



## Examining Adolescent Pregnancy

Laurie L. Meschke, Ph.D., and Suzanne Bartholomae, M.S., The Ohio State University

Despite the decline in births to teen mothers in the United States (Child Trends, 1997), adolescent pregnancy has been and continues to be a concern for parents, policymakers, and social service providers. This concern appears well justified. In reviewing the consequences associated with adolescent childbearing, not only is the young mother negatively affected, but the children of teen mothers and society at large also experience ramifications of the event. Here we examine the consequences associated with teen pregnancy and the factors related to an increased likelihood of adolescent pregnancy.

### Consequences

For the young mother, teen pregnancy and childbearing has been associated with several health risks and outcomes. Adolescent mothers, especially those under age 15, have higher rates of birth complications, including toxemia, anemia, hypertension, eclampsia, prolonged or premature labor, uterine dysfunction, pregnancy-related infections, postpartum hemorrhaging and abnormal bleeding, and premature rupture of the uterine membrane (Hayes, 1987; Jorgensen, 1993). In addition, teen mothers have higher rates of maternal mortal-

ity and morbidity than their older counterparts. Mothers under age 15 may experience a maternal death rate that is 2.5 times the rate for mothers aged 20 to 24. Teen mothers also have higher rates of premature and/or low birth weight babies, with mothers under 15 being twice as likely to have premature or low birthweight infants (Hayes, 1987). Finally, teen mothers are in jeopardy psychologically because they experience higher levels of stress, despair, depression, feelings of helplessness, low self-esteem, a sense of personal failure, and suicide and suicide attempts than their older counterparts (Jorgensen, 1993).

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### Editor's Note

Over the past twenty years, teen pregnancy has received increased attention, demonstrated by policy reform, program development, and services for young teen mothers and their children. In this issue, Suzanne Bartholomae and I review the consequences associated with teen pregnancy and the risk factors that could serve as intervention targets. We argue that as practitioners we have the opportunity via intervention to test the adolescent pregnancy models put forth by basic researchers. One such program, "Project Taking Charge," is shared by Jerelyn Schulz. Aspects of the successful development and implementation of this national program are discussed. In addition, Judy Kimberly, Jerry Bean, and Bob Hughes examine the importance and methods of evaluating teen pregnancy prevention programs. Issues discussed include the theory application, target group selection, and community involvement.

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Laurie L. Meschke, Issue Editor

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Besides health and medical risks, the economic implications for the adolescent mother and her child are of great consequence. As with the general population, the adolescent mother's level of academic achievement is closely linked to her economic outcomes, including earning potential and opportunity for employment and occupation. On average, teen mothers complete fewer years of school, and are less likely to earn a high-school diploma or to go on for post-secondary education than women who delay childbearing (Hayes, 1987). Even those studies controlling for academic ability, motivational factors, and socioeconomic status found that early childbearers were more likely to have reduced educational attainment than later childbearers.

Generally, teen mothers eventually make progress academically (especially in their late twenties), however, they do not catch up completely (Hayes, 1987). Those adolescent mothers who were more likely to return to school and complete their high school or college degree, also tended to be black, remain single, avoid repeat pregnancy within five years, and live with their parents (Hayes, 1987; Jorgensen, 1993). Further, the older aged (16, 17, 18 years) adolescents who become mothers are reported to be at greater risk of not finishing high school. Adolescents who give birth when they are younger are more likely to stay in school because they are living in their parents' home, whereas the older adolescent mothers' transitions into adulthood, including living independently, seeking employment and/or getting married, make it more difficult to stay in school (Hayes, 1987).

Research also indicates that adolescent mothers are more likely to experience unemployment and poverty as an adult, and to be financially dependent on government welfare programs. Further, adolescent mothers are often relegated to lower-paying and less skilled occupations resulting in lower overall lifetime earnings (Hayes, 1987).

In terms of family structure and family composition, the proportion of teenage mothers raising their children as single parents has doubled from 15 percent to 30 percent between 1960 and 1970, and doubled again to 64 percent in 1987 (Luster and Mittelstaedt, 1993). Of the adolescent mothers who do marry, the majority of these marriages are unstable, with higher rates of marital discord and divorce. Adolescent mothers also tend to have higher levels of fertility (by approximately one child), closer spacing of births, more nonmarital births and a higher proportion of unintended births than women who delay childbearing (Hayes, 1987).

Several negative outcomes for the children of adolescent mothers in the areas of health, cognitive ability, academic achievement, and social behavior problems have been found (Hayes, 1987). Regarding health risks, infants born to adolescent mothers are more likely to experience premature and low birth weight, and higher rates of infant mortality (including being stillborn, miscarried, aborted, or dying during infancy) (Luster and Mittelstaedt, 1993).

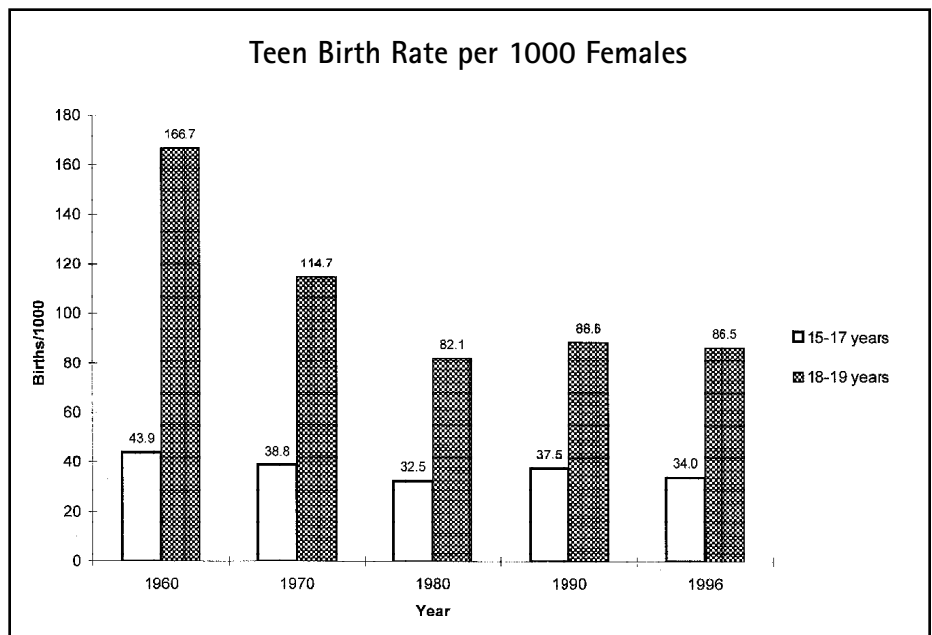
Other health risks include physiological abnormalities such as epilepsy, blindness, deafness, nervous disorders, and spinal and head injuries (Luster and Mittelstaedt, 1993; Jorgensen, 1993). In terms of cognitive ability and academic achievement, assessment scores of the children of adolescent mothers are reported to be lower than the scores of children born to older mothers. Further, these children are more likely to repeat a

grade and receive lower evaluations on school performance (Hayes, 1987).

Literature regarding socioemotional outcomes is limited. Of the data available, children of adolescent mothers have been found to have more signs of maladjustment, with greater risks of social impairment, including feelings of inferiority, fearfulness, and poor control of anger. Additionally, these youth also report higher levels of behavior disorders (e.g., aggressiveness and impulsiveness), school behavior problems (suspension), substance abuse, and sexual behavior than children born to older mothers (Hayes, 1987; Luster and Mittelstaedt, 1993).

Factors contributing to these outcomes, while not conclusive, are likely to involve the social and economic status of the adolescent mothers. (Generally, adolescent mothers tend to be poor, less educated, from disadvantaged neighborhoods, educated in low-quality schools, and from less stable families.) Further, adolescent mothers may be less competent to parent in terms of their emotional development, parenting experience, and parenting skills (Furstenberg, Brooks-Gunn, Chase-Lansdale, 1989).

Beyond the consequences posed to the adolescent mother and child as a result of early childbearing, ultimately, costs are passed onto society. Between welfare benefits paid in Medicaid, Aid to Families with Dependent Children, food stamps, and other support programs, the cost of adolescent childbearing has been estimated to cost the federal government billions of dollars annually (Jorgensen, 1993). The Robin Hood



Foundation recently estimated the annual cost of adolescent childbearing, compounded with the other disadvantages encountered by the mother, as being between \$13 and \$19 billion (Hughes and Sutton, 1996). Given the range and severity of consequences associated with teen pregnancy, measures to prevent this outcome are imperative.

## Risks Associated with Teen Pregnancy

Reviewing the factors related to an increased risk of teen pregnancy should aid in the development of more effective prevention programs. Such information aids in determining target populations and in selecting processes for the intervention's focus. Given that intercourse is a prerequisite of first intercourse will also be included in the review. Attention will be given primarily to those factors that could be targeted by teen pregnancy prevention programs.

Decision-making is affected by a number of issues, including the values or morals that we hold. Decision-making related to sexual behaviors leading to teen pregnancy is no exception. Adolescents who are more traditionally oriented or come from families with traditional or more conservative values are less likely to be sexually permissive and tend to delay first intercourse. Adolescents who attended church regularly reported later timing of first sexual intercourse (Hayes, 1987).

Although research on adolescent social interactions in relation to sexuality have focused almost exclusively on family and peer interactions, significant findings have emerged. A variety of interactions with parents has been found to be beneficial. Higher levels of parent-adolescent communication have been related to less permissive sexual attitudes (Wright, Peterson, and Barnes, 1990), whereas poor communication with parents and lack of parental support has been linked to earlier initiation of sexual activity (Jessor and Jessor, 1977). Both high levels of parental supervision and close relationships between adolescents and their parents were related to later timing of adolescent sexual activity. Parental support of adolescent autonomy has been associated with later initiation of sexual intercourse (Hayes, 1987). Consequently, the inclusion of parents in pregnancy prevention programs

should result in reducing teen pregnancy.

Peers can also aid in promoting or preventing teen pregnancy, via their attitudes and behaviors. Adolescents' perceptions of their peers' attitudes and behaviors are often more influential than their actual attitudes and behaviors. Thus, if an adolescent believes his or her peers are sexually active even though they are not, this belief will increase the adolescent's likelihood of having intercourse (Hayes, 1987).

Peers also provide an opportunity for an adolescent to have intercourse. Having a boyfriend or girlfriend has been related to an increased risk of adolescent pregnancy (Scott-Jones and White, 1990), especially if adolescent females are dating an older male peer (Stattin and Magnusson, 1990). Not surprising, dating, especially early steady dating, increases the risk of early first sexual intercourse (Moore, Sugland, Blumenthal, Gleit, and Snyder, 1995)

Early sexual behavior has also been related to various types of risk-taking behavior (e.g., delinquency, drugs, and truancy) (Moore, et al., 1995; Small and Luster, 1994). For example, alcohol and drug use appear to lower adolescents' inhibitions and decrease the likelihood of contraceptive use (Parker, Harford, and Rosenstock, 1994).

Finally, as outlined in the first section, chances of higher education and well-paying jobs diminish substantially for teen mothers. It would appear that this fact is not lost on many adolescents. In several studies, adolescents who prioritized education and future occupations were less likely to become adolescent parents and delayed their initiation of intercourse (Hayes, 1987). Similarly, poor grades also were related to early initiation of sexual behavior for both males and females (Small and Luster, 1994). Associating with peers who held priorities other than sexual intimacy and pregnancy has also been related to adolescent outcomes. For example, relationships with peers who have high achievement orientation have been related to delayed and decreased sexual activity (Grunbaum and Basen-Engquist, 1993).

In summary, current research on teen pregnancy has much to offer practitioners. First, the literature provides justification for preventative programs. Second, potential targets for intervention are found in examining factors associated with teen pregnancy. Through programming, practitioners have the opportunity to influence the processes found to have a relation to increased

risk of teen pregnancy, thereby testing whether particular models of teen pregnancy work. Together, solutions for this social problem may be found.

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# Project Taking Charge

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Project Taking Charge, developed by the American Association of Family and Consumer Sciences and the Office of Adolescent Pregnancy Prevention Program, is a family life education program for early adolescents that addresses the problem of adolescent pregnancy. The program promotes collaboration among schools, parents, and business communities. It has received positive recognition including citation by the Healthy Mother, Healthy Babies Coalition as an effective program; selection as one of twenty-five programs for inclusion in the Program Archive on Sexuality, Health, and Adolescence; and identification in a report, "The Best Intentions: Unintended Pregnancy and the Well-Being of Children in Families," by the Institute of Medicine/National Research Council as one of the most effective programs available.

Project Taking Charge is a six to nine week abstinence based educational program designed to help early adolescents "take charge" of their future by delaying the onset of sexual activity and other high risk behaviors. It focuses on imparting information and values that young teens need to successfully complete the developmental tasks of adolescence (Havighurst, 1952) and evolve into mature, socially responsible adults. Ten basic values generally regarded as basic tenets of sound personal ethics, fulfilling relationships, and good citizenship: equality, self-control, respect for others, responsibility, honesty, promise-keeping, self-respect or self-esteem, dependability, trustworthiness, and justice and fairness form a basis for the curriculum (Forliti, 1985).

The program is divided into five units and three parent/youth sessions. Unit 1 sets the stage for helping early adolescents take charge of their lives and contains lessons on basic values, gender roles and stereotypes, and diversity. Unit 2 assists students with planning for the future and achieving life goals, explores puberty, explains physical changes associated with reproduction, and helps teens learn to set goals and make decisions. Unit 3 introduces the concept of family and friends as support systems, explains successful communication techniques,

provides opportunities to practice them, and discusses sexual abuse and prevention techniques. Unit 4 addresses risky behaviors and how to say "no." Practice in "saying no" to sexual involvement and peer pressure is incorporated. In Unit 5 adolescents assess their inherent talents and abilities as well as identify challenges for growth. A job-shadowing exercise provides an opportunity to visit work sites and to interview individuals about their jobs. The parent/youth sessions focus on adolescent development, communication, and career development.

Project Taking Charge was field tested in twelve states and has undergone numerous revisions since its inception in 1990, primarily due to program facilitator's feedback. National and regional training programs for persons who wished to implement the program were designed and conducted and a Trainers Guide was developed. Project Taking Charge II, which was released in 1995, included additional lessons on topics such as diversity; sexual abuse; and alcohol and other drugs that were not in the first edition. The revision was fieldtested in New York, Florida, Texas, and Oklahoma before it was released. Finally, the Spanish version of the program, *El Futuro es Mio*, was developed and tested with assistance from the University of Puerto Rico.

Parental involvement is a critical component of Project Taking Charge. The key is to involve parents in deciding just how participation could most easily occur. Sharing in decision making is a major motivator for parental support. A simple survey is sent home asking parents to select from times sessions could be offered and soliciting information about barriers to attending (e.g., child care). If child care is needed, teachers are encouraged to work with a local youth group to help provide it. Providing refreshments and holding at least one session outside of the school setting (e.g., picnic area) also is recommended. In addition, contacts with the Parent Teachers Association executive board led to ideas to increase parent participation in both the parent/youth sessions and the job shadowing experience. PTA newsletters and meetings also provided a format to introduce the program and gain commitment and participation.

Preparation for the teacher/program implementer is essential for success. An extensive teacher preparation section outlines the advance steps necessary to implement certain lessons. Each lesson is designed to take approximately 45 minutes, but flexibility is built in and modifications and adaptations can be easily incorporated. Lastly, unit evaluations have been provided as well as pre- and post-program questionnaires for students and parents and a teacher feedback questionnaire.

Project Taking Charge also included a strong research/evaluation component from its onset. In summary, both adolescents and parents reported significant knowledge gains in the areas of human sexuality, sexual development, and sexually transmitted diseases (Jorgensen, 1991). A six-month follow-up of these same adolescents revealed that many of the knowledge gains found at the post-test were retained and program participants were less likely than comparison subjects to report the initiation of sexual intercourse (Jorgensen, Potts, and Camp, 1993). Evaluators concluded that Project Taking Charge has achieved a high level of acceptance and credibility in a number of communities.

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Project Taking Charge is available from the American Association of Family and Consumer Sciences, 1555 King Street, Alexandria, VA 22314-2752, 703-706-4600.

# Curricula for Pregnancy Prevention Programs

## It's My Child Too

### Purdue Cooperative Extension

"It's My Child Too" is a short-term parent education program for young fathers ages 14–25 who need parenting knowledge and skills. The curriculum is designed in modules (including proactive parenting, crying, diapering, and responsible decision-making) to better meet the needs of the participants. The program is designed to be taught as a series of six to eight sessions meeting once or twice a week for 90 minutes each.

The program costs \$75.00. For more information, or to order, please send requests to Aadron Rausch, Extension Specialist, Purdue Cooperative Extension and Assistant Director for Outreach, Center for Families, Purdue University. Credit card, check (to Purdue University), or purchase orders accepted.

## Project Taking Charge

### American Association of Family and Consumer Sciences

The course consists of a five-unit curriculum inclusive of the following topics:

- Who am I? Making healthy choices.
- Where am I going? Taking charge of my life.
- How do I get there? Making the most of relationships.
- How do I get there? Taking charge of my choices and behaviors.
- How do I get there? Taking charge of my vocational future.

Curriculum may be ordered from the American Association of Family and Consumer Sciences, 1555 King Street, Alexandria, VA 22314-2752. Telephone (703) 706-4600. Members of AAFCS pay \$75.00 for curriculum; nonmembers \$100.00 for each curriculum. Shipping and handling costs are \$5.00 per each curriculum. Trainers manuals are available for \$35.00 each with an additional \$5.00 for shipping and handling.

## Smart Moves

### Boys and Girls Clubs of America

This prevention program assists young people in resisting drugs, alcohol, tobacco, and premature sexual activity. A two-day training is offered for leaders, who receive a Smart Moves movie and the training skills necessary for program implementation.

Curriculum cost of the Smart Moves program (including Smart Kick) is \$35.00 plus \$3.50 for postage and handling. Make checks payable to Boys and Girls Clubs of America, c/o Program Services, 1230 West Peachtree Street, NW, Atlanta, GA 30309-3494, (404) 815-5760.

## Implementation Standards and Guidelines for Community-Based Projects: Lessons Learned from the School/Community Sexual Risk Reduction Project

### University of South Carolina, Department of Health, Promotion, and Education, School of Public Health

The program manual provides in-depth information about the school-community model used for program implementation and a conceptual framework for replicating a community-based program. Topics include practical strategies for acquiring community acceptance and support for community-based programs, strategies for using needs assessments and data to validate concerns of teen pregnancy in the community, and the use of practical intervention that enhances the health of teens and community residents.

Copies of this publication may be ordered through Murray Vincent, Department of Health Promotion and Education, School of Public Health, University of South Carolina, Columbia, SC 29208.

## Postponing Sexual Involvement

### Adolescent Reproductive Health Center, Grady Memorial Hospital, Atlanta, GA

Goals of the program are to enhance teens' understanding of societal pressures that

influence sexual behavior, help teens learn where to go for information and advice regarding sexual matters, and equip teens to deal with peer pressure situations through the use of assertive responses and actions. This series helps preteens think about, discuss, practice, and use information that will help them manage their emerging sexual feelings; and as they grow older, resist the social and peer pressures to become sexually involved.

The Postponing Sexual Involvement Educational Series consists of a leader guide and nine action videos for \$149.00 plus 10% shipping and handling. A curriculum for parents of preteens is available for \$80.00 plus 10% shipping and handling. Make checks payable to Marion Howard, PhD, Adolescent Reproductive Health Center, Box 26158—Teen Server Program, Grady Health System, 80 Butler Street, SE, Atlanta, GA 30335-3801 or call (404) 616-3513.

## Teen Outreach Program (TOP)

### Cornerstone Consulting Group

This prevention program is based on the school success model. The recently revised program, "Changing Scenes," uses the most current educational techniques to promote easy usage. Changing Scenes is designed to enhance the acquisition of adult independence, identity, intellect, integrity, and intimacy for 12 to 17 year olds. The seven-part curriculum package includes a "Facilitator Handbook" (curriculum information, instructional methodology, and classroom techniques and management), two "Service-Learning Supplements" (guide for the adult leader responsible for the service and individually packaged student handouts, and background on the research, theory, and practice of service learning and classroom activities that help students plan and process their volunteer experiences).

Curriculum may be ordered from Advocates for Youth, Suite 200, 1025 Vermont Avenue, NW, Washington, DC 20005. Telephone (202) 347-5700. Cost is \$165.00. Shipping and handling is included.

# Evaluating Teen Pregnancy Prevention Programs: An Overview

Judy A. Kimberly, Ph.D. and Jerry Bean, Ph.D., Ohio Family and Children First  
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Ohio has begun an era of system reform in which the state's education, health, and social services are concentrated in an effort to reach several shared policy goals, including a reduction in births to unwed teens. In an effort to provide some guidance to program planners and evaluators in this area, the logic of the Ohio Family and Children First evaluation strategy is shown in Figure 1. We promote a multifaceted approach to interventions (i.e., focusing on the teen, the community, the family, and peers).

Further, we believe the focus of programs should incorporate immediate and intermediate outcomes. Specifically, primary abstinence, secondary abstinence, or effective birth control use are outcomes of interest in addition to the far outcome goal of a reduction in the rate of births to unwed teens.

Finally, our position is that planning and evaluation are complementary activities that repeat in a cycle (see Figure 2). Program evaluation is an effort to ask how well a program is doing and to make changes to the program when it is not effective.

## Community Assessment and Goal Setting

Program need is a product of examining the community's needs and resources and should incorporate as many community stakeholders as possible. Within this phase, the need for the program is established, a target population is identified, and goals are set.

### Community Needs and Resources Assessment (Community Profile)

First, three key questions need to be answered:

- 1) What is the type, magnitude, and/or distribution of the problem (teen pregnancy)?
- 2) What resources (formal and informal) might address the problem?
- 3) How large is the gap between the problem and the community's resources?

Critical to this step is an accurate reflection of the community, resources, and potential partnerships. An exploration should occur of all possible community-based resources (i.e., agencies, churches, clinics, and groups that have activities in which teens participate) and programs already working with teens, especially in the area of pregnancy prevention.

### Identification of Target Population

After completing your assessment, a target population for intervention will emerge. Unless the teen population is very small, consider selecting a particular group of teens to serve. It may make sense to start with teens who are the most "ready" to change and gradually add teens who may be more resistant to change.

### Identification of Ideal Program Outcomes

Writing ideal outcomes can be difficult, however, answering questions in the following six areas may provide some guidance (United Way, 1996).

*Intent:* What will your program accomplish; what change will occur?

*Program Target:* Who or what changes as a result of your program?

*Geographic Target:* Where will your program take place; where will change be observed?

*Time Frame:* What time frame will be necessary to produce desired changes?

*Magnitude of Change:* How much change is expected?

*Measure:* How will you know when change has occurred?

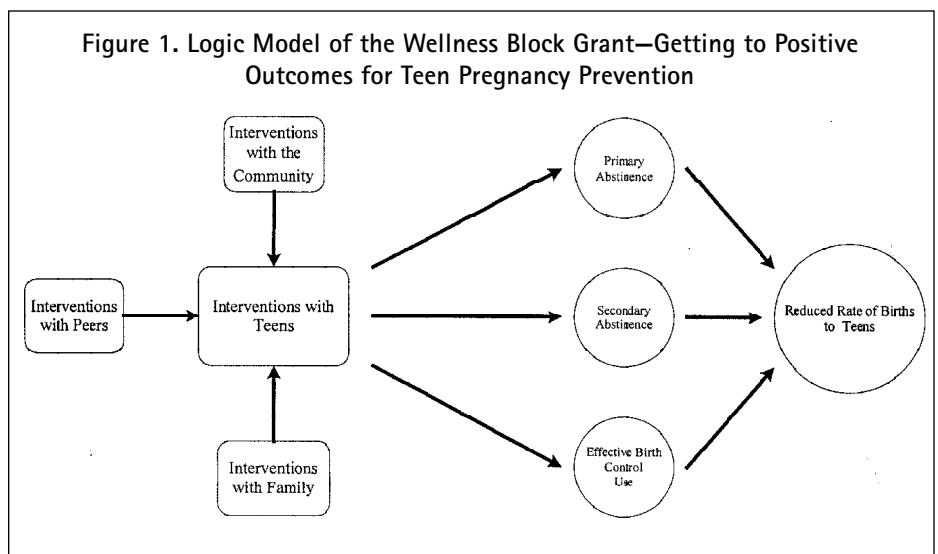
Having clear and well-defined goals or outcomes that incorporate the community's resources, capacities, and specified target population is critical to effective program design and implementation.

## Program and Evaluation Design

Within this phase, the strategy is devised for impacting previously identified needs. This is done by combining resources (staff, settings, key events) to form what is called a program. The ideal product of this phase is a well-designed, theoretically sound program strategy and a complete evaluation strategy that will produce answers about the program and its impacts. Major categories of activity in this phase follow.

### Use of Theory in Program Design and Development

Many researchers have developed theories to help explain a particular phenomenon or behavior thereby creating a framework for your program. Theories serve as guides for finding answers to questions. The difficulty



is in identifying a relevant theory and ensuring it is acceptable to the community values and perspectives.

### Designing a Multifaceted Program

Multifaceted teen pregnancy prevention programs utilize various approaches to holistically impact young people. Combining different methods or programs to change the environment around teens is believed to facilitate positive behavior change. For example, implementing a community awareness campaign about teen issues coupled with after-school activities, parent/teen events, mentoring, and support groups can help to influence multiple risk and protective factors at the same time.

### Specification of the Evaluation Strategy

Evaluation is one of the most difficult aspects of designing programs. Time spent on evaluation issues before implementing a program, however, is time well spent. Some questions critical to evaluation design are:

- What comparisons will you make?
- What measures will be used to represent program outcomes or impacts?
- When will measures be taken?
- How will measures be collected?
- How will measures be analyzed?

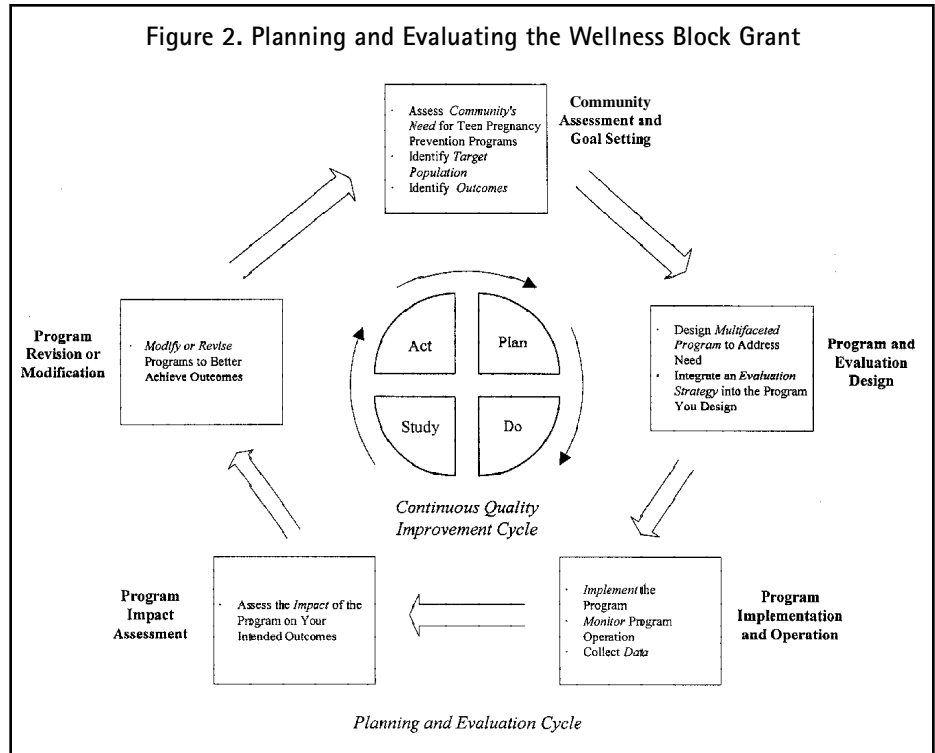
In addition to design type and measures, the strength of the strategy to answer your questions, the readiness of the community, the availability of staff and participants, and the cost are also necessary to consider.

### Program Implementation and Operation

The general purpose of the program accountability and monitoring phase is to find out how your program is being implemented and to keep track of the participation in activities and participants' program satisfaction. This is achieved through data collection. The type of data you collect will depend on the type of program, however, we have included some recommendations.

**Programmatic data.** These data are specifically related to your program and are collected to determine the program's effectiveness. The *Handbook of Adolescent Sexuality and Pregnancy* presents several instruments that may be of interest and utility to a variety of programs

Figure 2. Planning and Evaluating the Wellness Block Grant



**Utilization and satisfaction.** In the early stages of a program or for a program of short duration, this is a very appropriate type of measurement. For a new program, it usually makes little difference if the program has long lasting impact on children or families if they don't participate or enjoy the experience, or if they aren't responsive to the information presented.

**Demographic information** (e.g., ethnicity, age, gender, education, occupation) should be collected routinely about participants in an effort to monitor who the program is reaching and/or to assess whether utilization and satisfaction differs among various groups of participants.

### Data Entry

Transposing data from questionnaires to data files for statistical manipulation can be an arduous task, however, software programs such as Excel, Lotus 1-2-3, SPSS, or SAS make this relatively easy and straightforward.

### Program Impact Assessment

During this phase, explicit attention is given to producing evaluation results. If evaluation activities were completed in the prior stages, generating such results should be reasonably direct. Some statistical analyses

are required at this point and the level of sophistication may depend on the expertise of the personnel you have.

Analyses that should be performed regardless of the type of program you have implemented are:

- 1) Description of the Program Participants
  - Clients served (i.e., age, race/ethnicity, grade level, gender, SES)
  - Program presentation personnel (i.e., race/ethnicity, level of training, gender)
  - Other relevant descriptions
- 2) Client Outcomes
 

Based on outcomes identified, what happened to those served?

  - immediate outcomes
  - intermediate outcomes
  - long-term outcomes

If appropriate, and allowed for by the data:
- 3) Confirmation of Model/Theory Used in Program Design and Development
  - Is there evidence that the program caused outcomes?
  - Is there support for the theory of change used to design the program?

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Once you have the statistical information analyzed, interpreting and making sense of this information is the next step. Diagramming or graphing results can aid in understanding the meaning behind the numbers. When interpreting statistical data, the use of charts, figures, and/or tables is recommended.

## Summary

Comprehensive planning and evaluation within the teen pregnancy prevention arena are time consuming and challenges, requiring a great deal of commitment from professionals, school representatives, community members, government leaders, and youth. We believe this commitment is critical to enhancing the lives of today's youth.

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