THE INSTITUTE FOR
RESEARCH & EVALUATION

6068 S. Jordan Canal Rd.
Salt Lake City, UT 84118
ph. 801.966.5644
fx. 801.966.5644

Federally Funded *Teen Pregnancy Prevention* Programs:
Not What They Claim to Be

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A. EXECUTIVE SUMMARY

1. The *Teen Pregnancy Prevention* initiative endorsed 28 programs as proven effective.

The Office of Adolescent Health (OAH), in the Department of Health and Human Services (HHS), has issued 2010 funding for a new federal *Teenage Pregnancy Prevention* initiative, making available $75,000,000 "for the purpose of replicating evidence-based programs that have been proven through rigorous evaluation to reduce teenage pregnancy, behavioral risks underlying teenage pregnancy, or other associated risk factors" (p. 3).[1] On behalf of HHS, Mathematica Policy Research, Inc. has certified a list of 28 prevention programs as having met these criteria and been "proven to be effective through rigorous evaluation" (p.4).[1] These are the programs applicants must use in order to apply for the first tier of *Teen Pregnancy Prevention (TPP)* funding. Thus, these 28 programs have federal endorsement and have been established as standard models to employ when seeking federal funding for sex education. For this reason, it is vital for policy-makers and the public to be made aware of two major problems with this list that call into question its validity.

2. For most of the *TPP* programs, there is inadequate evidence of program effectiveness.

- For two-thirds of the 28 TPP programs the "rigorous proof" of program effectiveness consists of the evidence from *only one study conducted by the program's author*.[2]
- More than one-third of the *TPP* programs (9/28) did not demonstrate *any* long-term effects (lasting at least one year after the end of the program).[2]
- Only 9 (36%) of the 25 "comprehensive" *TPP* programs produced a long-term increase in teen condom use.[2]
- Only one of the 28 *TPP* programs demonstrated a reduction in teen pregnancy one year after the program.[2]
- Only 3 of the 28 programs demonstrated *any* long-term positive impact on the teen population *in a school classroom* setting[2] (which is likely the most cost-effective way to reach the largest number of youth).
- *This lack of demonstrated success was not reported in the TPP documentation. Instead, improvements on less protective or short-term outcomes were cited as "proof" that these programs were effective.*
- For example: The *Safer Sex* program was designed "to reduce the incidence of STDs and improve condom use among high-risk female adolescents."[2] It failed to achieve either of these outcomes, but did reduce "number of partners" (a less-protective outcome) 6 months after the program. However, *this effect had disappeared 12 months after the program*. Nonetheless, this lesser 6-month effect was cited as "proof" of program effectiveness, despite the fact the program failed to improve the two more protective outcomes.[2,3]

3. In addition, the content of most *TPP* programs is problematic.

- Many TPP programs contain objectionable material. For example, in one curriculum, by the author of 7 *TPP* programs, the teacher tells students that "grinding, massaging, masturbation, caressing, cuddling, and touching each other's genitals…may be good ways to express feelings to another person."[4]
- Two-thirds of the 28 programs teach teens how to use condoms, with many including simulated demonstrations of condom application; two-thirds *do not* emphasize abstinence as the appropriate and desired behavior for adolescents.[2]
- Most parents object to explicit content and want abstinence taught as the appropriate choice for teens.[5]

B. DETAILED EXPLANATION

I. Most of the TPP programs have *not* been proven to be effective: There is inadequate evidence of program effectiveness.

The *TPP* Funding Opportunity Announcement (FOA) states that the 28 programs it recommends are "*evidence-based* programs that have been *proven to be effective through rigorous evaluation*" (p. 4, emphasis added).[1] While an evidence-based" approach is laudable, a crucial issue is the *quality* of that evidence. The evidence of program effectiveness should meet two criteria: 1) the *scientific methods* used to verify a program's results must be of adequate quality to justify its designation as an "effective" program, and 2) the *kind of results* produced by the program must also be of adequate quality to justify the label of "effective." The list of 28 *TPP* programs contains major problems with both of these criteria. In many cases, the *science* behind the evidence does not meet recommended standards for effective programs or the *results* produced by the programs are not adequate indicators of effectiveness according to such standards.[a] Because of this, there are many programs on the *TPP* list that do not warrant federal endorsement and funding, or widespread dissemination.

There are four types of problems with the evidence for the *TTP* programs. The first two are problems of inadequate *scientific methods*; the second two are problems of inadequate *program results*:

1. **Evidence from just one study is inadequate scientific "proof" of program effectiveness. Yet for most of the *TPP* programs the evidence of effectiveness comes from only one study.**

Recommended Standard of Effectiveness: *SPR's* Standards of Evidence requires at least two rigorous studies as evidence of a program's readiness for dissemination.[7] *Blueprints for Violence Prevention* requires the same—an initial evaluation study and "at least one replication [study] with demonstrated effects"—in order to become a *Blueprints* model program. Their website states, "[Study] replication is an important element in establishing program effectiveness and understanding what works....Some programs are successful because of unique characteristics in the original site that may be difficult to duplicate in another site."[8]

TPP Evidence: For at least 19 of the 28 TPP programs, the "rigorous proof" of program effectiveness given in the *TPP Intervention Implementation Report (TPP-IIR)*[2] consists of the evidence *from only one study*; that is, there is no additional replication study named showing positive effects. Unfortunately, most of those who receive funding to implement these programs will not be required to conduct an evaluation study of the program to provide a replication of positive results because the programs are assumed to be effective.[1]

2. **Evidence from an independent evaluator is recommended in order for a program to merit dissemination. Yet for nearly all of the *TPP* programs, the only evidence of program effectiveness was one study conducted by the program's authors or marketers.**

[a]The development of standards for what constitutes sufficient scientific evidence of program effectiveness has been undertaken by prominent national entities like *The Society for Prevention Research (SPR), The What Works Clearinghouse*, *The National Registry of Evidence-based Programs and Practices*, *The Coalition for Evidence-based Policy*, and *Blueprints for Violence Prevention*.[6] A consensus has been proposed by *SPR's* Standards of Evidence Committee in their publication, "Standards of Evidence: Criteria for Efficacy, Effectiveness, and Dissemination."[7] These standards include criteria for both the quality of the *scientific methods* used to produce evidence of effectiveness and the quality of the program's *results*. These standards can be applied to programs designed to prevent teenage pregnancy and STDs, as well as to those designed to prevent the broader spectrum of social problems.

Recommended Standard of Effectiveness: The *SPR*'s Standards of Evidence Committee states that when "implementers have a stake in the outcome… measuring the impacts of a preventive intervention requires methods and data collectors independent of the interveners" and that for a program to qualify "for broad dissemination, it is desirable…to have some effectiveness trials that do not involve the developer" (pp. 156 and 162).[9] In other words, it is important that there is evidence of a program's effectiveness that has been produced by an independent evaluator—someone other than the program developer or implementer.

TPP Evidence: For 26 out of the 28 TPP programs, the author of the evaluation study was also the program developer and/or marketer.[2] Only one of these programs had a replication study by an independent, third party evaluator.[10]

3. **Programs that attempt to improve important protective outcomes and do not succeed should not be called "proven to be effective." Yet nearly one-half (43%) of the *comprehensive TPP* programs actually demonstrated failure to produce positive effects on such outcomes.**

Recommended Standard of Effectiveness: The SPR's Standards of Evidence Committee states that for important program outcomes, the "results must be reported for every measured outcome, regardless of whether they are positive, non-significant or negative… *not merely those showing positive effects*" and that "reporting only statistically significant results is misleading." Furthermore, "Efficacy can be claimed only... with a consistent pattern of statistically significant positive effects." And, "For an efficacy claim, there must be no serious negative (iatrogenic) effects on important outcomes." (p. 161, emphasis added).[9]

TPP Evidence:

a. Two replication studies of the *TPP*'s *CAS Carrera* program model found no positive effects and some statistically significant *negative effects*: one found an increase in teen pregnancy for program participants,[11] and the other reported an increase in both sexual initiation and pregnancy for girls in the program.[12] These negative results were not disclosed in the *TPP Intervention Implementation Report (TPP-IIR)*.[2] This report also did not mention that the sole study it cites as proof of the CAS-Carrera program's effectiveness found that although it decreased initiation and pregnancy for girls, the program failed to increase condom use for boys or girls and had no effects on sexual risk behavior for boys, after three years of program participation.[2,13] The effects on girls were "at the 3-year follow-up (from program start),"[2] which *suggests* a long-lasting effect, but they were actually measured *at the end of a 3-year program*, providing no evidence that they lasted beyond the program's end.

b. The *TPP-IRR* did not report the failure of many *comprehensive* programs on the *TPP* list—programs whose goals are to improve both rates of teen abstinence *and* condom use—to produce improvement on these major outcomes. Instead, the *TPP-IIR* often cited improvement on minor outcomes as evidence of these programs' effectiveness.
    1. *Promoting Health Among Teens/Comprehensive Intervention*—The program's main goals were to increase teen abstinence and consistent condom use. Its one evaluation study did not show significant improvement on *either* of these primary outcomes, but it reduced "number of partners in the past 3 months," a secondary outcome.[14] This was reported in the *TPP-IIR* as proof of the program's effectiveness, while its lack of effectiveness at improving the main, and more protective outcomes of abstinence and consistent condom use, was not disclosed.[2]

2. <u>*Safer Sex*</u>—The program was designed "to reduce the incidence of STDs and improve condom use among high-risk female adolescents." However, the *TPP-IIR* did not report the program's failure to achieve either of these goals (even when condom use was measured 3 different ways). The program reduced "number of partners" 6 months after the program *but not after 12 months* (again, not reported), yet this lesser 6-month effect was cited as proof of the program's effectiveness.[2,3]
3. <u>*Making Proud Choices*</u>—The program's main goals were to "promote skills supportive of abstinence and safer-sex practices," including consistent condom use (CCU).[2] Its one evaluation study did not show significant improvement in teen abstinence for any time period, and showed CCU had increased at 3 months after the program but not at 6 or 12 months.[15] The *TPP Intervention Implementation Report* did not report these failures. A reduction in the outcome of "unprotected sex" for a *subgroup* of the population 3 months after the program *but not 6 or 12 months after the program (*not reported) was cited as proof of program effectiveness, while the failure to achieve sustained effects on two of the program's primary behavioral outcomes was ignored.[2]
4. <u>*Draw the Line / Respect the Line*</u>—The main goals were to reduce the number of teens who initiate sex and to increase condom use by the sexually active. After receiving the program in 3 successive years (a large "dose"), condom use by sexually active teens did not increase (which was not reported in the *TPP-IIR*[2]) and sexual initiation was reduced only for boys, not girls.[16] Yet this curriculum made the *TPP* list of programs that "have been proven to be effective."[1]
5. <u>*All4You*</u>—The *TPP-IIR* did not report that the program failed to increase rates of teen abstinence or contraceptive use, and that the increase in condom use and decrease in frequency of sex that was measured 6 months after the program had disappeared 12 months after the program.[2,17] These short-term effects were reported as proof of program effectiveness.
6. <u>*Aban Aya*</u>—Participants received 16 to 21 lessons per year in school classrooms, grades 5 through 8—a very large program dose. The classroom-only version of the program had no significant positive effects, and the classroom-plus-community component reduced frequency of sex for boys but *had no significant effects on the girls in the program*.[18] These failures were not reported in the *TPP* documentation.[2] Furthermore, the effect on boys was stated as "at three-year follow-up (from program start),"[2] which *suggests* a long-term sustained effect, when it was actually measured at the end of a 3-year program, *at most <u>8 months after</u> the end of this long-running program*.

c. <u>*In total*</u>, 43% (11/25) of the "comprehensive" programs—those that attempted to improve rates of teen abstinence *and* condom/contraceptive use—failed to show any effect on one of these protective behaviors (either failed to increase teen condom/contraceptive use or failed to increase teen abstinence or both). Six of the 7 *TPP* programs that measured pregnancy as an outcome did not show a lasting effect, nor did one-third (2/6) of the programs measuring impact on STDs.
d. These failures of *TPP* programs to produce long-term impact on major protective outcomes were not reported in the *TPP Intervention Implementation Report*,[2] and apparently were not considered information that policy-makers should be made aware of.

4. For nearly one-half (46%) of the *TPP* programs, the positive results they *did* produce did not meet recommended standards for program effectiveness, e.g., only short-term effects, effects on less protective outcomes, subgroup effects, or non-generalizable effects.

A. <u>Lack of Long-term Effects</u>

<u>Recommended Standard of Effectiveness</u>: *SPR's* Standards of Evidence Committee states that "there must be a report of significant effects for at least one long-term follow-up at an appropriate interval beyond the end of the intervention (e.g., at least 6 months)" (p. 161).[9] According to *Blueprints for Violence Prevention*, "Although one criterion of program effectiveness is that it demonstrate success by the end of the treatment phase, it is also important to demonstrate that these program effects endure beyond treatment… Designation as a *Blueprints* program requires a sustained effect at least one year beyond treatment."[8] The *TPP* Funding Opportunity Announcement designates a short-term

outcome as one that lasts up to 6 months and a long-term outcome as one that is sustained for at least one year after the program (p.40).[1]

TPP Evidence:

1. One-third of the *TPP* programs (9/28) did not show *any* positive long-term effects (i.e., lasting at least one year after the end of the program).[2]
2. Nearly one-half (43%) of the programs did not demonstrate a long-term effect on the *intended population* of youth (i.e., not a subgroup).[2]
3. Only 15 of the programs (54%) showed a long-term effect on the intended population for at least one of four main protective outcomes—either teen abstinence, condom use, pregnancy, or STDs.[2]
4. Only 12 of the 25 *comprehensive-type* programs on the *TPP* list (or 48%) demonstrated long-term improvement for the intended population on at least one of these four protective outcomes (teen abstinence, condom use, pregnancy, or STDs).[2]
5. Only 3 of the 28 programs showed a long-term effect for the target population on at least one of these four protective outcomes *within a school classroom setting and population*.[2]

B. Lack of effects on the most protective outcomes: Consistent condom use, abstinence, STDs, pregnancy.

Recommended Standard of Effectiveness: According to the CDC, "To achieve the maximum protective effect, condoms must be used both consistently and correctly. Inconsistent use can lead to STD acquisition because transmission can occur with a single act of intercourse with an infected partner."[19] Some studies have also found that *non-consistent* condom use has provided inadequate STD protection or resulted in higher rates of STDs.[20]

TPP Evidence:

1. Of the 28 *TPP* programs, 15 (or 54%) demonstrated an increase in teen condom use lasting any period of time for any subgroup, as measured by frequency of condom use, use at last intercourse, consistent condom use, or contraceptive use.[2]
2. Only 11 (39%) of the *TPP* programs demonstrated a *long-term* increase in teen condom use, i.e., that lasted at least one-year after the program.[2]
3. Only 9 (36%) of the 25 "comprehensive" *TPP* programs demonstrated a long-term increase in teen condom use.[2]
4. Only 3 of the *TPP* programs demonstrated the ability to increase teen rates of *consistent condom use* (CCU) for any period of time or any subgroup (all were for the target population). None occurred in a school classroom.[2]
5. Only 2 of the *TPP* programs demonstrated the ability to produce a long-term increase in rates of teen CCU, i.e., lasting one year after the program.[2]
6. Only 8 of the 28 programs (29%) showed a long-term increase in rates of teen abstinence.[2]
7. Only 4 programs demonstrated a decrease in teen STD rates for at least one year.[2]
8. Only one of the *TPP* programs produced a one-year reduction in teen pregnancy.[2]
9. *Only 11 of the 28 TPP programs (39%) demonstrated a long-term (lasting one-year) improvement for the targeted teen population on at least one of the most protective outcomes—abstinence, CCU, pregnancy, or STDs.*[b]

[b] It should be noted that not every *TPP* program measured each of these outcomes, or measured program effects for a one-year time interval, so it is not known whether such effects would have been achieved if measured. Nonetheless, the *TPP* claim is that these 28 programs are "evidence-based." However, the *lack* of documented long-term effects for the target population on these important outcomes constitutes a serious *lack of evidence* of program effectiveness which contradicts this claim.

C. Non-generalizable effects: Effects found only for subgroups or atypical populations/settings.

Recommended Standard of Effectiveness:

According to *SPR*, the fourth requirement for a claim of efficacy is "Generalizability of Findings" (p. 159).[9] This is reflected in two concerns:

1. Effects should be broad-based, not limited to one subgroup of the study population. It is desirable that a prevention program demonstrate efficacy *across* the subgroups within the sample population, such as, "gender, ethnicity/race, risk levels." This is because "A small main effect may involve a large effect for a particular (e.g., high-risk) subgroup and small or no effects for other subgroups…. It is also possible that strong positive effects for one subgroup are accompanied by negative effects for another subgroup" (p. 159).[9]

2. Effectiveness should not be assumed beyond the tested population and setting. "It needs to be clear how well the [study] sample does or does not represent the intended population…. An intervention shown to be efficacious can claim to be so only for groups similar to the sample on which it was tested" (p. 159).[9]

TPP Evidence:

1. For one-fourth of the programs (7 out of 28), the effect was only demonstrated for a subgroup of the intended/target population.[2]
2. Many programs were tested only within a very specific or unique population and/or setting, thus, there is a lack of evidence for generalizability beyond that population/ setting, calling into question the program's readiness for widespread national distribution, *especially to adolescents in school classroom settings.*
    a. Nineteen of the 28 programs (68%) were designed for and tested only on inner-city minority youth.[2] Their efficacy can only be assumed for similar populations.
    b. Seven of the 28 were only tested within unique populations or settings: a juvenile detention facility (2), a residential drug treatment center (1), an alternative high school for troubled teens (1), a low-income housing project (1), children of HIV-infected parents (1), and a Marine Corps population in basic training (1).[2] Without a replication study that used a different setting/population, each of these programs can only be assumed to be effective for a similar setting/population.
    c. The *TPP Intervention Implementation Report* actually recommends 9 of the programs referred to in "a" and "b" above for populations or settings different from those with which they were tested, for which there is not evidence of their effectiveness.[2]
    d. Only 3 of the 28 *TPP* programs demonstrated a long-term protective impact on the target population *within a school classroom setting and population*.[2]

5. Summary of *TPP* Evidence Problems

There is a growing consensus in the field of prevention research that programs designated as effective should be those that have demonstrated long-term effects for the intended population on important outcomes. These effects should be generalizable and documented by more than one evaluation study, where at least one of the studies was produced by an independent evaluator—not the programs'

authors, marketers, or implementers. Most of the *TPP* programs have not met these standards of effectiveness:

- For nearly all of the TPP programs, the claim that they have been "proven to be effective" is supported by only one study conducted by the program's author. In addition to this…
- Only 12 of the 25 "comprehensive-type" *TPP* programs (48%) demonstrated lasting improvement on at least one major protective outcome (abstinence, condom use, pregnancy, or STDs) for the target population. Only 8 (32%) did so within a setting/population that was generalizable.
- Only 9 (36%) of the *comprehensive TPP* programs demonstrated an increase in rates of teen condom use that lasted one year.
- Only 2 *TPP* programs demonstrated the ability to increase adolescents' rate of *consistent condom use* for at least one year. Neither was a school-based program.

In sum, this lack of credible evidence of lasting effects on major protective outcomes constitutes a serious lack of evidence of effectiveness and contradicts the *TPP* claim that these programs have been "proven to be effective." Notwithstanding this lack of proof, these programs have been federally endorsed and recommended for federal funding and widespread distribution.

II. The content of most *TPP* programs is problematic: It is often sexually explicit and there is little emphasis on abstinence.

1. The majority of *TPP* programs teach teens how to apply and use condoms.

Eighteen of the 28 TPP programs teach condom use skills, usually including simulated condom application demonstrations and practice by students, which often occurs in a mixed-gender classroom. For at least 8 of the 28 programs, this condom instruction is intended for students as young as 11 or 12 years old.[2]

2. Some *TPP* programs teach teens to engage in "safe" alternative sexual behaviors.

Some of the *TPP* programs teach youth to participate in alternative types of sexual contact that will not put them at risk for pregnancy or STDs.[2] Some of the 8 *TPP* programs developed by the Jemmotts, many of which are intended for young teens 11 to 13 years old, contain such content. For example, the *Making A Difference* curriculum contains references to masturbation and sexual fantasies, in addition to role-plays suggested for 2 lesbian girls, 2 gay boys, and a lesbian girl with a bisexual girl. For one activity (pp. 63–66),[4] the teacher is instructed to put up a poster entitled "How Do People Express Their Sexual Feelings?" It lists: oral sex, dancing, anal sex, talking, sexual intercourse, sexual fantasy, saying 'I like you,' hugging, kissing, holding hands, touching, grinding, massaging, masturbation, caressing, cuddling, and touching each other's genitals. The teacher is supposed to "Be sure students identify oral, anal, and vaginal intercourse as behaviors to avoid when practicing abstinence," but the curriculum then says, "All other behaviors may be good ways to express feelings to another person." This idea is also repeated in a later module of the *Making A Difference* curriculum (pp. 114–118),[4] where the teacher is instructed to say the following to youth who "abstained" in a game about STD transmission: "You may have done other sexually pleasurable things without having intercourse (e.g., masturbation, kissing, talking, massaging, having fantasies, etc.)." It should be noted that *Making A Difference* is classified as an "abstinence" curriculum.

3. Abstaining from sex is not a primary focus in the majority of *TPP* programs.

For 18 of the 28 *TPP*-approved programs, teaching teens to abstain from sex is not a primary focus of the curriculum. If mentioned as an option, or even the most protective option, it often is discussed as one of several legitimate alternatives from which students may choose for themselves; and the majority of the curriculum content is about condom negotiation, application, and use.[2]

4. Most parents would not agree with the content of many *TPP* programs.

A. *Most U.S. parents object to their children being taught explicit sexual behaviors in school*. When parents of teens and pre-teens (ages 10 to 16) are made aware that some "comprehensive" sex education (CSE) curricula contain the above explicit content that demonstrates condom application and/or teaches "safe" sexual contact between teens, approximately 70% reject these programs.[5]

B. *Most U.S. parents want their child's sex education to place more emphasis on abstinence than condom use instruction and want abstinence taught as the desired choice, not one of several acceptable options.*[5]

- 68% of parents reject CSE programs that spend most of the time teaching condom use and application and spend little time teaching abstinence.[5]
- 78% agree that "sex education classes in public schools should place more emphasis on promoting abstinence rather than on condom and other contraceptive use."[5]
- 82% say that it is important that their child wait to have sex until marriage.[5] This does not appear to be taught in any of the 28 *TPP* prevention programs.[2]

III. Summary of this Report

1. Inadequate Evidence of *TPP* Program Effectiveness

The *TPP*-FOA asserts that the 28 programs it has authorized for federal funding and widespread dissemination have been "proven through rigorous evaluation" to be effective. Yet the majority of these programs do not meet recommended standards for proof of effectiveness. For the large majority, the scientific evidence comes from only one study that has been conducted by the program's author(s). Close to one-half (43%) of the programs have not demonstrated any positive long-term effect on the intended population of youth. And nearly 2/3 (61%) have failed to demonstrate long-term improvement for the intended population on any of the most protective outcomes—teen abstinence, consistent condom use, STDs, or pregnancy. Finally, the large majority of programs were designed for and tested only on specific types of youth or in unique settings, and should not be used more broadly without further evidence showing they can be generalized to other populations or settings.

2. Problematic *TPP* Program Content

Many of the *TPP*-approved programs include objectionable explicit sexual content such as demonstrations of condom application on anatomical models in mixed gender classrooms and/or recommendations of "safe" alternative sexual contact such as "massaging, masturbation, touching each other's genitals." Two-thirds of the programs do not emphasize abstinence as the appropriate and desired behavior for adolescents. This type of sex education content contradicts the wishes of the large majority of U.S. parents of adolescents.

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20. A study in Uganda (*N*=17,264) published in the journal *AIDS* found, "Consistent condom use significantly reduced HIV incidence, syphilis, and gonorrhea/Chlamydia…Irregular condom use was not protective against HIV or STD and was associated with increased gonorrhea/Chlamydia risk." See page 2171, in Ahmed S, Lutalo T, Wawer M et al. (2001). HIV incidence and sexually transmitted disease prevalence associated with condom use: a population study in Rakai, Uganda. *AIDS; 15*(16):2171–9. A Denver study (*N*=26,291) reported that "Among the total population, rates of STD were higher among inconsistent users than nonusers…However, STD rates were significantly lower among consistent than inconsistent users." See p. 528, in Shlay JC, McCung MW, Patnaik JL et al. (2004). Comparison of sexually transmitted disease prevalence by reported level of condom use among patients attending an urban sexually transmitted disease clinic. *Sex Transm Dis; 31*(3):154–60.

The Institute for Research and Evaluation (IRE) is a nonprofit research and development organization that has gained national recognition over the past 20 years for its work evaluating sex education programs, including abstinence education interventions. IRE has conducted program evaluations for federal Title V, CBAE, and Title XX projects in 30 states, and has evaluated sex education program in three foreign countries. The Institute has collected data from more than 500,000 teens, and conducted over one hundred evaluation studies of abstinence education. In addition, IRE has evaluated comprehensive sex education programs in two states, has recently completed a nationwide evaluation of marriage enrichment (divorce prevention) programs, and has developed and/or evaluated character education curricula for elementary school children. IRE staff members have published articles in professional journals and frequently speak at professional conferences and workshops. Dr. Stan Weed, Founder and Director of IRE, has served as a national consultant for federal Title XX and CBAE projects, and was a charter member of the National Campaign to Prevent Teen Pregnancy. He has been invited to provide expert testimony about sex education to state legislative bodies, the U.S. Senate, the U.S. House of Representatives (April, 2008), and the White House (June, 2009).

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