

# Adolescent Pregnancy Prevention Project 2013-2014

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## INTRODUCTION

This is the final summary report for the 2013-2014 Adolescent Pregnancy Prevention Project sponsored by the Maternal and Child Health Service (MCH) of the Oklahoma State Department of Health (OSDH). The curricula used for the 2013-2014 school year were *Making A Difference! An Abstinence Approach to Prevention of STDs, HIV and Teen Pregnancy* and *Making Proud Choices! A Safer-Sex Approach to HIV/STDs and Teen Pregnancy Prevention*. *Making a Difference* is an evidence-based curriculum that offers students the knowledge, confidence, and skills necessary to reduce their risk of sexually transmitted diseases (STDs), the Human Immunodeficiency Virus (HIV), and pregnancy by abstaining from sex. *Making Proud Choices* is an evidence-based curriculum that provides young adolescents with the knowledge, confidence and skills necessary to reduce their risk of sexually transmitted diseases (STDs), HIV and pregnancy by abstaining from sex or using condoms if they choose to have sex. *Making Proud Choices* is based on cognitive-behavioral theories, focus groups, and the curriculum developers' extensive experience working with youth.

## METHODS

Oklahoma has one of the highest teen birth rates in the nation. In an effort to reduce teen birth rates in Oklahoma, counties with the highest teen birth rates in the state were selected to participate in the Adolescent Pregnancy Prevention Project. The Adolescent Pregnancy Prevention Project offers participating schools three evidence-based curricula from which to choose: *Making a Difference (MAD)*, *Making Proud Choices (MPC)*, and *Reducing the Risk (RTR)*. Prior to the implementation of curriculum in the classroom, each Adolescent Health Specialist receives permission from school administration to offer the curriculum. The Adolescent Health Specialist provides the school with consent forms to send home to the parent(s) or guardian(s), outlining the purpose and scope of the curriculum. The parent(s) or guardian(s) can choose whether or not their child will participate in the project. Additionally, the student can choose to stop participating at any time during the project. The Adolescent Health Specialist also holds a parent night meeting in the community at

# Adolescent Pregnancy Prevention Project 2013-2014

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which time parents can view the curriculum materials and have any questions or concerns addressed.

## Entry and Exit Surveys

Program participants were given an Entry Survey prior to curriculum instruction and an Exit Survey after curriculum instruction. Due to the sensitive nature of some of the questions, only students in grades 9-12 were given the Entry Survey. All students, regardless of age or grade, were given the Exit Survey. Participation in the Entry and Exit Surveys was voluntary. Additionally, students could stop participating in the surveys at any time or choose to skip questions that made them feel uncomfortable.

## Participants

Two of the curricula, MAD and MPC, were offered during the 2013-2014 fiscal year. There were 686 participants that completed the program and 619 (90%) of which attended 75% or more of the program sessions (Table 1). Of the 686 that completed the program, 337 were presented the MAD curriculum and 349 were presented the MPC curriculum.

**Table 1. Program Participants by Curriculum: Adolescent Health Pregnancy Prevention Project 2013-2014**

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	Number of Students		
	Attended at Least 1 Session	Completed the Program	Attended at Least 75% of Program Sessions
MAD	338	337	310
MPC	350	349	309
<b>TOTAL</b>	<b>688</b>	<b>686</b>	<b>619</b>

Only 111 participants completed the Entry Survey. This was likely because of three reasons: due to sensitive questions, the Entry Survey was only offered to students in grades 9-12; most programs were underway before the Entry and Exit Surveys were approved at the Federal level; completing the Entry and Exit Surveys was voluntary.

# Adolescent Pregnancy Prevention Project 2013-2014

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Among those who completed the Entry Survey, 37.8% were male and 62.2% were female, exactly one-third were in 10<sup>th</sup> grade, one-third in 11<sup>th</sup> grade, and one-third in 12<sup>th</sup> grade. More than half of participants were White (51.3%), followed by Hispanics (24.3%), Multiple Races (12.6%), and Black (9.0%).

More than 500 program participants completed the Exit Survey, among which 43.0% were male and 57.0% were female. Seventh and eighth graders comprised the majority of participants at 29.9% and 41.9%, respectively. Whites comprised less than half of participants at 45.4%, followed by Native Americans (20.3%), Hispanics (14.2%), and Multiple Races (13.4%).

**Table 2. Demographic Characteristics of Participants: Adolescent Pregnancy Prevention Project 2013-2014**

Characteristic	Entry Survey		Exit Survey	
	n	%	n	%
<b>Gender</b>				
Boy	42	37.8	227	43.0
Girl	69	62.2	301	57.0
<b>Grade</b>				
6 <sup>th</sup>			15	2.8
7 <sup>th</sup>			158	29.9
8 <sup>th</sup>			221	41.9
9 <sup>th</sup>			14	2.6
10 <sup>th</sup>	37	33.3	36	6.8
11 <sup>th</sup>	37	33.3	44	8.3
12 <sup>th</sup>	37	33.3	40	7.6
<b>Race/Ethnicity</b>				
Asian/Pacific Islander	-	-	-	-
Black	10	9.0	32	6.1
Hispanic	27	24.3	74	14.2
Multiple Races	14	12.6	70	13.4
Native American	2	1.8	106	20.3
White	57	51.3	237	45.4
<b>*Total</b>	<b>111</b>	<b>100</b>	<b>528</b>	<b>100</b>

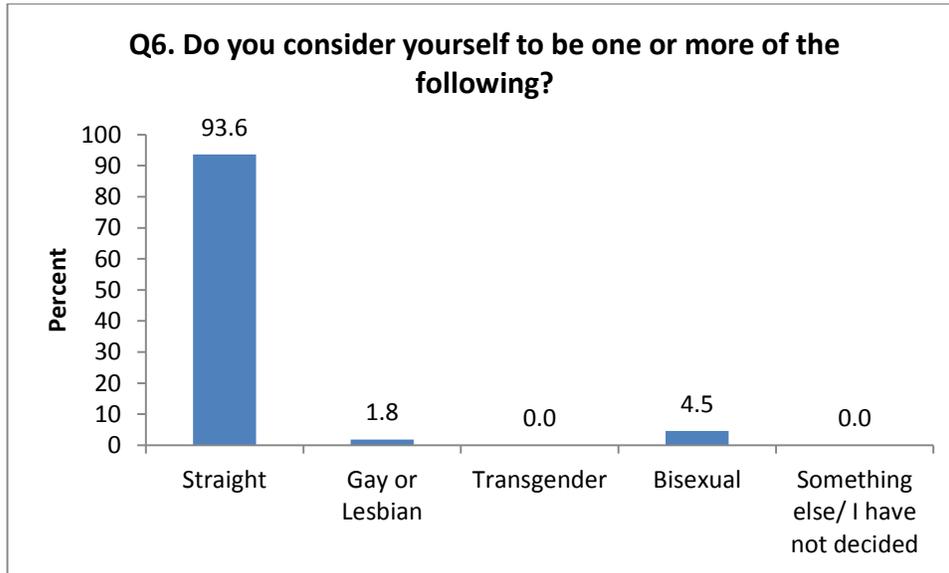
(-) Data not shown due to small numbers

\*Six records were missing for Race/Ethnicity on the Exit Survey

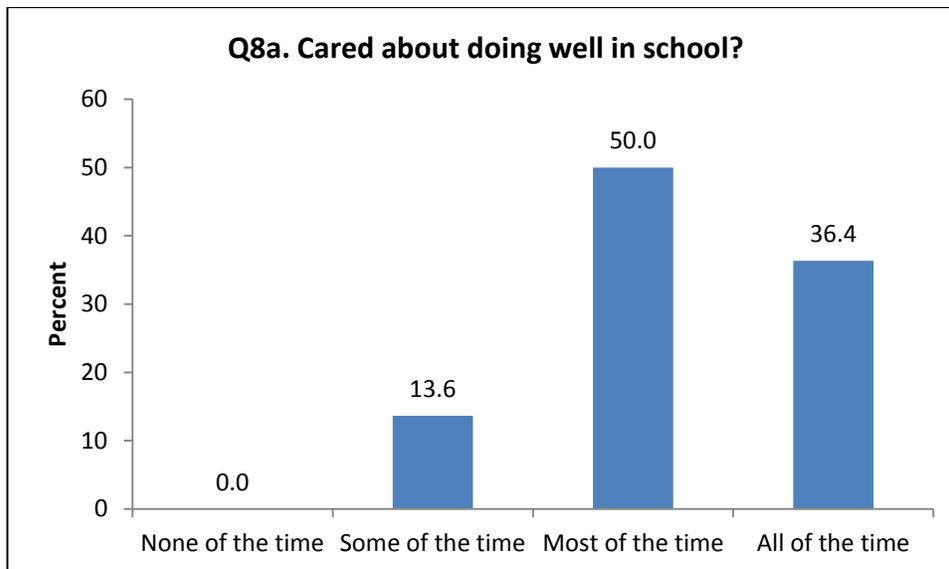
# Adolescent Pregnancy Prevention Project 2013-2014

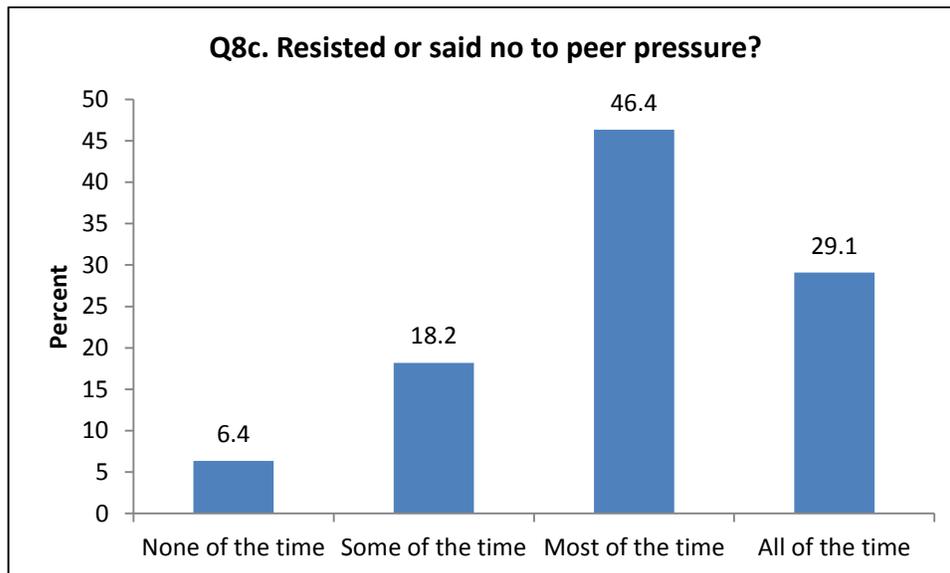
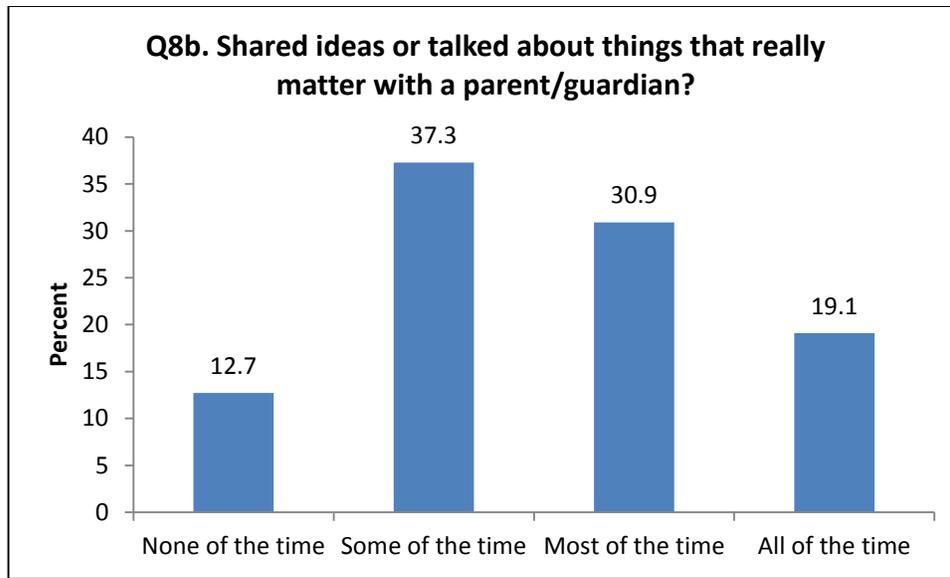
## RESULTS

The following results are from the Entry Survey. Percentages may not sum to 100% due to rounding. Results from questions 1-5 and 7 are presented in Table 1.



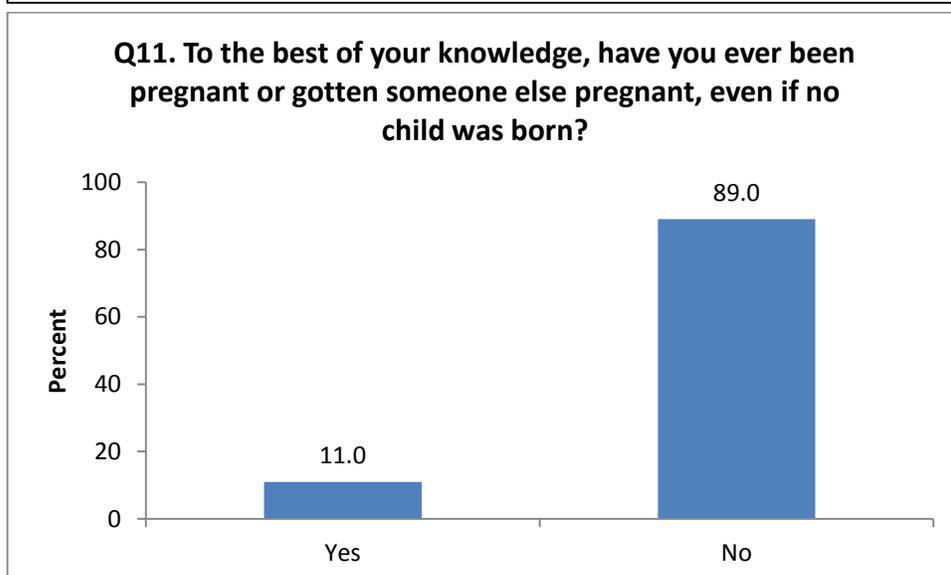
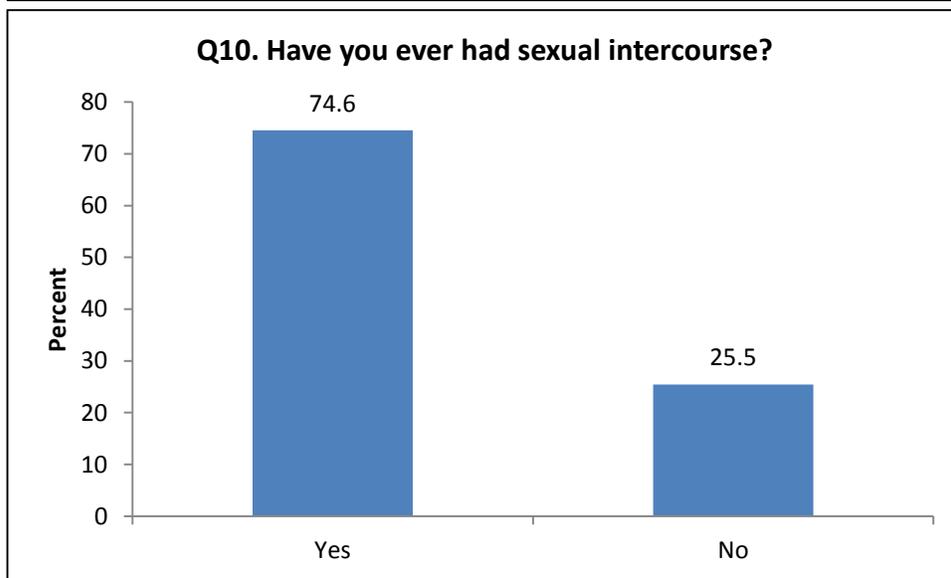
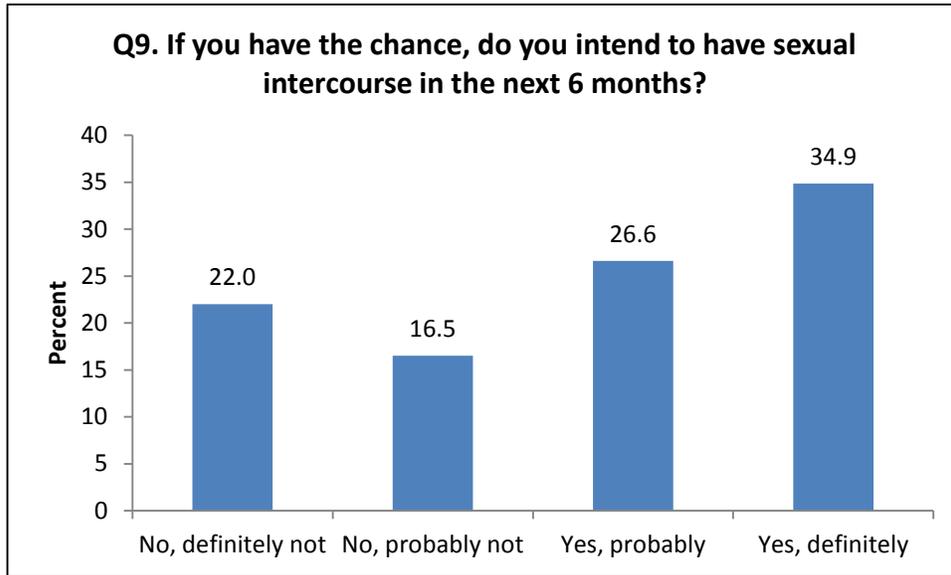
For questions 8a-8d: In the past three months, how often would you say you...

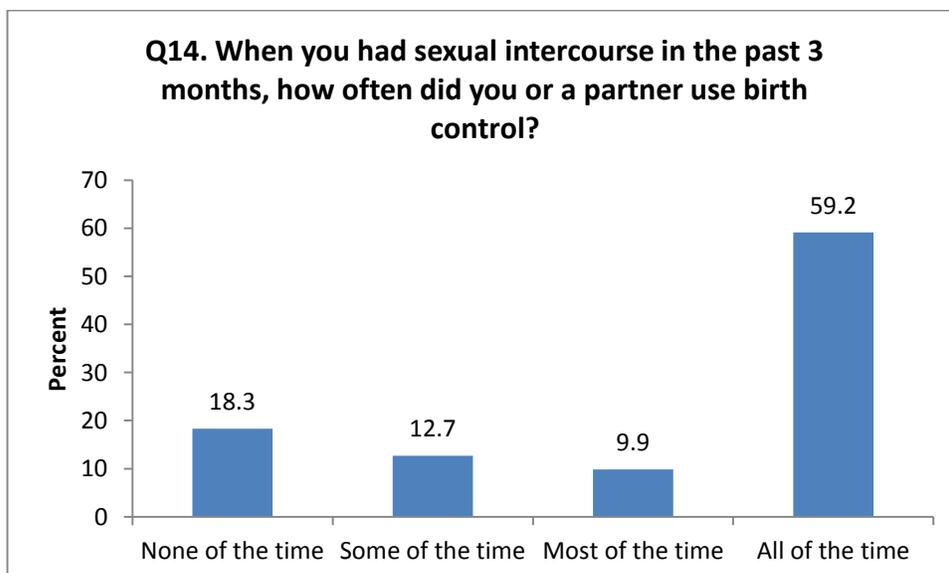
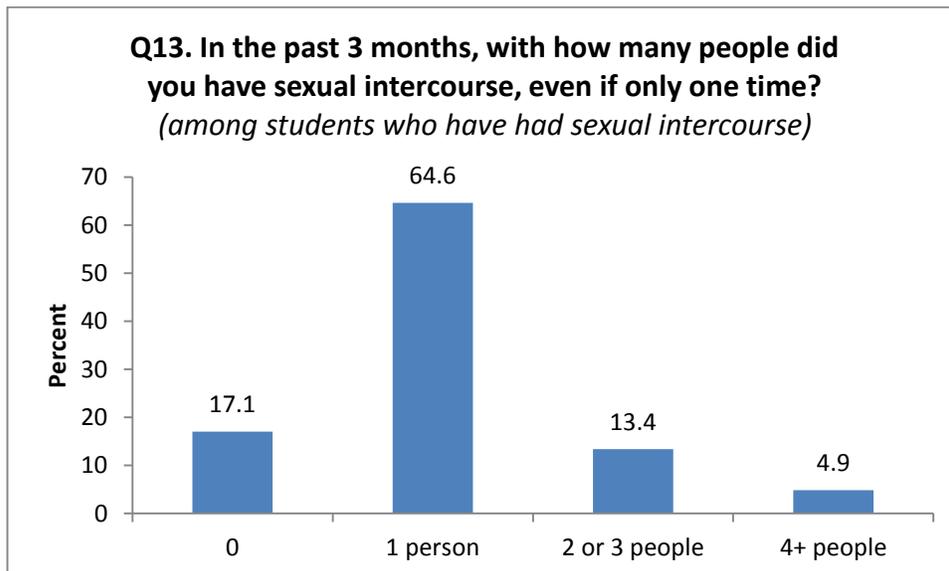
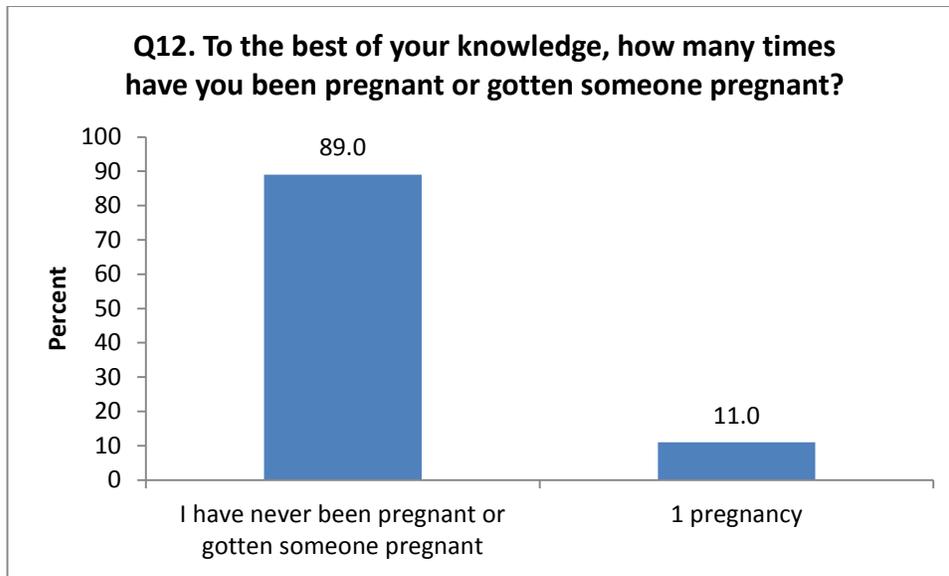


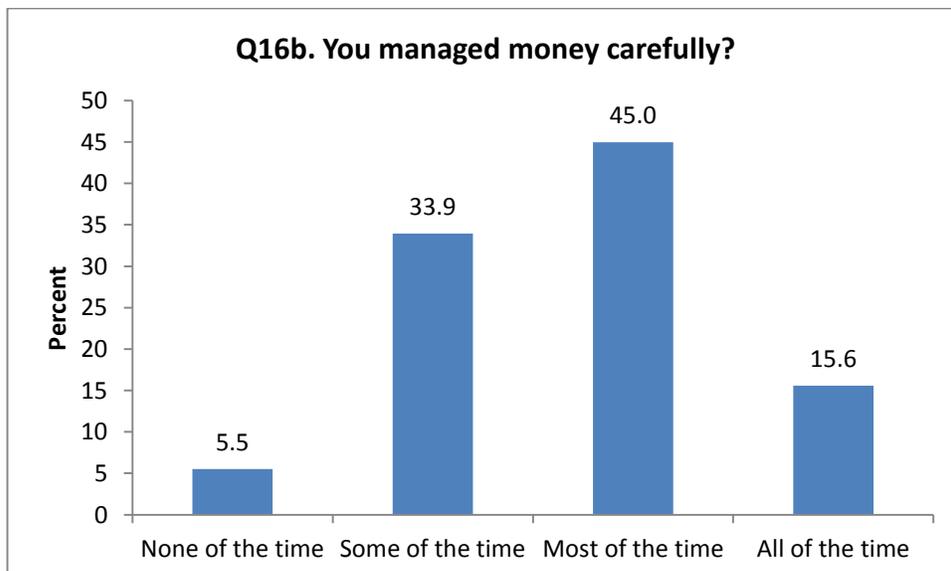
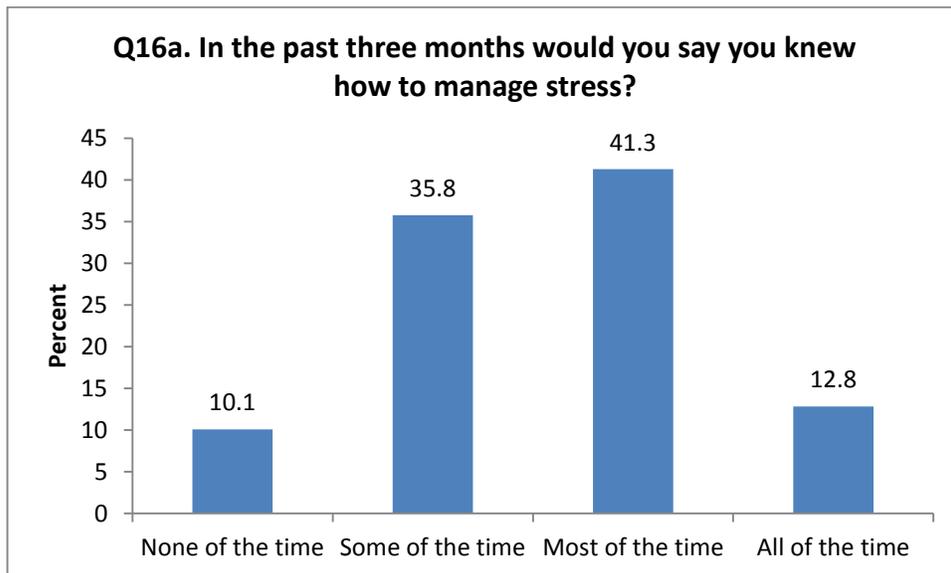
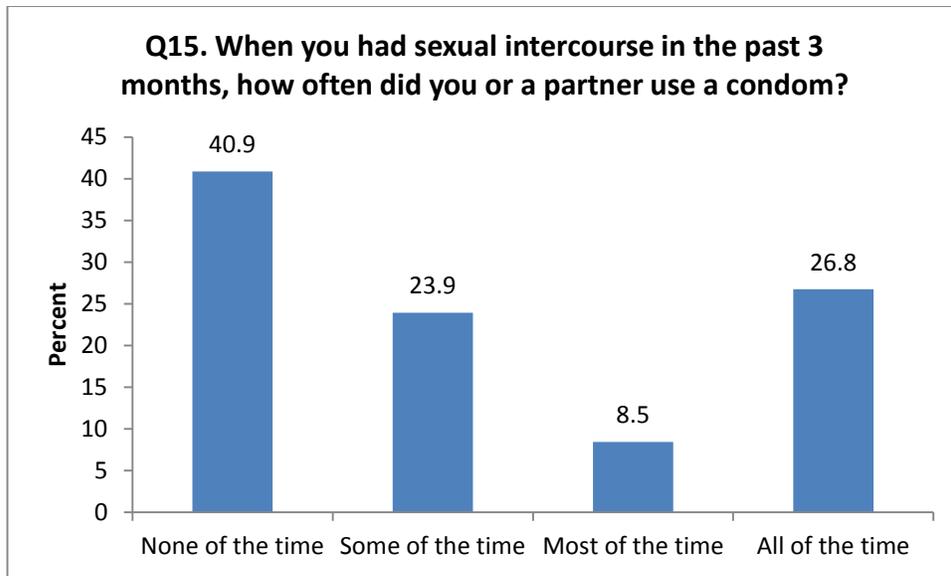


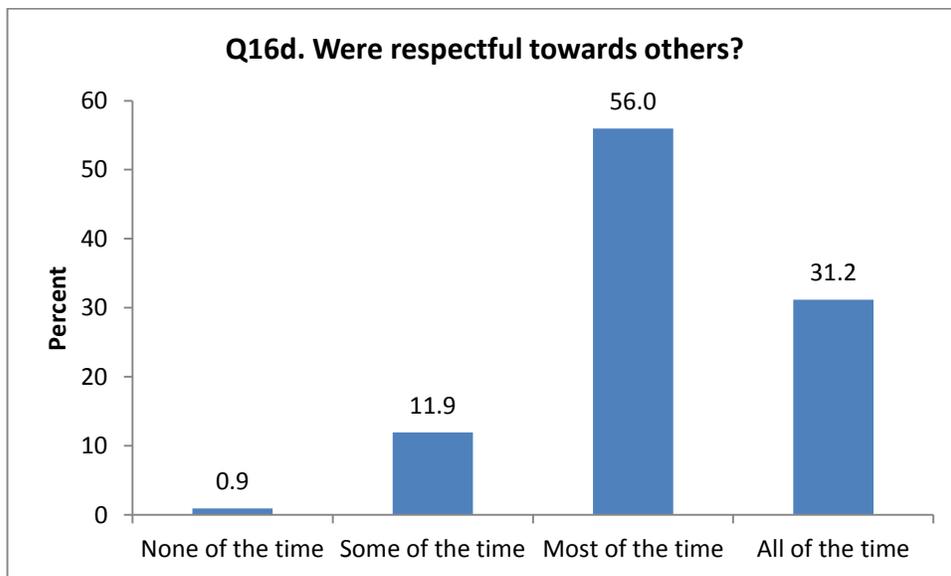
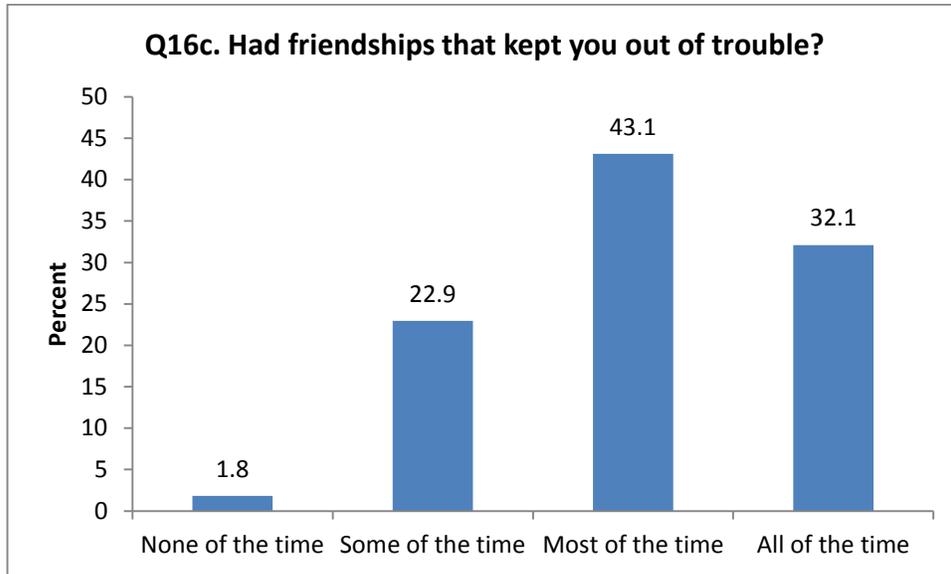
# Adolescent Pregnancy Prevention Project 2013-2014

The next questions ask about sexual intercourse and your risk of pregnancy and sexually transmitted diseases.





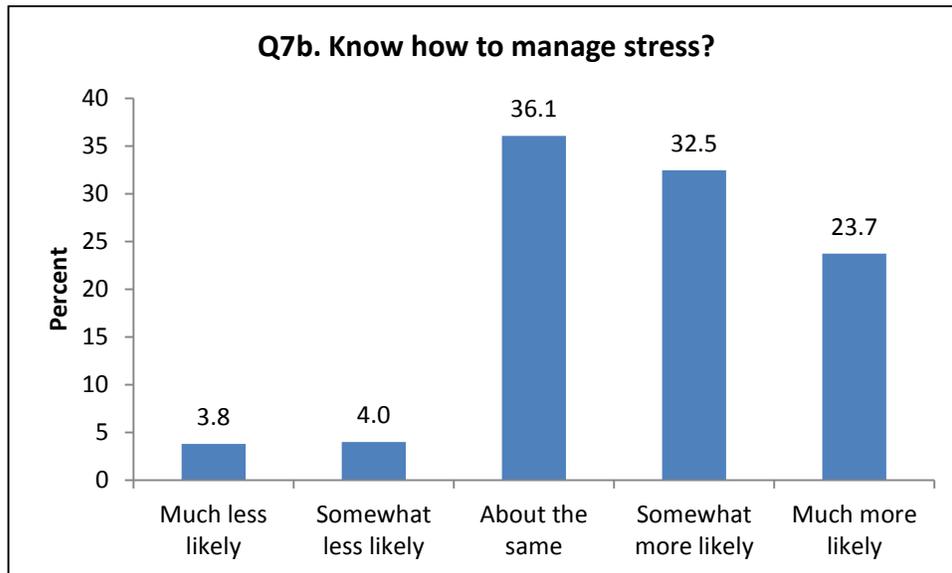
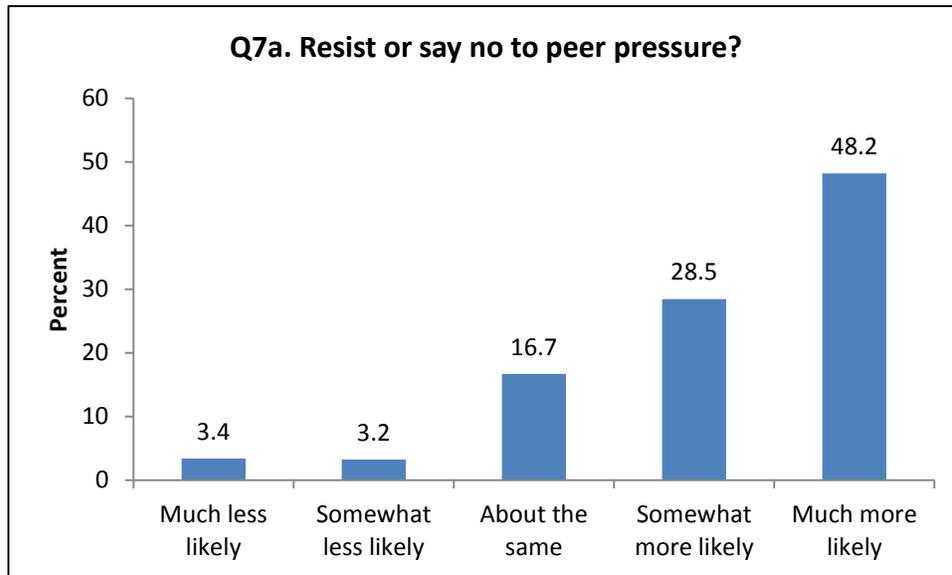


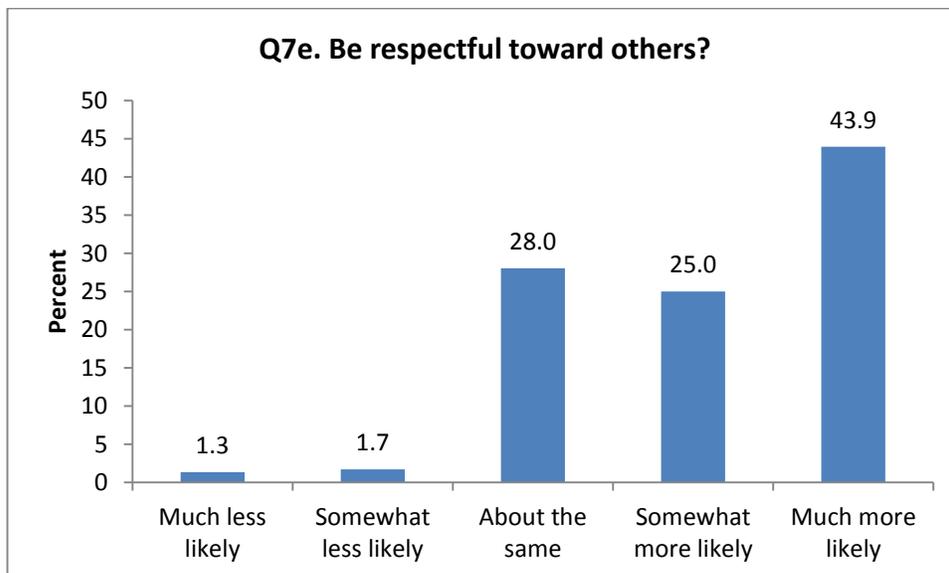
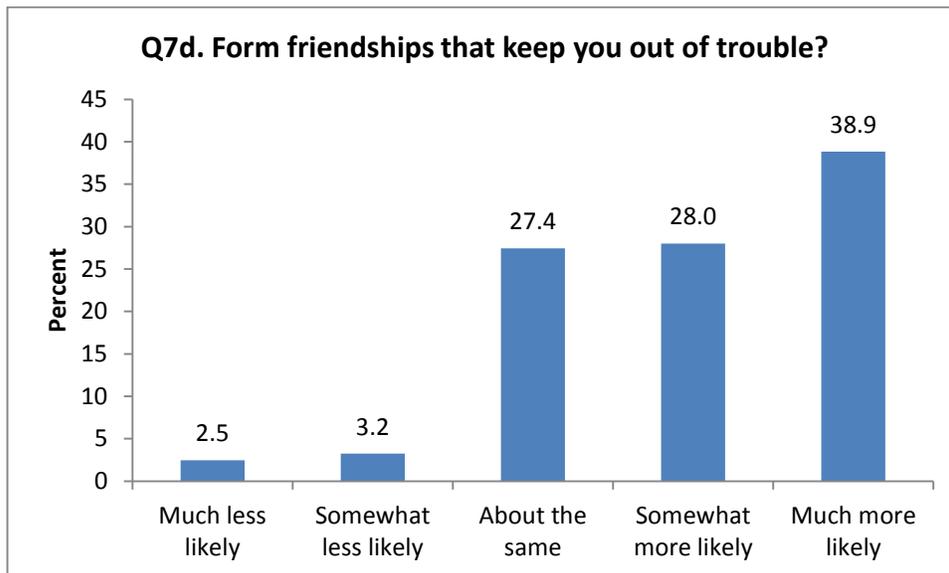
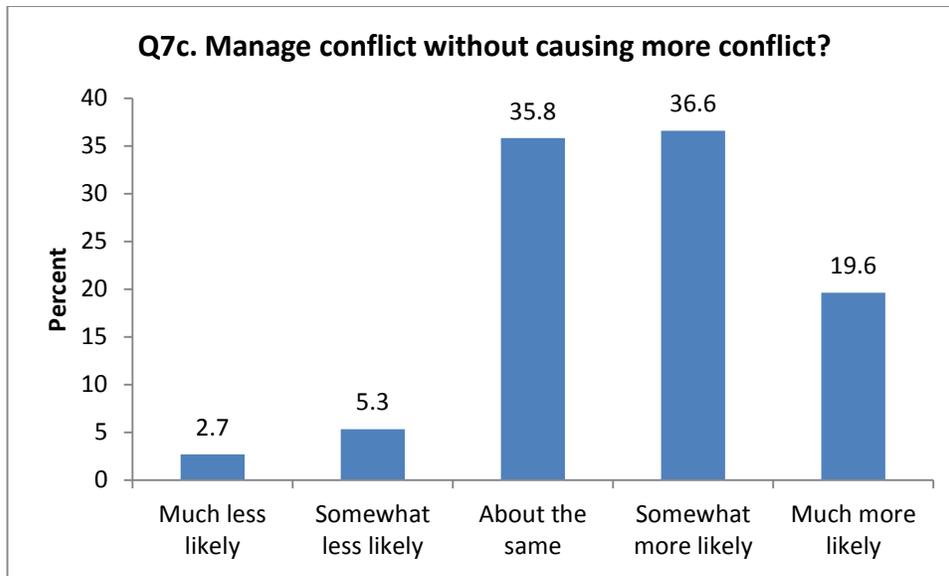


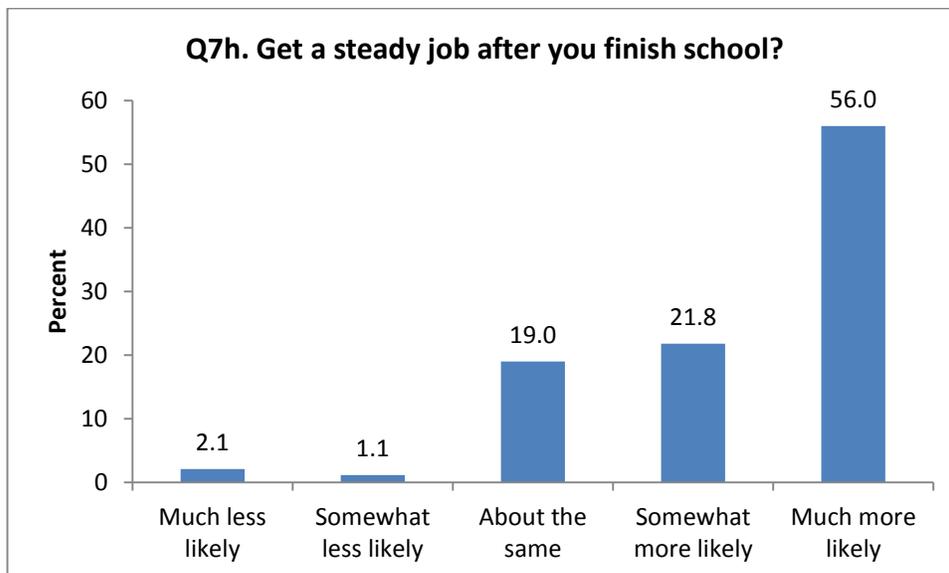
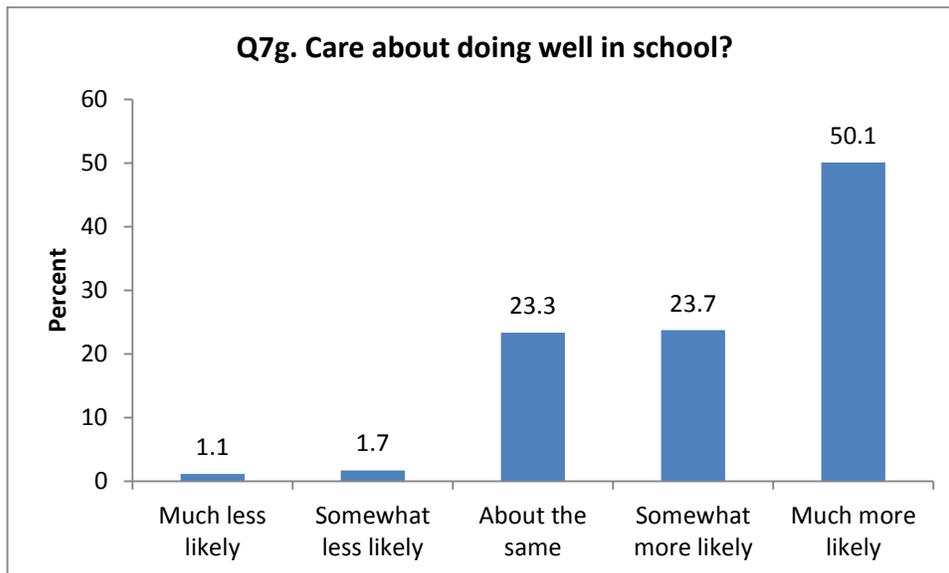
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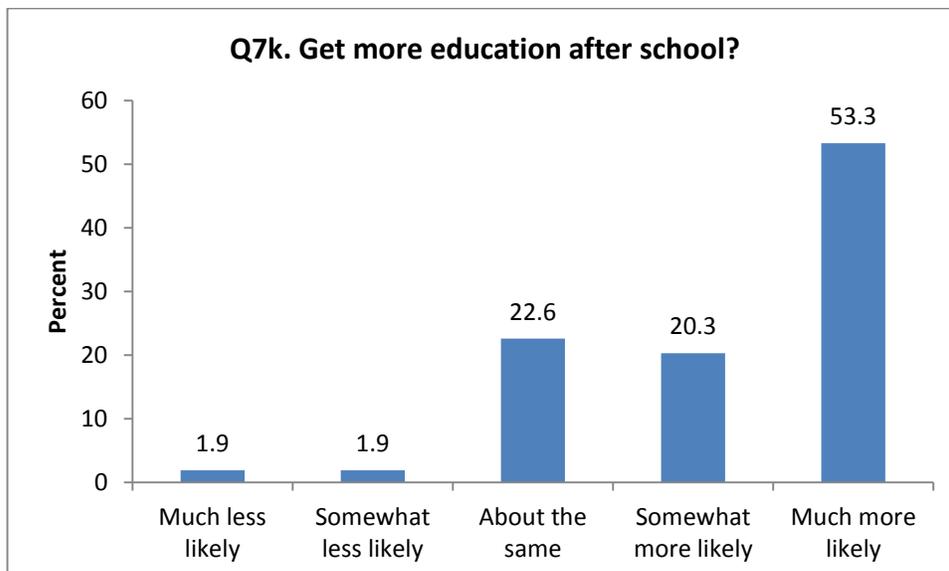
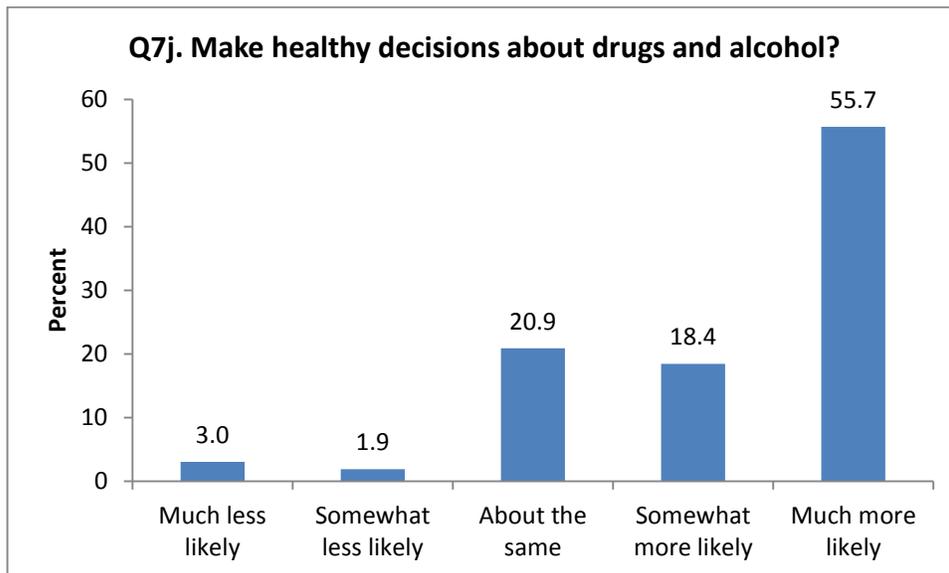
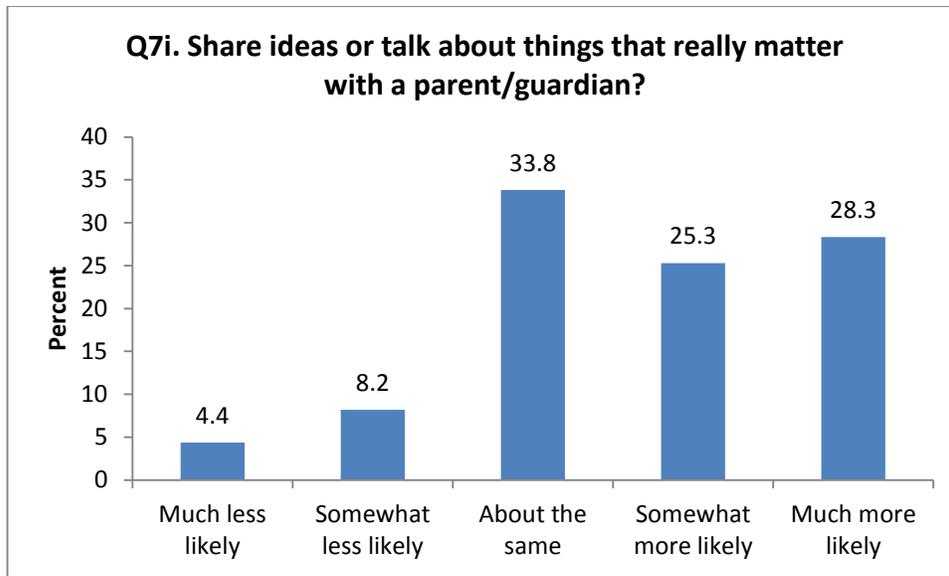
The following are the results from the Exit Survey. Percentages may not sum to 100% due to rounding.

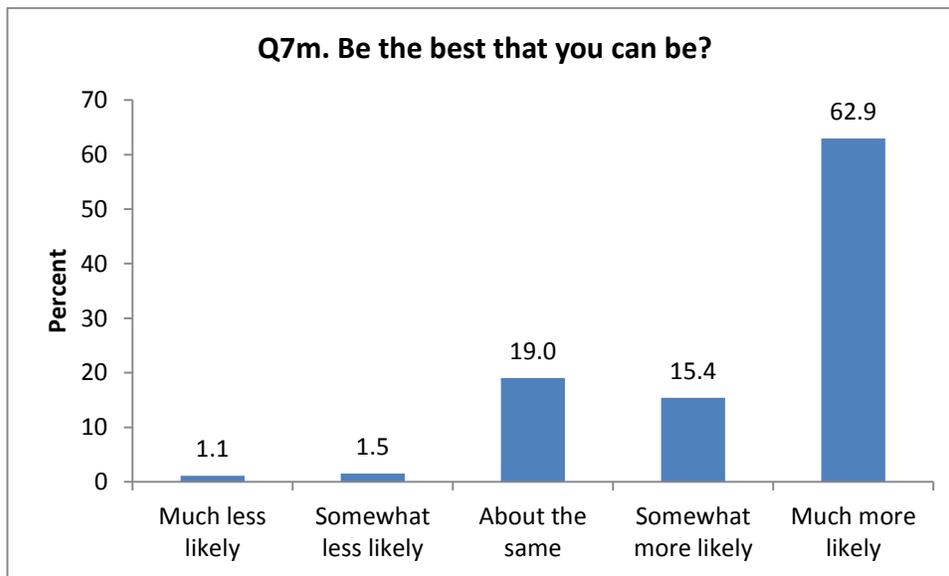
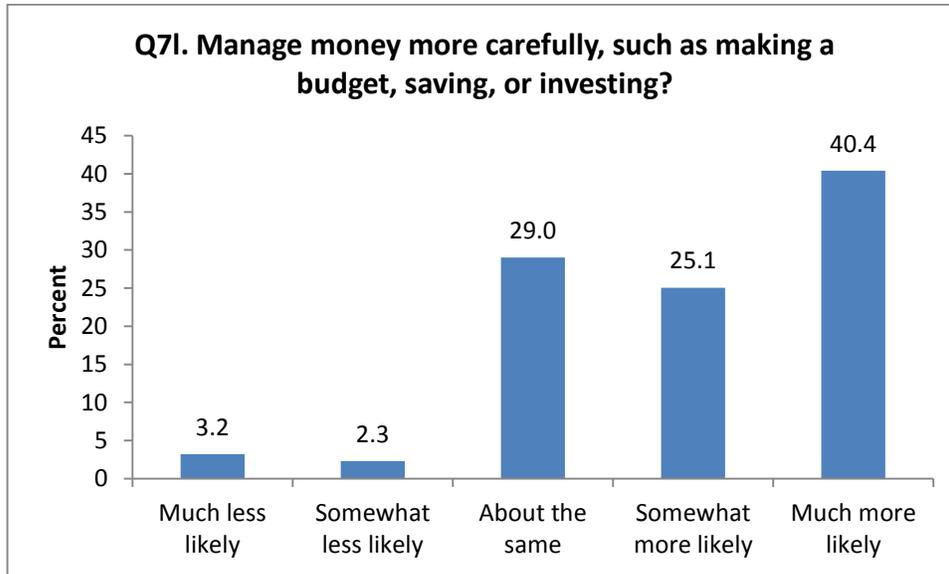
For questions 7a-7m: Please think about how the program that you just completed has affected you. Even if your program didn't cover a topic, would you say that being in the program has made you more likely, about the same, or less likely to...





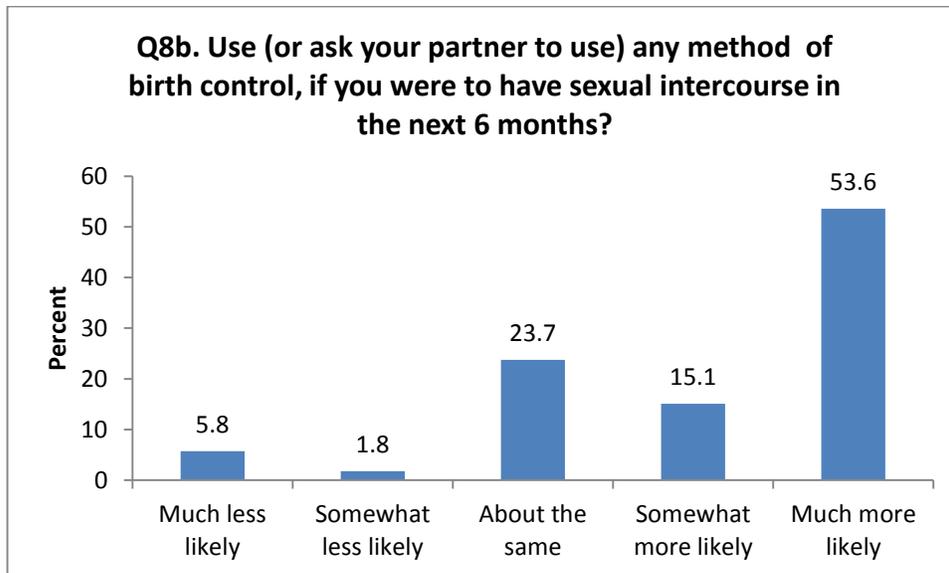
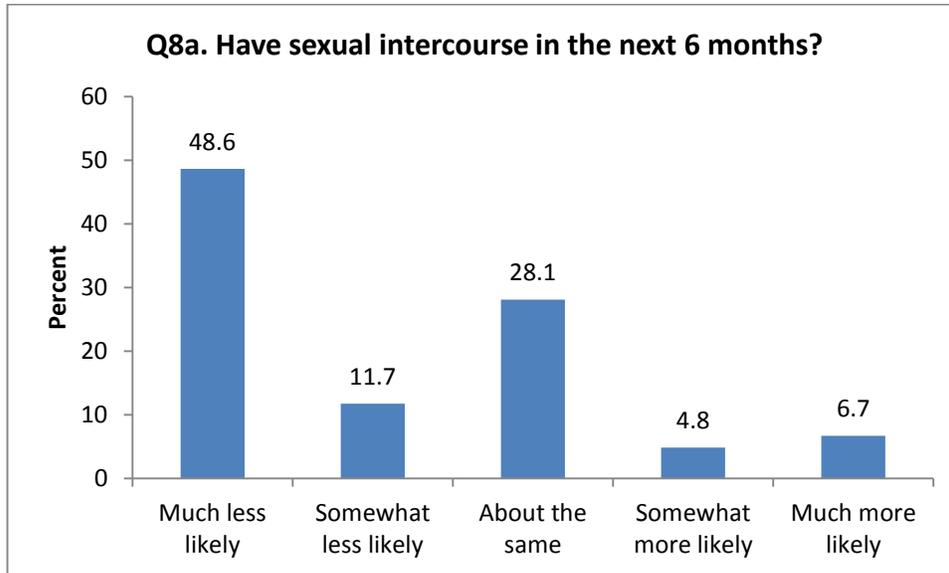


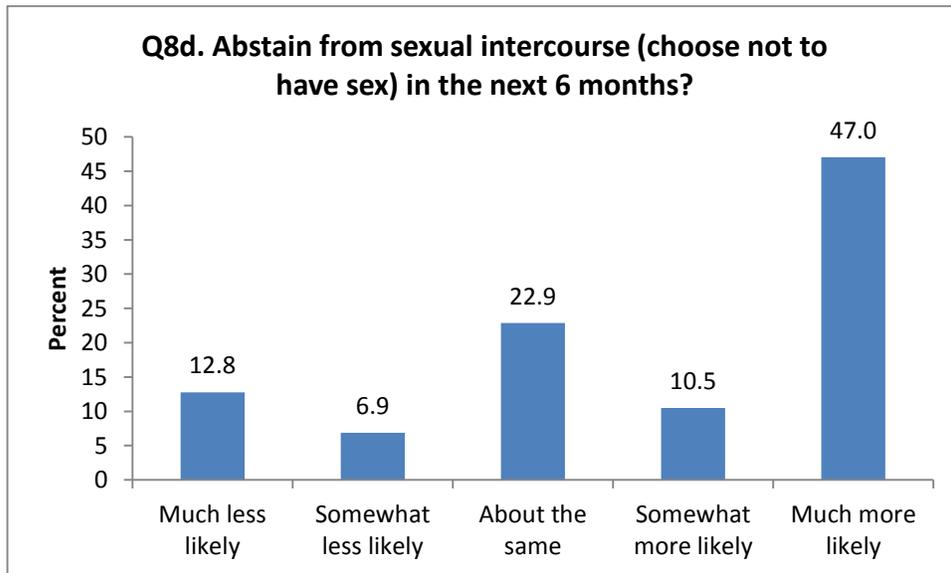
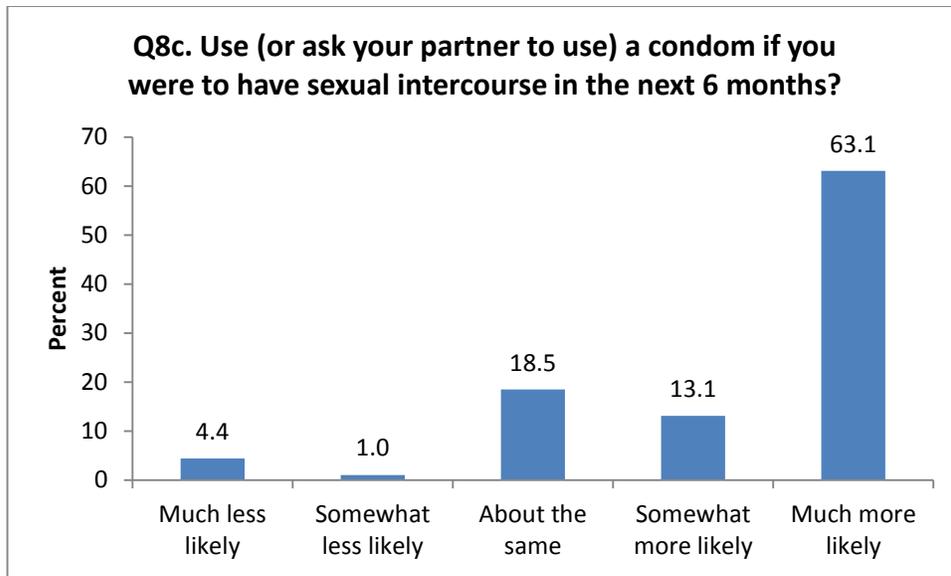




# Adolescent Pregnancy Prevention Project 2013-2014

For questions 8a-8d: The next few questions refer to sexual intercourse and your risk of pregnancy and sexually transmitted diseases. Please respond, even if you are not planning on having sex in the next 6 months. Would you say that being in the program has made you more likely, about the same, or less likely to...



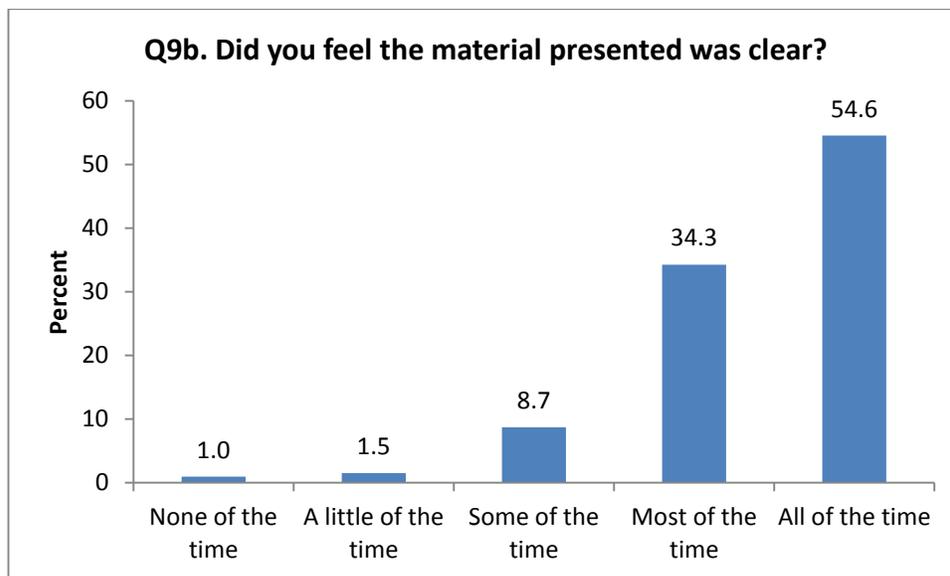
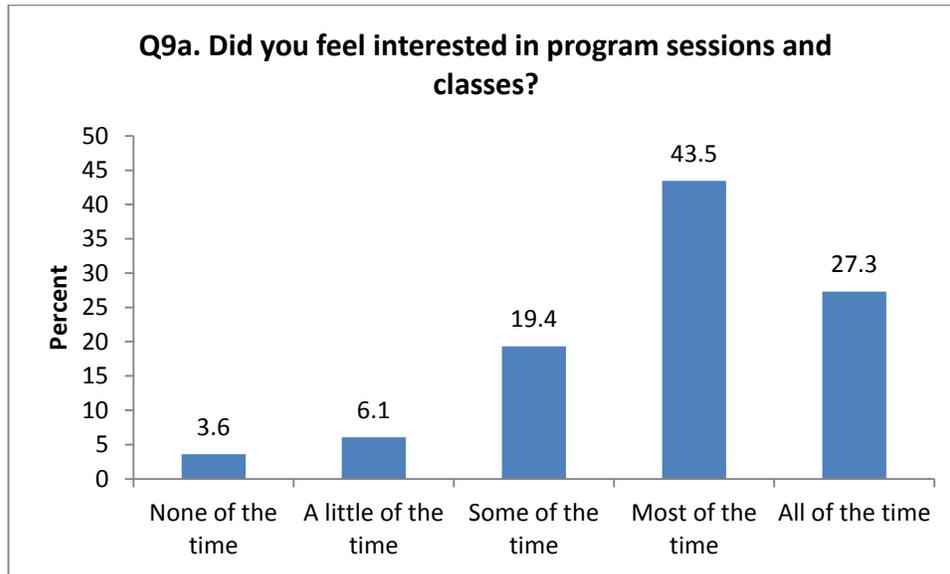


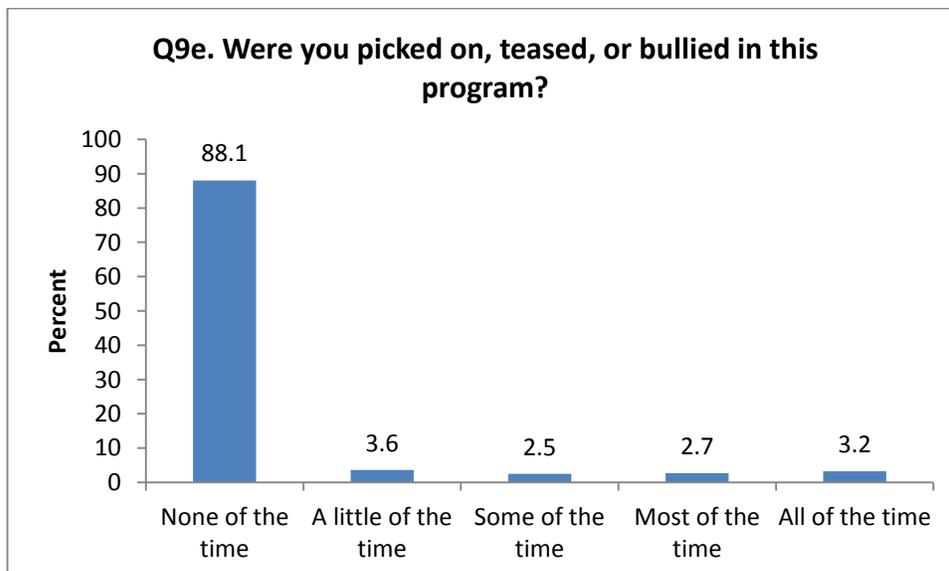
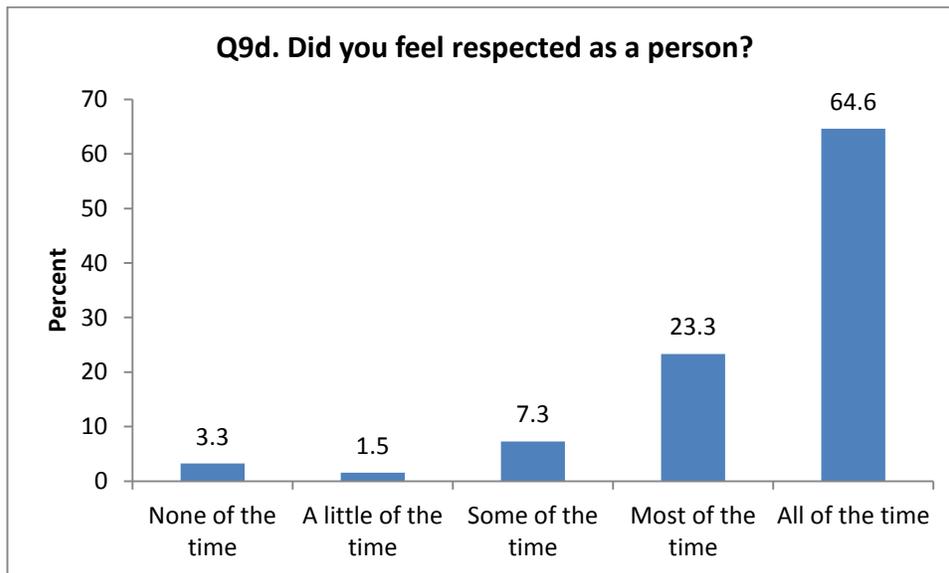
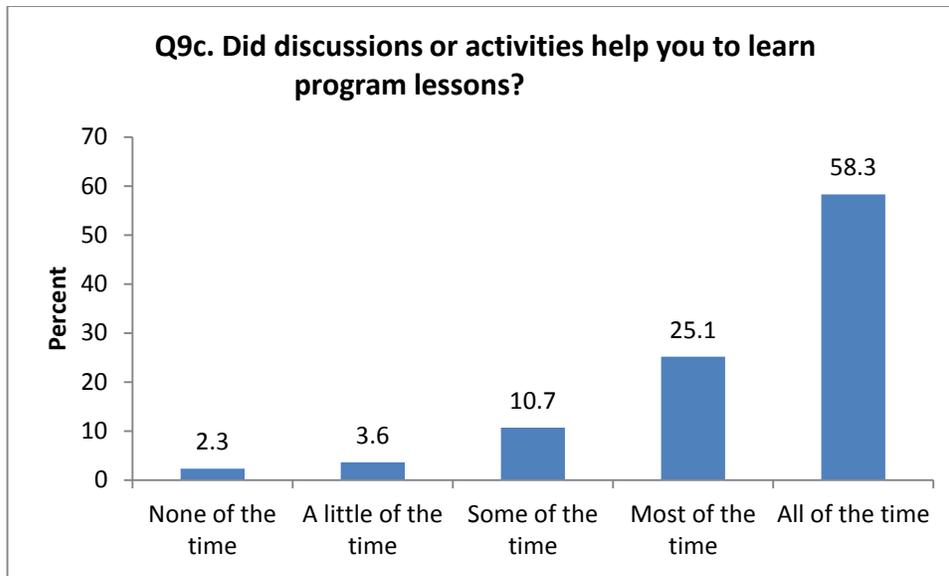
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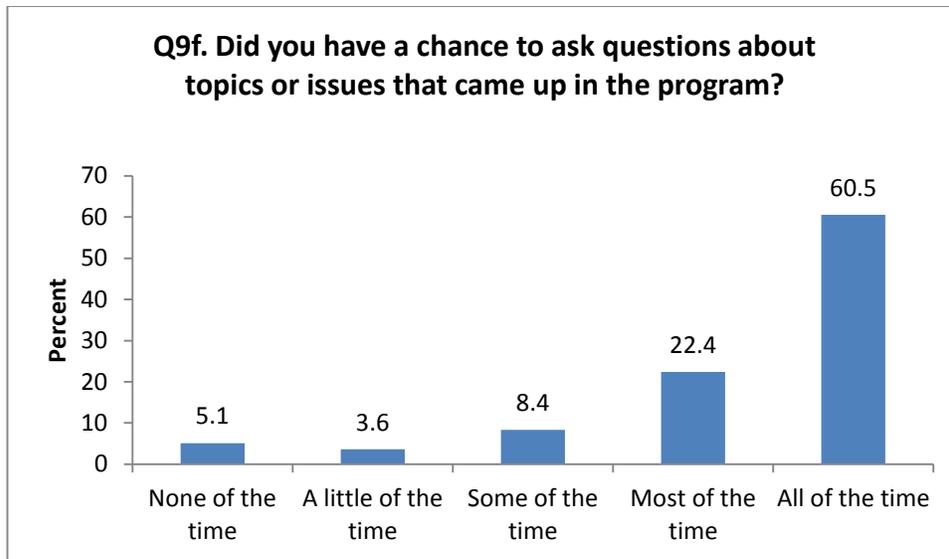
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For questions 9a-9f: The next questions ask you about your experiences in the program that you just completed. Think about all of the sessions or classes of the program that you attended.

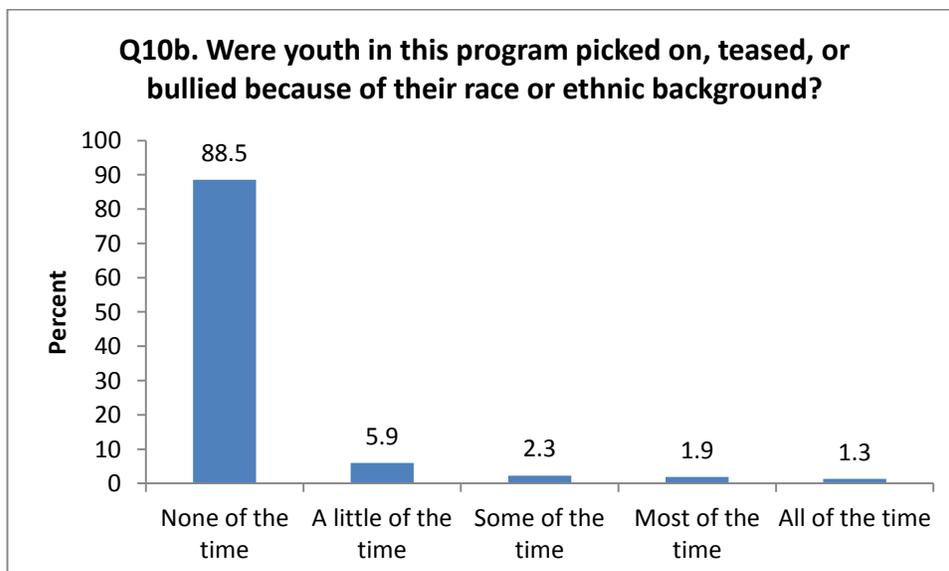
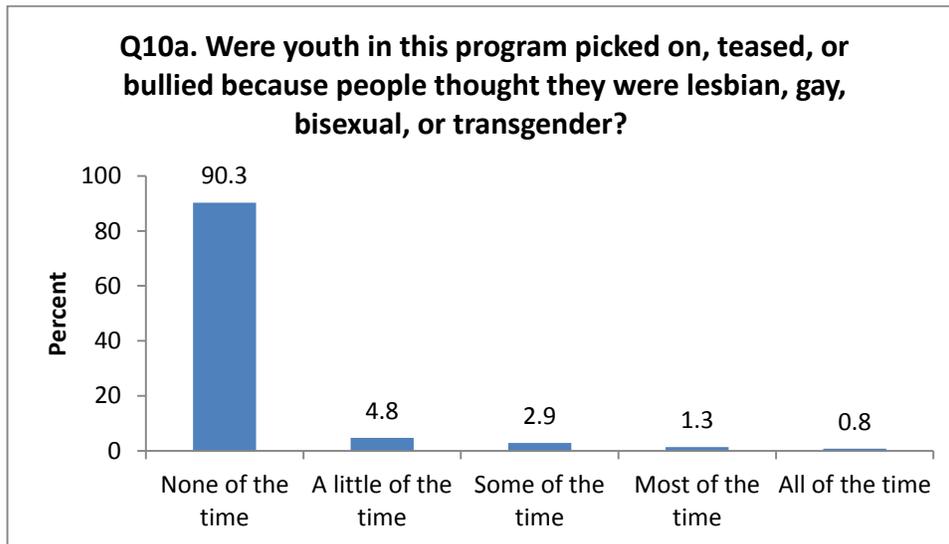
Even if you didn't attend all of the sessions or classes in this program, how often *in this program...*







*Now thinking about all youth in this program, how often...*



## **Limitations**

Data for this report come from participant responses to an Entry Survey prior to curriculum instruction and an Exit Survey after curriculum instruction. Participant responses in the Entry Survey are not linked to their responses in the Exit Survey. The results of this report are not intended to measure the efficacy of the curriculum implemented. No control or comparison groups were used; therefore, any changes noted in the results cannot be attributed conclusively to the curriculum instruction but instead only reflect change that took place over the implementation period based on self-reporting by the program participants. Conversely, lack of changes observed does not signify failure of the curriculum to produce intended results. Results cannot be generalized to broader Oklahoma school populations or to greater student populations within schools that received curriculum instruction. Additionally, despite measures taken to ensure the participants of confidentiality and anonymity, participants may report socially desirable behaviors or attitudes instead of actual behaviors or attitudes due to the presence of adults in the classroom or fear of having their responses known by others. It is also worth noting that in the Entry Survey, sexual intercourse is defined in several questions as “the act that makes babies.” Considering that a high percentage of youth self-identified as being gay or lesbian, these percentages may actually be higher if a more comprehensive definition of sexual intercourse is used (in the project curricula, sexual intercourse is defined as being oral, anal, or vaginal sex).

## **SUMMARY**

Oklahoma adolescent health programs should consider using this report during programmatic development and implementation. Although responses from the Entry and Exit Surveys cannot be linked, several noteworthy observations can be made. These observations may influence program direction and scope. One observation to consider, as reflected by the Entry Survey answers, is the need to address adolescent reproductive and sexual health issues even prior to this type of project implementation. Another consideration, as reflected by the Exit Survey answers, is the need to further explore and promote comprehensive reproductive health

education's positive effect on adolescent behavior and intention. A final consideration is how to address effectively those responses from both the Entry and Exit Surveys that would benefit from additional topic coverage.

In looking at Entry Survey answers, certain adolescent reproductive and sexual health issues may need to be addressed prior to this type of project implementation. Less than two percent (1.8) of the Entry Survey respondents identified as being gay or lesbian and 4.5% identified as being bisexual. These populations may need a different approach for project buy-in than just teen pregnancy prevention. Highlighting risks that result in increased STDs and HIV, as well as pointing out that the LGBTQ (lesbian, gay, bisexual, transgender, and questioning) community and same-sex couples face many of the same issues, may be a better way to address the needs of these adolescents and to get them involved. These young people need many of the same tools as those adolescents that identify as being heterosexual such as healthy communication and how to resist peer pressure.

Another issue that may need addressing as indicated by the Entry Survey answers is parent-child communication. Research shows that a strong parent-child communication relationship helps decrease risk-taking behaviors in youth. However, only half of respondents on the Entry Survey reported that they shared ideas or talked most or all of the time about things that really mattered with a parent or guardian.

Nearly 62% of adolescents taking the Entry Survey said they intended to have sex in the next 6 months. Moreover, almost 75% reported already having sexual intercourse. This percentage is higher than the 50% reported from the 2013 Oklahoma Youth Risk Behavior Survey (YRBS) of high school students for the same question. Among students who reported ever having sex on the Entry Survey, nearly 83% reported having had sex with at least one person or more in the last 3 months. Although the results from this project are not generalizable, these percentages

highlight the need for addressing reproductive health issues early and often, particularly since Oklahoma does not provide comprehensive health education.

Another observation from the Entry Surveys to consider is the use of birth control among adolescents. Slightly more than 59% of students reported that in the past 3 months they or their partner used some form of birth control (birth control pills, condoms, the shot, the patch, the ring, IUD, or implant) all of the time. However, in the next question, only 27% of students reported that in the past 3 months they or their partner used a condom all of the time. This could mean that students who are sexually active may be protecting themselves from pregnancy (by using hormonal or Long Acting Reversible Contraceptive methods) but not from STDs and HIV (since they are not using condoms at a higher percentage). This gap in method use can be addressed through additional education. Moreover, considering the high number of students that self-identified as gay or lesbian on the Entry Survey, promoting the use of a barrier method to prevent STDs and HIV is important and likely more relevant for this population (even taking into account that more females completed the Entry Survey than did males).

In reviewing at Exit Survey answers, there appears to be a need to further explore and promote comprehensive reproductive health education's positive effect on adolescent behaviors and intentions. Students reported on the Exit Survey that the program they completed made them more likely to resist or say no to peer pressure, to make healthy decisions about drugs and alcohol, to form friendships that keep them out of trouble, to care about doing well in school, and to make plans to reach their goals. All of these indicators help to reduce risk-taking behaviors. However, while almost 54% of students reported they were more likely to share ideas or talk about things that really mattered with a parent or guardian after completing the program, another almost 34% reported that this was about the same as before the program began. This again may point out the need for more activities, such as trainings, workshops, and outreach, regarding parent-child communication.

## Adolescent Pregnancy Prevention Project 2013-2014

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There were some risk-reducing intentions reported by students on the Exit Survey in terms of sexual intercourse and risk of pregnancy and STDs. After completing the program, approximately 60% of students reported they were less likely to have sexual intercourse in the next 6 months. Additionally, almost 69% reported being more likely in the next 6 months to use or ask their partner to use birth control and 76% of students were more likely to use or ask their partner to use a condom.

Yet, almost 24% and 19% of students, respectively, stated that going through the program made them about the same in terms of using or asking a partner to use birth control or use condoms. There is no way to quantify what “about the same” means to each student (i.e. some may be using birth control or condoms with every act and plan to continue while others may not be using it at all and plan to continue not using anything). Therefore, this could potentially create a gap for Adolescent Health Specialists and other professionals that facilitate the curricula in knowing how to present needed information regarding birth control use and communication with partners. Following program fidelity will help to prevent this being an issue.

A final consideration is how to address effectively those responses from both the Entry and Exit Surveys that would benefit from additional topic coverage. One way to do this may be through specific adulthood preparation topics presented prior to program implementation. The curricula used in this project all have incorporated in them at least three of the six adulthood preparation topics. However, more time may be needed to review with administrators and parents the available options and to tailor the content to that particular adolescent population. Several of the issues discussed previously could fit within the topics of healthy relationships, adolescent development, parent-child communication, or healthy life skills. Financial literacy and educational and career success are the only two adolescent preparation topics that do not readily appear to be a natural fit for the issues brought up in the Entry and Exit Surveys.

## Adolescent Pregnancy Prevention Project 2013-2014

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Another way to address the types of topics identified in the Entry and Exit Surveys would be through a different delivery means. Parent-child communication was an issue on both surveys. This topic might be addressed through community or school presentations or activities surrounding national observances (such as Let's Talk Month in October, National Teen Pregnancy Prevention Month in May, or STI Awareness Month in April). Adolescent health programs could also partner more closely with schools or other community organizations to provide ongoing trainings, workshops, and awareness events (such as media releases, community chats, and essay and art competitions for youth) around these issues within Oklahoma communities.

The findings of this analysis, along with previous research in adolescent pregnancy prevention and adolescent reproductive health, can help shape programmatic direction in Oklahoma. Adolescent Health Specialists and other professionals that facilitate the curricula must continue to work to ensure that the environments they create are safe for all students. Furthermore, Adolescent Health Specialists can use these findings to guide presentation of their adulthood preparation subjects, time allotment on specific areas, and target additional content areas needing coverage within certain Oklahoma adolescent communities.