A Program Evaluation of Planned Parenthood

Teen Council

by

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ABSTRACT

Planned Parenthood Teen Council is an intervention intended to reduce teen pregnancy and sexually transmitted infection through comprehensive sexual education and youth development. This program evaluation is intended to identify opportunities for improvement and provide program information to potential funders. Teen Council was found to increase protective factors that influence teen sexual risk taking: increased knowledge of sexuality and adolescent health and access to related resources; increased positive attitudes towards sexuality; increased plans for the future; increased promotion of contraceptives among peers; and increased community involvement. This evaluation found evidence that Teen Council is successful in influencing the determinants of teen sexual risk taking. Opportunities for improvement are identified and recommendations are offered.

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Chapter I: Introduction

Planned Parenthood of Minnesota, North Dakota and South Dakota (PPMNS) Teen Council is an intervention intended to reduce teen pregnancy and sexually transmitted infection through comprehensive sexual education and youth development. Teen Council is in its third year of operation, with locations in Duluth, Minneapolis-St. Paul (Metro), and Rochester.

Statement of the Problem

Although Teen Council has been previously evaluated (Reardon, 2004), it is not known if the program in its current iteration is successful in influencing the determinants of teen sexual risk taking. An evaluation of the program will provide information regarding successes and opportunities for improvement in influencing the determinants that result in pregnancy and sexually transmitted infection.

Purpose of the Study

The purpose of this evaluation of PPMNS Teen Council is formative as well as pragmatic in nature. This evaluation will improve the PPMNS Teen Council program by measuring outcomes of interest, detailing strengths and opportunities for improvement, and providing recommendations. This evaluation will also provide a means to transfer information regarding program effectiveness to potential sources of program funding.

Methodology

Twenty-four participants completed both the pre- and post-questionnaire measures. Participants were between the ages of 15 and 17 with the exception of one 21 year old participant. The majority of participants were White females. The questionnaire measure included six demographic items and 68 true/false, multiple-choice, matching, and Likert-scale items intended to answer four evaluation questions. Questionnaires were administered by Teen Council leaders during weekly Teen Council meetings.

Twenty-three participants participated in focus groups. Focus groups were conducted by location, resulting in focus group sizes of four, nine, and ten participants. Participants were between the ages of 15 and 17 with the exception of one 21 year old participant. The majority of participants were White females. Focus groups consisted of 13 questions intended to answer seven evaluation questions. Focus groups were conducted during weekly Teen Council meetings and were moderated by the evaluator.

Chapter II: Literature Review

Teen Pregnancy Rates

Teen pregnancy is a pervasive problem in the United States, with women having a cumulative risk of approximately thirty-four percent for becoming pregnant at least once before age twenty (*Factsheet,* 2004). In the year 2000, the most recent year for which data is available, there were more than 820,000 pregnancies to teens between age 15 and 19 (Henshaw, 2004), or about 2000 pregnancies per day. In addition to being a wide-spread problem, teen pregnancy has occurred at a high rate in the United States for more than thirty years. The average rate of pregnancy among all 15-19 year old women has varied from 95 pregnancies per 1000 in 1972, to a high of 117 pregnancies per 1000 in 1990, followed by a low of 84 pregnancies per 1000 in 2000 (Henshaw, 2004). Although teen pregnancy rates decreased 24% from 1992 to 2000, there has been little change in the overall number of teen pregnancies due to a rise in the number of adolescent females in the population (*U.S. Teenage Pregnancy*, 2004).

Teen pregnancy rates in the United States do not compare favorably with other industrialized nations. In 1996, the rate of pregnancy per 1000 women age 15-19 in the United States was 83.6, compared to 25 pregnancies per 1000 in Sweden, 20.2 in France, 45.7 in Canada and 46.7 in Great Britain. The higher rate of teen pregnancy in the United States is not a result of a larger number of teens having intercourse, as the rates of intercourse for these countries is similar, with 51.3 per 1000 teens age 15-19 in the United States having had sex as compared to 49.3 per 1000 in France, 50.9 per 1000 in Canada and 61.1 per 1000 in Great Britain. The higher rate of teen pregnancy in the United States may, however, be related to a lack of contraceptive use, with 20% of women age 15-19 reporting no method of contraception used at last

intercourse as compared to 6.5% in Sweden, 11.9% in France and 4.1% in Great Britain (Darroch, Singh, & Frost, 2001).

Minnesota is no exception to the problem of teen pregnancy in the United States. In the year 2003, the rate of teen pregnancy in Minnesota was the eighth lowest in the United States, with 38.2 pregnancies per 1000 women age 15-19. Minnesota experienced a reduction of 37% in the rate of pregnancies among women age 15-19 from 1990 to 2003. Despite these positive indicators, there were still 6,830 teen pregnancies in Minnesota in 2003 (*2005 Minnesota State*, 2005). These statistics related to teen pregnancy coincide with the rate of intercourse among teens. In 2004, 21% of ninth grade males and 18% of ninth grade females in Minnesota had engaged in intercourse. Additionally, 46% of 12th grade males and 49% of 12th grade females had engaged in intercourse (*Preliminary Minnesota*, 2004).

Teen Pregnancy Outcomes

Teen pregnancy is a problem because it results in many undesirable outcomes. One such undesirable outcome is abortion. In 1996 there were 29.2 abortions in the United States per 1000 women age 15-19 as compared to 54.4 births per 1000. Put another way, the abortion ratio in the United States is 34.9 abortions per 100 pregnancies. Although this rate compares favorably to the abortion rates of 68.8 per 1000 in Sweden, 50.5 in France, 46.4 in Canada, and 39.4 in Great Britain, the much higher rate of teen pregnancy in the United States results in far more abortions than in these countries (Darroch, Singh, & Frost, 2001). In Minnesota, the rate of abortion for women 15-19 has decreased 13% from 2000 to 2003, but continues to be a significant problem (Minnesota Center for Health Statistics, 2004).

Second is the higher rate of low birth weight babies born to teen mothers. While only 2.7% of babies born to mothers age 20-21 are considered low birth weight, 7.2% of babies born

to mothers age 17 and under weigh less that what is considered healthy (Terry-Humen, Manlove, & Moore, 2005). Additionally, the likelihood of giving birth to a low birth weight baby is 21% higher for teen mothers than for 20-24 year old mothers (Martin, et al, 2002). Through this higher rate of low birth weight babies, teen pregnancy is associated with Sudden Infant Death Syndrome, deafness, blindness, chronic respiratory problems, mental retardation, mental illness, and cerebral palsy. Low birth weight babies born to teen mothers also have double the risk for hyperactivity, dyslexia, and other disabilities.

Third, both teenage mothers and their offspring are more likely to fail academically. Teen pregnancy is the number one cause of women leaving high school, with less than one third of teen mothers finishing high school (Maynard, 1996). Far fewer teenage mothers go on to college, with less than 1.5% of teen mothers earning a college degree by age 30 (*While Adults Are Arguing*, 1998). In addition, the children born to teen mothers also tend to perform poorly in school: children born to teen mothers are fifty percent more likely to repeat a grade, do not perform as well on standardized tests, and are less likely to complete high school (*Whatever Happened*, 1997).

The failure of teen mothers to achieve academically results in a lack of the skills required to be hired to a job with the type of pay and benefits necessary to support a family. Additionally, few of the positions available to teen mothers provide daycare or have a salary that is sufficient to pay for daycare. This results in an impossible situation where these mothers can either work or care for their child but not both. Without a means of income, teen mothers and their offspring often end up on public support. Teen mothers are more likely to receive welfare than women from the same background who postpone childbearing until after age 20. In addition, almost one-half of all teenage mothers and more than three-quarters of all unmarried teen mothers begin

receiving welfare within five years of the birth of their first child (*Whatever Happened*, 1997). Finally, children of teen mothers are significantly more likely to end up in foster care than the children of mothers who have children later (Maynard, 1996).

A fourth undesirable outcome is child abuse. The children of teen mothers suffer abuse at a higher rate compared to children who are born to mothers who have children in their early twenties. In the 1990s, there were 110 reports of abuse or neglect per 1000 families headed by teen mothers, more than double the 51 reports for those households headed by mothers in their early twenties (Maynard, 1996). This high rate of abuse is attributed to the lack of parenting skills and support that is typical for teen mothers.

A final undesirable outcome of teen pregnancy is the economic cost to state and federal governments. Economic costs to the federal government as a result of teen pregnancy are estimated to be in excess of seven billion dollars per year (Maynard, 1996). The State of Minnesota is also economically impacted by teenage pregnancy, with welfare contributions to teen mothers and their offspring resulting in significant costs for Minnesota government and taxpayers. In December 2001, 20,794 of the 39,023 of the cases in the Minnesota Family Investment Program were families that began with a teen birth, resulting in more than 55% of the program's budget, or $13.3 million, spent on this problem (*Minnesota Education Now*, 2002). Although it is important to assist teen mothers and their children, these expenditures could be avoided by preventing teen pregnancy.

Sexual Risk and Protective Factors

Factors that influence teen sexual risk taking fall into two categories: protective factors and risk factors (Kirby, Lepore, & Ryan, 2005). A protective factor, such as parental support and family connectedness, can decrease sexual risk taking by discouraging behavior that could result

in a pregnancy or a sexually transmitted infection or encouraging behavior that could prevent these outcomes. Similarly, a risk factor, such as drug and alcohol use, can contribute to sexual risk taking by encouraging behavior that could result in a pregnancy or sexually transmitted infection or by discouraging behavior that could prevent these outcomes. There are over 400 protective and risk factors that correlate with teen sexual risk taking (Kirby et al., 2005).

Four key themes encompass all of these sexual risk taking factors. The first theme, biological factors unique to each teen, is comprised of factors such as having higher levels of testosterone in males and experiencing puberty at an earlier age in both males and females. Another theme, disadvantage, disorganization, and dysfunction in the life of the teen as well as in their environment, is comprised of factors such as living in areas with high poverty rates, low levels of education, high residential turnover, and high divorce rates. In addition, this theme includes having parents who have low levels of education, being poor, experiencing a divorce or separation or having parents never married, and having mothers and older sisters that have given birth as adolescents.

A third theme, sexual values, attitudes, and modeled behavior, is comprised of factors such experiencing sexual pressure or abuse, earlier dating, and, if the teen is a female, dating an older male. Additionally, this theme includes holding more permissive attitudes toward premarital sex, having sex with more partners, having more negative attitudes toward contraception, having less confidence about acquiring and using contraception, and not actively wanting to avoid having a child (Kirby, 1997). Finally, a fourth theme, connection to adults that discourages sex, unprotected sex, or early childbearing, is comprised of factors such as having parents who are not skilled in caring for children or provide less support and supervision and being involved in school, faith, or communities (Kirby, 1997; Kirby, Lepore, & Ryan, 2005).

Sexuality Education

The United States federal government is the primary source of funding for the health classes that provide teens with sexuality education in local schools. In 1996, with the passage of the Title V provision of the Personal Responsibility and Work Opportunity Reconciliation Act, federal and state funding for sexuality education became legally linked to an abstinence-only curriculum. Title V provides only sexuality education funding to states that provide sexuality education that meets federal abstinence-only guidelines. The Act also stipulated that each state must provide a matching contribution of three dollars for every four dollars of federal funding in order to receive funding. In addition to Title V, Congress in 2000 created the Special Projects of Regional and National Significance initiative which provided additional funding to abstinence-only programs (Hymowitz, 2003).

Although the details of abstinence-only programs are varied, to receive funding, these programs must Title V requirements, which are shown in Table 1 (http://www.ssa.gov/).

Table 1

Section 510(b) of Title V of the Social Security Act: Eight Point Definition

For the purposes of this section, the term 'abstinence education' means an educational or motivational program which:
A. Has as its exclusive purpose teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;
B. Teaches abstinence from sexual activity outside marriage as the expected standard for all school age children;
C. Teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;

D. Teaches that a mutually faithful monogamous relationship in the context of marriage is the expected standard of human sexual activity;

E. Teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;

F. Teaches that bearing children out of wedlock is likely to have harmful consequences for the child, the child's parents, and society;

G. Teaches young people how to reject sexual advances and how alcohol and drug use increase vulnerability to sexual advances; and

H. Teaches the importance of attaining self-sufficiency before engaging in sexual activity.

School districts that have a district-wide policy on sexuality education comprise 69% percent of districts nation-wide, with a disproportionate 86% of all students residing in these districts. Of these school districts with a district-wide policy, only 14% have a comprehensive sexuality education program and 51% utilize a program that promotes abstinence as the preferred option while also providing information regarding contraceptives (also known as abstinence-plus education). Abstinence-only education, due to the economic incentives provided by Title V, is provided by 35% of school districts with a district-wide policy (Landry, Kaeser, & Richards, 1999).

Due to dependency on federal funds, the sexuality education program most widely implemented in Minnesota is based on an abstinence-only model. This wide spread abstinence-only program is in spite of the 78% of Minnesota parents who prefer that sexuality education programs "promote abstinence and teach about contraception" (*Minnesota Education Now*, 2002). These Minnesota findings mirror those of a nationwide 2001 poll that found that 68.8% of

parents and 67.4% of teens supported programs that emphasize both abstinence and birth control in contrast to the 23.2% of parents and 18.4% of teens who supported abstinence-only programs (*With One Voice*, 2001).

Minnesota's Education Now and Babies Later (MN ENABL) program is the abstinence-only program that is most commonly used. According to program literature, "the goal of MN ENABL is to reduce adolescent pregnancy by decreasing the number of adolescents who engage in sexual activity and by promoting abstinence until marriage utilizing a multi-faceted community approach" (*Minnesota Education Now,* 2002, p. 4). MN ENABL is based on a California program of the same name which was conducted from June 1992 through February 1996 when it was abruptly terminated following a less than favorable evaluation (Cagampang, Barth, Korpi, & Kirby, 1997). The MN ENABL program consists of an abstinence-only curriculum combined with strengthening community norms regarding abstinence through community organizing activities and media campaigns.

The MN ENABL program was evaluated in 2002 and involved assessing the impact of 4,250 community-organizing activities, 3,150 public awareness activities, and the implementation of the program with over 45,500 middle school students between 1998 and 2002. Although the program was implemented as intended, the evaluation found results that were not as positive as program supporters had predicted. MN ENABL programming was linked with increased communication between parents and children, with 16% more parents in MN ENABL communities reporting that they talked to their child about sex in the past six months compared to communities without MN ENABL (*Minnesota Education Now,* 2002). Unfortunately, despite the increased communication between parents and children, there was no significant difference between the rate of abstinence among ninth grade students who recently participated in MN

ENABL and those who did not with 78% reporting abstinence in both groups. In contrast, twelfth grade students in counties where MN ENABL programming was implemented were found to report a four percent higher rate of abstinence compared to those where MN ENABL was not implemented. Although this difference was significant, the twelfth grade students had not participated in the program since middle school and had not shown a difference just following participation. This difference most likely shows a general upward trend in abstinence in this age group during the time of the evaluation rather than program success.

Prevention Approaches

There are three types of teen pregnancy and sexually transmitted infection prevention programs. The first and most commonly utilized prevention program is the sexual antecedent program. Sexual antecedent programs involve educating teens regarding sexuality and adolescent health, typically in a health class or clinic setting. These programs expect that participants will make good decisions based on the information provided in the program. The second type of prevention program is the non-sexual antecedent program. These programs address the broader psychosocial reasons for teen pregnancy and sexually transmitted infections. These programs are based on the relations between non-sexual factors and teen pregnancy and sexually transmitted infection. The final type of prevention program is a combination of the first two programs, addressing both educational deficits and the relations between non-sexual factors and teen pregnancy and sexually transmitted infections.

Sexual antecedent programs provide participants with information related to sexuality and adolescent health. These programs exist along a continuum between providing only an abstinence-until-marriage message and providing comprehensive sexual education without any emphasis on abstinence. Most sexual antecedent programs provide services somewhere between

these two extremes, typically emphasizing abstinence as the most desirable option but also providing information on contraception. Some sexual antecedent programs have been shown to be effective at delaying the onset of intercourse, reducing the frequency of sex, increasing condom and contraception use, and reducing the number of sexual partners (Kirby, 2001). Kirby (2001) has identified ten characteristics of the most effective sexual antecedent intervention programs, which are shown in Table 2.

Table 2

Ten Characteristics of Effective Sex and HIV Education Programs from Kirby, 2001

The curricula of the most effective sex and HIV education programs share ten common characteristics. These programs:
1. Focus on reducing one or more sexual behaviors that lead to unintended pregnancy or HIV/STD infection.
2. Are based on theoretical approaches that have been demonstrated to influence other health-related behavior and identify specific important sexual antecedents to be targeted.
3. Deliver and consistently reinforce a clear message about abstaining from sexual activity and/or using condoms or other forms of contraception. This appears to be one of the most important characteristics that distinguishes effective from ineffective programs.
4. Provide basic, accurate information about the risks of teen sexual activity and about ways to avoid intercourse or use methods of protection against pregnancy and STDs.
5. Include activities that address social pressures that influence sexual behavior.
6. Provide examples of and practice with communication, negotiation, and refusal skills.
7. Employ teaching methods designed to involve participants and have them personalize the information.

8. Incorporate behavioral goals, teaching methods, and materials that are appropriate to the age, sexual experience, and culture of the students.
9. Last a sufficient length of time (i.e., more than a few hours).
10. Select teachers or peer leaders who believe in the program and then provide them with adequate training.

Youth development is one type of non-sexual antecedent intervention. Youth development "prepares young people to meet the challenges of adolescence and adulthood through a coordinated, progressive series of activities and experiences which help them to become socially, morally, emotionally, physically, and cognitively competent" (National Youth Development Information Center, 2005, p. 1). Youth development addresses the developmental needs of the participants rather than addressing only problems. By taking this approach, youth development focuses on the positive and views youth as a resource to be supported and utilized.

One form of youth development is peer education. Peer education programs involve participants who serve as peer educators. Peer educators educate, train, and support people who share some characteristic, such as age (Campbell, 2005). Although peer educators are providing education, training, and support to their peers regarding sexuality and adolescent health, the peer educators themselves are also recipients of the benefits of the program. Research to determine the precise mechanism by which peer education influences the peer educator has not been able to identify a theory that can provide a complete explanation, leading some researchers to describe peer education as "a method in search of a theory" (Turner & Shepard, 1999, p. 235).

Research on the effects of peer education on peer educators in relation to teen pregnancy and sexually transmitted infection is inconclusive, primarily because few studies have been done

in this area (Main, 2002). Some studies found positive effects from serving as a peer educator. Positive effects of serving as a peer educator included: more positive attitudes (Caron, Godin, Otis, & Lambert, 2004; Strange, Forrest, Oakley, & The RIPPLE Study Team, 2002), increased condom use (Caron et al., 2004; Smith & DiClemente, 2000), increased knowledge (Pearlman, Camberg, Wallace, Symons, & Finison, 2002; Slap, Plotkin, Khalid, & Michelman, 1991; Strange et al., 2002), increased perception of self as a change agent (Pearlman et al., 2002), decrease in unprotected sex (Smith & DiClemente, 2000), and increased confidence about communication and relationship skills (Strange et al., 2002) although other research did not find positive effects among peer educators (Ebreo, Feist-Price, Siewe, & Zimmerman, 2002).

Another form of youth development is service learning. Although precise definitions for service learning are varied, researchers and practitioners agree that the service must be organized according to an academic course or curriculum; have clearly stated learning objectives, address real community needs in a sustained manner over a period of time; and assist students in drawing lessons from the service through regularly scheduled, organized reflection or critical analysis activities, such as classroom discussions, presentations or directed writing (National Center for Education Statistics, 1999).

Service learning influences teen behavior by affecting developmental changes through learning opportunities, encouraging civic and social responsibility, improving interpersonal relations, and formenting a positive view of youth. In this way, service learning addresses the numerous psychosocial factors that influence teen sexual risk taking and recognizes that learning highly specific protective skills may not be sufficient to reduce teen pregnancy and sexually transmitted infections. Although the exact mechanism by which service learning works to reduce teen pregnancy has not been determined, research indicates that participants may be developing

relationships with program facilitators, gaining a sense of autonomy and feeling more competent in their relationships with peers and adults, and feeling empowered to make a difference in the lives of others (Kirby, 2001).

The service learning programs that show the most promising results are Teen Outreach Program, Reach for Health, and Children's Aid Society-Carrera (Kirby, 2001). The Teen Outreach Program is designed to engage participants in structured community service linked to classroom discussion and has been shown to reduce teen pregnancy (Allen, Philliber, Herling, & Kuppermine, 1997). Reach for Health is a similar program, consisting of community service and classroom discussion and has been shown to delay sexual initiation and reduce sexual activity (O'Donnell, et al., 1999). Children's Aid Society-Carrera is a year-round after school program using a comprehensive youth development model that has been shown to delay sexual initiation, reduce teen pregnancy, and increase the use of condoms and hormonal contraception (Philliber, Kaye, Herrling, & West, 2002). In addition, the Learn and Serve programs, a group of youth development programs based on community service and discussion, showed marginally significant results in reducing teen pregnancy when evaluated together (Melchior, 1999).

Teen Council Program Description

PPMNS is classified as a 501 (c) (3) not-for profit, tax exempt organization that is intended to provide direct health care services and educational programs to men, women and teens in Minnesota, North Dakota, and South Dakota. PPMNS exists as an affiliate of the Planned Parenthood Federation of America, a nationwide 501 (c) (3) not-for profit, tax-exempt organization that serves as a resource and authority for reproductive rights and reproductive health care nationwide (http://www.ppmns.org/).

PPMNS Teen Council is based on the Planned Parenthood of Western Washington (PPWW) Teen Council program, a youth development program in existence since 1988. PPWW Teen Council began as a method for evaluating the relevance of PPWW teen oriented activities. As teens became involved with evaluating activities, they also began to participate in delivering these activities to their peers. Through anecdotal evidence, PPWW staff determined that delivery of an adolescent health message to peers by a teen was more effective than an adult delivering the same message. In the PPWW Teen Council program, teens are educated regarding HIV/AIDS prevention, pregnancy prevention, abstinence and other topics related to sexuality and decision making in order to empower peers to make informed and healthy life choices through school and community organization presentations (*Teen Council*, 2000).

In 2003, PPMNS staff created their own version of the PPWW Teen Council program in Duluth and Rochester. The PPMNS program was created based on PPMNS staff interest in the promising results of youth development as a teen sexual risk taking intervention as well as the reported success of the PPWW Teen Council program. While there are similarities in the PPMNS and PPWW programs, the PPMNS Teen Council requires participants to engage in separate community service in addition to peer education presentations and issue advocacy. The required community service is intended to provide teens with experience serving as community role models and also acting as social activists on issues while learning how these issues influence the well-being of the community.

After two years, Teen Council expanded to include another location in Minneapolis-St. Paul, known as Metro Teen Council. In its three locations, Teen Council operates as a youth development program that incorporates comprehensive sexual education, peer education, and service learning to increase teen sexuality and adolescent health knowledge, increase self-

esteem, improve school performance and engagement in school activities, and improve participants' outlook on the future. In addition, Teen Council provides education regarding sexuality and adolescent health to teens who are not participants (*Teen Council*, 2006).

PPMNS Teen Council Logic Model

Interventions intended to reduce teen sexual risk taking should be based on the interactions between determinants (risk and protective factors), the behaviors that are influenced by these determinants, and the program activity interventions that are taken to reduce the influence of risk factors and increase the influence of protective factors (Kirby, 2004). A Behavior, Determinant, Intervention (BDI) Logic Model is a visual representation of these interactions. A BDI Logic Model shows the intervention (program activity), the determinants that the intervention increases or reduces, the resulting behavior change and the health goal that should be met as a result (Kirby, 2004). In the BDI logic model that PPMNS staff created for the Teen Council program, the health goals desired are a reduction in teen pregnancy and a reduction in teen sexually transmitted diseases. In order to achieve these goals, the behaviors desired of teens are delaying sexual initiation, reducing the frequency of sex and increasing the correct and consistent use of condoms.

PPMNS staff used current research in the field of teen sexual risk taking intervention to identify the determinants which a youth development program could most feasibly influence and which are most significant in determining teens' sexual risk taking behavior. Staff incorporated eight factors into the logic model that research shows are significant in influencing teens' sexual risk taking behavior (Kirby, 2001). These factors were (1) positive attitudes about avoiding pregnancy and sexually transmitted infections, (2) greater knowledge of contraception and sexually transmitted infections, (3) positive peer norms and support for condom and

contraceptive use, (4) improved educational aspirations and plans for the future, (5) less use of drugs or alcohol and other risky behaviors, (6) improved interpersonal and communication skills, (7) parental support and family connectedness, and (8) connections and sense of involvement with the community. Based on the logic model, increasing protective factors and decreasing risk factors is likely to reduce sexual risk taking and, therefore, pregnancy and sexually transmitted infections among Teen Council participants.

PPMNS Teen Council Recruitment

PPMNS Teen Council applicants should be between the ages of 15 and 19. Applicants should also be willing to commit to participating in Teen Council from August through May. Participation consists of two and a half hours per week for Teen Council meetings, five to ten hours per week for peer education presentations and community service, and a three-day, two-night training retreat. Applicants should be interested in finding answers and providing solutions to community and world events and issues; passionate about peer education concerning teen sexuality issues, decision making, and healthy relationships; and interested in community service, leadership and participation in community events. Applicants also should have parental permission to participate in the program. Applicants are not required or expected to have any sexuality or adolescent health knowledge or presentation experience (*Educate Advocate Serve*, 2006).

Participants are recruited for the program primarily through schools. Current Teen Council members assist in recruitment by announcing opportunities for joining Teen Council during peer education presentations in classrooms and elsewhere. Typically, applicants discuss the program with staff prior to application. Applicants then apply in writing and PPMNS staff use applications to select qualified candidates. PPMNS staff then interviews the candidates and

selects participants. Approximately 15 teens applied to the Rochester Teen Council and eight were selected. Two participants later withdrew due to a code of conduct violation and being called upon to work on the family farm, resulting in retention of six participants throughout the year. Eleven teens applied to the Metro Teen Council and all eleven were selected. One participant later withdrew due to scheduling conflicts, resulting in retention of ten participants throughout the year.

Approximately 20 teens applied to the Duluth Teen Council and 14 were selected. Three participants later withdrew, resulting in retention of 11 participants throughout the year. The low number of applicants and high rate of selection for Teen Council recruitment was due to the process of discussing the required commitment potential applicants prior to their official application to the program, which dissuaded potential applicants who were not suited to program participation. The level of self selection among Teen Council applicants resulting from the discussion of the commitment required for participation is consistent with research indicating that when potential applicants are provided with a realistic job preview, the number of candidates who drop out from further consideration for a job increases (Premack & Wanous, 1985).

PPMNS Teen Council Training

Teen Council provided participants with training in sexuality and adolescent health related topics. This training began with a three-day, two-night retreat for leaders and participants that provided a shared bonding experience for leaders and participants as well as training for participants in anatomy, sexuality, peer education, leadership, and communication skills. After the retreat, training for participants continued during weekly Teen Council meetings, with further training in anatomy, abstinence, contraception, sexually transmitted infections, abortion, pregnancy, domestic violence, and other health related topics. Some weekly meetings

incorporated field trips to activities such as a health clinic tour or discussion forum in order to provide further knowledge and experience to participants.

Teen Council participants were also provided training in the skills required to be effective peer educators. Participants attended a presentation skills retreat where Teen Council leaders provided training in leadership development, problem solving, communication, peer education, presentation, issue advocacy, and other topics related to presentation skills, which are shown in Table 3.

Table 3

PPMNS Teen Council Weekly Meeting Topics and Associated Skills

Educational topic	Skill training
Orientation	Introductions: New members, contracts, and goals
Anatomy	Reproductive anatomy training
Anatomy and abstinence	Reproductive anatomy and abstinence training
Advocacy workshop	Advocacy training
MAP Forum	Gain knowledge regarding gay men and AIDS
Birth control	Contraception training
Parents' reception	Demonstrate knowledge and skills training to parents
STIs	Sexually transmitted infections training
Fundraising event	Participate in fundraising
Clinic tour	Experience health clinic environment
Crisis Nursery	Service project
HIV/AIDS speaker	HIV/AIDS training
Highland Clinic tour	Abortion training

Educational topic	Skill training
Midwife speaker	Pregnancy training
Adoption speaker	Adoption training
Domestic violence speaker	Domestic violence training

PPMNS Teen Council Program Activities

Teen Council consisted of educational sessions, peer education, and service learning. Participants were able to provide peer education on a topic only after receiving training on a topic themselves. Typically, participants presented in middle and high school classrooms but occasionally presented in other venues. Pairs of participants presented together and were supervised by Teen Council leaders. Participants gave 223 presentations, reaching 4117 peers, as shown in Table 4.

Table 4

PPMNS Teen Council Peer Education Sessions and Peers by Topic

Topic	Number of sessions	Number of peers	Percent of peers
Comprehensive education	1	8	.9%
Communication skills	1	85	.9%
Contraception	82	1472	40.7%
Delaying intercourse	11	66	1.8%
Healthy relationships	32	736	11.5%
Other*	32	545	15.9%
Planned Parenthood	1	25	.9%
Puberty	2	40	.9%
Safer sex	3	38	.9%

Topic	Number of sessions	Number of peers	Percent of peers
Self-esteem	2	60	.9%
Sexuality	13	241	6.2%
STIs	41	783	17.7%
Teenage pregnancy	2	18	.9%
Total	223	4117	100.0%

*Gender stereotypes, body image, anatomy, health exams, pregnancy options, abstinence.

Teen Council participants were also involved in community service as part of the service learning component of the program. Community service was not limited to sexuality and adolescent health topics but involved other social issues as well. Some community service topics addressed by Teen Council participants included World AIDS Day, National Condom Week, and advocacy for the homeless.

Chapter III: Methodology

This evaluation was intended to measure the impact of Teen Council on the program's eight intended outcomes. These were the same intended outcomes as those explored previously by the 2004 evaluation. Ten specific evaluation questions, created from the intended outcomes, were answered in this evaluation. These evaluation questions were also the same as those used in the previous evaluation. The impact of the program on teens who received peer education was not considered to be within the scope of this evaluation. The impact of Teen Council activities on their communities was also not considered to be within the scope of the evaluation. Table 5 shows Teen Council activities, intended outcomes related to those activities, and the associated evaluation questions.

Table 5

PPMNS Teen Council Activities, Intended Outcomes, and Evaluation Questions

Activity	Intended outcome	Evaluation question
The overall Teen Council experience	Teen Council members recognize the importance of delaying pregnancy and maintaining good adolescent health.	1. In what ways has the Teen Council experience affected the teens' attitudes towards sexuality and adolescent health?
	Teen Council members feel hopeful about their future after high school.	2. How do the teens feel the Teen Council experience will impact their future after high school?
	Teen Council members will promote contraceptive use among their peers.	3. Do the teens promote contraceptive use among their peers?

Activity	Intended outcome	Evaluation question
Weekly education sessions	Teen Council members will have a solid understanding of adolescent and reproductive health.	4. Is there an increase in knowledge from pre- to post-questionnaire?
		5. What do the teens say they learned most from Teen Council?
	Teen Council members will know how to access reproductive health-related resources.	6. Do the teens feel they have resources they could refer someone to if asked about various reproductive health-related topics?
Presentations to peers	Teen Council members will communicate comfortably and knowledgeably about sexuality and adolescent health issues with others, including their family.	7. Did the teens' communication and presentation skills improve?
		8. Do the teens feel more comfortable and confident in their ability to communicate effectively with their peers and family?
Community service projects	Teen Council members will understand the issues within their local community that impact pregnancy rates and the transmission of STIs.	9. What impact did volunteering have on the teens' knowledge and awareness of issues within their local community?

Activity	Intended outcome	Evaluation question
	Teen Council members will believe they have the power to make a positive impact on their community.	10. Do the teens feel empowered to make a difference in their communities and beyond?

PPMNS Teen Council Questionnaire Subject Selection and Description

In August 2005, pre-questionnaires were administered to 13 Duluth participants, 11 Metro participants, and eight Rochester participants. In May 2006, post-questionnaires were administered to 10 Duluth participants, 10 Metro participants and 5 Rochester participants. Absent and withdrawn participants resulted in 9 Duluth, 10 Metro, and 5 Rochester participants who completed both the pre- and post-questionnaire. Only the questionnaire data from members who completed both questionnaires were included in this evaluation (n=24).

Sampled Duluth participants included eight females and one male. At the time of the pre-questionnaire, Duluth participants ranged from 15 to 17 years old, with a mean age of 16.11. Sampled Metro participants included nine females and one male. At the time of the pre-questionnaire, Metro participants ranged from 15 to 17 years old, with a mean age of 15.9. Sampled Rochester participants included nine females and one male. At the time of the pre-questionnaire, Rochester participants ranged from 15 to 16 years old, with the exception of one 21 year old participant. The 21 year old participant was accepted due to their high school student status. Without this outlier, the mean age of Rochester members was 15.50.

PPMNS Teen Council Questionnaire Instrumentation

The goal of the questionnaire was to answer four evaluation questions:

1. In what ways has the Teen Council experience affected the teens' attitudes towards sexuality and adolescent health?

4. Is there an increase in knowledge from pre- to post-questionnaire?

6. Do the teens feel they have resources they could refer someone to if asked about various reproductive health-related topics?

8. Do the teens feel more comfortable and confident in their ability to communicate effectively with their peers and family?

The questionnaire used in this evaluation was originally created by PPMNS staff and later updated following the 2004 evaluation. The pre- and post-questionnaire were identical with the exception of an additional page of open-ended questions following the post-questionnaire. Data from the additional post-questionnaire page was not used in the evaluation. The questionnaire also included a demographic information section (gender, age, grade in school, race, and living situation). The questionnaire measured attitudes towards sexuality and adolescent health, knowledge of sexuality and adolescent health, perceived access to sexuality and adolescent health-related resources, and frequency of conversations with peers and family regarding sexuality and adolescent health. These items consisted of true/false, multiple-choice, matching, and Likert-scale questions. Questionnaire content validity was based on PPMNS staff expertise in the field of comprehensive sexual education. The test-retest reliability of the knowledge scale was $r = .45, p < .05$.

PPMNS Teen Council Questionnaire Data Collection Procedure

Teen Council leaders administered pre- and post-questionnaires during weekly meetings. Leaders assured participants that questionnaire responses would remain confidential. Six digit codes were used to match pre- and post-questionnaires but could not be used to identify

participants. Leaders collected the questionnaires when completed and mailed them to the evaluator in a sealed envelope.

PPMNS Teen Council Questionnaire Data Analysis

Questionnaire responses were coded and entered into Microsoft Excel 2003. Data from items 4, 18 and 28 were not used due to poor item construction. A Knowledge Scale, shown in Appendix C, was created from true/false, multiple-choice, and matching items that could be scored as correct or incorrect. Questionnaire items were scored one point per correct item response for a maximum possible Knowledge Scale score of 30 points. Incorrect and missing responses were scored zero points. A Sexual Attitudes Scale, shown in Appendix D, was created from seven Likert-scale items that assessed sexual attitudes.

A Self-Esteem Scale, shown in Appendix E, was created from five Likert-scale items that assessed participants' self esteem. An Access to Resources Scale, shown in Appendix F, was created from five true/false items that assessed participants' access to resources. A Parental Communications Scale, shown in Appendix G, was created from six multiple choice items that assessed participants' communication with parents. A Sexual Communication Frequency Scale, shown in Appendix H, was created from four multiple choice items that assessed participants' frequency of communication regarding sexuality. A Sexual Communication Comfort Scale, shown in Appendix I, was created from four multiple choice items that assessed participants' comfort in communication regarding sexuality.

Data was analyzed using Microsoft Excel 2003 and SPSS version 12.0. Individual questionnaire item results were assessed using frequency distributions and means. Changes in Knowledge, Sexual Attitudes, Self-Esteem, Access to Resources, Parental Communications,

Sexual Communication Frequency, and Sexual Communication Comfort Scales were measured using paired samples t-tests, with an alpha level of .05.

PPMNS Teen Council Focus Groups Subject Selection and Description

Approximately one month prior to the event, Teen Council leaders informed participants that focus groups would be held instead of a weekly meeting. Leaders emphasized that focus group participation was be voluntary and participants would not be penalized for not attending the focus groups. Sampled Duluth participants included eight females and one male. Sampled Metro participants included nine females and one male. Sampled Rochester participants included two females and two males. Focus group participants' ages ranged from 15 to 21.

PPMNS Teen Council Focus Groups Instrumentation

The goal of the focus groups was to answer seven evaluation questions:

1. In what ways has the Teen Council experience affected the teens' attitudes towards sexuality and adolescent health?

2. How do the teens feel the Teen Council experience will impact their future after high school?

3. Do the teens promote contraceptive use among their peers?

5. What do the teens say they learned most from Teen Council?

7. Did the teens' communication and presentation skills improve?

9. What impact did volunteering have on the teens' knowledge and awareness of issues within their local community?

10. Do the teens feel empowered to make a difference in their communities and beyond?

Thirteen specific questions (shown in Appendix J) were asked during the focus groups in order to elicit discussion that could be used to answer the evaluation questions. In addition, the

evaluator, acting as focus group moderator, asked further related questions when the initial question did not result in sufficient discussion.

PPMNS Teen Council Focus Groups Data Collection Procedure

Participant assent forms (shown in Appendix K) and Parental consent forms (shown in Appendix L) were distributed by Teen Council leaders prior to the focus groups as per University of Wisconsin-Stout Institutional Review Board instructions. The consent and assent forms informed parents and participants that participation was voluntary, discussion would remain confidential, and that participants could withdraw at any time without penalty. Participants were required to have both forms completed prior to focus group participation. The Duluth focus group was conducted April 13th in a conference room at a coffee shop in Duluth; the Metro focus group was conducted April 25th at the Minneapolis Uptown Planned Parenthood Clinic; and the Rochester focus group was conducted April 12th at the Rochester Planned Parenthood Clinic. Focus groups lasted between one and two hours each. The evaluator facilitated the Duluth and Metro focus groups with the assistance of Planned Parenthood co-facilitators who were neither involved with Teen Council nor known to participants. The evaluator facilitated the Duluth focus group without a co-facilitator due to the lack of an available volunteer who was not involved with Teen Council or known to participants.

PPMNS Teen Council Focus Groups Data Analysis

Focus groups were conducted based on best practices research. Focus groups recordings were made on a digital voice recorder and stored on a computer that could only be accessed by the evaluator. Written notes were also taken by co-facilitators. Transcriptions of the focus group recordings were made, with comments attributed to facilitator and participant (Krueger, 1998).

Focus group comments were coded into themes that corresponded with evaluation questions. Sorted comments were analyzed based on best practices research. One factor used to analyze comments was frequency, or the number of times a comment was made by any participant. Another factor was extensiveness, or how many different participants made a comment. A third factor was intensity, or the evaluator's perception of the strength of the participant's feelings. The final factor used was specificity, or whether a speaker discussed a personal experience or a topic in abstract (Krueger, 1998).

Chapter IV: Results

Questionnaire Results

Evaluation question 1: In what ways has the Teen Council experience affected the teens' attitudes towards sexuality and adolescent health?

Participants' attitudes related to the number of children desired, the best age to have a first child, the best age for a female for first intercourse, and the best age for a male for first intercourse were assessed through multiple-choice items on the questionnaire. Item 53 assessed the number of children desired by participants. Table 5 shows frequency of responses by questionnaire. Most participants wanted either 1-2 (37.5%) or 3-4 children (45.8%) prior to participation in Teen Council. Participants wanted fewer children following participation in Teen Council, with most responding that they wanted 1-2 children (62.5%). In response to the pre-questionnaire, one participant selected 3-4 but noted that two of these children would be adopted. This response was scored as 3-4 for analysis.

Table 6

Item 53 Frequency of Responses by Questionnaire

Questionnaire	None	1-2	3-4	5-6	More than 6
Pre	8.3%	37.5%	45.8%	8.3%	0.0%
Post	12.5%	62.5%	20.8%	4.2%	0.0%

N = 24

Item 54 assessed participants' attitudes regarding the best age for a first child. Table 6 shows frequency of responses by questionnaire. Most participants believed that the best age to have a first child was 24-29 (66.7%) prior to participation in Teen Council. Most participants believed that 24-29 is the best age to have a first child (71.4%) following participation in Teen

Council, but fewer participants believed 20-24 was the best age and more believed 31-35 is best. Some participants wrote in responses rather than selecting from those provided. One participant wrote in *30* on the post-questionnaire, most likely because this response was mistakenly not provided as an option. This response was scored as missing because it is not known if the participant actually wanted to indicate that 30 was the best age to have a child or if the participant simply wanted to point out that the questionnaire did not provide this response as an option. Additionally, one participant wrote in *never* on the post-questionnaire. A third participant selected 24-29, 21-35, and after age 35. This participant likely believes that any age 24 or older is best for a first child. These responses were scored as missing and were not used for analysis.

Table 7

Item 54 Frequency of Responses by Questionnaire

Questionnaire	Under 16	16-19	20-24	24-29	31-35	After age 35
Pre	0.0%	0.0%	28.6%	66.7%	4.8%	0.0%
Post	0.0%	0.0%	14.3%	71.4%	14.3%	0.0%

N = 21

Item 55 assessed participants' attitudes regarding the best age for female first intercourse. Table 7 shows frequency of responses by questionnaire. Most participants believed that 17-19 is the best age for female first intercourse (53.3%) prior to participation in Teen Council. Most participants believed that 17-19 is the best age for female first intercourse (53.3%) following participation in Teen Council, but fewer participants believed that 14-16 is the best age and more believed that 20-22 is best. Six participants wrote in responses rather than selecting from those provided. On both the pre- and post-questionnaire, two participants wrote in *when ready*. On the

post-questionnaire, one participant wrote in *any age* and another selected both 17-19 and 20-22. These responses were scored as missing and were not used for analysis.

Table 8

Item 55 Frequency of Responses by Questionnaire

Questionnaire	Under 14	14-16	17-19	20-22	23-25	Over age 25
Pre	0.0%	13.3%	53.3%	26.7%	0.0%	6.7%
Post	0.0%	6.7%	53.3%	40.0%	0.0%	0.0%

N=15

Item 56 assessed participants' attitudes regarding the best age for male first intercourse. Table 8 shows frequency of responses by questionnaire. The largest group of participants believed that 17-19 is the best age for male first intercourse (50.0%) prior to participation in Teen Council. Most participants believed that 17-19 is the best age for male first intercourse (56.3%) following participation in Teen Council. Six participants wrote in responses rather than selecting from those provided. On both the pre- and post-questionnaire, two participants wrote in *when ready*. On the post-questionnaire, one participant wrote in *any age* and another indicated both 17-19 and 20-22. These responses were scored as missing and were not used for analysis.

Table 9

Item 56 Frequency of Responses by Questionnaire

Questionnaire	Under 14	14-16	17-19	20-22	23-25	Over age 25
Pre	0.0%	12.5%	50.0%	31.3%	0.0%	6.3%
Post	0.0%	12.5%	56.3%	31.3%	0.0%	0.0%

N=15

Items 57 through 63 assessed participants' attitudes relating to sexuality using Likert-scale responses. Table 9 shows frequency of responses by questionnaire. Responses were scored to create a Sexual Attitudes Scale score, with one point awarded to strongly agree responses through five points awarded to strongly disagree responses. Scores on items referring to positive attitudes, Items 58, 61, and 62, were reversed. Sexual Attitudes Scale scores (n = 24) increased from pre- ($M = 29.79$, $SD = 2.95$) to post-questionnaire ($M = 30.54$, $SD = 2.48$). This difference was tested using a paired samples t-test and was not shown to be significant, $t(23) = 1.32$, $p > .05$.

Table 10

*Sexual Attitudes Scale Frequency of Responses by Questionnaire**

Item	Strongly Agree		Agree		Neutral		Disagree		Strongly Disagree	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Item 57. If I have sex while I'm a teenager, it would make me feel sort of important.	0.0	0.0	8.3	0.0	20.8	33.3	37.5	37.5	33.3	29.2
Item 58. I think it is OK to say "NO" when someone wants to touch me.	87.5	87.5	12.5	12.5	0.0	0.0	0.0	0.0	0.0	0.0
Item 59. "Love" and "having sex" mean the same thing.	4.2	0.0	0.0	0.0	4.2	8.3	25.0	16.7	66.7	75.0

Item	Strongly Agree		Agree		Neutral		Disagree		Strongly Disagree	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Item 60. Having sex while I'm a teenager would just be doing what everybody else is doing.	4.2	0.0	8.3	12.5	33.3	20.8	29.2	33.3	25.0	33.3
Item 61. People who want to have sex should respect the right of others to say "No."	87.5	87.5	8.3	8.3	0.0	0.0	4.2	0.0	0.0	4.2
Item 62. If I do have sex, I feel comfortable that I know how to use a condom.	70.8	83.3	25.0	8.3	0.0	0.0	4.2	0.0	0.0	8.3
Item 63. I feel that I can make good decisions even if I've been drinking or using drugs.	8.3	4.2	16.7	12.5	25.0	16.7	29.2	29.2	20.8	37.5

**Numbers shown are in percent.*

Items 64 through 68 assessed participants' attitudes relating to self-esteem using Likert-scale responses. Table 10 shows frequency of responses by questionnaire. Items were combined to create a Self-Esteem Scale score, with one point awarded to strongly agree responses through five points awarded to strongly disagree responses. Scores on items referring to positive attitudes, Items 64, 65, and 68, were reversed. Self-Esteem Scale scores (n = 24) increased from

pre- ($M = 22.04$, $SD = 2.40$) to post-questionnaire ($M = 22.54$, $SD = 2.17$). This difference was tested using a paired samples t-test and was not significant, $t(23) = 1.212$, $p > .05$.

Table 11

*Self-Esteem Scale Frequency of Responses by Questionnaire**

Item	Strongly Agree		Agree		Neutral		Disagree		Strongly Disagree	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
64. I feel that I have a number of good qualities.	54.2	62.5	41.7	37.5	4.2	0.0	0.0	0.0	0.0	0.0
65. I am able to do things as well as most other people.	43.5	70.0	56.5	30.4	0.0	0.0	0.0	0.0	0.0	0.0
66. I feel I do not have much to be proud of.	0.0	4.2	0.0	0.0	12.5	0.0	29.2	37.5	58.3	58.3
67. I'm confused about my personal sexual values and beliefs.	0.0	0.0	0.0	0.0	12.5	12.5	41.7	20.8	45.8	66.7
68. I have a clear picture of what I'd like to be doing in the future.	54.2	45.8	25.0	29.2	16.7	12.5	4.2	8.3	0.0	4.2

**Numbers shown are in percent.*

Evaluation question 4: Is there an increase in knowledge from pre- to post-questionnaire?

Thirty items regarding contraception, sexually transmitted infections, and other topics assessed participants' factual knowledge. Table 11 shows frequency of responses by questionnaire. To create a Knowledge Scale score, correct responses were awarded one point for a possible total of 30 points. Knowledge Scale scores (n = 24) increased from pre- ($M = 25.54$, $SD = 3.51$) to post-questionnaire ($M = 28.63$, $SD = 2.06$). This difference was tested using a paired samples t-test and was shown to be significant, $t(23) = 4.76$, $p < .01$.

Less than 90% of participants responded to the following items correctly on the post-questionnaire:

2. True or False: A young woman can get pregnant before she has her first menstrual period.

7. True or False: A young man should put on a condom just before he ejaculates (comes).

8. True or False: If a condom is used, a young man should pull out before he loses his erection.

26. Is Herpes a bacteria, virus, or parasite?

Table 12

Knowledge Scale Frequency of Correct Responses by Questionnaire

Construct	Item	Percent Responding Correctly	
		Pre	Post
Contraception	1	87.5%	100.0%
	6	100.0%	100.0%
	7	75.0%	79.2%
	8	66.7%	87.5%
	16	87.5%	91.7%
	17	62.5%	91.7%

Construct	Item	Percent Responding Correctly	
		Pre	Post
	31	79.2%	100.0%
	32	66.7%	95.8%
	33	100.0%	100.0%
	34	100.0%	100.0%
	35	91.3%	100.0%
	36	91.7%	100.0%
	37	69.6%	95.7%
	38	95.8%	100.0%
STIs	5	95.8%	95.8%
	11	87.5%	100.0%
	22	66.7%	100.0%
	23	95.8%	100.0%
	24	45.8%	91.7%
	25	95.8%	100.0%
	26	58.3%	87.5%
	27	79.2%	95.8%
	29	78.3%	100.0%
	30	100%	100%
Other	2	70.8%	79.2%
	3	83.3%	91.7%
	15	100.0%	100.0%

Construct	Item	Percent Responding Correctly	
		Pre	Post
	19	91.7%	100.0%
	20	79.2%	91.7%
	21	95.8%	91.7%

Evaluation question 6: Do the teens feel they have resources they could refer someone to if asked about various reproductive health-related topics?

Items 10 through 14 assessed participants' perceived access to resources. Table 12 displays frequency of responses by questionnaire. To create an Access to Resources Scale score, responses of true were awarded one point, for a total of five points possible. Access to Resources Scale scores (n = 24) increased from pre- ($M = 4.08$, $SD = 1.14$) to post-questionnaire ($M = 4.83$, $SD = .48$). This difference was tested using a paired samples t-test and was shown to be significant, $t(23) = 3.42$, $p < .01$.

Less than 90% of participants indicated on the post-questionnaire that they had access to resources for persons who believed they may be gay, lesbian, or bisexual. In addition, fewer participants indicated on the post-questionnaire than on the pre-questionnaire that they have the appropriate language and communication skills to talk effectively about sexuality.

Table 13

Access to Resources Scale Frequency of True Responses by Questionnaire

Questionnaire item	Percent responding *true*	
	Pre	Post
10. I feel that I have resources I could refer someone to if someone asked me where they could go to get an abortion.	75%	100.0%
11. I feel that I have resources I could refer someone to if someone asked me where to go to get STI tests	87.5%	100.0%
12. I feel that I have resources I could refer someone to if someone thought he or she might be gay, lesbian, or bisexual.	66.7%	87.5%
13. I feel that I have resources I could refer someone to if he/she was the victim of dating violence.	79.2%	100.0%
14. I feel that I have the appropriate language and communication skills to talk effectively about sexuality.	100.0%	95.8%

Evaluation question 8: Do the teens feel more comfortable and confident in their ability to communicate effectively with their peers and family?

Items 39 through 44 assessed participants' communication with parents regarding topics related to sexuality. Table 13 displays frequency of responses by questionnaire. To create a Parental Communication Scale score, responses of *yes* were awarded one point, for a total of six points possible. Parental Communication Scale scores (n = 24) increased from pre- ($M = 4.38$, $SD = 1.72$) to post-questionnaire ($M = 4.96$, $SD = 1.57$). This difference was tested using a paired samples t-test and was not shown to be significant, $t(23) = 1.94$, $p > .05$.

Less than 90% of TC members responded on the post-questionnaire that they had discussed the following items with parents:

40. How pregnancy occurs

41. Sexually transmitted infections (STIs)

42. How to say no to sex

43. Methods of birth control

44. How to prevent HIV/AIDS using safe sex practices

Table 14

*Parental Communication Scale Frequency of Responses by Questionnaire**

Have you ever talked with one or both of your parents about:	Percent responding *yes*	
	Pre	Post
39. The female menstrual cycle	95.8%	95.8%
40. How pregnancy occurs	79.2%	87.5%

Have you ever talked with one or both of your parents about:	Percent responding *yes*	
	Pre	Post
41. Sexually transmitted infections (STIs)	62.5%	75.0%
42. How to say no to sex	66.7%	83.3%
43. Methods of birth control	66.7%	83.3%
44. How to prevent HIV/AIDS using safe sex practices	66.7%	70.8%

**Numbers shown are in percent.*

Items 45 through 48 assessed participants' communication with parents and peers. Table 14 displays frequency of response by questionnaire. To create a Sexual Communication Frequency Scale score, responses of *not at all* were awarded zero points through four points for *more than 6*, for a total of 16 points possible. Sexual Communication Frequency Scale scores (n = 24) increased from pre- ($M = 6.33$, $SD = 2.50$) to post-questionnaire ($M = 7.00$, $SD = 2.80$). This difference was tested using a paired samples t-test and was not shown to be significant, $t(23) = 1.26$, $p > .05$.

Items 45 through 48 were also analyzed individually. Items 45 through 48 assessed participants' communication with parents and peers. Table 14 displays frequency of responses by questionnaire. Responses were coded from zero for responses of *not at all* through four for responses of *more than 6*. Item 45 responses (n = 24) increased from pre- ($M = .92$, $SD = .97$) to post-questionnaire ($M = 1.04$, $SD = .96$). This difference was tested using a paired samples t-test and was not shown to be significant, $t(23) = .65$, $p > .05$. Item 46 responses (n = 24) increased from pre- ($M = 2.79$, $SD = 1.14$) to post-questionnaire ($M = 2.96$, $SD = 1.16$). This difference

was tested using a paired samples t-test and was not shown to be significant, $t(23) = .70, p > .05$. Item 47 responses (n = 24) increased from pre- ($M = .63$, $SD = .65$) to post-questionnaire ($M = .67$, $SD = .64$). This difference was tested using a paired samples t-test and was not shown to be significant, $t(23) = .33, p > .05$. Item 48 responses (n = 24) increased from pre- ($M = 2.00$, $SD = .98$) to post-questionnaire ($M = 2.33$, $SD = .96$). This difference was tested using a paired samples t-test and was not shown to be significant, $t(23) = 1.36, p > .05$.

Table 15

*Sexual Communication Frequency Scale Frequency of Responses by Questionnaire**

During an average week, how many times do you have a conversation or discussion about:	Not at all		1-2		2-4		4-6		More than 6	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
45. Sex with your parents?	41.7	33.3	33.3	37.5	16.7	20.8	8.3	8.3	0.0	0.0
46. Sex with your friends?	0.0	0.0	16.7	16.7	25.0	16.7	20.8	20.8	37.5	45.8
47. Birth control with your parents?	45.8	41.7	45.8	50.0	8.3	8.3	0.0	0.0	0.0	0.0
48. Birth control with your friends?	0.0	4.2	37.5	8.3	33.3	50.0	20.8	25.0	8.3	12.5

**Numbers shown are in percent.*

Items 49 through 52 assessed participants' comfort level during communication regarding sexuality. Table 15 displays frequency of response by questionnaire. To create a Sexual Communication Comfort Scale score, responses were awarded one point for *very uncomfortable* through four points for *comfortable*, for a total of 16 points possible. Responses of *this does not*

apply - I have not been in this situation were excluded from analysis. Sexual Communication Scale scores (n = 20) decreased from pre- (M = 14.60, SD = 1.73) to post-questionnaire (M = 14.35, SD = 2.66). This difference was tested using a paired samples t-test and was not shown to be significant, $t(19) = .48$, $p > .05$.

Items 49 through 52 were also analyzed individually. Items 49 through 52 assessed participants' comfort level during communication regarding sexuality. Table 15 displays frequency of response by questionnaire. Responses were coded from one for responses of *very uncomfortable* through four for responses of *comfortable*. Responses of *this does not apply - I have not been in this situation* were excluded from analysis. Item 49 responses (n = 24) decreased from pre- (M = 4.00, SD = .00) to post-questionnaire (M = 3.63, SD = 1.01). This difference was tested using a paired samples t-test and was not shown to be significant, $t(23) = -1.81$, $p > .05$.

Item 50 responses (n = 23) increased from pre- (M = 3.65, SD = .57) to post-questionnaire (M = 3.70, SD = .64). This difference was tested using a paired samples t-test and was not shown to be significant, $t(22) = .44$, $p > .05$. Item 51 responses (n = 23) increased from pre- (M = 3.09, SD = .95) to post-questionnaire (M = 3.26, SD = 1.01). This difference was tested using a paired samples t-test and was not shown to be significant, $t(22) = .72$, $p > .05$. Item 52 responses (n = 21) decreased from pre- (M = 3.86, SD = .66) to post-questionnaire (M = 3.57, SD = .93). This difference was tested using a paired samples t-test and was not shown to be significant, $t(20) = 1.83$, $p > .05$.

Table 16

*Sexual Communication Comfort Scale Frequency of Response by Questionnaire**

How comfortable are you:	Very uncomfortable		Somewhat uncomfortable		A little uncomfortable		Comfortable	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post
49. Talking with friends about sex.	0.0	12.5	0.0	0.0	0.0	0.0	100.0	87.5
50. Talking with a date or a boy/girlfriend about sex.	0.0	0.0	4.3	8.3	26.1	16.7	69.6	75.0
51. Talking with parents/guardians about sex.	8.3	4.3	12.5	26.1	37.5	8.7	41.7	60.9
52. Talking about sexuality issues with those whose sexuality is different than your own.	4.3	9.1	0.0	0.0	0.0	18.2	95.7	72.7

**Numbers shown are in percent.*

Focus Group Results

Evaluation question 1: In what ways has the Teen Council experience affected the teens' attitudes towards sexuality and adolescent health?

Teen Council has influenced participants' individual attitudes toward sexuality and adolescent health. Participants changed from holding a view of sexuality as taboo to considering it to be an acceptable and normal topic of discussion. Prior to Teen Council, most participants held the position that they had not been able to see sexuality as serious or factual but rather saw

it as a topic that was only appropriate to joke about or could only be discussed in a way that was embarrassing. One participant described changing from viewing sexuality as a topic which was not acceptable to talk about to considering it to be "part of everyday life." Another participant described the change and the realization of how different their view had become from that of the average person. This participant described the change in attitudes resulting from the Teen Council experience as a "change in perception" and also pointed to the need to be "open and honest around the subject of sexuality." Other participants indicated that, not only were their attitudes regarding sexuality not developed prior to the Teen Council, but their command of knowledge in the area was also lacking. These participants further indicated that the Teen Council experience had provided them with sufficient knowledge and had helped to develop their personal attitudes regarding sexuality and adolescent health.

Teen Council also influenced participants to have increased acceptance of people who are different, particularly in sexuality or health areas. Participants typically described having an increased awareness or understanding of race, gender, cultural, and religious differences and the bigotry that some hold for these differences. Additionally, many participants indicated that Teen Council had influenced them to have increased acceptance and understanding of gay and lesbian people and their culture. One telling remark is an example: "I have to admit that before [Teen Council] I was kind of, I wasn't a homophobe but I was just a little leery of homosexuals." While no participants indicated that they were prejudiced prior to Teen Council, most described a change from having little familiarity or knowledge of homosexuality to accepting and feeling comfortable with gay and lesbian people.

A minority of participants indicated that their attitudes were not changed by Teen Council due to already having a significant knowledge base of information regarding sexuality

and adolescent health that was similar to that which Teen Council provided. This theme is evidenced by the following statement: "I don't think I've learned much in terms of actual sexual health. I've been through several Sex Ed. courses and my mom teaches pregnancy classes, I'm surrounded by it all the time. But I think (Teen Council) just kind of reaffirmed my commitment to comprehensive Sex Ed." Although this participant felt that the Teen Council experience was valuable for other reasons, there was little room for improvement in their participant's already positive outlook on teen sexuality or adolescent health.

Evaluation question 2. How do the teens feel the Teen Council experience will impact their future after high school?

Teen Council has had a positive impact on participants' futures after high school. Some participants indicated that the Teen Council has changed their career plans. Typically, Teen Council changed participants' interests from a field unrelated to Teen Council activities to women's studies or health care.

> "I always knew I was going to go to college but I didn't know what I wanted to do. Last year when I was in Teen Council I decided that I was going to become a RN at a reproductive health clinic. Just seeing the passion of the people, and seeing that I could directly help somebody made me want to do it... It inspired me to take this a step further and to actually make sure that it is my future."
>
> "Before I wanted to be a criminal psychologist but now I'm thinking of going into health care. I know I'm going into something pharmaceutical to try to get easier access to teens for birth control and the emergency contraceptive pill."
>
> "This is something I personally want to go to school for, maybe minor in public health or women's studies; I never thought about that before, but now I want to do it."

"It's made me second guess what I want to do. There's another field that I might want to go into: women's studies. I really love theater but then again there's all this other stuff that's been opened up to me since coming into Teen Council."

Other participants indicated that Teen Council had not changed their plans for the future but instead has strengthened the career plans they were already considering.

"I wanted to be a professor before this, but (Teen Council provides) teaching experience, more teaching experience."

"I really enjoy teaching so I guess my favorite part of Teen Council is getting in the classroom and being rewarded by what the students have learned."

"I don't see how it's changed my career path in the future; I'll still be committed to education so I can see that as being an influence but I don't see it changing my future from what I thought about it before."

Teen Council members whose plans did not change as a result of the Teen Council experience and were not interested in related careers still plan to utilize the knowledge gained from Teen Council in the future.

"I've been hell bent on going to school as a mechanic so I'm still going to do that but (Teen Council) will still be a big share of my life. It's just good knowledge to have as a resource."

Additionally, Teen Council has opened participants to new non-career interests to pursue.

"I want to open up a non-profit organization that targets African-American youth that are at high risk for teen pregnancy, violence and gangs and find more positive outlets for them."

Another participant indicated that they want to support victims of rape or abuse: "I really want to get on a help line or that kind of thing."

"It makes me want to travel and educate around the world. (In America) we have sex everywhere and people still don't know anything. We're concerned if people have abstinence-only education but there are places where they don't have education, they don't even know about condoms or how AIDS is transmitted."

Evaluation question 3: Do the Teen Council members promote contraceptive use among their peers?

Teen Council participants promote contraceptive use among their peers by providing information regarding contraception to peers in informal conversation as well as providing free condoms to those peers who want them. Most participants indicated that it was commonplace to discuss contraception options with peers, typically in the school setting. Participants are seen as valuable resources by their peers: "people will come up to you that know you're in Teen Council; they trust you as an information source." Participants indicated that discussing contraception with peers in other settings is common: "I feel like my biggest thing, besides working in schools, was talking with friends; I'm shocked at some of the stuff that I thought my friends knew not to do."

Participants also promoted contraceptive use by providing free condoms to their peers. Most participants indicated that they had provided peers with condoms, usually at their schools but also in other contexts. Participants disagreed about whether peers who were receiving condoms would have used condoms without participants providing them. Some participants felt very strongly that providing condoms increased use: "A lot of teens are scared to go buy them because half the time they're behind the counter so you have to ask for them so I think a lot of

my friends would be pregnant if I wouldn't have given them condoms." Other participants indicated that their peers had access to condoms, but that providing condoms was beneficial because that process presented an opportunity to provide peers with information to help them avoid pregnancy and sexually transmitted infection. Differences in the peers that participants contact provide a likely explanation for this divergence, and participants agreed that providing condoms was beneficial regardless of the situation.

Evaluation question 5. What do the teens say they learned most from Teen Council?

Participants learned valuable lessons and information as a result of their Teen Council experiences. Participants most often mentioned becoming more open to new ideas and experiences due to Teen Council. Many participants indicated that they now were more able to understand the perspective of others.

> "I think it helped me get to relate to other people better, people who are more different than me than the people that I usually hang out with."

Participants learned a great deal about people of other races, ethnicities and socioeconomic backgrounds.

> "Learning from the different cultural backgrounds of everybody here, and the different schools, I know for me it's been being exposed to a lot of different things and I really appreciate that part of it."
>
> "Respect for everybody; everyone's opinions, everyone's thoughts; what anybody has to say."

Participants also gained a new appreciation for differences in sexuality.

> "Open-mindedness that there are other people out there that have other things done to them."

"Knowing that the girl next to you may be completely different and being OK with that."

"Just knowing what else is out there besides what's regular to your body and being open-minded and OK with it."

In addition, most participants felt that there was not one most important lesson or fact to be learned from Teen Council.

"Advocacy; confidentiality; when teens teach teens they pay more attention. We can't settle on one thing."

Evaluation question 7: Did the teens' communication and presentation skills improve?

Teen Council improved participants' communication and presentation skills. In particular, participants' large audience presentation skills increased immensely. Many participants had little or no presentation experience prior to participating in Teen Council. "We'd have to do a presentation at school and I'd be up there shaking, I was terrified of even reading in front of the class so I was terrified to teach in front of a class." One participant described the learning experience: "I had trouble getting up in a big group of people but I've given five presentations (with) stage fright or whatever, and it's taken it away now." Following the Teen Council experience, participants felt differently about their abilities and even looked forward to presenting to a large audience. Additionally, most participants indicated that improving their large audience presentations skills was a welcome skill that will be useful in other areas: "talking in front of classroom is definitely a strong and positive thing that I have gained."

Teen Council also improved participants' comfort level in communicating about sexuality. Many participants indicated discomfort discussing sexuality prior to Teen Council but were now capable of discussing sexuality related topics in any situation. One participant described this change: "[When] I started high school I couldn't say any words that involved

sexuality. That was freshman year and now I'm here and teaching kids about it, it's completely different than how I used to be." The increased comfort level discussing sex translated, for some participants, into an increased comfort discussing any topic, as evidenced by the statement "if you can talk about sex, you can talk about anything."

Additionally, Teen Council improved participants' communication skills in general. Some specific communication skills mentioned included: "speaking your mind in a respectful manner," "[knowing] what to say and when it's appropriate to say it," "thinking on your feet," and "being more confident." Participants indicated that they would not have improved these specific communication skills without Teen Council.

Finally, many participants indicated that their personal communication style had changed as a result of the TC experience.

> "I wasn't necessarily shy (before Teen Council) but now I'm a lot more outgoing and I'm more willing to talk to my peers. Now I teach at my school and I have a wide variety of friends, I've met people that I probably never would have met and I have gotten so many opportunities."
>
> "We go to the class and teach the right things. (Teen Council has provided) the courage and the knowledge to say no, that's not right, this is how it is, and to be able correct them on it."

Evaluation question 9: what impact did volunteering have on the teens' knowledge and awareness of issues within their local community?

Volunteering resulted in increased knowledge and awareness of issues among participants. Although participants did not indicate that they learned about any issues that were completely unknown to them, significant new connections were made to through volunteering to

provide relief or awareness of common issues. Volunteering resulted in participants who had an increased knowledge of factual information regarding social problems, increased awareness of the extent of familiar problems, were more engaged in solving those problems, and were more empathic towards those who are affected. Two specific issues that participants gained a new appreciation for were AIDS and homelessness. Participants indicated that they were already aware that these problems existed, but either did not know the extent of the problems or did not believe that they were present in their communities. One such issue was homelessness: "I was aware of it but I didn't realize that it hit so close to home and I didn't realize that there were homeless people in Rochester." Participants followed up on their new knowledge and awareness of issues by becoming engaged in solving these problems through Teen Council activities, such as participating in World AIDS Day and creating and living in homes made from cardboard boxes to promote the awareness of homelessness. Volunteering also increased participants' awareness of gay and lesbian issues: "I've just been more aware and conscious and supportive, not being negative about certain situations."

Teen Council also increased participants' overall awareness and concern for all social issues, not just those that they became involved in. Participants became interested in learning more about social issues that they are already aware of and becoming aware of new issues. Participants also described discussing social issues with parents and friends and reading the newspaper or watching the news to stay updated on issues. Prior to Teen Council, these participants were not interested in these activities.

Evaluation question 10: Do the teens feel empowered to make a difference in their communities and beyond?

Teen Council empowered participants to make a difference in their communities and beyond. Participants described issues that they had volunteered for through Teen Council and discussed how they had already made a personal contribution. Again, World AIDS Day was mentioned: "I felt like I was giving something back to the community; I felt like I'm teaching, maybe helping save someone else's life." Participants also feel empowered to help relatives: "I have eleven nieces and nephews. My sisters and my parents both know that if they need a resource I'm there. They actually listen to me because a lot of them look up to me." Additionally, participants feel empowered to provide a positive influence for their peers: "just last week we were teaching at Girl Power and we were talking about discrimination and those girls had no idea. I think they learned a lot."

"I started a group with teen moms called Coffee Break. I want to help keep teen moms on track with school. A lot of them feel that they don't know how to protect themselves anymore, they are so vulnerable, that they already have one kid so [others assume] that they'll have sex. I want to help those that are on the same level that I was on."

Participants intend to continue making a difference in their communities in the future.

"I got a leadership scholarship for doing a date rape health fair so next year I'll be going to area schools and teaching about date rape and acquaintance rape."

"I'll probably do this again...I feel its valuable to society and it impacts peoples lives."

"Hopefully, when I go off to college I will find a program similar to (Teen Council) or maybe I'll lead or facilitate."

"I definitely (will continue to volunteer). Why? I just love it, because I learned more and I help other people learn more. So I'll do this as long as I can."

Participants feel empowered to make a difference in spite of the obstacles that they see, including the influence that government policy has on social issues.

"There's so much that I see that I can change because in this program I learned so much about how things are run like school administrations and the government. In this program we learned that we can make a difference."

"I like the legal stuff that we learn about; consent laws, what's happening in the government, the rally we're going to go to next week about them not passing the marriage amendment."

Participants are generally satisfied with the influence they had on the community, although most realized that there was a limit to the impact they would have and the positive changes they would be able to observe.

"I think that going into the classroom and having someone of their age talking about sex and being protected is good because it promotes knowledge. I feel like I am making a change whether I know that I am or not. I can't see it but I'm making a difference but hopefully I am."

"(It is satisfying) knowing that someone's listened to what you've said so that you can go to sleep that night and you can rest easier knowing that at least you got out there and you said it."

Participants are also empowered to indirectly make a difference in their communities through Teen Council. Participants described a process of changing the opinion or perception of one of their peers and that individual spreading their newly held opinion or perception to others who the participant did not contact. Participants have confidence that, although they may not be able to directly observe their influence, they are able to make a difference.

Chapter V: Discussion

Evaluation question 1: In what ways has the Teen Council experience affected the teens' attitudes towards sexuality and adolescent health?

Teen Council is effective in improving participants' attitudes towards sexuality and adolescent health. A strength of the Teen Council program is the change in participants' attitudes towards discussing sexuality and adolescent health. As a result of the peer education component of the program, participants are able to discuss sexuality and adolescent health topics in a way that is open and honest. The ability to communicate regarding sexuality and adolescent health is important in preventing pregnancy and sexually transmitted infections for participants. Communication between sexual partners is essential to making decisions regarding avoiding pregnancy, contraception and condom use, and sexually transmitted infections testing in order to promote and maintain participants' wellbeing in the future.

Another strength of the Teen Council program is the change in participants' open-mindedness regarding differences between themselves and others. As a result of the service learning component of the program, participants are exposed to new ideas, experiences, and people. Introducing participants to new concepts and providing new perspectives for familiar ideas are critical to increasing participants' acceptance of cultural, racial, and socioeconomic variations among those people in their communities. In particular, Teen Council is effective in increasing participants' understanding and empathy for gays and lesbians. This specific change is due in part to the focus of the education component of Teen Council on sexuality and health topics, as the program provides information regarding gays and lesbians through education sessions. In addition, service learning activities increase participants' awareness of issues that face this group, such as the prevalence of HIV/AIDS and the challenge of intolerance.

An additional strength of the Teen Council program is the change in participants' attitudes toward the number of children they want. Prior to the program, nearly half of participants wanted to have three or four children, while approximately one-third wanted one or two. As a result of program activities, the number of children participants wanted changed, with nearly two-thirds now wanting only one or two children. A decrease in the number of children desired by participants is important in preventing teen pregnancy because it is likely that teens who want fewer children are also more likely to attempt to avoid pregnancy in order to have those children with an appropriate partner at an appropriate time.

The effect of Teen Council on participants' attitude toward the best age for a first child is unclear. Teen Council participants all felt, before program activities, that 20 years of age or older was the best time for a first child. After experiencing the program, participants' responses did not change. Although the best age for a first child was expected to increase to reflect participants' recognition of the importance of delaying pregnancy, this did not happen because participants entered Teen Council with a healthy pre-existing attitude regarding the best age for a first child. Instead, these results reflect the selection process for program participants. The type of teen who is likely to apply to Teen Council is also likely to be interested in sexuality and adolescent health and already hold positive attitudes in this area. In this way, Teen Council cannot be described as effective or ineffective in influencing participants' attitudes in this area because there was no room for participants' attitudes to improve.

An opportunity for improvement for Teen Council may exist in influencing participants' attitudes towards the best age for sexual initiation. Prior to the program, approximately half of participants felt that age 17 to 19 was the best age for sexual initiation, while approximately one-third felt that age 20 to 22 was ideal. After experiencing the program, participants' responses did

not change. Depending on the perspective, there may be room for improvement in participants' attitudes in this area. At age 17 and older teens are physically prepared to engage in intercourse, but in order to best prevent teen pregnancy and sexually transmitted infections, it would be ideal for teens to avoid sex prior to marriage. Other service learning programs have delayed sexual initiation in participants, so it is certainly possible that the Teen Council program would also accomplish this (O'Donnell, et Al., 1999; Philiber, Kaye, Herrling, & West, 2002).

Unfortunately, many of the participants in the program are likely to have already had sex and those who have not are not likely to remain abstinent until marriage. In this way, participants' responses are likely a reflection of a practical and sensible outlook on this issue. These participants are likely, despite education in the value of abstinence, to view safer sex activities as the key to avoiding pregnancy and sexually transmitted infections rather than avoiding sex completely. In addition, participants' responses may be mirroring the language of the item; if the item asked about the *ideal* age for sexual initiation instead of *best*, participants may have responded entirely differently. This means that participants' attitudes may have changed, but the measure used to determine this may not have been able to capture this change. Therefore, this evaluation did not show that Teen Council is effective in influencing participants' attitudes toward the best age for sexual initiation but it is important to note that, when the emphasis is placed on practical and pragmatic solutions, this is not likely to be the most significant factor for reducing teen pregnancy and sexually transmitted infection in these participants.

The meaning of the results from the Sexual Attitudes Scale and the Self-Esteem Scale are unclear. Based on these results, Teen Council was not found to have a significant effect on participants' attitudes toward sexuality or on their self-esteem. These results are likely the result

of shortcomings in the validity or reliability of the scales themselves rather than deficiencies in the Teen Council program. While the Sexual Attitudes Scale and Self-Esteem Scale used in this evaluation are only comprised of 11 items combined, valid and reliable scales intended to measure the same constructs require 23 items for the Brief Sexual Attitudes Scale (Hendrick & Hendrick, 1987) and 10 items for the Rosenberg Self-Esteem Scale (Rosenberg, 1989). Therefore, the results from the Sexual Attitudes Scale and the Self-Esteem Scale were not used in evaluating Teen Council. In order to more accurately determine whether Teen Council is effective in influencing participants' sexual attitudes and self-esteem it will be necessary to use validated scales with psychometric information.

Evaluation question 2: How do the teens feel the Teen Council experience will impact their future after high school?

Teen Council has strongly impacted the participants' futures. One strength of the Teen Council program is the influence that the program had on participants' plans for higher education and careers. Many participants changed their plans for higher education and careers to reflect new interests that they gained through service learning. Other participants committed themselves more strongly to their pre-existing plans for the future. These teens had future plans that already coincided with Teen Council activities and so gained a greater understanding of what would be required of them in order to achieve their goals. Despite these improvements in participants' futures, the nature of Teen Council dictates that there will be limited room for improvement in participants' plans for the future. It is not likely that Teen Council will be able to influence a teen to change their life from delinquency to achievement, because teens with serious problems are not likely to apply for the program, are not likely to be selected for the program, and are likely to drop out of the program before completion. In general, the demands of the Teen Council

program draw applicants who are already likely to become successful individuals. In the same way, the recruitment process selects participants who have the characteristics required to become successful Teen Council participants; characteristics that are less likely to be associated with teens with serious problems. In this way, Teen Council is not able to influence participants' plans in an extreme way because participants are likely to already have a positive outlook on the future, with ambitious but achievable plans and goals.

Improving participants' educational plans and aspirations for the future is an important component of Teen Council as an intervention against teen pregnancy and sexually transmitted infections. Increased future orientation is a protective factor that results in delay of sexual initiation. This means that teens that think about the future more and are more positive about that future are more likely to recognize the negative impact that a pregnancy or sexually transmitted infection would have on achieving their goals. In addition, having higher educational aspirations or plans for higher education are protective factors that delay sexual initiation, reduce the frequency of sexual activity, and reduce pregnancy (Kirby, Lepore, & Ryan, 2005). This means that teens that have plans for higher education are also more likely to take action to avoid the negative outcomes associated with sexual activity can be detrimental to successfully graduating from college.

Evaluation question 3: Do the teens promote contraceptive use among their peers?

Teen Council participants are effective in promoting contraceptive use among their peers. One strength of the Teen Council program is that participants promote contraceptive use by providing accurate information regarding contraception to peers. Participants transfer information through peer education, during both formal presentations to groups and informal one-on-one conversations. Although it is likely that these peers were exposed to the same

contraception information through school health classes, many teens are not well informed about the benefits of contraception, contraception options, or how to obtain contraception. Inaccurate information from peers, the media, and even teachers and parents exacerbates this problem for teens who are attempting to make decisions about contraception. Teen council participants are able to reduce the problem of peer contraception ignorance by informing peers about contraception.

Another strength of the Teen Council program is that participants promote contraceptive use by providing condoms to peers. This practice is beneficial for a variety of reasons: teens avoid the embarrassment of buying condoms, teens avoid having to decide between spending limited funds on contraception or on other needs, and teens avoid not having a condom because of inconvenience. Although providing condoms to peers did not always increase the number of teens using condoms because these teens may have acquired condoms through some other means, participants felt like providing condoms in this situation was still important because the interaction provided an opportunity to show support for the continued use of contraception and also to act as a resource for sexuality and adolescent health information. Providing support for peers' use of condoms is important because having peer norms that support condom use is a protective factor that leads to increased condom use among teens (Kirby, Lepore, & Ryan, 2005). Increased condom use is important because condoms are useful in preventing pregnancy and sexually transmitted infections among sexually active teens.

Evaluation question 4: Is there an increase in knowledge from pre- to post-questionnaire?

Participants' knowledge of sexuality and adolescent health topics increased as a result of Teen Council. One strength of the Teen Council program is the overall increase in sexuality and adolescent health knowledge among participants. Despite participants' relatively high level of

sexuality and adolescent health knowledge prior to Teen Council, weekly education sessions provided the instruction necessary for improvement. The correspondence between the topics covered in these sessions and the knowledge areas assessed by the questionnaire measure as well as focus groups comments indicating that these activities were effective provide support for the conclusion that Teen Council is responsible for the increase in knowledge and not any identified threat to internal validity.

One opportunity for improvement for Teen Council is ensuring that participants know facts related to the items that fewer than 90% of participants responded to correctly. These items variously assessed adolescent health, contraception, and sexually transmitted infection knowledge, indicating that there is not one topical area where improvement is necessary. In addition, Duluth, Metro, and Rochester participants performed equally well on these items, indicating that there is not one Teen Council location where instruction requires improvement. This evaluation was not able to identify the cause for participants' lower scores on these items. Possible explanations are that Teen Council training was not effective for these facts or that participants were not paying attention or were answering randomly on these items.

The increase in sexuality and adolescent health knowledge among participants is supported by evaluation results from other peer education programs that have also resulted in increased knowledge (Pearlman, et Al., 2002; Strange, Forrest, Oakley, & The RIPPLE Study Team, 2002; Slap, Plotkin, Khalid, & Michelman, 1991). Increasing knowledge of sexuality and adolescent health among participants is important because increased knowledge in these areas is a protective factor for teen pregnancy and sexually transmitted infections. In particular, increased knowledge of condoms and contraception is a protective factor resulting in increased use of condoms or contraception among teens. In addition, increased knowledge of sexually transmitted

infections is a protective factor resulting in fewer sexual partners as well as increased condom use among teens (Kirby, Lepore, Ryan, 2005).

Evaluation question 5: What do the teens say they learned most from Teen Council?

Creating an increased understanding of others' positions and increased respect for those positions among participants is a strength for Teen Council. This increase in understanding and respect was due to the fact that participants gained a wider view of the issues covered in Teen Council. These issues could be related to the education component of the program, such as issues associated with sexuality and adolescent health topics, or to the service learning component of the program, such as the issues that participants became advocates for. In particular, Teen Council was effective in increasing participants' understanding and respect for people of different races, cultures, sexualities, and economic classes. This increase was the result of participants' knowledge of the issues that face these groups as well as individual contact with representative individuals through Teen Council.

Evaluation question 6: Do the teens feel they have resources they could refer someone to if asked about various reproductive health-related topics?

Participants in Teen Council program feel that they have resources to refer to if asked about various reproductive health-related topics. A strength of the Teen Council program is the improvement in participants' perceived access to resources related to sexuality and adolescent health. Teen Council increased participants' perceived access to resources so that virtually all of the participants felt that they had access to resources related to abortion, sexually transmitted infection testing, and dating violence following Teen Council. Despite focus group comments indicating that communications skills increased, fewer participants indicated on the post-questionnaire that they had the appropriate language and communication skills resources to talk

effectively about sexuality. Perhaps the participants who did not feel like they had these skills had come to recognize the complexity and difficulty of this topic or perhaps these participants simply made an error in responding.

An opportunity for improvement for Teen Council is ensuring that participants have access to resources for peers who feel that they might be gay, lesbian, or bisexual. Although Teen Council is successful in improving participants' access to other resources, fewer than 90% of participants perceive that they have access to resources for peers who feel that they might be gay, lesbian, or bisexual. Despite this lower rate, Teen Council was effective in increasing participants' perceived access to these resources by approximately 20%. There was no difference in response rates between Duluth, Metro, and Rochester participants, indicating that there is not one particular Teen Council location where instruction requires improvement. Although this improvement is impressive, it is expected that all participants would be able to refer a peer to appropriate resources in this area at the conclusion of the program. The less than perfect rate of perceived access to resources on only this item indicates that participants have the potential to retain this knowledge, but do not. One explanation for the lower rate for this item is that, because peers do not ask about these resources as often as other resources, participants are less likely to retain their knowledge of these resources even though Teen Council instruction in this area is effective. Alternatively, it is also possible that Teen Council is not effective at training participants in this area.

Evaluation question 7: Did the teens' communication and presentation skills improve?

Teen Council improved participants' communication and presentation skills. A strength of the Teen Council program is the improvement in participants' communication and presentation skills. The increase in communication and presentation skills among participants is

the result of extensive training, practice, and experience in classroom presentations and individual peer education. Participants entered Teen Council with average skill and experience in this area but left the program with impressive communication skills and hours of presentation experience. Participants also acknowledged that training and practice were important in improving communication and presentation skills. The improvement in communication skills among participants is supported by the evaluation results of another peer education program that also increased communication skills (Strange, et Al., 2002).

Evaluation question 8: Do the teens feel more comfortable and confident in their ability to communicate effectively with their peers and family?

Teen Council increased participants' comfort and confidence in their ability to communicate effectively. A strength of the Teen Council program is participants' improvement in comfort and confidence in their ability to communicate effectively with their peers. These improvements in comfort and confidence came primarily from experience discussing sexuality and adolescent health topics with peers. Greater comfort and confidence came with each successful interaction with peers through both one-on-one conversations and presentations. Since many conversations were similar, previous interactions provided experience for participants to draw upon when faced with new challenges. In addition, improvements in participants' skills related to presentation and communication were important in increasing participants' comfort and confidence. Finally, sexuality and adolescent health knowledge is essential to confidence in communication because this knowledge provides a factual basis for conversations with peers. In these conversations, participants were confident that they would be able to support their position with facts and examples. Since facts help to provide participants with the confidence to communicate with peers, it is important that participants are well trained. If participants are not

confident in their knowledge of facts, it is less likely that they will be confident in communication with peers.

Quantitative data did not support the conclusion that participants' comfort and confidence in communication with peers increased because 100% of participants reported being comfortable talking with friends about sex prior to Teen Council. In addition, no significant increase was found in the number of conversations between participants and peers regarding either sex or birth control. Rather than contradicting focus group comments, it is likely that the number of conversations between participants and friends regarding sex and birth control increased but the questionnaire measure was not able to detect this change. Perhaps it is too difficult for participants to remember and correctly quantify the number of conversations that occurred over their entire Teen Council experience and prior to it or perhaps participants were not paying attention when responding to this item.

Another strength of the Teen Council program is participants' improvement in comfort and confidence in their ability to communicate effectively with their parents. Again, as participants became more experienced in communications with parents regarding sexuality and adolescent health, they also became more comfortable and confident. Similarly, as participants' presentation and communication skills increased, their comfort and confidence also increased. Finally, as participants' knowledge of facts increased, their comfort and confidence also increased. Despite the improvement in participants' comfort and confidence in communication with parents, there remains room for improvement. Participants are not completely comfortable discussing all sexuality and adolescent health topics with participants. In particular, participants discussed situations which would not be comfortable, such as disclosing a sexually transmitted infection. Although the ideal would be for participants to feel comfortable and confident in

discussing any topic with a parent, it is not reasonable to expect that participants will be comfortable in a situation such as this.

One opportunity for improvement for Teen Council is participants' frequency of conversations with parents regarding sexuality and adolescent health topics. Teen Council is not effective in influencing the number of conversations between participants and parents regarding either sex or birth control, based on quantitative data. It is unclear how much strength conclusions based on this data should be given because quantitative data also indicates that the number of conversations between participants and peers regarding sex or birth control did not change, while focus group comments indicate that these conversations increased significantly. Unfortunately, participants did not provide any information regarding the frequency of their conversations with parents in focus groups. In any case, it is important that participants are able to discuss these topics with parents. One explanation for these results is that participants are more comfortable and confident in discussing these topics with parents, but do not feel an increased need to have these conversations because of the level of sexuality and adolescent health knowledge that they command. Without the need to ask factual questions, participants may not have a reason to discuss these topics with parents, therefore the number of conversations does not increase.

Another opportunity for improvement for Teen Council is whether participants discuss particular sexuality and adolescent health topics with parents. Fewer than 90% of participants had discussed with parents: how pregnancy occurs, how to say no to sex, and birth control at the conclusion of Teen Council. Furthermore, only 70% of participants had discussed HIV/AIDS and safer sex and only 75% had discussed sexually transmitted infections. Although there were non-significant increases in the number of participants who had discussed these topics with

parents, the occurrence of these conversations is too low. Given nearly a year for program participants to discuss these topics with parents, it is expected that these topics would have come up in conversation at least once.

Communication with peers and parents is related to both improved interpersonal and communication skills and parental support and family connectedness. Improved interpersonal and communication skills and parental support and family connectedness are teen pregnancy and sexually transmitted infection protective factors. Increases in these areas, based on the Teen Council logic model, are likely to lead to reduced teen pregnancy and sexually transmitted infections by delaying sexual initiation, reducing the frequency of sex, and increasing the correct and consistent use of contraception and condoms. Research supports these conclusions (Kirby, Lepore, & Ryan, 2005) and also provides evidence of other peer education programs that resulted in increased interpersonal and communication skills (Pearlman, Camberg, Wallace, Symons, & Finison, 2002).

A final opportunity for improvement for Teen Council is the level of comfort of participants in discussing sexuality issues with peers whose sexuality is different, for example, a heterosexual participant discussing sexuality issues with a gay or lesbian peer. While participants' comfort in communicating in other areas increased, participants' comfort in discussing sexuality issues with peers whose sexuality is different actually decreased. While this evaluation is not able to explain this result, this is an area that should be examined by program staff.

Evaluation question 9: What impact did volunteering have on the teens' knowledge and awareness of issues within their local community?

Volunteering through Teen Council increased participants' knowledge and awareness of issues within their local communities. A strength for Teen Council is participants' knowledge and awareness of issues within their local communities. Participants reported becoming aware about issues they had not been previously aware of as well as learning about the extent of issues they already were familiar with. In addition, community service and advocacy contributions made by participants resulted in participants who not only knew about problems but also knew how to contribute to solutions. Specific issues which participants became most concerned about were those that they had been most involved in during Teen Council. In addition to becoming more knowledgeable and aware of issues that they volunteered for, participants also became more interested in social issues in general. Many participants also became interested in issues which they had not been involved with part of the service learning component of Teen Council.

Increased involvement in the community among participants is an important component of Teen Council because research has shown that community involvement is a protective factor for teen pregnancy and sexually transmitted infections, resulting in delayed sexual initiation and increased use of contraception (Kirby, Lepore, & Ryan, 2005). This means that teens who are involved in the community are less likely to have sex and, if they do, they are more likely to use contraception.

Evaluation question 10: Do the teens feel empowered to make a difference in their communities and beyond?

Teen Council is effective in increasing participants' feelings of empowerment to make a difference. One strength of Teen Council is that participants feel enthusiastic about improving

their communities and standing up for their beliefs. Serving as peer educators results in participants who feel that they have already had a direct impact on the lives of many of their peers. Participants were able to help their peers in ways that ranged from helping with small problems, such as talking about a relationship, to larger ones, such as discussing the positive and negative aspects of adoption with a pregnant teen. Based on their experiences improving their communities during the program, participants intend to continuing to make a difference after Teen Council by continuing to learn about sexuality and adolescent health and providing information to their peers and others.

One common theme that participants discussed in relation to making a difference was the power of indirectly affecting others. Participants feel that they positively influence the lives of many of their peers through social networks. When participants communicate accurate sexuality and adolescent health information to one peer, they provide an opportunity for that information to spread to any contact that the peer makes. In this way, participants are confident that they are having a much larger impact on their communities than they are able to directly observe.

In addition to feeling empowered to help their peers, participants also feel empowered to make a larger impact in their communities and beyond. Participants discussed specific plans to continue to volunteer or to enter a career where they feel they can make a difference. These participants interest in making a difference was in areas that they were involved with directly during Teen Council as well as in areas that were not related to Teen Council activities. This shows that participants not only felt capable of making a difference in areas they were familiar with, but also in new areas that they would have to explore without the Teen Council leader or other members.

Recommendations Based on Findings

Results of this evaluation found that the Teen Council program is effective in positively influencing some of the determinants of teen pregnancy and sexually transmitted infection. Although there is not unequivocal evidence that Teen Council reduces the incidence of pregnancy and sexually transmitted infection in participants, increasing sexual risk taking protective factors and reducing risk factors is likely to reduce the incidence of these negative outcomes. Despite the success of Teen Council in these areas, this evaluation has identified opportunities for improvement and provides recommendations based on those opportunities as follows.

Program Recommendations

The evaluator recommends that Teen Council incorporate further opportunities for improved communication between participants and parents. Results indicate that participants are not completely comfortable in communicating about sexuality and adolescent health with parents and also have never discussed some selected topics related sexuality and adolescent health. Although it is not expected that participants will be completely comfortable discussing sexuality and adolescent health with parents, program activities should be implemented that attempt to improve participants' comfort and confidence in this area. Furthermore, Teen Council should include activities that require participants to have conversations with parents regarding sexuality and adolescent health topics, such as how pregnancy occurs, sexually transmitted infections, how to say no to sex, birth control, and HIV/AIDS if the program is intended to have this effect.

The evaluator recommends that further measures are implemented to ensure that participants are thoroughly familiar with the facts regarding sexuality and adolescent health that are taught in Teen Council. Participants must be experts in the information that they provide to

peers in order to be effective peer educators. Although Knowledge Scale scores were very good, opportunities for improvement exist in this area. Any wrong answer by participants is an indication that potentially damaging inaccurate information may be being spread to peers. It is certainly not possible to achieve perfection in this area, but Teen Council should attempt to ensure that participants retain the information they learn through the conclusion of the program.

In order to address this opportunity for improvement, the tests that are used at the end of each education session should be comprehensive in nature. These comprehensive tests would not only incorporate all of the existing items that assess knowledge from the current education session related but would also use selected items from previous tests to assess knowledge retention. Participants would still be required to achieve 100% correct on the education session knowledge items but would not be held to the same standard for items assessing retention. In this way, participants would have additional incentive to maintain their knowledge of previous topics and, more importantly, participants and Teen Council leaders would be aware of what knowledge participants have retained and what areas need improvement.

The evaluator recommends that further activities take place that ensure that participants are aware of resources for peers who believe that they may be gay, lesbian, or bisexual. Questionnaire data indicates that, while most participants have access to these resources, some participants do not. It is important that participants are able to assist peers who may need these resources in order to be effective peer educators. In addition, the decrease in participants' comfort in discussing sexuality issues with peers whose sexuality is not the same should be addressed through additional program activities.

Evaluation Recommendations

The evaluator recommends that future evaluation use an improved quantitative measure. Although the questionnaire used was effective, some items and scales were not. First, poorly constructed items should be rewritten or removed from the questionnaire. This includes items 4, 18, and 28. In addition, responses for item 54 need to be rewritten. Second, questionnaire multiple choice items should follow best practices (Haladyna, 2004; Haladyna, Downing, & Rodriguez, 2002). Third, validated scales with psychometric information should be used if they are available. Thus, it is recommended that the existing Sexual Attitudes Scale be replaced with the Brief Sexual Attitudes Scale (Hendrick & Hendrick, 1987) and the existing Self-Esteem Scale be replaced with the Rosenberg Self-Esteem Scale (Rosenberg, 1989). Finally, it is recommended that both the questionnaire instructions and Teen Council leaders emphasize the importance of using the responses provided on the questionnaire. Written in responses are not easily incorporated into analysis and reduce the validity of the questionnaire results.

The evaluator recommends that Teen Council leaders ensure that all participants are administered both the pre- and post-questionnaire. The validity of this evaluation is limited because one-third of Teen Council participants were not administered both questionnaires. The results from pre-questionnaires that could not be matched to a corresponding post-questionnaire or vice-versa were not able to be analyzed for the purposes of evaluation. When one-third of the quantitative data cannot be used, the conclusions that result from the remaining data almost certainly do not accurately reflect the reality of the program being evaluated.

The evaluator recommends that any future evaluation of Teen Council utilize a control group comprised of non-participants to the program. Quantitative data gathered from this control group could be compared to that of the participants who were involved in Teen Council

activities. Although a control group would not result in a true experiment due to the lack of random assignment possible with a voluntary program like Teen Council, a quasi-experimental design with a control group would reduce the limitations on internal validity within the quantitative component of the evaluation. Therefore, a control group would make it possible to determine the influence of Teen Council activities with more certainty.

The evaluator recommends that focus groups are conducted in a way that more closely reflects best practices research in the field (Krueger, 1998) in regard to the number of focus group participants. Due to the distance from the evaluator to the Teen Council locations as well as time restrictions among the participants, only one focus group per location was conducted. Despite conducting only three focus groups, every participant was invited to attend. Therefore, two of the three focus groups conducted involved far more than the maximum recommended number of six participants. Compared to the focus group with four participants, these larger focus groups had sufficient discussion but less depth than desired.

In addition, it was difficult for participants to maintain their concentration on the focus group activities because there were not enough opportunities for every participant to express there opinion. While it was beneficial to include as many opinions as possible, a deeper, more detailed discussion is more useful than a shallow discussion, even if it means that some program participants are not involved in the focus group component of the evaluation. Therefore, future evaluation should conduct multiple focus groups in each location to limit focus groups to a maximum of six participants or, if necessary, conduct one focus group per location, excluding some participants at random.

The evaluator recommends that the effect of peer education on its recipients is studied in a future evaluation. To study the effect of peer education on its recipients, a short quiz comprised of multiple choice items related to contraception or sexually transmitted infection should be used. A pre-test, post-test design would be used and scores would be compared. If scores improved, it would support the conclusion that Teen Council peer education presentations are effective in educating recipients.

Limitations of the Study

The lack of a control group or random assignment in this program evaluation means that a causal statement cannot be made indicating that Teen Council is responsible for any differences observed in the outcomes measured by the evaluation. Threats to internal validity may instead be responsible for any differences observed. First, volunteer bias may be present because teens who apply to become participants in Teen Council are likely to be more interested in and knowledgeable about sexuality and adolescent health than the average teen. Second, selection bias may be present because the recruitment process used by PPMNS staff results in program participants who are more interested in and knowledgeable about sexuality and adolescent health than the average teen. Third, maturation effects may be present because participants may have experienced age related developmental changes during the time that they participated in the program.

Fourth, history effects may be present because forces external to Teen Council may have resulted in changes in the outcomes. Finally, measurement bias may be present because participants may be motivated to improve because they know that they will be tested at the conclusion of Teen Council. Additionally, the external validity of this study is limited because the majority of participants are White, female, and are more interested in and knowledgeable

about sexuality and adolescent health than the average teen. This limited external validity means that the conclusions of this evaluation cannot necessarily be applied to all teens, but instead are most applicable to teens that are similar to Teen Council participants.

The quantitative questionnaire measure results in specific threats to internal validity. First, repeated testing effects may be present because the same items are used on both the pre- and post-questionnaire. This similarity may result in participants scoring higher on the post-questionnaire because of their exposure to the identical pre-questionnaire. Second, experiment mortality effects may be present because 25% of the participants who completed a pre-questionnaire did not complete a post-questionnaire. Although the pre-questionnaire data that could not be paired with corresponding post-questionnaire data were not used, there may be differences between those participants that completed both questionnaires and those who did not. These differences could mean different outcomes would be observed if all of the participants in the program had completed both questionnaires.

Third, instrumentation effects may be present because the questionnaire measure itself was flawed in some ways. Data from items 4, 18, and 28 were not used in analysis because each of these items provided more than one correct response which was confusing to participants. Similarly, one participant's responses to item 54 were not utilized in analysis because this item did not provide a complete range of possible responses to the question, leading this participant to respond with the option that was not provided. Finally, only the knowledge scale was tested for reliability while the other scales used were not tested for reliability at all, meaning that it is not known if the questionnaire results in consistent scoring.

The use of focus groups also results in specific threats to internal validity. First, this measure is dependent on self-report by participants. Therefore, participants' perceptions and

memories of experiences and attitude changes are reported, which can result in recall error. Second, the analysis of qualitative data is inherently subject to evaluator bias. Although the evaluator of Teen Council focus groups data attempted to remain unbiased, no second evaluator was available to code the data. Failure to have multiple evaluators code the data results in a potential lack of inter-rater reliability. Additionally, the large size of focus groups occasionally resulted in a lack of depth in discussions. Best practices research indicates that a maximum of six participants should be included in any focus group (Krueger, 1998). Two of the three focus groups conducted in this evaluation far exceeded this recommended number. The large number of participants meant that some participants may have been discouraged from elaborating beyond yes or no answers on some topics and may not have felt compelled to fully contribute to discussion.

Conclusion

This evaluation found evidence that Teen Council is successful in influencing the determinants of teen sexual risk taking. Teen Council was found to increase protective factors that influence teen sexual risk taking: increased knowledge of sexuality and adolescent health and access to related resources; increased positive attitudes towards sexuality; increased plans for the future; increased promotion of contraceptives among peers; and increased community involvement. Opportunities for program improvement include: providing opportunities for improved communication between participants and parents; ensuring that participants are familiar with facts regarding sexuality and adolescent health; and ensuring that participants are aware of resources for peers who believe they may be gay, lesbian, or bisexual. Opportunities for evaluation improvement include: improving the quantitative measure; ensuring that all participants are

administered both the pre- and post-questionnaire; utilizing a control group; conducting focus groups using the principles described in best practices research; and studying the effects of peer education on recipients.

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Appendix A: Institutional Review Board Approval

Date: March 22, 2006

To: Justin Meyer

Cc: Dr. James Tan

From: Sue Foxwell, Research Administrator and Human Protections Administrator, UW-Stout Institutional Review Board for the Protection of Human Subjects in Research (IRB)

Subject: **Protection of Human Subjects in Research**

Your project, "*Program Evaluation*" is **Exempt** from review by the Institutional Review Board for the Protection of Human Subjects. The project is exempt under Category 5 of the Federal Exempt Guidelines and holds for 5 years.

The reviewer had the following comments:
Here are some principles of good ethical practice you may wish to consider incorporating into your project:

- In your consent form for the participants, I'd recommend removing the sentence "these feelings should not last for long."
- Since you indicate that they may experience some minor feelings of discomfort or uneasiness in participating, please consider including information in your consent form about who to contact if they would like to talk with someone about these feelings.
- On your parental consent form, you say: "by signing this consent form you agree to participate in ...." The parents are actually signing to indicate that they are giving consent for their son/daughter to participate-I would recommend revising your parental consent form.

Please copy and paste the following message to the top of your survey form before dissemination:

> This project has been reviewed by the UW-Stout IRB as required by the Code of Federal Regulations Title 45 Part 46

Please contact the IRB if the plan of your research changes. Thank you for your cooperation with the IRB and best wishes with your project.

***NOTE: This is the only notice you will receive – no paper copy will be sent.**

Appendix B: Questionnaire

Planned Parenthood of Minnesota/North Dakota/South Dakota
Teen Council
Pre-Questionnaire

Please fill out the form below as carefully and completely as you can. Your answers will be confidential, so please be completely honest with us.

Today's date___/___/___
Mo/Day/Year

Are you a female of male?

1 Female
2 Male

In what month and year were you born?

_____ _____
MONTH YEAR

How old are you? _____years

What grade are you in at school?
_____GRADE

Which one category best describes your racial background?

1 White
2 Black, or African American
3 American Indian, or Native American
4 Asian, Oriental, or Pacific Islander
5 Hispanic or Latino
6 Other (PLEASE NAME)
_____

At this time (right now), with what adults do you live?

(CIRCLE ALL THAT APPLY)

1 Mother
2 Stepmother
3 Father
4 Stepfather
5 Other adult relatives (PLEASE NAME: for example, aunt)
_____
6 Other adults (PLEASE NAME: for example, foster parent)_____
7 I do not live with any adult

TRUE/FALSE

Here are some questions about various topics. Read each statement, then decide if you think it is true or false, or if you don't know.

		True	False	Don't know
1	A sexually active girl can become pregnant if she forgets to take her birth control pills for several days in a row.			
2	A young woman can get pregnant before she has her first menstrual period			
3	An abortion can be done safely and easily by a doctor during the first 12 weeks of pregnancy.			
4	Condoms or rubbers should be used with spermicidal foam or jelly.			
5	Using a condom can help prevent HIV/AIDS.			
6	A condom can be used more than once.			
7	A young man should put on a condom just before he ejaculates (comes).			
8	If a condom is used, a young man should pull out before he loses his erection.			
9	You can tell if a person is gay or lesbian by the way he or she looks.			

Here are some questions about access to resources. Read each statement, then tell us if it is true or false.

		True	False
10	I feel that I have resources I could refer someone to if someone asked me where they could go to get an abortion.		
11	I feel that I have resources I could refer someone to if someone asked me where to go get STI tests.		
12	I feel that I have resources I could refer someone to if someone thought he or she might be gay, lesbian, or bisexual.		
13	I feel that I have resources I could refer someone to if he/she was the victim of dating violence.		
14	I feel that I have the appropriate language and communication skills to talk effectively about sexuality.		

MULTIPLE CHOICE

15. A good peer educator:
    a. listens
    b. explains clearly
    c. is knowledgeable
    d. all of the above
    e. none of the above
    f. I don't know

16. The method of birth control which is least effective is:
    a. A condom with foam
    b. The diaphragm with spermicidal jelly
    c. Withdrawal (pulling out)
    d. The pill
    e. Abstinence (not having sex)
    f. I don't know

17. Which of the following is not a step in properly putting on a condom?
    a. squeeze the tip
    b. stretch the condom
    c. unroll the condom over the erect penis
    d. check the expiration date
    e. none of the above

18. Having a baby when you are in high school:
    a. Is not a problem at all
    b. Is not a problem because your family helps
    c. Is a problem but it is okay
    d. Is a problem for the mother and the baby but not for the father of the baby
    e. Is a problem for the father and the baby but not for the mother of the baby
    f. Is a problem for the mother, the baby, and the father of the baby.

19. All forms of sexual violence are about:
    a. Power and control
    b. Sex drive
    c. Romantic relationships
    d. I don't know

20. Who is responsible for sexual violence?
    a. Victim
    b. Perpetrator
    c. Both a and b
    d. I don't know

21. Which of the following is not a step in problem solving?
    a. define the problem
    b. gather more information
    c. weigh the alternatives
    d. ask for help
    e. none of the above, they are all steps in problem solving

Please identify each STI as being either a bacteria, virus or parasite (bug).

		Bacteria	Virus	Parasite
22.	Gonorrhea			
23.	Pubic Lice			
24.	Genital Warts (HPV)			
25.	HIV/AIDS			
26.	Herpes			
27.	Chlamydia			

28. Bacterial STIs are:
    a. Treatable
    b. Curable
    c. Both
    d. Don't know
29. Viral STIs are:
    a. Treatable
    b. Curable
    c. Both
    d. Don't know
30. You can get and/or transmit STIs through:
    a. Oral sex
    b. Anal sex
    c. Vaginal sex
    d. All of the above

MATCHING

Write the letter of the description that fits each type of birth control/STI prevention device.

31.___ IUD (intrauterine device)	A. This is worn on the outside of the body and releases hormones into the blood. It is changed once a week.
32.___ Female Condom	B. This is put on an erect penis and prevents sperm from going into the vagina.
33.___ Ortho Evra (The Patch)	C. This is a shot that is given to a woman once every three months.
34.___ Male Condom	D. This is a latex barrier that is put on the outside of a woman's vagina to prevent STIs.
35.___ Depo-Provera	E. This is a latex ring placed inside a woman's vagina and left in place for three weeks at a time.
36.___ Nuva Ring	F. This is inserted in a doctor's office or clinic and provides birth control for up to 5 years
37.___ Dental Dam	G. A woman would take one of these every day to prevent pregnancy.
38.___Birth Control Pills	H. This is a latex barrier that is placed inside a woman's vagina to prevent pregnancy and STIs.

What we know about sex and having babies and where we learned it can have an important effect on our lives. In your own life, have you ever talked with one or both of your parents about: (Please check yes or no.)

		YES	NO
39.	The female menstrual cycle- that is, the monthly cycle?	1	2
40.	How pregnancy occurs?	1	2
41.	Sexually transmitted infections (STIs)?	1	2
42.	How to say no to sex?	1	2
43.	Methods of birth control- that is, stopping pregnancy from happening?	1	2
44.	How to prevent HIV/AIDS using safe sex practices?	1	2

The following questions ask about activities during an AVERAGE week. Think about the number of times you have had conversations.

45. During an average week, how many times do you have a conversation or discussion about sex with your parents?

____ 1-2 Times ____ 2-4 ____ 4-6 ____ More than 6 ____ Not at all

46. During an average week, how many times do you have a conversation or discussion about sex with your friends?

____ 1-2 Times ____ 2-4 ____ 4-6 ____ More than 6 ____ Not at all

47. During an average week, how many times do you have a conversation or discussion about birth control with your parents?

____ 1-2 Times ____ 2-4 ____ 4-6 ____ More than 6 ____ Not at all

48. During an average week, how many times do you have a conversation or discussion about birth control with your friends?

____ 1-2 Times ____ 2-4 ____ 4-6 ____ More than 6 ____ Not at all

For the following items, we want to know how uncomfortable you are doing different things. Being "uncomfortable" means that it is difficult for you and it makes you nervous.

How comfortable are you:

49. Talking with friends about sex.
    a. Comfortable
    b. A little uncomfortable
    c. Somewhat uncomfortable
    d. Very uncomfortable
    e. This does not apply – I do not talk to my friends about sex.

50. Talking with a date or a boy/girlfriend about sex.
    a. Comfortable
    b. A little uncomfortable
    c. Somewhat uncomfortable
    d. Very uncomfortable
    e. This does not apply – I have not been in this situation.

51. Talking with parents/guardians about sex.
    a. Comfortable
    b. A little uncomfortable
    c. Somewhat uncomfortable
    d. Very uncomfortable
    e. This does not apply – I do not talk to my parents about sex.

52. Talking about sexuality issues with those whose sexuality is different than your own (e.g., LGBT youth if you are straight and vice versa).
    a. Comfortable
    b. A little uncomfortable
    c. Somewhat uncomfortable
    d. Very uncomfortable
    e. This does not apply – I have not been in this situation.

FILL IN THE BLANK

53. How many children do you want to have in your life, if any?
    ___ None ___ 1 – 2 ___ 3 – 4 ___ 5 – 6 ___ More than 6

54. What do you think is the best age, if any, for you to have your first child?
    ___ Under 16 ___ 16 – 19 ___ 20 – 24 ____ 24 – 29 ___ 31 – 35 ___ After age 35

55. What is the best age for a girl to have sex for the first time?
    ____ Under 14 ___ 14 – 16 ____ 17 – 19 ____ 20 – 22 ___ 23 – 25 ___ Over age 25

56. What is the best age for a boy to have sex for the first time?
    ____ Under 14 ___ 14 – 16 ____ 17 – 19 ____ 20 – 22 ___ 23 – 25 ___ Over age 25

AGREE/DISAGREE

Please read the following statements. For each, please check the statement that best describes how you feel.

		Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
57	If I have sex while I'm a teenager, it would make me feel sort of important.					
58	I think it is OK to say "NO" when someone wants to touch me.					
59	"Love" and "having sex" mean the same thing.					
60	Having sex while I'm a teenager would just be doing what everybody else is doing.					
61	People who want to have sex should respect the right of others to say "No."					
62	If I do have sex, I feel comfortable that I know how to use a condom					
63	I feel that I can make good decisions even if I've been drinking or using drugs					
64	I feel that I have a number of good qualities.					
65	I am able to do things as well as most other people.					
66	I feel I do not have much to be proud of.					
67	I'm confused about my personal sexual values and beliefs.					
68	I have a clear picture of what I'd like to be doing in the future.					

Thank you!!

Appendix C: Knowledge Scale

Item number	Questionnaire item	Possible responses
1.	A sexually active girl can become pregnant if she forgets to take her birth control pills for several days in a row.	True, false, don't know.
2.	A young woman can get pregnant before she has her first menstrual period.	True, false, don't know.
3.	An abortion can be done safely and easily by a doctor during the first 12 weeks of pregnancy.	True, false, don't know.
5.	Using a condom can help prevent HIV/AIDS.	True, false, don't know.
6.	A condom can be used more than once.	True, false, don't know.
7.	A young man should put on a condom just before he ejaculates (comes).	True, false, don't know.
8.	If a condom is used, a young man should pull out before he loses his erection.	True, false, don't know.

9.	You can tell if a person is gay or lesbian by the way he or she looks.	True, false, don't know.
15.	A good peer educator	Listens, explains clearly, is knowledgeable, all of the above, none of the above, I don't know.
16.	The method of birth control which is least effective is:	A condom with foam, the diaphragm with spermicidal jelly, withdrawal (pulling out), the pill, abstinence (not having sex), I don't know.
17.	Which is not a step in properly putting on a condom?	Squeeze the tip, stretch the condom, unroll the condom over the erect penis, check the expiration date, none of the above.
19.	All forms of sexual violence are about:	Power and control, sex drive, romantic relationships, I don't know.
20.	Who is responsible for sexual violence?	Victim, perpetrator, victim and perpetrator, I don't know.
21.	Which of the following is not a step in problem solving?	Define the problem, gather more information, weigh the alternatives, ask for help, none of the above they are all steps in problem solving.
22.	Gonorrhea	Bacteria, virus, parasite.
23.	Pubic lice	Bacteria, virus, parasite.
24.	Genital warts (HPV)	Bacteria, virus, parasite.

25.	HIV/AIDS	Bacteria, virus, parasite.
26.	Herpes	Bacteria, virus, parasite.
27.	Chlamydia	Bacteria, virus, parasite.
29.	Viral STIs are:	Treatable, curable, both, don't know.
30.	You can get or transmit STIs through:	Oral sex, anal sex, vaginal sex, all of the above.
31.	IUD (intrauterine device)	• This is worn on the outside of the body and releases hormones into the blood. It is changed once a week. • This is put on an erect penis and prevents sperm from going into the vagina. • This is a shot that is given to a woman once every three months. • This is a latex barrier that is put on the
32.	Female condom	
33.	Ortho Evra (the patch)	
34.	Male condom	
35.	Depo-Provera	
36.	Nuva Ring	
37.	Dental dam	

38.	Birth control pills	outside of a woman's vagina to prevent STIs. • This is a latex ring placed inside a woman's vagina and left in place for three weeks at a time. • This is inserted in a doctor's office or clinic and provides birth control for up to 5 years. • A woman would take one of these every day to prevent pregnancy. • This is a latex barrier that is placed inside a woman's vagina to prevent pregnancy and STIs.

Appendix D. Sexual Attitudes Scale

Item number	Questionnaire item	Possible responses
57.	If I have sex while I'm a teenager, it would make me feel sort of important.	• Strongly agree • Agree • Neutral • Disagree • Strongly disagree
58.	I think it is OK to say "NO" when someone wants to touch me.	
59.	"Love" and "having sex" mean the same thing.	
60.	Having sex while I'm a teenager would just be doing what everybody else is doing.	
61.	People who want to have sex should respect the right of others to say "No."	
62.	If I do have sex, I feel comfortable that I know how to use a condom.	
63.	I feel that I can make good decisions even if I've been drinking or using drugs.	

Appendix E. Self-Esteem Scale

Item Number	Questionnaire Item	Possible Responses
64.	I feel that I have a number of good qualities.	• Strongly agree • Agree • Neutral • Disagree • Strongly disagree
65.	I am able to do things as well as most other people.	
66.	I feel I do not have much to be proud of.	
67.	I'm confused about my personal sexual values and beliefs.	
68.	I have a clear picture of what I'd like to be doing in the future.	

Appendix F. Access to Resources Scale

Item number	Questionnaire item	Possible responses
10.	I feel that I have resources I could refer someone to if someone asked me where they could go to get an abortion.	True, false.
11.	I feel that I have resources I could refer someone to if someone asked me where to go get STI tests.	True, false.
12.	I feel that I have resources I could refer someone to if someone thought he or she might be gay, lesbian, or bisexual.	True, false.
13.	I feel that I have resources I could refer someone to if he/she was the victim of dating violence.	True, false.
14.	I feel that I have the appropriate language and communication skills to talk effectively about sexuality.	True, false.

Appendix G. Parental Communication Scale

Item number	Questionnaire item	Possible responses
39.	The female menstrual cycle- that is, the monthly cycle?	Yes, no.
40.	How pregnancy occurs?	Yes, no.
41.	Sexually Transmitted Infections (STIs)?	Yes, no.
42.	How to say no to sex?	Yes, no.
43.	Methods of birth control- that is, stopping pregnancy from happening?	Yes, no.
44.	How to prevent HIV/AIDS using safe sex practices?	Yes, no.

Appendix H. Sexual Communication Frequency Scale

Item number	Questionnaire item	Possible responses
45.	During an average week, how many times do you have a conversation or discussion about sex with your parents?	• Not at all • 1-2 times • 2-4 • 4-6 • More than 6
46.	During an average week, how many times do you have a conversation or discussion about sex with your friends?	
47.	During an average week, how many times do you have a conversation or discussion about birth control with your parents?	
48.	During an average week, how many times do you have a conversation or discussion about birth control with your friends?	

Appendix I. Sexual Communication Comfort Scale

Item number	Questionnaire item	Possible responses
49.	How comfortable are you talking with friends about sex?	• Comfortable • A little uncomfortable • Somewhat uncomfortable • Very uncomfortable • This does not apply- I have not been in this situation
50.	How comfortable are you talking with a date or a boy/girlfriend about sex?	
51.	How comfortable are you talking with parents/guardians about sex?	
52.	How comfortable are you talking about sexuality issues with those whose sexuality is different than your own (e.g., LGBT youth if you are straight and vice versa)?	

Appendix J: Focus Group Questions

1. What is you most fun memory from Teen Council this year?
2. What things in your community do you think about more or care about more now than you did when you first started TC?
3. Can you give an example of something you've done as a TC member that you feel has made a difference in your community?
4. Will you continue to volunteer and be involved in these issues? Why or why not?
5. How might your experience as a TC member change your future after high school?
6. What did you like most and least about the program? If there was one thing you could change about TC, what would it be?
7. How have your attitudes towards sexuality and adolescent health changed since the start of the TC program?
8. Which part of the TC program influenced you attitudes the most?
9. What are some skills you have gained or improved on as a result of participating in TC?
10. What types of information or resources that you learned through TC have you talked with your friends about on an informal basis?
11. Reflecting back on the year, what would you say is the on most important thing you learned from participating in TC?
12. What makes a good adult leader of TC?
13. Would you recommend TC to a friend? Why or why not?

Appendix K: Participant Assent Form

UW-Stout Signed Consent Form for Research Involving Human Subjects
Consent to Participate In UW-Stout Approved Research

Title: *Planned Parenthood Teen Council Program Evaluation*

Investigator:
Justin Meyer
1-608-774-7950
meyerj@uwstout.edu

Research Sponsor:
Dr. James Tan
1-715-232-5224
tanj@uwstout.edu

Description:
The Teen Council program at Planned Parenthood of Minnesota and South Dakota is conducting an evaluation. This evaluation is interested in determining how the Teen Council program can be improved. The Teen Council evaluation will consist of a survey and focus group. The evaluation will also employ archival data from previous evaluations of the program. The results of the evaluation will be given to Katherine Meerse of Planned Parenthood. These results will be used to make improvements to the program. Mr. Meyer is conducting this evaluation as part of the research component of his graduate program (the Master of Science in Applied Psychology program at the University of Wisconsin-Stout). As part of the research component, a paper detailing the results of this evaluation will be available on the World Wide Web. ***It is important to note that no identifying names or any other identifying information will be used in Mr. Meyer's research paper.***

Risks and Benefits:
While participating in the evaluation, your child may experience some minor feelings of discomfort or uneasiness associated with his/her participation in the survey or interview. As the program is directed at reducing teen pregnancy and the spread of sexually transmitted infections, questions relating to these topics will be asked. It is not expected that completing a survey or participating in an interview on these topics will pose a risk to program participants. The benefits of allowing your child to participate in this evaluation are great. The program will be improved as a result and will continue to reduce teen pregnancy and teen sexually transmitted infections not just in the program participants but also in the population that the program is in contact with in schools and the community. Additionally, program information will be provided to potential funders in order to allow the program to be possible economically.

Special Populations:
Due to the fact that Planned Parenthood will be conducting focus groups with program participants who are under the age of 18, it is important that the researcher first obtains parental consent for their child's participation in the focus groups. It is important that you, the parent, know that:

1. *Planned Parenthood will not force any child to participate in the focus group even if parental consent has been given.*
2. *Planned Parenthood will only allow those students whose parents have granted consent to participate in the focus groups.*

3. *Planned Parenthood will require your child to provide their consent in addition to the parental consent.*
4. *Planned Parenthood will allow your child to withdraw his/her participation from the focus groups as any time without adverse consequences.*

Time Commitment:
Each questionnaire is expected to require 30 minutes to complete. Each focus group is expected to require 60 minutes to complete.

Confidentiality:
Neither your name or your child's name will not be included on any documents. The researcher does not believe that you or your child can be identified from any of the information collected during the evaluation. This informed consent form will not be kept with any of the other documents completed during the course of the research.

Right to Withdraw:
Your child's participation in this study is entirely voluntary. Your child may choose not to participate without any adverse consequences to him/her. Should your child choose to participate and later choose to withdraw from the study, he/she may discontinue his/her participation at any time without incurring adverse consequences.

IRB Approval:
This study has been reviewed and approved by The University of Wisconsin-Stout's Institutional Review Board (IRB). The IRB has determined that this study meets the ethical obligations required by federal law and University policies. If you have questions or concerns regarding this study please contact the Investigator or Advisor. If you have any questions, concerns, or reports regarding your rights as a research subject, please contact the IRB Administrator.

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IRB Administrator
Sue Foxwell, Director, Research Services
152 Vocational Rehabilitation Bldg.
UW-Stout
Menomonie, WI 54751

Statement of Consent:
By signing this consent form you give permission for your child to participate in the project entitled, *Planned Parenthood Teen Council Program Evaluation.*

_____
Signature..... Date

Appendix L: Parental Consent Form

UW-Stout Signed Consent Form for Research Involving Human Subjects
Consent to Participate In UW-Stout Approved Research

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Signature..... Date