

Healthy Teen Network

MAKING A DIFFERENCE IN THE LIVES
OF TEENS AND YOUNG FAMILIES

A keynote address by Douglas Kirby, PhD, honoring the National Organization on Adolescent Pregnancy, Parenting and Prevention's 25th Annual Conference and 25 years of effort to reduce teen pregnancies and support teen parents in the United States.

**We've Come a Long Way
in 25 Years —**

We Keep Doing the Impossible!

Douglas Kirby, PhD
Keynote Address
NOAPPP's 25th Annual Conference
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3 Welcome

In 2004, the National Organization on Adolescent Pregnancy, Parenting and Prevention (NOAPPP) was busy deciding how best to celebrate 25 years as a national leader in the field of teen pregnancy, parenting and prevention. We embraced Sankofa, a Ghanaian concept connoting learning from the past to guide the future, as the theme for our annual conference. We decided to open with a keynote speaker who would highlight the past 25 years of research and growth in this area. Who better to do this than Doug Kirby, a long time researcher and friend of the field? We approached Doug with what we wanted and he agreed. We then trusted Doug to deliver. Boy, did he ever!

There wasn't a dry eye in the house as Doug reminisced with us, sharing good and bad news and reminding us of the effects of teen pregnancy, sexually transmitted diseases and HIV on adolescents, particularly among our African brothers and sisters. Finally he gave us hope as he reminded us of the gains we have made over the past 25 years, gains that at one time seemed impossible.

We may not agree with everything Doug has to say, particularly around the ABC approach for which there is much indecision and a little rancor, but we can feel his love for the field and his optimism for the future and we too can dream of the "impossible" progress yet to come.

We trust you'll enjoy Doug's words and continue to support those of us working to develop a nation of healthy youth.

Warmly,
Pat Paluzzi, CNM, DrPH
President and CEO
Healthy Teen Network

I was truly honored and thrilled to be asked by Pat to open NOAPPP's 25th Anniversary Conference. I became even more excited as we discussed the focus of my remarks and I began to reflect on all that we have learned and all the progress that we have made in the last 25 years. I realized that we have had major disappointments, but we have persevered. And, in the long run, we have set goals and eventually met them and then set higher goals and met those as well. We keep achieving goals that at one time we would have considered impossible. I'm confident that in the future, we will continue to make even more strides as we gain more knowledge about what works for teens.

I hope you will enjoy my comments and share them with your colleagues. They reflect the dedication, work and efforts by all of us. I encourage you to keep up your great work and to continue your support for organizations like NOAPPP so that all teens will make responsible decisions about their sexual and reproductive health.

Warmly,
Doug Kirby, PhD
Senior Research Scientist
ETR Associates

4 Introduction

It is an honor and a pleasure to have the opportunity to speak with you today on the 25th anniversary of the founding of the National Organization on Adolescent Pregnancy, Parenting and Prevention (NOAPPP). During the last 25 years we have learned a great amount; we have made incredible progress; we have repeatedly done the impossible.

We should acknowledge some of those people who made this possible. There are the many practitioners who cared about youth, developed new programs, and exposed their programs to rigorous evaluation. They have developed a wide variety of creative programs, and if they learned their programs were ineffective, they reviewed their own programmatic experience with youth, theory, and research, and designed still more creative and effective programs. There are the researchers who evaluated programs and reported results to the field. When their results were positive, the researchers and their results were well received. When their results were not encouraging, some researchers nevertheless reported these results in a balanced and accurate manner, thereby helping the field move forward. Sometimes reporting these negative results was difficult. And critically, there are the tens of thousands of young people who agreed to be randomly assigned to intervention and comparison groups and who carefully answered questions about their own personal lives, including their own sexual behavior. They trusted the researchers and typically answered questions carefully and honestly.

Today I'm going to talk about the last 25 or 26 years. Much of this is based on my own perspective of events in the field and on my own memory. Other people in the field undoubtedly have different (and equally valid) perspectives on events during these years and they may have better memories as well!

26 Years Ago . . .

Let's look back about 26 years, to the time before NOAPPP was founded. In the national arena, prior to NOAPPP, there was an organization called NACSAP (National Association Concerned with School-Age Parents). It had state affiliates, a few of which still exist. However, when it folded because of financial difficulties, people recognized the need for a national organization that focused on this topic, and NOAPPP rose from the ashes of NACSAP. People, such as Toni Brown Belew, helped found and direct NOAPPP, and then they wisely hired Sharon Rodine to become its Executive Director, fund raiser, etc. As many of you know, Sharon Rodine has an enormous amount of energy, enthusiasm, and insight and under her leadership NOAPPP expanded rapidly and moved to Washington, D.C.

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Regarding my own life, 26 years ago, I was doing mathematical modeling of U.S. and Soviet missile capability and giving presentations to the Arms Control and Disarmament Agency. After working on the computer for a few hours one morning, I looked up and yawned. That yawn dramatically changed the course of my career forever. I got up, walked out of the highly classified and secure part of the building and passed the Vice-President of another division of my employer (Mathematica) that did only military work. As I passed, he just happened to comment facetiously to his secretary that they should submit a proposal to the Centers for Disease Control to study sex education. (He was reading the announcement of the funding). Remembering that I had written an appendix on methods of studying human sexual behavior for a human sexuality college textbook, I facetiously suggested that I write a proposal. The Vice President, in desperate need of new sources of funding, immediately tried to convince me to write such a proposal. I replied that "this was impossible." Not only had I never written a proposal before, I had never even seen a proposal.

. . . And so began my career studying teen sexual behavior and programs to reduce sexual risk taking.

25 Years Ago . . .

Let's look back about 25 years. What did we believe then? And what have we subsequently learned was reality?

Belief: Many teens do not have a good understanding of contraception, pregnancy and its consequences. If we can increase their knowledge, they will become more likely to use contraception.

Twenty-five years ago, there were numerous published papers presenting the results of knowledge tests and documenting that young people did not know many specific facts that we all believed young people should know in order to make informed decisions about sexual behavior, including contraceptive use. For example, they did not fully understand the risks of pregnancy or the effectiveness of different methods of birth control. We believed that if programs increased knowledge, then young people would make better sexual decisions, especially about contraception.

Reality: Nearly every sex education program increased knowledge, but programs that focused primarily on knowledge did not change behavior.

For many years I kept track of the studies that measured the impact of sex education programs on knowledge. Nearly every study found that programs did increase knowledge. After documenting about 100 such studies, I stopped keeping track. Clearly, sexuality was like other topics – when it was taught well, students did learn. However, they may learn even more about sexuality, because students are typically much more personally interested in this topic.

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However, studies also found that programs that were designed primarily to increase knowledge (and did so) typically did not reduce teen sexual risk-taking. Why? Because knowledge about sexuality, contraception, and related topics is *weakly related* to sexual behavior and contraceptive use, but knowledge about these topics is not *highly related* to these behaviors. Many other factors such as attitudes and norms play more important roles.

This does not mean that ignorance is the answer, for it is not. Knowledge does provide a foundation for behavior change. However, simply improving that foundation is commonly not sufficient to change behavior. Other factors that affect teen sexual behavior also need to be changed. Thus, our early research on sex education programs confirmed previous international research on family planning programs, the “KAP” (knowledge-attitude-practice) research demonstrating the need to address more than knowledge.

About 15-25 Years Ago . . .

Belief: If programs increase knowledge, help clarify basic values, teach decision-making skills, and teach communication skills, then they will reduce sexual risk-taking.

For many years, we believed that if we provided information about important topics related to sexual behavior, we would increase students’ knowledge and provide a better foundation for their decision-making about sexual behavior. We believed that if we conducted values clarification exercises, we would help young people clarify their own values about sexual behavior. (In practice, however, these values clarification exercises were sometimes generic and did not involve decisions about sex or contraception). We believed that if we taught generic decision-making skills (e.g., the five or so steps to making a good decision), we would improve their decision-making skills, and together with their stronger foundation of knowledge and their clearer values about sexual behavior, they would make better decisions about sexual behavior. And finally, we believed that if we taught them generic communication skills (e.g., “I-messages”), then they would use these communication skills to convey their better decisions about sexual behavior to their potential romantic partners.

Reality: Only a few studies measured the impact of these programs, and none of them found any significant impact on sexual risk behavior.

Programs did increase knowledge; they did help clarify basic values and sometimes they helped clarify values about sexuality; they did increase knowledge of decision-making and communication skills; but they typically did not significantly reduce sexual risk-taking behavior. Once again, values, like knowledge, do have some relationship with sexual behavior. However, programs still failed to address some of the important determinants of teen sexual behavior.

Belief: Sex education programs should be value neutral; they should provide accurate information and skills but should let teens decide what is best for themselves.

In large part to avoid controversy and in part to avoid offending young people with varied values about sexual behavior, many programs strove to be value neutral. They were based on the belief that given correct information and skills, youth would naturally make the right decisions for themselves.

Reality: These programs did not reduce sexual risk-taking behavior.

Studies indicated that these value-neutral programs did not significantly change behavior either. Perhaps even more importantly, subsequent research demonstrated that just the opposite was true, namely that a “clear message about behavior” was one of the most important characteristics of effective programs that did reduce sexual risk behavior. This will be further discussed later.

Belief: If programs simply increase access to contraception, teens will be more likely to use contraception.

Many people believed that if programs increased access to contraception, particularly if they improved access to youth-friendly, confidential, non-judgmental reproductive health services, then teens would be more likely to use contraception. This was one of the beliefs that increased support for school-based clinics that prescribed (and sometimes dispensed) contraception.

Reality: When school-based clinics simply provided contraception, typically they did not increase contraceptive use.

Several studies demonstrated that school-based clinics, even a few that prescribed or dispensed contraceptives, did not significantly change either sexual behavior or contraceptive use. Commonly, students simply obtained contraception from the clinic instead of from some other source.

However, when school-based clinics provided contraception and gave a very clear message about always using contraception if sexually active, then a couple of studies found that the clinics did increase contraceptive use. This provides additional evidence for the importance of a clear message about sexual and contraceptive behavior.

8 About 10-15 Years Ago, More or Less . . .

Before I continue, I should observe that my estimates of time are very rough. Some people held these beliefs more than 15 years ago and some people may still hold them.

Belief: Programs should not focus on delaying the initiation of sex, because programs can't stop teens from having sex.

When some people argued that sex education programs should focus more on abstinence, others argued that programs could not stop teens from having sex. The latter group pointed out that since the advent of contraception in the United States, the proportion of young people having sex had either increased or remained constant over periods of time, but had never decreased.

Belief: If programs talk about sex, provide accurate information about contraception, tell teens where to obtain contraception, teach skills to insist on use of contraception, and encourage teens to use contraception if they are having sex, then teens will be more likely to have sex.

Many people believed this to be true in part because they thought that both talking about sex and actually reducing the perceived risks of STD or pregnancy through condom or contraceptive use would encourage sex.

Belief: If programs encourage teens both to be abstinent and to use contraception if they do have sex, they will only confuse the teens and not improve either of these behaviors.

Many people believed this was a mixed message and would either confuse teens or increase their sexual behavior.

Reality: None of these beliefs is true, either in the United States, other developed countries or developing countries.

If we review all studies meeting specific criteria, we find that none of these three beliefs is true. That is, many programs do reduce sexual activity, comprehensive programs covering condoms and contraception do not increase sexual behavior, and some programs emphasizing both abstinence and contraception can increase both abstinence and contraceptive use.

The evidence for these conclusions is overwhelming. In Table 1 are the preliminary results of all studies found in a systematic review that met the following programmatic and methodological criteria. The studies evaluated programs that targeted young people up to age 25, were curriculum-based with structured activities involving groups of youth (not one-on-one interaction), were implemented in schools or community settings, and were implemented anywhere in the world. In addition, the studies employed

experimental or quasi-experimental designs, had sample sizes of 100 or larger, measured impact upon behavior for at least 3 months, and were published in 1990 or later.

In the United States there have been 27 studies meeting these criteria that measured the impact of programs on the initiation of sex. Of these 27 studies, 11 (or slightly more than a third) found that the programs significantly delayed the initiation of sex. Fifteen of them had no significant impact on the initiation of sex, and one study found that the program hastened the initiation of sex.

Worldwide, there have been 50 studies meeting these criteria, and of these 50 studies, 18 (or close to one-third) delayed the initiation of sex and only one significantly hastened the initiation of sex.

Similarly, turning to the frequency of sex, 11 of 29 (or about one-third) of the studies in the U.S. and 12 of 38 studies worldwide (or slightly less than one-third) indicated that their respective programs significantly reduced the frequency of sex and only one program in the U.S. and two programs worldwide found significant increases in frequency.

Table 1:
Preliminary Estimates of the Number of Programs with Indicated Effects on Sexual Behaviors
(Based on review of 80 eligible programs worldwide)

	United States (n=54)	Other Developed Countries (n=8)	Developing Countries (n=18)	All Countries in World (n=80)
<u>Initiation of Sex</u>				
Delayed initiation	11	2	5	18
Had no sig impact	15	6	10	31
Hastened initiation	1	0	0	1
<u>Frequency of Sex</u>				
Decreased frequency	11	0	1	12
Had no sig impact	17	1	6	24
Increased frequency	1	1	0	2
<u># of Sexual Partners</u>				
Decreased number	9	0	4	13
Had no sig impact	18	0	2	20
Increased number	0	0	1	1
<u>Use of Condoms</u>				
Increased use	17	2	6	25
Had no sig impact	21	3	6	30
Decreased use	0	0	0	0
<u>Use of Contraception</u>				
Increased use	4	1	1	6
Had no sig impact	6	1	2	9
Decreased use	0	0	0	0

10 Finally, in the U.S., 9 out of 27 programs (one-third) reduced the number of sexual partners and none increased the number of sexual partners. The same pattern was found world wide.

In sum, these studies provide very strong evidence that programs do not increase any commonly used measure of sexual behavior when they emphasize that abstinence is the safest and best choice for young people and also emphasize that youth who do have sex should always use condoms and contraception. To the contrary, about one-third of the programs actually delay the onset of sex and about one-third reduce frequency of sex. If someone had made these claims 15 years ago, we would have replied "That's impossible."

Only one study in the United States found that its program both hastened the onset of sex and increased frequency. Moreover, that one study found these negative effects for only one time period (and not for others) and it did not focus primarily on sexual behavior. It placed greater emphasis on other non-sexual behaviors. Furthermore, when 14 or more studies measure the impact of programs on behavior, chance alone is likely to cause one of the results to appear significant.

Turning to condom and contraceptive use, we see even more positive findings. Exactly 17 out of 38 programs in the U.S. (or slightly less than half) increased condom use and almost half did so worldwide. In addition, 4 out of 10 in the U.S. and 6 out of 15 worldwide increased contraceptive use.

In sum, sex and HIV education programs do not increase sexual activity. Between one-third and one-half of them delay initiation of intercourse, reduce the frequency of sex, reduce the number of sexual partners and/or increase condom and contraceptive use. Quite remarkably, a few produce more than one of these positive behavioral results. If someone had described these results 15 years ago, we most certainly would have replied "That's impossible."

In general, we have learned that emphases upon abstinence, fewer partners and condoms/contraception are compatible, not conflicting. We do not have to choose one behavioral goal over another; rather we can produce positive change in all of them.

Belief: Programs will have an impact only on particular groups of youth.

For example, some people believed programs would only delay the initiation of sex among girls, not boys, assuming that girls were more affected by values and norms and boys were more affected by internal sexual drives. Some people believed that programs would only increase reported condom use among boys, not girls, because boys typically have greater control over whether or not condoms are used. Some people believed that programs would only reduce sexual risk-taking among youth in advantaged communities because they had fewer insurmountable deficits in their lives to overcome, while others believed that programs would have

a greater impact on youth in disadvantaged communities because they had more deficits that could be addressed and more room for improvement. Finally, some people believed that programs would be more effective with younger youth (before they had sex and before their sexual habits were formed) than with older youth whose sexual practices may already have been formed.

Reality: Programs can be effective with all these groups.

In particular, studies have demonstrated that programs can delay sex and increase condom use with both males and females, all major racial/ethnic groups, both youth in advantaged communities and youth in disadvantaged communities, and both younger and older youth.

About 10 Years Ago . . .

Belief: 10 characteristics distinguish effective from ineffective sex and HIV education programs.

Very close to 10 years ago a few of us reviewed many of the studies of sex and HIV education programs and their associated curricula that existed at the time and concluded that 10 different characteristics distinguished those curricula that produced desirable behavioral change from those curricula that had no significant impact on behavior. We concluded that effective programs:

1. Focused on reducing sexual risk-taking behavior;
2. Gave a clear message about sexual intercourse and condom or contraceptive use (i.e., avoiding sexual intercourse or always using condoms/contraception);
3. Were based on psychosocial and educational theories that 1) were effective in other areas and 2) identified psychosocial sexual risk and protective factors;
4. Provided basic accurate information about risks of unprotected intercourse and methods of avoiding intercourse or using condoms or contraception;
5. Addressed social pressures on sexual behavior;
6. Provided modeling of and practice in communication and refusal skills;
7. Used teaching methods to involve participants and help them personalize information;
8. Incorporated behavioral goals, teaching methods, and materials that were appropriate to the age, sexual experience and culture of the students;
9. Lasted a sufficient length of time to complete important activities; and
10. Selected teachers or peers who believed in the program and then provided them with training.

12 *Reality: Most of the 10 characteristics continue to be supported by more recent research, but they also need to be updated slightly.*

During the last ten years numerous studies have been published and the large majority of these provide further support for the 10 characteristics. Some studies of sex or HIV education programs in other countries (e.g., Tanzania) are consistent with these characteristics. Moreover, reviews of tobacco prevention and drug abuse prevention programs have produced remarkably similar sets of common characteristics of their effective programs.

However, it is also true that these characteristics and in particular, the 9th and 10th characteristics need to be updated. While programs offered in school typically need to be 15 or more class sessions long in order to complete enough interactive activities to improve knowledge, attitudes, perceptions of peer norms, self-efficacy to refuse sex or insist on condom or contraceptive use, some much shorter programs with a different structure have been found to be effective. For example, if youth participate voluntarily (instead of involuntarily in school), if youth are fresh on a Saturday morning (instead of being tired after English, math and science), and if they participate in groups of about 6 (instead of entire classrooms of about 30), then programs can be effective in as little as 5 hours. Even more remarkably, in clinic settings, if the clinician provides more than routine information, focuses on sexual and contraceptive behavior (including the client's individual barriers to using condoms and contraception), gives a clear message about sexual and contraceptive behavior, does role playing with the client, and completes other activities, then a single clinic visit may even increase condom or contraceptive use.

In regard to the 10th characteristic, it remains true that it can be very difficult to implement with fidelity all the activities in an effective curriculum, especially those covering particularly sensitive topics or those involving role playing or other interactive activities that may require special classroom management skills. Thus, teacher/educator training continues to be highly recommended.

On the other hand, one soon-to-be published study found that three different levels of teacher training did not have a significant impact on whether or not the curriculum changed the teens' behavior. In this study, the educators may already have had sufficient experience. Thus, this study does not mean that educators should not be trained, but it does indicate that training is not always a prerequisite for the effective implementation of programs, especially if the educators already have the knowledge and skills required to implement a particular curriculum.

Postscript: Since I gave my presentation, I have continued to review close to 100 studies of sex and HIV education programs around the world. While they continue to support what I've said above, I now have about 13 especially important characteristics and a few more that are less critical. I can't say for sure how they will end up. I encourage you to "stay tuned" and I will release them in the coming year.

Belief: *Sex and HIV education programs can only affect behavior for short periods of time.*

Many years ago, the goal of many program developers in the field was to reduce sexual risk behavior for as long as three months. Some people believed that other factors in teens' lives (e.g., sex in the media or attraction to a romantic partner) would overwhelm the positive impact of a program over time.

Reality: *It is possible to have a long term impact.*

Multiple programs have demonstrated positive behavior effects for as long as one year, and one program (*Safer Choices*) delayed the initiation of sex among Hispanic youth and increased condom and contraceptive use among all racial/ethnic groups of youth over a 31-month time period. Many years ago, some people would have thought "That's impossible." This intervention may have had a long term impact in part because it included ten classroom sessions in the 9th grade and ten more classroom sessions in the 10th grade and in part because it also included school-wide activities that were implemented every year and may have continually reinforced important messages throughout the 11th and 12th grades.

Another program delayed the initiation of sex among males for 36 months. It included sequential lessons during grades six through eight.

Belief: *Sex education programs that focus on both abstinence and condoms/contraception are THE answer.*

In their effort to support and implement effective comprehensive sex education programs, a few people hoped that these programs alone could make a dramatic difference and they relied primarily on these programs to reduce adolescent sexual risk.

Reality: *The most effective programs can reduce sexual risk behaviors by roughly one-third.*

This means, for example, that if over a period of time 30 percent of the youth in the control group initiate sex, then in the intervention group only 20 percent will initiate sex. Or, if 30 percent of the control group has sex without condoms, then only 20 percent of the intervention group will have sex without a condom.

14 One can view this effectiveness in two ways. One can focus on the fact that two-thirds of the sexual risk-taking still continues. Thus, it is correct to conclude that comprehensive sex or HIV education programs are not a complete solution, and that other large and effective components are needed in a larger more comprehensive initiative to reduce teen pregnancy or sexually transmitted disease.

On the other hand, one can also focus on the one-third reduction. If we could reduce unintended teen pregnancy and STD by roughly one-third by broadly implementing these effective sex and HIV education programs, that would be a truly incredible achievement!

Belief: If programs do not even talk about sex, they certainly cannot reduce sexual risk behavior.

Ten and more years ago many people believed that programs had to talk about sex or at least address sex in order to have an impact on sexual behavior. This just seemed like common sense. How can we change sexual behavior if we don't even talk about it?!

Reality: Some youth development programs without a good sexuality education program did not reduce teen sexual risk-taking or pregnancy, but some did!

When the earliest studies showed that service learning programs (in particular the early versions of the *Teen Outreach Program*) did not include the words "sexual intercourse" or "condoms" or "contraception" in their curricula, but nevertheless reduced reported teen pregnancy, many of us exclaimed "That's impossible." However, subsequently more rigorous studies confirmed that intensive service learning programs with both community service and on-going small group discussions did in fact either delay sex or reduce pregnancy.

Belief: Programs that address both sexual and non-sexual risk and protective factors may be more effective than those that address only sexual factors.

Logically, if both *sexual* risk and protective factors (e.g., values about sex and attitudes towards condoms and contraception) and *non-sexual* risk and protective factors (e.g., connection with parents or belief in the future) significantly affect sexual behavior, then programs that address both groups of factors may be more effective than those that address only one group of factors.

Reality: True! The Children's Aid Society Carrera Program addresses both factors and has the greatest demonstrated impact on reported teen pregnancy.

- 15 The Carrera program is a very intensive program that involves youth many days per week over the course of high school (and sometimes middle school) years. It includes many components (e.g., help with school, job club, sex education, health and mental health services, art and sports). A rigorous evaluation demonstrated that it delayed initiation of sex and increased combined condom and contraceptive use among females. Most importantly, it reduced pregnancy by half for 3 years as reported by females. (It did not have a positive significant impact on male sexual behavior or reported impregnation).

Now . . .

Belief: *We are a divided nation and it is exhausting trying to achieve common ground in the abstinence-only versus condom/contraception debate.*

Reality: *We have been divided, we remain divided, and it is exhausting, but we probably can find common ground.*

For many years people in the United States have been divided over the best approaches to pursue in order to reduce unintended teen pregnancy and sexually transmitted disease. On the one hand, those of us who advocate for a comprehensive approach involving both abstinence and condoms and contraception have to recognize that people in the United States pay a huge price for sex outside of long-term mutually monogamous relationships such as marriage. For example, if people did not have sex outside of truly long-term mutually monogamous relationships, then we would dramatically reduce out-of-wedlock childbearing and childbearing without two mutually committed parents and therefore we would dramatically reduce poverty in this country. We would also dramatically reduce rates of sexually transmitted disease. Thus, we pay a huge price for having sex outside of long-term mutually monogamous relationships.

On the other hand, those of us who advocate for abstinence-only or abstinence-until-marriage programs have to recognize that more than 60% of all students have sex before they graduate from high school and that much larger percentages of both males and females have sex before they get married, if they ever get married. Furthermore, large percentages of people who are sexually active prior to or outside of marriage highly value their sexual intimacy with others and do not wish to forgo it. They believe that they enjoy it, they learn from it, and they find it meaningful. Thus, it is quite unlikely that in the foreseeable future a large percentage of young people will abstain from sex until marriage.

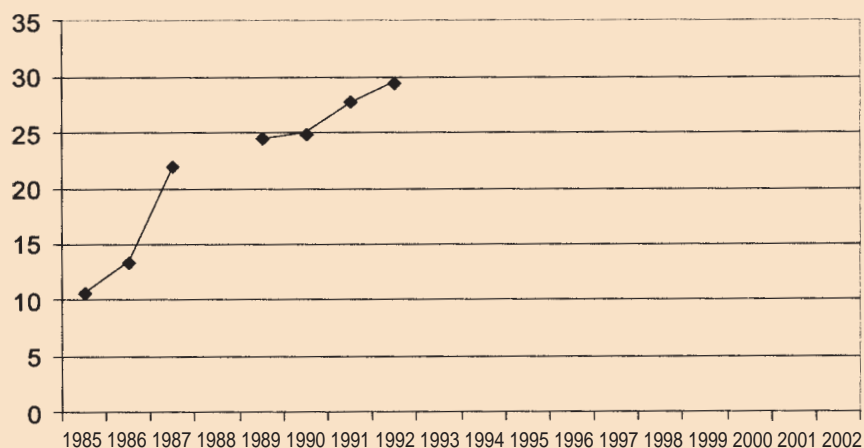
My hope for achieving some common ground is based in part on the fact that I see groups at the local, state, national and even international levels recognizing the need for common ground and striving for it, however difficult that process may be. I commonly hear or read the old proverb

16 “When the elephants are fighting, the grass gets trampled” and a contemporary version “While the adults are arguing, the teens are getting pregnant.” People are recognizing the need to try to end our division and to achieve common ground.

My hope both for achieving common ground and for the positive impact of achieving common ground is also based on the work that I have done in Uganda during the past few years. Uganda was the first country in the world to experience a generalized HIV/AIDS epidemic. That means that HIV/AIDS was not limited to particular groups of people such as men who have sex with men, sex workers or IV drug users; rather it infected the general population. The epidemic did not begin in the capital of Uganda, Kampala, but as Figure 1 shows, the proportion of people infected with HIV grew rapidly during the 1980s and early 1990s. By 1992, nearly 30 percent of all the women who attended the primary prenatal care clinic in Kampala were infected by HIV.

In Uganda, the best university is Makerere University. At that university, 40 percent of the coeds were HIV positive. As I walked through the campus and saw groups of coed students pass me, I knew that two out of five were going to die of AIDS. When I conducted focus groups with youth in different areas, I knew that probably at least a couple of youth in each group were going to die of AIDS. I wanted to adopt them all and save them all. I was (and remain) profoundly and deeply touched by the incredible tragedy that has befallen that country. But Uganda also gave me hope and created a vision of a more positive future.

Figure 1:
The Percent of Women Obtaining Prenatal Care in the Primary Clinic in Kampal, Uganda who were HIV Positive: 1985-1992

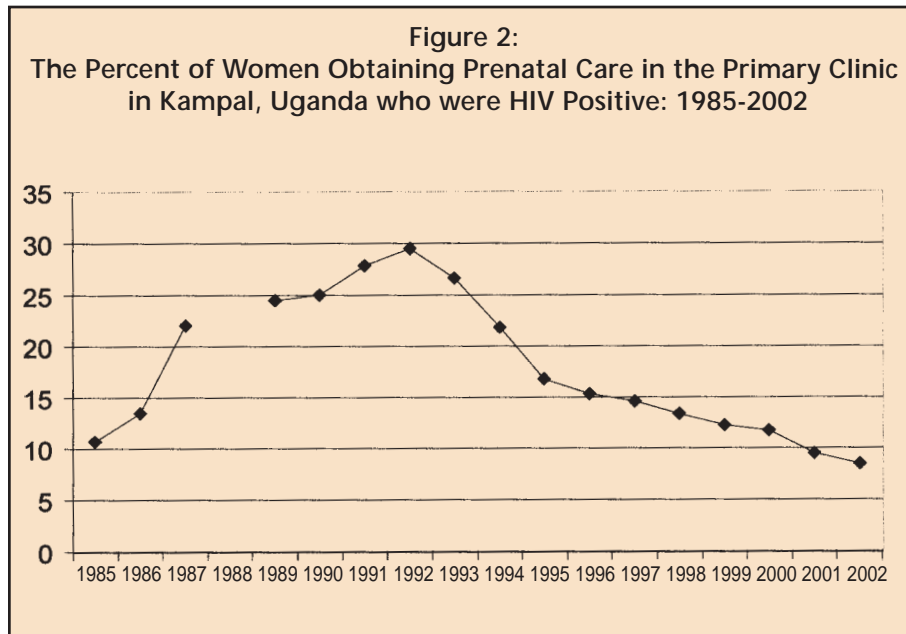


In 1992, the situation in Uganda was tragic and the future looked even more dismal. However, suddenly in 1993 the HIV prevalence rate among antenatal care women suddenly began to decline and then continued to decline every subsequent year for which data are available (Figure 2). Thus, Uganda became the first nation with a horrific generalized AIDS epidemic to dramatically reduce the prevalence of AIDS. In 1992, if Ugandan leaders had been shown Figure 2, they would have exclaimed with joy “That’s impossible.”

What contributed to the success of Uganda? The reality is that many things contributed to its success and the complete story cannot be covered in this presentation. However, one very important element in the Uganda success was a very clear “ABC” message. That message took the form:

- **A**bstinence is safest
- If you have sex, **B**e faithful to one partner (husband/wife)
- If you must have sex with others, always use a **C**ondom

This message provided a common ground for the many diverse groups who supported it, including government ministries, health clinics, traditional healers, schools, faith communities, non-governmental organizations, community leaders and others.



Some of us familiar with this message crafted a similar message for leaders from around the world to sign. Remarkably, 140 leaders from conservative faith-based organizations to condom social-marketing organizations have signed it. It has been published in *Lancet*, a respected international medical journal, for World AIDS Day (December 1, 2004). Months ago, if we had been told that people with such diverse views and from such diverse organizations would sign it, we would have replied “That’s impossible.” This shows that sometimes it is possible, even internationally, to find common ground.

The success of the “ABC” message for people of all ages in Uganda raises the question, “What might be an appropriate message for young people in the United States?”

One possibility follows. I want to emphasize several things before presenting it. First, this represents my own personal views and reading of research; others may be able to substantially improve upon it. In fact, I am still in the process of changing and refining it. Thus, this should be perceived as an initial draft, not as a finished product. Second, this is quite public health oriented. That is, the choices are determined primarily (but not solely) by the needs to prevent pregnancy and sexually transmitted disease, not by people’s values about sexuality or concerns about emotional health. Those important elements still need to be added. Third, these are recommendations for young people. Clearly, many young people of any age will still choose to have sex under any conditions and they should most certainly have full access to all reproductive health services. Fourth, the first choice, abstinence, does not mean that people should abstain from sex forever. Rather, it simply means that abstinence is simply the safest choice at any point in time. Finally, the message needs to be reworked so that youth can more easily remember it all. Given those caveats, the following is a possible ABC message that is designed not to be the final message, but is designed to start people thinking about what message would produce common ground in their communities:

Behavioral Choices:

A = Abstain from sex

(This choice is absolutely the safest).

B = Before you have sex,

Be sure having sex is completely voluntary and consensual,

Be at least 18 or graduated from high school, (Note: Young women under 18 are less likely to be fully mature physically and thus are more likely to contract sexually transmitted diseases (STDs) if their partners are infected).

Be in love and in a mutually monogamous relationship for at least 4-5 months, (*Note: After 4-5 months after initial infection, some people, especially males, will be less infectious with a few STDs such as HPV, and HIV tests will detect previous infections occurring 4-5 months earlier*).

Be tested and treated for STDs,

Be protected against pregnancy (use contraception).

(This choice is not as safe as A, but is much safer than other choices).

C = Consistently and Correctly use Condoms every time you have sex.

(Logically, if people have sex and either are not in a long-term mutually monogamous relationship, have not been tested for STDs (and treated if necessary), or are not protected by contraception, then it is very important to use a condom correctly and consistently. This choice is less safe than A or B, but is much safer than sex without protection against pregnancy or sexually transmitted disease).

These ABC guidelines recognize the failure or limitations of many current messages to young people. Currently, most programs either emphasize that abstinence (especially until marriage) is the only acceptable option for young people (abstinence-only programs) or they emphasize that abstinence is the safest and best choice, but encourage those young people who do have sex to always use condoms and contraception consistently (comprehensive sex and HIV education programs). In the terminology of the ABC paradigm, these are either "A" or "AC" messages.

Unfortunately, these A and AC messages are inadequate for at least two reasons. First, when young people do have sex, very rarely do they continue to use condoms with the same sexual partner over time. After they have had sex a few times, young people feel close to their partner, believe they "know their partner" and trust their partner does not have an STD. Thus, they stop using condoms and sometimes contract an STD at that time.

Second, while condoms provide considerable protection against HIV and STDs such as gonorrhea and syphilis that survive in semen or vaginal fluids, they provide much poorer protection against STDs such as herpes and HPV (human papilloma virus) that can be transmitted by skin-to-skin contact.

Thus, young people need to limit their number of sexual partners and the conditions under which they have sex, in addition to using condoms and contraception. The ABC message described provides a choice, "B", which does not require using condoms and is safer than using condoms if properly followed.

- 20 Yet another problem with the AC messages is that they may not include psychological consequences of sex nor values or expectations that most adults have for young people's sexual behavior. These need to be further incorporated into messages for young people.

Postscript: More recently, when designing a message for youth in alternative schools, we recognized that they did have multiple sexual partners and that the "ABC" message described above might not be as appropriate as an "ACB" message which places greater emphasis on always using condoms. In a different study, we are emphasizing a dual protection message that emphasizes that young women should always use hormonal contraception to protect against pregnancy and young men should always use a condom to protect against STDs. Alternatively, to protect against STDs, a couple needs to be in a mutually monogamous relationship and be tested (and treated) for STDs.

The primary point of my presentation was not to "push" any particular message, but to get people to seriously think about somewhat more complex messages, more appropriate messages, and possibly more effective messages, and to use a process in designing messages that will bring people together.

When trying to find common ground for this ABC message or for other messages for young people, it is often important to recognize the following principles of support:

- Not all groups have to support all elements. (Thus, for example, faith communities may emphasize that abstinence and even abstinence-until-marriage is the safest and best option, while reproductive health clinics may focus on the use of condoms and contraception).
- No group should undercut or contradict any element. (For example, abstinence groups can emphasize the superiority of abstinence, but should not report that condoms or contraception are less effective than they actually are, while reproductive health services can encourage condom and contraceptive use, but neither exaggerate their effectiveness nor fail to recognize that abstinence is safest).
- Overall, across organizations and in young people's environment, there should be an appropriate balance across the elements.

Belief: *There are too many factors affecting teen sexual behavior that we cannot control (e.g., the media and desires for intimacy), and therefore we cannot dramatically reduce teen pregnancy or childbearing.*

Frankly, sometimes it just all feels overwhelming. We sometimes feel, "How can we make a difference?" Sometimes this is especially felt in big states with high pregnancy rates.

Reality: *We can DRAMATICALLY reduce teen pregnancy and childbearing.*

This has been demonstrated by the United States overall, by California and by other states.

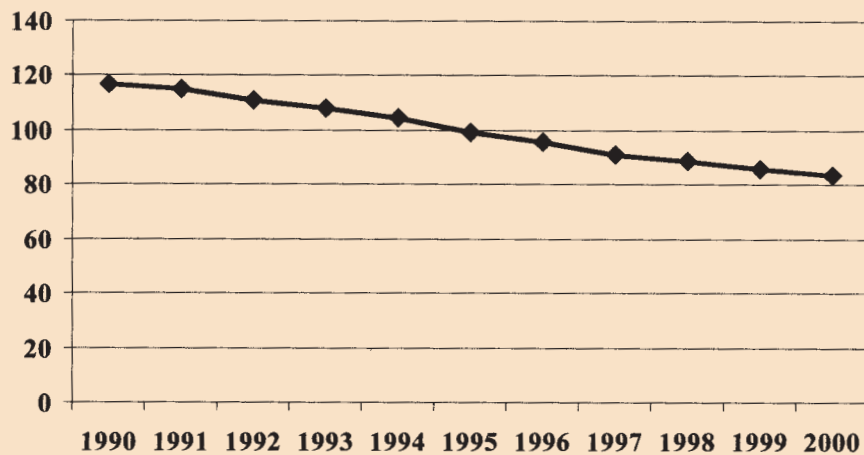
21 In the United States, the teen pregnancy rate has declined from 11.7 percent in 1990 to 8.4 percent in 2000 (Figure 3). This represents a decline of 28 percent, a remarkably large decrease in a single decade. Also in the United States, the birth rate declined from 6.2 percent to 4.3 percent, a decline of 30 percent.

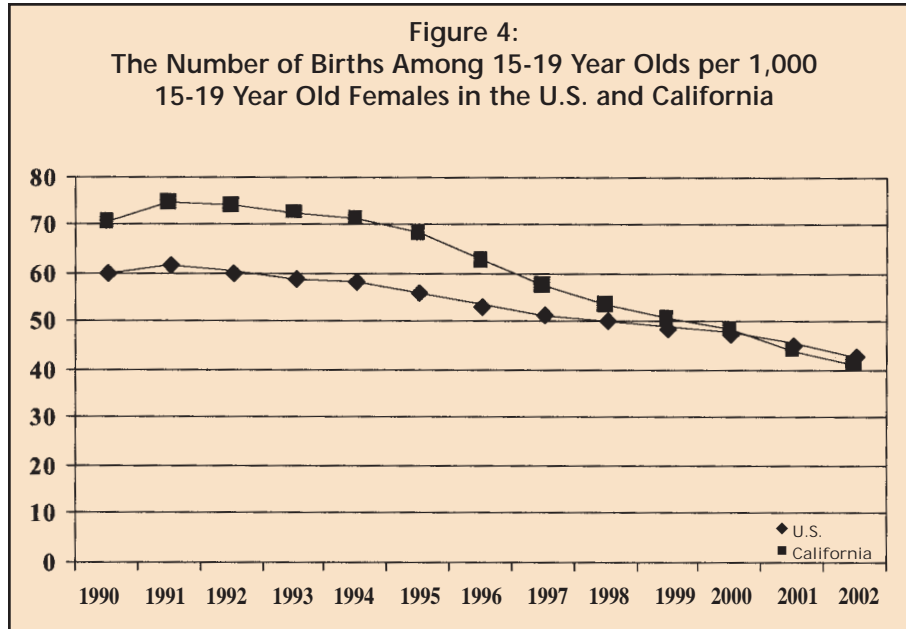
In California, abortion data are not well measured. Thus, the best trend data are for birth rates. In California, the birth rate declined from 7.5 percent to 4.1 percent, a decline of 45 percent! Now “that’s impossible.”

Over the past decade, this, of course raises the important question: What did California do? The reality is that California did many things that may have helped reduce teen pregnancy and birth rates. A partial list of them includes:

- Enacted federal welfare reform requirements that placed greater limitations on payments to teen mothers
- Devoted substantial and diverse resources to reducing teen pregnancy
- Targeted “hotspots” (areas with very high birth rates)
- Achieved common ground on a comprehensive approach that included emphases on both abstinence and greater use of contraception
- Turned down federal abstinence-only funds

Figure 3:
Number of Pregnancies Among 15-19 Year Olds per 1,000
15-19 Year Old Females in the U.S.





- Implemented media campaigns
 - o To help youth say no to sex or to use contraception
 - o To encourage male responsibility regarding fatherhood
 - o To encourage adult/child communication about sexuality
 - o To encourage use of clinical services through Family Pact
- Funded implementation of research-based programs in schools and communities
- Funded youth development programs
- Funded programs specifically for males
- Made contraception more available free of charge through Medical health providers (Family Pact)
- Established more linkages to contraceptive providers
- Made emergency contraception more available through pharmacies
- Funded programs to increase awareness of HIV
- Provided on-going training for some grantees of state funds
- Conducted on-going evaluation to improve some programs

- 23 The relative contribution of each of these activities to the decrease in teen childbearing is unknown, but each of these and other activities may have contributed.

Postscript: Since my presentation, a few of us have further analyzed data on California and now more fully recognize the roles that AIDS and public awareness of AIDS played in first increasing the teen birth rate in California and then decreasing it. That is, the huge declines in teen birth rates in California were affected not only by the efforts listed above, but also by larger historical factors that may have disproportionately affected California. A few of us will be writing about this in the coming months.

Conclusions

We have learned a huge amount in 25 years. We have learned how to design more effective programs. We have learned that we can target both abstinence and condom and contraceptive use and change both, sometimes with the same programs. We have learned that we can address either sexual or non-sexual risk and protective factors and thereby change teen sexual risk behavior. We have learned that when we effectively address both, we may have the greatest impact. We have learned that a clear message to youth about sex may be one of the most important programmatic elements. And perhaps most important, we have learned that through our combined efforts, we can delay sex, we can reduce sexual activity once youth are sexually experienced, and we can increase both condom and contraceptive use. And by doing all these things, we can reduce teen pregnancy rates, teen abortion rates and teen birth rates. We can do it all.

Furthermore, each of you can make a difference. You can help implement with fidelity programs that are effective. You can help implement programs that have the characteristics of effective programs. You can help develop more effective programs. You can support research to advance our field and you can help search for common ground.

And together we can continue to do the impossible, as we have done for 25 years!



Douglas Kirby, PhD, is a Senior Research Scientist at ETR Associates in Scotts Valley, California. For more than 25 years, he has directed state-wide or nation-wide studies of adolescent sexual behavior, abstinence-only programs, sexuality and HIV education programs, school-based clinics, school condom-availability programs and youth development programs. He co-authored research on the *Reducing the Risk*, *Safer Choices*, and *Draw the Line* curricula, all of which significantly reduced unprotected sex, either by delaying sex, reducing the number of partners, increasing condom use, or increasing contraceptive use. He has painted a more comprehensive and detailed picture of the risk and protective factors associated with adolescent sexual behavior, contraceptive use, and pregnancy, and has identified important common characteristics of effective sexuality education and HIV education programs. In 2001, he authored *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy*, which has been widely acclaimed. Over the years, he has also authored or co-authored more than 100 volumes, articles and chapters on adolescent sexual behavior and programs designed to change that behavior. These have included reviews of the field for the National Campaign to Prevent Teen Pregnancy, the Centers for Disease Control, the National Institutes of Health, and others.

Currently he is reviewing the effectiveness of sex and HIV education programs in the developing world and is studying the factors leading to the decline of HIV prevalence in Uganda.