The PASHA EPL is updated on an on-going basis, most recently in 2002.

To be eligible for PASHA, a program must target youth aged 10–19; STD/HIV prevention programs targeting college students are also eligible. Evaluation criteria include an experimental or quasi-experimental design and pre-test and post-test assessments. A follow-up period of at least six months beyond completion of the intervention is required for pregnancy prevention programs; for STD/HIV prevention programs, the minimum follow-up period is three months. For programs targeting teens aged 16 and older, the program must have shown a positive impact on one or more of the following: initiation of intercourse; frequency of intercourse; number of sexual partners; contraceptive/condom use at first intercourse or most recent intercourse; consistent contraceptive/condom use at every intercourse; substitution of lower-risk sexual behaviors for higher-risk ones; other prevention-related behaviors (i.e., increased condom purchasing, voluntary condom carrying); and prevention of pregnancy and/or STD/HIV. For programs targeting youth aged 15 and younger, a significant positive effect on fertility- or STD/HIV-related refusal or negotiation skills, values, and/or attitudes (towards risk-taking behavior) is accepted as preliminary evidence of effectiveness. Programs that appear to meet these standards are submitted to a five-member independent scientific expert panel for review and scoring of their priority for inclusion in PASHA (Card, Niego, Mallari, & Farrell, 1996).

The 41 programs that have been accepted to date for PASHA appear in Appendix B. Of these, the developers of 28 have agreed to make their programs available for replication through PASHA. Nine of the remaining 13 programs are available from the original developers. Only four of the programs on the PASHA EPL are not readily available for replication.

Advocates (2003)

In 2003, Advocates for Youth published *Science and Success: Sex Education and Other Programs that Work to Prevent Teen Pregnancy.* It focuses on "what works" to reduce primary pregnancies and/or STD/HIV infection. Secondary pregnancy prevention programs were not eligible for inclusion, nor were programs that used a one-on-one format (such as counseling and physical exam protocols, testing for pregnancy or STDs). (Sue Alford, Advocates for Youth, personal communication, 9/9/03.) Programs considered for selection could target youth ranging in age from infancy to the teen years (Advocates, 2003). With respect to evaluation design and methods, Advocates for Youth required an experimental or quasi-experimental design with treatment and control/comparison conditions, a total of at least 100 youth combined in the treatment and control/comparison groups, and publication of results in a peer-reviewed journal (as a proxy for high quality design and analysis methods). In addition, programs that were listed either (1) had an evaluation design that included follow-up data collection at least three months after the intervention ended, and results in which two risky sexual behaviors showed significant positive change in the treatment group as compared to the control/comparison youth; or (2) demonstrated a significant reduction in pregnancy and/or STD/HIV rates in treatment versus control/comparison youth, regardless of follow-up period length (Advocates, 2003). As a result of the selection process, 19 programs were included in "what works" and appear in Appendix B.

5

What Are the Implications of the Different Criteria for the Effective Program Lists and Program Replication Efforts?

As described in Section Four, each EPL used a somewhat different set of criteria for program selection. Consequently, no two lists examined here have an identical set of programs. Appendix B lists the programs included in each EPL discussed in this report.

Variation in inclusion criteria affected the lengths of the EPLs. For example, PASHA (2002) includes the most programs (41) because (1) it uses relatively broad program criteria (e.g., it includes secondary pregnancy prevention programs and programs for college undergraduates); and (2) it has less rigid evaluation criteria for programs for younger adolescents (i.e., it permits program selection based on changes in skills, values, and/or attitudes for youth aged 15 and younger, rather than behavioral and health criteria required for youth aged 16 and older). Kirby (2001) had the fewest programs (eight) because of very rigorous evaluation criteria, particularly with regard to the required follow-up period (one year). The other EPLs had criteria that fell between these two extremes and, consequently, had an intermediate number of programs.

A total of nine programs were included in at least three of the four EPLs. These nine comprise all eight programs selected by Kirby (2001) and one additional program (Be Proud! Be Responsible!) that was included in the other three EPLs. These programs may be grouped within three prevention approaches: sex education, service learning, and multicomponent (sex education plus youth development). A listing of the nine programs and their approaches is provided in Appendix C.

The question that follows is: should practitioners try to replicate only the programs that have exhibited long-term positive behavioral and/or health outcomes within very rigorous evaluation designs? Kirby (2001) asserts that — because a limited number of such programs exist — community leaders should examine a broader range of interventions and find the one that best fits the community's needs. Kirby also points out that no single program has eliminated all sexual risk-taking among its participants, so using a variety of approaches is important.

6

How Should Practitioners Use Effective Program Lists to Select Programs for Replication?

The following tips provide additional guidance regarding factors to consider in using EPLs to select programs for replication. It is also worth noting that original developers and others who have run the program can provide additional important information on the resources needed for program planning and operation, as well as tips on participant recruitment and retention, staffing, and program operation and evaluation. PASHA (2002) and Advocates (2003) offer program developer contact information for many programs on their EPLs.

Aim for programs with evidence of effectiveness in achieving behavioral and health-related goals and objectives that are relevant for and acceptable to the target population and community.

Before settling on a program, it is important to make sure it is appropriate for the target population. Simply having been proven effective is not enough if the program's goals do not correspond to the needs of the target population, or are not accepted by the local community. Changing behavioral and health-related program goals to make them more appropriate for the new population may undermine the *program theory* (i.e., the program developers' theory of how the program components achieve positive change in the target population) that contributed to the program's effectiveness in the first place.

If no appropriate effective programs can be identified, it may be necessary to develop a new program or adapt an existing one even if it does not have rigorous evidence of effectiveness. In such cases, to maximize the likelihood of success, practitioners can use *logic modeling.* This process enables practitioners to identify and link goals, objectives, and program components and to incorporate characteristics of effective programs that use similar prevention approaches. More information on logic modeling and characteristics of effective programs can be found in Kirby, 2001.

Keep in mind that each time a program is replicated, it means a new opportunity for the teen pregnancy prevention field to learn more about what works. Sound evaluation plans should be an integral part of every program that is duplicated in a new community and/or with a new population. Moreover, the evaluation's results — positive and negative — should be shared with others in the

field to enhance our collective understanding of what it takes to achieve a successful replication.

Look for programs that were effective with a population similar to the new target population.

If a program has strong evidence for effectiveness with a particular population, then it is likely to have comparable results with a similar population if it is replicated faithfully (Kirby, 2001). Ideally, the new target population should resemble the original group in a variety of ways, including age, gender, ethnicity, sexual orientation, incarceration status, drug and alcohol use, and literacy level. These factors can affect the likelihood that the target population will engage in risky sexual behavior and can also influence program participants' interest in and ability to benefit from the prevention services. That is why a program's activities may need to be altered if the new target population is significantly different. In this event, changes should be made systematically using a logic modeling process.

Consider the fit of the program with available agency resources, such as setting, staffing, and funding.

A program can be operated fully only if the sponsoring organization has adequate resources to devote to it. Such resources include funds, staff, space, and relevant expertise. Although precise cost information may not be available for all programs included in the EPLs, consideration of several key issues can help clarify whether or not a particular program and agency match up well. For instance, in most cases the following costs will be incurred: production or acquisition of staff/facilitator training materials and materials for participants; staff/facilitators' time (salary, benefits, training fees, etc.); space costs; and evaluation planning and execution. Obtaining copies of materials from already-established programs can be a great time and money saver for those interested in carrying out replications. Program leaders also should consider creative ways of tapping into outside resources. These would include, for example, asking a community center to donate space for a program or requesting that a local business be a sponsor and pay for printing. Asking other program leaders where their funding came from may also lead to new ideas.

Determine the availability of replication kits or program materials.

It is difficult to successfully replicate a program if the original program materials are not publicly available in a user-friendly format. PASHA (http://www.socio.com/pasha.htm) offers replication kits for 28 effective programs and directs the user to other sources of materials for nine of the additional 13 programs it has designated "effective." Advocates (2003) also provides contact information for program information and materials.

7

Moving Forward: Science and Practice

The EPLs reviewed in this report include sets of effective programs that are overlapping but not identical, due to differences in program, evaluation, and other criteria. Collectively, these EPLs provide a rich research base from which practitioners can select appropriate programs to replicate in their communities. Most of these programs have publicly available, practitioner-focused materials that can facilitate replication. Using the information in these EPLs, community leaders and agency staff can capitalize on the best available programs, processes, and materials that science has to offer, while also bringing to bear their expertise, creativity, and energy, to promote a reduction in sexual risk-taking among young people. And by evaluating their own replication efforts, program leaders can contribute greatly to understanding in the field about what works to reduce teen pregnancy and STD/HIV infection in the United States.

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Glossary

Attrition: Loss of study subjects during an evaluation; may be due to ineligibility or a decision to end participation.

Comparison Group: The group of youth in an experimental or quasi-experimental evaluation that receives no intervention or an alternative intervention to the program being studied. It must be well-matched to the treatment group in order to attribute behavior changes to the program.

Control Group: A comparison group developed through random assignment of youth to receive no intervention or an alternate intervention.

Effective Programs List (EPL): A list of programs that was compiled using scientifically rigorous criteria for evaluation methodology and results.

Experimental Design: An evaluation design that compares the outcomes of two groups of youth—a treatment group and a control group—who were randomly assigned to their respective groups.

Evaluation Criteria: The characteristics of the program evaluations considered when determining whether to include a program on an EPL. These include the evaluation design, length of follow-up, sample size, and outcomes.

Logic Modeling: The process of identifying and linking program goals, objectives, and components.

Non-Random Assignment: Participants in a study are assigned to treatment and comparison groups through self-selection or another non-random process, which can produce biased results.

Post-Test: An assessment of participants performed immediately at the end of a program or at some time period afterwards.

Pre-Test: An assessment of participants performed at the beginning of a program; also referred to as baseline assessment.

Program Criteria: The characteristics used to define the types of programs that were included in an effective programs list. Examples include the health-related goal, the prevention approach used, and the age of the target population.

Program Theory: The program developers' theory of how the program components will achieve positive change in the target population.

Quasi-Experimental Design: An evaluation design that compares the outcomes of two groups of youth —the treatment group and the control group— who were *not* randomly assigned to their respective groups.

Random Assignment: Participants in a study are assigned to treatment and control groups using random number tables or other similar lottery-style procedures so that there is no selection bias.

Statistically Significant: An outcome that is detectable by statistical analyses.

Treatment Group: The group of youth in an experimental or quasi-experimental evaluation that participates in the program being evaluated.

Appendices

Appendix A. Overview of Program and Evaluation Criteria for Selected Effective Program Lists (EPLs)

EPL	PROGRAM CRITERIA			EVALUATION CRITERIA			No. of programs identified
	Ultimate health outcome(s) addressed	Program approach	Age of primary target population	Evaluation design, methods, and findings	Required peer-reviewed publication?	Required review and selection by a scientific expert panel?	
Kirby (2001)	Primary pregnancy prevention[1] STD/HIV prevention	Any approach eligible	High school age or younger (roughly 18 and younger)	To be *reviewed for potential inclusion,* a program had to meet the following criteria: ■ Appropriate and valid experimental or quasi-experimental design ■ Sample size of at least 100 in the combined treatment and comparison groups in the actual statistical analysis ■ Same method of parental consent for intervention and control/comparison groups ■ Researchers knew whether each study participant was a treatment or control/comparison group member (this information was not based on subject recall after participation.) ■ Measurement of behavioral and/or health status outcomes (e.g., initiation of intercourse, condom or contraceptive use, frequency of sex, pregnancy, and/or child-bearing) ■ Proper statistical analyses ■ Either a follow-up period of at least six months, if initiation of sex was measured, or a follow-up of two months after the intervention or four months after pre-test (whichever was shorter), if other behavioral or health status effects were measured To be *selected for the list of programs with strong evidence of effectiveness,* a program had to meet one of the following additional sets of criteria:	No	No	8

1 Primary prevention means prevention of a first pregnancy.
2 Secondary prevention means prevention of a second or subsequent pregnancy.
3 Any program that showed a significant impact on one or more of these outcomes is considered part of Child Trend's list of "effective programs," for purposes of this report.

Appendix A. Overview of Program and Evaluation Criteria for Selected Effective Program Lists (EPLs) (continued)

EPL	PROGRAM CRITERIA			EVALUATION CRITERIA			No. of programs identified
	Ultimate health outcome(s) addressed	Program approach	Age of primary target population	Evaluation design, methods, and findings	Required peer-reviewed publication?	Required review and selection by a scientific expert panel?	
Kirby (2001) *(continued)*				(1) Evaluation with an experimental design (random assignment to treatment and control groups), large sample size, strong statistical analyses, and statistically significant and programmatically important behavioral effects for at least one year OR: (2) Two or more evaluation studies conducted by independent research teams, each with at minimum a quasi-experimental design (including intervention and comparison groups, and baseline and follow-up data), acceptable sample size and statistical analyses, and statistically significant and programmatically important behavioral effects for at least one year			
Child Trends (2001, 2002)	Primary pregnancy prevention[1] Secondary pregnancy prevention[2] STD/HIV prevention	Any approach eligible	Early childhood through adolescent years	Rigorously implemented experimental designs that measured outcomes during adolescence, regardless of the age of the youth while they were in the program. Programs that found a significant impact on one or more of the following outcomes (among at least one subgroup of youth, in at least one site) were classified in the "what works" or "mixed reviews" categories:[3] ■ Initiation of sex ■ Use of condoms for STD and/or pregnancy prevention ■ Use of contraception ■ Frequency of sexual activity ■ Number of sexual partners ■ Contracting STDs ■ Pregnancies/births	No	No	20

3 Any program that showed a significant impact on one or more of these outcomes is considered part of Child Trend's list of "effective programs," for purposes of this report.

Appendix A. Overview of Program and Evaluation Criteria for Selected Effective Program Lists (EPLs) (continued)

EPL	PROGRAM CRITERIA			EVALUATION CRITERIA			No. of programs identified
	Ultimate health outcome(s) addressed	Program approach	Age of primary target population	Evaluation design, methods, and findings	Required peer-reviewed publication?	Required review and selection by a scientific expert panel?	
PASHA (2002)	Primary pregnancy prevention[1] Secondary pregnancy prevention[2] STD/HIV prevention	Any approach eligible	Age 10–19; for STD/HIV prevention programs, interventions for college students were also eligible	Appropriate experimental or quasi-experimental design (including treatment and control/comparison groups) and pre-test and post-test assessments. Additionally: ■ *For pregnancy prevention programs,* a follow-up assessment of treatment and control/comparison youth must have occurred at least six months after the completion of the intervention ■ *For STD/HIV prevention programs,* the minimum follow-up assessment period was three months Furthermore: *Programs focusing on youth age 16 or older* must have demonstrated a positive impact on one or more of the following behaviors or health status outcomes for one or more intervention subgroups of teens in relation to control/comparison group members: ■ Postponing sexual intercourse ■ Decreasing frequency of intercourse ■ Decreasing number of sexual partners ■ Increasing contraceptive/condom use at first intercourse or most recent intercourse ■ Increasing consistent contraceptive/condom use at every intercourse ■ Substitution of lower-risk sexual behaviors for higher-risk sexual behaviors ■ Increasing other prevention-related behaviors (i.e., increased condom purchasing, voluntary condom carrying) ■ Preventing pregnancy or STD/HIV *Programs aimed primarily at youth age 15 or younger* must have demonstrated a positive impact on fertility- and/or STD/HIV-related refusal/negotiation skills, intentions, values, and/or attitudes.	No	Yes; each panel member scores the program from 1–10; scores of 7 and higher indicate a recommendation of acceptance. Programs receiving a median score of 7 or higher and a mean score of at least 6.6 are accepted.	41

Appendix A. Overview of Program and Evaluation Criteria for Selected Effective Program Lists (EPLs) (continued)

EPL	PROGRAM CRITERIA			EVALUATION CRITERIA			No. of programs identified
	Ultimate health outcome(s) addressed	Program approach	Age of primary target population	Evaluation design, methods, and findings	Required peer-reviewed publication?	Required review and selection by a scientific expert panel?	
Advocates (2003)	Primary pregnancy prevention[1] STD/HIV prevention	Programs employing a one-on-one format (e.g., counseling and physical exam protocols, pregnancy or STD testing) were excluded from consideration[4]	Early childhood through teen years	Experimental or quasi-experimental design with treatment and comparison/ control conditions, and at least 100 young people in treatment and control/comparison groups combined. Furthermore, the program evaluation had to have *Either:* (1) Collected data from treatment and comparison groups at three or more months post-intervention, and demonstrated *at least two* of the following behavioral changes in treatment vs. comparison youth: ■ Postponed/delayed sex initiation ■ Reduced frequency of sex ■ Reduced number of partners/increased monogamy ■ Increased use or consistency of use of effective contraception methods and/or condoms ■ Reduced incidence of unprotected sex *Or:* (2) Showed reduced rates of pregnancy or STD/HIV in treatment vs. comparison youth	Yes	No	19

4 This information was provided by Sue Alford of Advocates for Youth (personal communication, 9/9/03).

Appendix B. Programs Included in Selected Effective Program Lists (EPLs)

KEY:

✓ Included in the source's effective programs list.
– Not included in the source's effective programs list.
* Accepted for inclusion in PASHA, but original developer has chosen not to participate in disseminating the program through the Archive.

Name of Program	Key Evaluation Reference(s)	EPL			
		Kirby (2001)	Child Trends (2001, 2002)	PASHA (2002)	Advocates (2003)
Abecedarian Project	Campbell et al. (2002)	–	✓	–	✓
Adolescent Compliance in the Use of Oral Contraceptives	Jay et al. (1984)	–	–	✓*	–
Adolescents Living Safely: AIDS Awareness, Attitudes & Actions	Rotheram-Borus et al. (1991)	–	–	✓*	–
Adolescents Living Safely: AIDS Awareness, Attitudes & Actions for Gay, Lesbian & Bisexual Teens	Rotheram-Borus et al. (1994)	–	–	✓	–
AIDS Prevention and Health Promotion Among Women	Hobfoll et al. (1994) Levine et al. (1993)	–	–	✓	–
AIDS Prevention for Adolescents in School	Walter & Vaughan (1993)	–	–	✓	✓
AIDS Risk Reduction for College Students	Fisher et al. (1996)	–	–	✓	–
ARREST: AIDS Risk Reduction Education and Skills Training Program	Kipke et al. (1993)	–	–	✓	–
ASSESS (Awareness, Skills, Self-Efficacy/Self-Esteem, and Social Support)	Boekeloo et al. (1999)	–	✓	–	–
Be Proud! Be Responsible!	Jemmott et al. (1992)	–	✓	✓*	✓[1]
Becoming a Responsible Teen	St. Lawrence et al. (1995)	✓	✓	✓*	✓
California's Adolescent Sibling Pregnancy Prevention Program	East et al. (2003)	–	–	–	✓
Children's Aid Society-Carrera Program	Philliber et al. (2002)	✓	✓	✓*	✓
A Clinic-Based AIDS Education Program for Female Adolescents	Rickert et al. (1990) Rickert et al. (1992)	–	–	✓	–
Conservation and Youth Services Corps	Jastrzab et al., 1997	–	✓	–	–
Draw the Line/Respect the Line	Coyle et al. (2000)	–	✓	–	–

1 Advocates (2003: 30–31) used the program title "Be Proud! Be Responsible! A Safer Sex Curriculum," but their program description and evaluation study citation indicate that they were referencing the program called "Be Proud! Be Responsible!" by other EPLs.

Appendix B. Programs Included in Selected Effective Program Lists (EPLs) (continued)

KEY:

✓ Included in the source's effective programs list.
– Not included in the source's effective programs list.
* Accepted for inclusion in PASHA, but original developer has chosen not to participate in disseminating the program through the Archive.

Name of Program	Key Evaluation Reference(s)	EPL			
		Kirby (2001)	Child Trends (2001, 2002)	PASHA (2002)	Advocates (2003)
Elmira Nurse Home Visiting Program	Olds et al. (1986) Olds et al. (1988) Olds et al. (1993) Olds et al. (1999)	–	✓	✓*	–
Family Growth Center: A Community-Based Social Support Program for Teen Mothers and Their Families	Solomon & Liefeld (1998)	–	–	✓	–
Focus on Kids	Stanton et al. (1997)	–	–	✓	–
Get Real About AIDS	Main et al. (1994)	–	–	✓	✓
A Health Care Program for First-Time Adolescent Mothers and Their Infants	O'Sullivan & Jacobsen (1992)	–	–	✓	–
High/Scope Perry Pre-School Project	Schweinhart et al. (1993)	–	✓	–	–
Human Sexuality-Values & Choices: A Values-Based Curriculum for 7th and 8th Grades	Donohue (1987)	–	–	✓	–
Information-Motivation-Behavioral (IMB) Skills HIV Prevention Program	Fisher et al. (2002)	–	–	✓	–
Making a Difference: An Abstinence Approach to STD, Teen Pregnancy, and HIV/AIDS Prevention[2]	Jemmott et al. (1998)	✓	✓	✓*	–
Making Proud Choices![3]	Jemmott et al. (1998)	✓	✓	✓*	✓
Poder Latino: A Community AIDS Prevention Program for Inner-City Latino Youth	Sellers et al. (1994) Smith et al. (1993)	–	–	✓	✓

2 This is the program title that was used by Kirby (2001). Other EPLs used different titles for the same program: Child Trends (2001, 2002) used "Be Proud! Be Responsible! A Sexual Abstinence Curriculum," and PASHA (2002) used "Abstinence HIV Risk-Reduction Intervention for African-American Adolescents."

3 This is the program title that was used by Advocates (2003). Other EPLs used different titles for the same program: Kirby (2001) used "Making a Difference: A Safer Sex Approach to STD, Teen Pregnancy, and HIV/AIDS Prevention; Child Trends (2001, 2002) used "Be Proud! Be Responsible! A Safer Sex Curriculum"; and PASHA (2002) used "Safer Sex HIV Risk-Reduction Intervention for African-American Adolescents."

Appendix B. Programs Included in Selected Effective Program Lists (EPLs) (continued)

KEY:

✓ Included in the source's effective programs list.
– Not included in the source's effective programs list.
* Accepted for inclusion in PASHA, but original developer has chosen not to participate in disseminating the program through the Archive.

Name of Program	Key Evaluation Reference(s)	EPL			
		Kirby (2001)	Child Trends (2001, 2002)	PASHA (2002)	Advocates (2003)
Postponing Sexual Involvement	Howard & McCabe (1990) Howard & Mitchell (1993)	–	–	✓*	✓
Postponing Sexual Involvement, Human Sexuality & Health Screening	Aarons et al. (2000)	–	✓	–	✓
Project Taking Charge	Jorgensen (1991) Jorgensen et al. (1993)	–	–	✓	–
Quantum Opportunities Program	Hahn et al. (1994) Opportunities Industrialization Centers of America (1995)	–	✓	✓	–
Queens Hospital Center's Teenage Program	Rabin et al. (1991)	–	–	✓	–
Reach for Health Community Youth Service	O'Donnell et al. (1999) O'Donnell et al. (2002)	✓	✓	✓	✓
Reducing the Risk	Hubbard et al. (1998) Kirby et al. (1991)	✓	–	✓	✓
Reproductive Health Counseling for Young Men	Danielson et al. (1990)	–	✓	✓	–
Rikers Health Advocacy Program (RHAP)	Magura et al. (1994)	–	–	✓	–
Safer Choices: A School-Based HIV Prevention Program	Coyle et al. (1999) Coyle et al. (2001) Markham et al. (2000) Wang et al. (2000)	✓	✓	✓*	✓
Safer Sex Efficacy Workshop	Basen-Engquist (1994)	–	–	✓	–
School/Community Program for Sexual Risk Reduction Among Teens	Koo et al. (1994) Paine-Andrews et al. (1999) Vincent et al. (1987)	–	–	✓	✓

Appendix B. Programs Included in Selected Effective Program Lists (EPLs) (continued)

KEY:

✓ Included in the source's effective programs list.
– Not included in the source's effective programs list.
* Accepted for inclusion in PASHA, but original developer has chosen not to participate in disseminating the program through the Archive.

Name of Program	Key Evaluation Reference(s)	EPL			
		Kirby (2001)	Child Trends (2001, 2002)	PASHA (2002)	Advocates (2003)
A School-Based Intervention Program for Adolescent Mothers	Seitz & Apfel (1993)	–	–	✓*	–
Seattle Social Development Project	Hawkins et al. (1999) Lonczak et al. (2002)	–	–	✓*	✓
Self Center (School-Linked Reproductive Health Center)	Clark et al. (1984) Frost & Forrest (1995) Zabin et al. (1986) Zabin et al. (1988)	–	–	✓	✓
Stay Healthy/Act Safe: An Intervention for Youths Living with HIV	Rotheram-Borus et al. (2001)	–	–	✓*	–
Tailoring Family Planning Services to the Special Needs of Adolescents: New Adolescent Approach Protocols	Winter & Breckenmaker (1991)	–	–	✓	–
Teen Outreach Program	Allen & Philliber (2001) Allen et al. (1990) Allen et al. (1997)	✓	–	✓*	✓
Teen Talk	Eisen & Zellman (1987) Eisen et al. (1990) Eisen et al. (1992)	–	✓	✓	–
Untitled (clinic-based program including counseling and instruction from a medical provider)	DeLamater et al. (2000)	–	✓	–	–
Untitled (program in Washington State including youth development and sex education components)	McBride & Gienapp (2000)	–	✓	–	–
Untitled (clinic-based behavioral intervention to increase condom use among high-risk female adolescents)	Orr et al. (1996)	–	✓	–	–
Youth Aids Prevention Project (YAPP)	Levy, Perhats, & Weeks et al. (1995) Levy, Perhats, & Handler et al. (1995)	–	–	✓	–
Youth and AIDS Project's HIV Prevention Program	Remafedi (1994)	–	–	✓	–

Appendix C. Programs Included in At Least Three of the Four Effective Program Lists (EPLs)

KEY:

✓ Included in the source's effective programs list.

Name of Program	EPL			
	Kirby (2001)	Child Trends (2001, 2002)	PASHA (2002)	Advocates (2003)
SEX EDUCATION APPROACH				
Be Proud! Be Responsible!		✓[1]	✓	✓
Becoming a Responsible Teen	✓	✓	✓	✓
Making a Difference: An Abstinence Approach to STD, Teen Pregnancy, and HIV/AIDS Prevention[2]	✓		✓	✓
Making Proud Choices![3]	✓	✓	✓	✓
Reducing the Risk	✓	✓		✓
Safer Choices: A School-Based HIV Prevention Program	✓	✓	✓	✓
SERVICE LEARNING APPROACH				
Reach for Health Community Youth Service	✓	✓	✓	✓
Teen Outreach Program	✓	✓		✓
SEX EDUCATION PLUS YOUTH DEVELOPMENT APPROACH				
Children's Aid Society – Carrera Program	✓	✓	✓	✓

1 Advocates (2003: 30–31) used the program title "Be Proud! Be Responsible! A Safer Sex Curriculum," but their program description and evaluation study citation indicate that they were referencing the program called "Be Proud! Be Responsible!" by other EPLs.

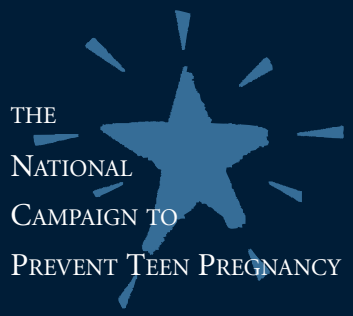
2 This is the program title that was used by Kirby (2001). Other EPLs used different titles for the same program: Child Trends (2001, 2002) used "Be Proud! Be Responsible! A Sexual Abstinence Curriculum," and PASHA (2002) used "Abstinence HIV Risk-Reduction Intervention for African-American Adolescents."

3 This is the program title that was used by Advocates (2003). Other EPLs used different titles for the same program: Kirby (2001) used "Making a Difference: A Safer Sex Approach to STD, Teen Pregnancy, and HIV/AIDS Prevention; Child Trends (2001, 2002) used "Be Proud! Be Responsible! A Safer Sex Curriculum"; and PASHA (2002) used "Safer Sex HIV Risk-Reduction Intervention for African-American Adolescents."

About the Authors

Julie Solomon, Ph.D., is a Senior Research Associate and the Director of Training Support at Sociometrics Corporation, a social science research and development firm based in Los Altos, CA. She directs publicly- and privately-funded evaluation, training, and technical assistance projects in a number of health-related areas, including teen pregnancy, STD/HIV, and violence prevention. She also oversees and serves as an instructor for Sociometrics' annual Institute for Program Development and Evaluation, a training program for teen pregnancy and youth STD/HIV/AIDS prevention practitioners. Prior to joining Sociometrics in 1999, Dr. Solomon worked for several non-profit institutions in the San Francisco Bay Area on reproductive health-related research projects, while completing a Ph.D. in linguistics.

Josefina J. Card, Ph.D., is the Founder and President of Sociometrics Corporation, a social science research and development (R & D) firm based in Los Altos, CA. Under her leadership, Sociometrics has been a pioneer in the establishment and operation of social science-based resources, products and services that address the incidence, prevalence, antecedents and consequences of sexual, contraceptive, and drug-use behaviors. Dr. Card has served as Principal Investigator of over 60 R&D projects, many of them multi-year investigations. She has also served on many private as well as federal advisory committees. Alongside her track record as a project leader, she has established a solid track record as a health and population scientist and is the author of over 70 books, monographs, and peer-reviewed journal articles. Throughout her career, Dr. Card has recognized the importance of communicating scientific findings both to scientists as well as to other professionals (such as service providers, policymakers, and health practitioners) who could benefit from the body of knowledge. She has devoted a significant portion of her career to facilitating the development and scientific evaluation of social intervention programs. She has given dozens of evaluation workshops around the United States over a 20-year period.



The National Campaign to Prevent Teen Pregnancy is a nonprofit, nonpartisan initiative supported almost entirely by private donations. The Campaign's mission is to improve the well-being of children, youth, and families by reducing teen pregnancy. Our goal is to reduce the rate of teen pregnancy by one-third between 1996 and 2005.

NATIONAL CAMPAIGN TO
PREVENT TEEN PREGNANCY
1776 MASSACHUSETTS AVENUE, NW
SUITE 200
WASHINGTON, DC 20036
(202) 478-8500
(202) 478-8588 FAX
CAMPAIGN@TEENPREGNANCY.ORG
WWW.TEENPREGNANCY.ORG