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Preventing Early Sexual Intercourse and Teenage Pregnancy - A Review of Recent Effectiveness Research

Blerta Peçi, University of Tirana
PhD. Cand in Psychology, Faculty of Social Science, Department of Psychology and Education, Albania.
Corresponding author email id: blerta-p@hotmail.com

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***Abstract* – Reviews of international policies indicate that crisis pregnancies and sexually transmitted infections can be prevented. There are three broad approaches to promoting positive sexual health and preventing pregnancy and STIs. The following sections provide an overview of the research evidence of the effectiveness of different strategies aimed at preventing unintended pregnancy and promoting positive sexual health. The first part of this section provides an overview of approaches to sex education and presents the current evidence of their effectiveness in preventing pregnancy and promoting sexual health. The second part of the section presents an overview of contraceptive counselling and service delivery and presents the current research knowledge of these services in reducing unintended teenage pregnancy and sexually transmitted infections.**

This paper has summarised the most up-to-date knowledge on the effectiveness of educational approaches aimed at preventing teenage pregnancy and/or promoting sexual health among adolescents. The evidence is mixed. Programmes which focus on the issues of sexuality and contraception have demonstrated some effectiveness in delaying sexual intercourse and in improving the use of protection/birth control. Programmes that focus on antecedents that indirectly impact on sexual health outcomes, such as poor educational attainment, have also demonstrated positive effects on teenage sexual behaviour and teenage pregnancy. Programmes that combine sexuality education and youth development have provided very strong evidence of a reduction of teenage pregnancy. These findings support our increasing knowledge about the antecedents of teenage sexual behaviour and teenage pregnancy.

***Keywords* – Teenage Pregnancy, Early Sexual Intercourse, Health, Adolescent.**

I. INTRODUCTION

Preventing Teenage Pregnancy and Promoting Positive Sexual Health.

Approaches to Prevention

Reviews of international policies indicate that crisis pregnancies and sexually transmitted infections can be prevented. There are three broad approaches to promoting positive sexual health and preventing pregnancy and STIs, which include:

1. The provision of sex education in order to:
   - provide skills and confidence to form and maintain respectful relationships
   - provide information and skills to encourage delay in initiation of sexual activity
   - provide information and skills to encourage protected sexual activity
   - increase knowledge of contraceptive use and availability of contraceptive services
   - increase awareness and understanding of post-coital contraception.
2. The provision of contraceptive services and counselling to:
   - increase contraceptive use and compliance
   - increase use of post-coital contraception in case of contraceptive failure or unprotected sex.
3. Good general education/vocational programmes:
   - to increase aspirations and expectations from the future (thus avoid early parenthood)
   - as a motivation to avoid risk behaviour.

The following sections provide an overview of the research evidence of the effectiveness of different strategies aimed at preventing unintended pregnancy and promoting positive sexual health. The first part of this section provides an overview of approaches to sex education and presents the current evidence of their effectiveness in preventing pregnancy and promoting sexual health. The second part of the section presents an overview of contraceptive counselling and service delivery and presents the current research knowledge of these services in reducing unintended teenage pregnancy and sexually transmitted infections.

Evidence of Effectiveness

Evaluating Prevention Programmes

Over the last two decades the evaluation of sexual health promotion programmes has been plagued by a number of methodological and logistical challenges. One of the major obstacles in the evaluation of programmes is the absence of clear and measurable objectives (Hayes 1987, Smith and Gorry 1980, Moore et al. 1995). The usefulness of an evaluation is dependent on the meaningfulness of the outcome measures selected to establish effectiveness. For example, outcome measures of sex education programmes can range from changes in knowledge, attitudes and values to measures of behavioural change including initiation of sexual activity and pregnancy rates. Over the last decade there has been some debate about the usefulness of judging the effectiveness of sex education programmes solely in terms of behavioural outcomes (British Medical Association (BMA) Foundation for AIDS 1996). The aims of sex education are often ambitious, relating to lifelong quality of relationships, as well as pregnancy and STI prevention.

Evaluation Research Designs

The term evaluation covers a number of designs that aim to describe the processes and/or outcomes of a given programme/service. Process evaluation refers to the ways in which the programme or service is delivered. Outcome or impact evaluations are designed to generate answers about the effectiveness of particular interventions in

changing specific outcomes. In outcome evaluation, the randomised controlled trial (RCT) is often considered to be the most rigorous research method for evaluating the effectiveness of a given programme. Using the RCT, individuals/groups have an equal and known chance of receiving the programme. The random allocation to either the programme or control aims to overcome the possible contribution of the range of outside influences (such as exposure to media), which might contribute to any observed differences. As the previous chapters have highlighted, a number of external social factors influence decisions about sexual activity. Using the randomised control design, the researcher acknowledges that these outside influences cannot be controlled or eliminated, but as both the programme group and control group will experience the same background influences[4] any observed differences between the two groups after the programme can be attributed to the programme.

A number of reviews have commented on the difficulties in evaluating prevention programmes. (Kirby 2002, DuCette 1989). One review (Stahler 1991) has outlined the key barriers to programme evaluation which include:

Cost – Rigorously controlled impact studies using comparison or control groups are relatively expensive.

Staffing - One is an issue of the competency of the individuals carrying out the evaluation and the second is the relationship that develops between the evaluators and the implementers.

Time - Usually too little time is allowed between the programme and the follow-up evaluation.

Data collection - The process of compiling complete and accurate data is difficult. The project must also be sure that it is collecting data on all factors that may be affecting the outcomes to be measured.

Establishing control groups - Random assignment is the best method to ensure comparability between groups; however, such assignment is not always possible.

An additional factor omitted from this list is the difficulty in measuring the impact of programmes on outcomes which have low incidence within the research population e.g. pregnancy among under sixteen year olds is quite low. A large sample size is required in order to have sufficient power to identify statistical differences. A number of researchers have therefore chosen to use proxy measures such as time of initiation of intercourse, contraceptive use or number of sexual partners rather than short-term changes in pregnancy rates as indicators of success.

II. Conceptual Basis

Sexual health promotion programmes - what works?

The search identified twenty reviews of research in the area of teenage pregnancy and sexual health promotion, of which five were considered to be relevant and of high quality (Peersman et al. 1996, NHS Centre for Reviews and Dissemination 1997, Kirby 2001, Dicenso et al. 2002, Swann et al. 2003). An additional five reviews, although not systematic, were also included as important source material [Collins et al. 2002, UNICEF 2001, Kirby & Coyle 1997, Kirby 2002, Grunseit 1997].

One of the reviews (Dicenso et al. 2002) adopted very strict criteria for the inclusion of evaluation studies. Studies that did not use randomisation in the study design were excluded from the review. This meant that studies that included control or comparison groups and had long-term follow-up but did not use randomisation (to decide who received the programme) were omitted from the review. However, despite the strict inclusion criteria adopted by DiCenso et al., included studies were not rated by sample size and/or follow-up period, which resulted in findings from studies with small sample size and short follow-up receiving equal weight to large-scale studies with substantial follow-up. A further limitation of the DiCenso review was the exclusion of studies that only measured condom use. These exclusion criteria meant that a large number of evaluations of the most theoretically advanced and behaviourally effective adolescent health education programmes were not included in their final analysis.

The remaining reviews (NHS Centre for Reviews and Dissemination 1997, Kirby 2001, Swann et al. 2003) acknowledge the strength of the evidence from well designed studies that include randomisation (Level 1), but also include the findings from non-random evaluations that include comparison/control groups, applying caveats where necessary. It is the view of the author that a pragmatic approach is necessary in the appraisal of evaluative studies, which incorporates the findings from both process (generally qualitative research) and outcomes (behavioural changes).

These reviews, together with additional searches, identified more than fifty evaluations of programmes aimed at preventing teenage pregnancy or promoting positive sexual health among young people. The key features of the evaluations are summarised in Appendix 2. The majority of the evaluations of educational approaches to prevent teenage pregnancy have been conducted in the USA, and are principally comparisons of new methods of delivering sex education and those programmes that are routinely provided.

III. Empirical Basis

Approaches to school-based sex education

Sex education is an essential part of any sexual health promotion strategy. The NATSAL survey indicates that young people learn about sex from a range of sources including parents and family, school, friends, media and health professionals. Parents and school have been found to be important sources of sex education for young people if poor sexual outcomes are to be prevented.

Colllins and colleagues (2002) have grouped approaches to sex education into two categories: abstinence-only programmes and comprehensive sex education (or Abstinence-Plus Programmes).

School-based Education with Parental Involvement

A small number of programmes have attempted to involve parents in school-based sex education, with

different degrees of success. The multi-component Safer Choices programme (Coyle et al. 2001) included a parent component as part of the school-based programme. Parents received three newsletters that provided information about the programme, as well as information regarding HIV/AIDS and other STIs and pregnancy. The newsletter provided tips on talking with teenagers about these issues, and included student/parent homework activities to facilitate communication. The Safer Choices programme was found to reduce selected risk behaviours at twelve-month follow-up

The Growing Together programme was designed to help parents communicate with their daughters. Five two-hour interactive sessions located in Girls Clubs were designed to help parents communicate with their daughters. Follow-up at 24 months (Nicholson and Postrado 1991, 1992) found that those in the programme group were less likely to initiate sexual activity, but the sample size was quite small which limited the generalisability of the programme.

In a slightly larger study, Miller, Norton, Jenson, Lee, Christopherson and King (1993) evaluated the Facts and Feelings programme, a home-based video programme (with/without mailed newsletters). After the materials were sent to the home, bi-weekly home calls were made to parents to encourage them to use the material. At three- and twelve-month follow-up no differences were found in the sexual behaviour of the young people, but a significant improvement was found in the quality of parent-child communication within the programme group.

In summary, the effectiveness of parent involvement programmes appears to be dependent on their content. While only a small number of comprehensive programmes (Safer Choices and Growing Together programmes) included a parent involvement element, such programmes appear to be more useful in effecting change than the abstinence programmes. Again, methodological weaknesses (design and short follow-up) in the evaluations of the abstinence programmes may obscure the effects of such programmes.

School-based Programmes Linked with Contraceptive Services

Programmes that combine sex education with access to contraceptive services have been proven to be effective in increasing contraceptive use (Zabin et al. 1986, Koo, Dunteman, George, Green and Vincent 1994). Zabin et al. (1986) undertook one of the earliest evaluations of a school-based sex education programme combined with an on-site sexual health advice and contraceptive service in Baltimore, USA. The key findings of the study were a delay in the onset of sexual activity amongst the young women involved, an increase in contraceptive use amongst those men and women already sexually active prior to the study and a significant decrease in pregnancy rates for the surrounding area. When the programme was discontinued, however, the pregnancy rate returned to the pre-programme level.

One multifaceted community approach featured sexuality Evaluations of school-based and school-linked clinics providing health and contraceptive services in the USA have been methodologically weak with poor selection of comparison groups and the results are contradictory. Some show delay in sexual initiation, (Kisker 1984) and reduction in birth rate (Ralph and Edgington 1983), but no changes in contraceptive use (Kisker 1984, Kirby, Waszak and Ziegler 1991).

It is important to note that many of the studies of schools with health clinics and schools with condom availability have consistently shown that the provision of condoms or other contraceptives through schools does not increase sexual activity (Kirby 2001). While studies of school condom availability consistently demonstrate that such programmes do not increase sexual activity, they provide conflicting results about their impact on school-wide use of condoms. These studies may reflect methodological limitations, differences in availability of condoms in the community, or differences in the programmes themselves (Kirby 2001).

One-to-one Counselling

A small number of studies have evaluated the effectiveness of one-to-one education through counselling within health care settings. Again, the evaluation designs are weak and findings mixed (Baker 1990, Danielson, Marcy, Plunkett, Wiest and Greenlick 1990, Winter and Breckenmaker 1991).

Of particular interest are programmes targeted at 'hard to reach' groups. A number of US programmes delivered outside school hours have exhibited some success in changing young people's sexual activity. For example, the Behaviour Skills Training programme, delivered to substance-dependent black young people in a health centre, was successful in delaying sexual initiation, reducing the numbers of sexual partners and increasing the use of protection during sexual activity (St Lawrence, Jefferson, Banks and Cline 1994). A second programme, Be Proud, Be Responsible, which provided culturally and developmentally-appropriate active learning activities to young black people found some short-term increase in condom use (Jemmott 1993).

Becker and Barth (2000) used a before-and-after study (no comparison group) to evaluate Power Through Choices, delivered as part of an independent living programme for young people in public care. The generalisability of the programme is limited due to the weak design, but short-term evaluation indicated positive feedback from participants and changes in knowledge levels. Currently in the UK, the researchers at the Thomas Coram Research Unit are developing programmes based on the needs of young people in public care.

Finally, an educational programme delivered to young women in sheltered housing was effective in improving preventative sexual behaviours (Rotheram-Borus, Koopman, Haignere and Davies 1994). At six-month follow-up, young people in the programme group were more consistent condom users and had avoided high-risk situations.

Youth Development Programmes

Youth development programmes provide a further opportunity to promote positive sexual health. These programmes do not focus primarily on sexuality, but attempt to improve young people's life skills and belief in

their future. Given the strength of the evidence about the influence of general education and socio-economic factors on sexual behaviour, these programmes address some of the antecedents of unprotected sex and teenage pregnancy. Some programmes strive to provide mechanisms for youth to fulfil their basic needs including a sense of safety and structure, belonging to a community, increasing self-worth and control over their lives. As such tasks cannot be achieved quickly, such programmes tend to be long-term in duration.

To date, none of the evaluations of youth development programmes have examined their impact on adolescent sexual behaviour (sexual initiation, condom use or numbers of partners) but a number have examined the impact on teenage pregnancy. For example, the Youth Incentive Entitlement Project (YIEP) targeted youths from low-income households. It offered part-time jobs during the school year and full-time jobs during the summer if participants stayed at school (Olsen and Farkas 1991). The evaluation compared eight matched community sites with and without the YIEP. The study evaluated the impact on all youths in the participating areas (including those who did not participate in the programme). The study concluded that increasing economic opportunity decreased adolescent birth rates among blacks (the only group studied).

The Summer Training and Education Programme (STEP) programme targeted fourteen and fifteen year olds from poor urban areas who were seriously behind academically (Walker and Vilella-Velez 1992). 4800 participants were randomly assigned to programme or control group. During each of two successive summers, the programme provided 90 hours of work experience, 90 hours of academic support focusing on remedial reading and maths, and eighteen hours of lifeskills education that included sexuality education. During the school year, the program provided between five and fifteen hours of other support with limited one-to-one contact, recreation, and other non-education activities. However, those in the comparison group in the evaluation were offered summer jobs. The evaluation failed to find any consistent or significant effect on sexual behaviour or contraceptive use.

A number of programmes, which combined sex education with career planning or work experience during the summer holidays, have shown some success in increasing contraceptive use (Smith 1990, Nicholson and Postrado 1992, Smith 1994) and reducing pregnancy rates (Philliber and Allen 1992, Allen and Philliber 1997). The Teen Outreach Programme (TOP), a year-long curriculum and volunteer-service programme implemented in several cities, achieved reductions in teenage pregnancies among participating teenagers. The primary aim of the TOP was to foster positive development of adolescents using three approaches. Youth participated in individual and group service projects and engaged in discussions that enhanced their personal growth and development by exploring their values as well as their relationship with family and peers. This process developed communication and decision-making skills and goal setting. Finally, they used a process of reflective discussion to connect learning from school and the Teen Outreach Programme(Zoritch, Roberts and Oakley 2000).

Delivery of Programmes

Delivery of Sex Education - Peers

The delivery of educational messages ranges from the traditional didactic approach to more innovative, participatory approaches such as peer education. Peers have been identified as an important influence on young people's health behaviours, and are considered to be credible role models and disseminators of social information. They have been used to deliver a number of health promotion activities (Fennell 1993). Government policy in the UK has recently recommended peer-led approaches for delivering sex education in schools (Social Exclusion Unit 1999). Peer education has been reported to be popular with young peer educators, and professionals have enthused about its application (Mellanby, Newcombe, Rees and Tripp 2001, Strange et al. 2002a, Strange et al. 2002b). However, until recently robust evidence of effectiveness was limited (Harden, Oakley and Oliver 2001). One large-scale study, funded by the Medical Research Council in London, is currently evaluating the impact of the school-based, peer-delivered RIPPLE programme. The findings from the process evaluation have recently been published (Strange et al. 2002a, Strange et al. 2002b). The findings echo conclusions from other studies, which highlight the benefits for the peer educators.

Delivery of Programmes – Peers Versus Adults

School-based education programmes have been delivered by a range of personnel including peers, teachers, and healthcare professionals. As already stated, the RIPPLE programme in England, a peer-led school-based programme (Strange et al. 2002a, Strange et al. 2002b) is currently being evaluated. In contrast, the SHARE programme is a teacher-led sex education programme currently being evaluated in Scottish schools. Whilst is not possible to compare the findings - as the content of the programmes and the context in which the programmes are delivered may differ across the two countries - important learning will emerge from both studies.

Few studies have compared the effectiveness of different forms of programme delivery of the same programme. Two recent publications have attempted to compare peer and adult-led sex education (Jemmott et al. 1998, Mellanby et al. 2001). Mellanby and colleagues compared peer and adult delivery of the APAUSE programme. They concluded that both adult- and peer-led methods have an important place in effective sex education. Similarly, Jemmott and colleagues found little difference in the impact of adult or peer delivery of programmes, but did find differences in the effectiveness of different programmes (abstinence v abstinence plus).

IV. Summary and Conclusions

This review of evaluations of programmes designed to reduce teenage pregnancy and/or promote positive sexual

health among adolescents confirms that sex education does not lead to early sexual behaviour.

The few studies that have demonstrated a reduction in teenage pregnancy and/or promotion of positive sexual health adopted a multifaceted approach linking sex education programmes with youth development projects and/or contraceptive services. However, the lack of evidence of effectiveness of other approaches may reflect poor evaluation design: lack of an appropriate control group, small sample sizes or short follow-up. Such design flaws may account for the absence of significant effect, rather than the ineffectiveness of the programme.

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AUTHOR'S PROFILE

Blerta Peci. Please allow me to introduce myself. My name is Blerta Peçi. I have graduated from Department of Psychology and Pedagogy, Faculty of Social Sciences, University of Tirana, Masters Program with a degree in Clinical , Developmental and Relations Psychology on July, 2011 . I am a PhD student , Faculty of Social Sciences , degree "Doctor", Department of Psychology- Pedagogy, Psychology field since July 2012.
My coursework and 5 year experience has prepared me for my career working with individuals with disabilities, children, adolescents, couples, etc. In addition to my major degree, I feel that I am very well prepared I feel that I am very well prepared to make further research in Psychology field.
I am currently employed as a Part Time Lecturer of Psychology at Faculty of Social Sciences and also as a Specialist on National Employment Service, Ministry of Youth and Social Welfare.

Table 1

Comprehensive Sex Education (Abstinence – Plus Education)	Abstinence – Only Education
Teach that sexuality is a natural, normal, healthy aspect of life • Promote abstinence from sex • Offer students the opportunity to explore and define their values • Acknowledge that many teenagers will become sexually active • Teach about contraceptive and condom use • Include discussions about contraception, abortion, sexually transmitted diseases and HIV	Abstinence-only education includes discussion about values, character building, and in some cases, refusal skills • Teaches that sex outside marriage will have emotional, physical and social consequences • Promotes abstinence from sex • Teaches one set of values as morally correct for all students • Does not acknowledge that many young teenagers will be sexually active • Avoids discussions of abortion • Cites STIs and HIV as reasons for a bstinence • Discusses condoms only in terms of failure rate, often exaggerates failure rate