

This article presents the Prevention Minimum Evaluation Data Set (PMEDS), a ready-to-use questionnaire or tool for evaluating teen pregnancy prevention and teen STD/HIV/AIDS prevention programs. Recognizing the diversity of approaches taken by these programs, PMEDS has two parts. Part 1 contains a primary questionnaire applicable to all programs. Part 2 consists of 15 additional supplementary modules for optional use by programs with a more specific target population or intervention approach that matches the module's content. It is hoped that PMEDS will facilitate the conducting of high-quality evaluations, first by highlighting important aspects of a program model that should be included in an evaluation, such as the demographic profile of the target population, the specific aspects of the intervention or treatment received by each participant, and the short-term outcomes and long-term goals that the program is trying to affect; second, by presenting measures for these evaluation constructs that have been extensively pretested and used in large-scale national studies and for which national comparison norms and data exist.

**THE PREVENTION
MINIMUM EVALUATION
DATA SET (PMEDS)**
A Tool for Evaluating Teen
Pregnancy and STD/HIV/AIDS
Prevention Programs

JOSEFINA J. CARD
JAMES L. PETERSON
STARR NIEGO
Sociometrics Corporation
CLAIRE BRINDIS
*Center for Reproductive Health
Policy Research
Institute for Health Policy Studies*

There has been significant activity in the field of teen pregnancy prevention in the last decade. In response to the AIDS epidemic, many programs have been developed that are aimed at preventing not only pregnancy among teens, but also sexually transmitted diseases (STD) and HIV/AIDS. Basic research into the causes and consequences of the problem has continued apace: since 1990, 2,272 publications—an average of 325 publications per year—have been published as books or in peer-reviewed journals. Abstracts of these 1990 through 1996 publications are now available on a single, searchable CD-ROM (*Information Resource on Adolescent Health, 1997*).

Evaluation research into the effectiveness of ameliorative or preventive intervention programs has also moved forward. During the last 5 years, there have been at least nine articles reviewing published evaluations of over 100 teen pregnancy and STD/HIV/AIDS prevention programs (Card, Niego, Mallari, & Farrell, 1996; Centers for Disease Control and Prevention, 1996; Frost & Forrest, 1995; Institute of Medicine, 1995; Kirby, 1995, 1997; Kirby et al., 1994; Miller, Card, Paikoff, & Peterson, 1992; Moore, Miller, Gleib, & Morrison, 1995; Philliber & Namerow, 1995). A recent article reported results from a meta-analysis of 32 outcome studies on the primary prevention of adolescent pregnancy (Franklin, Grant, Corcoran, Miller, & Bultman, 1997).

Bridging the gap between research and practice, a new resource—the Program Archive on Sexuality, Health & Adolescence (PASHA)—has just been established (Card et al., 1996). PASHA is making publicly available, for use by practitioners, service providers, and teachers, 23 promising teen pregnancy and STD/HIV/AIDS prevention programs. All the programs in PASHA have been shown by evaluation research to be effective in changing sexual risk-related behavior—or attitudes, for programs aimed at middle-school youth—in at least one site. In addition to disseminating the curriculum and associated materials from these promising programs, PASHA is providing evaluation-related instruments and technical assistance to encourage the replication, creative adaptation, and reevaluation of these interventions.

Program development efforts have tackled new frontiers. Many communities have embarked on community-wide teen pregnancy prevention initiatives, with collaboratives composed of schools, community groups, and family planning clinics established to coordinate these broad efforts within the community. The Centers for Disease Control and Prevention (CDC) has awarded cooperative agreements to 13 community-wide coalition partnership programs to demonstrate that community partners, in communities with a population of 200,000 or more, can mobilize and organize community resources in support of community-wide, comprehensive, risk-specific, effective, and sustainable programs for the prevention of initial and repeat teen pregnancies. The community-wide coalition partnership programs are located in the following cities: Boston, Massachusetts; Chicago, Illinois; Jacksonville, Florida; Kansas City, Missouri; Milwaukee, Wisconsin; Oklahoma City, Oklahoma; Philadelphia, Pennsylvania; Pittsburgh, Pennsylvania; Rochester, New York; San Antonio, Texas; San Bernardino, California; Winter Park, Florida; and Yakima, Washington (Centers for Disease Control and Prevention, 1996).

Interest has begun to focus on broader youth development programs, programs such as the Teen Outreach Program, the Quantum Opportunities Program, Upward Bound, the Youth Corps, and the Youth Incentive Entitlement Pilot Project (YIEPP) aimed at helping youth with the transition to adulthood by providing comprehensive assistance in the educational, work, and social domains. Although these programs have not focused on sexuality per se, evaluation data appear to indicate varying levels of success in reducing sexual risk-taking behavior, pregnancy, or childbearing (Hahn, 1995; Jastrzab, Blomquist, Masker, & Orr, 1997; Jastrzab, Masker, Blomquist, & Orr, 1996; Myers & Schirm, 1997; Olsen & Farkas, 1987; Philliber Research Associates, 1996).

The 1990s have also been marked by efforts to refocus the issue away from the prevailing problem or disease model to the more positive challenge of how a nation teaches its children what healthy and responsible sex means in the adolescent and young adult years (National Commission on Adolescent Sexual Health, 1995).

All these efforts have coalesced into increasing national attention to the issue of adolescent pregnancy prevention. With encouragement

from the president of the United States, the privately funded National Campaign to Prevent Teenage Pregnancy was incorporated in 1996. The campaign is aimed at reducing the pregnancy rate among teenage girls, 17 and younger, by one third by the year 2005. In 1991, the pregnancy rate for girls 14 and under was 3.2 per 1,000 and for girls 15 to 17 years old, it was 74.6 per 1,000 (National Campaign to Prevent Teen Pregnancy, 1996).

PROGRAM EVALUATION

Of the new developments described above, the one with the arguably greatest potential for reducing the teen pregnancy rate has been the growing acceptance—among funders, service providers, practitioners, and researchers alike—of the importance of conducting scientific evaluations of the effectiveness of teen pregnancy prevention programs. Growing consensus has emerged that program development should be guided not only by what might work (based on moral, ideological, personal, or political beliefs) but also on what does work (based on rigorous scientific evaluation). The importance of supporting evaluation efforts with appropriate funding has been recognized as well.

FACILITATING PROGRAM EVALUATION: A CORE QUESTIONNAIRE

To facilitate the evaluation of teen pregnancy and teen STD/HIV/AIDS prevention programs, we have worked with 19 expert researchers, evaluators, and program administrators to develop the Prevention Minimum Evaluation Data Set (PMEDS). A *minimum evaluation data set* for evaluating a group of topically related interventions is a core set of baseline and outcome measures collected in similar fashion by programs sharing a common goal or set of goals. The PMEDS instrument described in this article offers a set of such measures, in written survey questionnaire format, for the evaluation of programs aimed at preventing teen pregnancy and teen STD/HIV/AIDS. Because these prevention programs tend to be quite

varied in their approach, ranging from Just Say No programs to sex education programs to contraceptive provision programs to life-option enhancement or youth development programs, PMEDS is organized as a core set of data elements common to almost all pregnancy and STD/HIV/AIDS prevention programs (the primary questionnaire) and as a series of optional sections (the supplementary modules), each appropriate for one or more specific kinds of pregnancy or STD/HIV/AIDS prevention programs.

All teen pregnancy and STD/HIV/AIDS prevention programs, despite their diverse goals, objectives, participants, approaches, resources, and ecological factors, must provide answers to similar questions if they are to produce valid evaluations of their effectiveness in reducing sexual risk-taking behavior.

1. Who are the program participants? Who constitutes the target audience for the intervention? What do these clients bring to the program in terms of previous experiences; exposure to similar programming; and current relevant behavior, skills, knowledge, or attitudes?
2. What are the program's goals and objectives? What does the program want to accomplish in terms of developing, strengthening, or changing behavior and/or skills knowledge and attitudes within the target group?
3. What is the treatment or intervention? What program activities are conducted to bring about the hoped-for developments and changes in the participants?
4. Did the program accomplish its short-term objectives and long-term goals? What was the result or impact of the treatment program on participants' subsequent behavior, skills, knowledge, or attitudes? Did this impact vary for different subgroups of participants (e.g., boys versus girls, younger versus older teens, White versus Hispanic versus African American teens)?
5. What was the comparative impact of the program? Did the program accomplish its objectives more effectively than: (a) another similar program; (b) no treatment at all; (c) the program as constituted before this new intervention; or (d) a standard obtained from a national, regional, or local comparison?

PMEDS was designed to help program personnel answer these program evaluation-related questions with well-tested items covering

important aspects of a wide variety of program models, thus saving duplication of effort in instrument development while contributing to the development of a shared pool of common evaluation data.

DEVELOPMENTAL HISTORY AND METHODS

The first edition of PMEDS was developed in 1989. It was based on the collective research and evaluation experience of a group of 19 expert researchers, evaluators, and program administrators who participated in a national evaluation conference sponsored by the Henry J. Kaiser and Hewlett Foundations and chaired by Dr. J. J. Card. Most of the original PMEDS items were taken from questionnaires that conference participants had used and found acceptable in their own studies. PMEDS was initially published by Sociometrics Corporation in 1989 as part of a monograph titled "Evaluating Programs Aimed at Preventing Teenage Pregnancies." It was reprinted in 1993 as part of Sage Publications' *Handbook of Adolescent Sexuality and Pregnancy: Research and Evaluation Instruments* (Card, 1989, 1993).

In 1996, Sociometrics revised PMEDS for the PASHA, sponsored by the U.S. Office of Population Affairs, and for the *Guidebook: Evaluating Teen Pregnancy Prevention Programs*, sponsored by the Centers for Disease Control and Prevention. This edition (a) streamlines the structure of PMEDS' primary questionnaire so that the same survey can be used at all data collection points; (b) adds a table of contents; (c) updates the wording of some questions to reflect recent national surveys such as AddHealth 1994-96, the National Survey of Adolescent Males 1990-91, and the National Health and Social Life Survey 1992; (d) incorporates measures of STD/HIV/AIDS-related behaviors and attitudes; (e) enhances the layout and design of the instrument; (f) includes as an option a diskette with WordPerfect and Microsoft Word for Windows files of the instrument; and (g) focuses the outcome measures on 13 key criteria of effectiveness developed for the PASHA, as described below.

As part of its work identifying promising prevention programs, the PASHA developed a set of criteria for measuring program effectiveness. Evidence of a demonstrated, positive impact on one or more of

the following fertility-related and/or STD/HIV/AIDS-related risk behaviors in teens was required for inclusion in the collection.

- Postponing sexual intercourse
- Decreasing the frequency of sexual intercourse
- Decreasing the number of sexual partners
- Increasing contraceptive use at first intercourse
- Increasing contraceptive use at most recent intercourse
- Increasing consistent contraceptive use among the sexually active at every intercourse
- Preventing pregnancy
- Increasing use of effective STD/HIV/AIDS-prophylactic method at first intercourse
- Increasing use of effective STD/HIV/AIDS-prophylactic method at most recent intercourse
- Increasing consistent use of effective STD/HIV/AIDS-prophylactic method at every intercourse
- Substitution of lower risk sexual behaviors for high-risk behaviors
- Increasing STD/HIV/AIDS prevention-related behaviors (i.e., increased condom purchasing, increased voluntary condom carrying)
- Preventing STDs/HIV/AIDS

For programs aimed at children 15 or younger, demonstrated, positive impact on fertility-related and/or STD/HIV/AIDS-related refusal/negotiation skills, intentions, values, and attitudes was accepted as preliminary evidence of the program's promise. Measures of the above effectiveness criteria have been incorporated into the present edition of PMEDS.

COMPONENTS

As previously mentioned, PMEDS is divided into two sections: a core primary questionnaire and a set of supplementary modules. Items in the primary questionnaire are recommended for all prevention programs. The supplementary modules offer optional items that a program may wish to consider including in its questionnaire, depending on the match between the module's content and (a) the program's target population (e.g., a program may decide to include items in the

module on high-risk behavior if it serves a high-risk target population) and (b) its goals, objectives, and intervention approach (e.g., a program may decide to include items measuring the quantity and quality of parent-child communication if it includes intervention components aimed at enhancing such communication).

The primary questionnaire. Because the primary questionnaire is intended to include only core questions—ones that virtually every teen pregnancy prevention program would include in any evaluation—it is relatively short: 59 questions in 14 pages. Any given respondent could respond to as few as 33 questions or as many as 54. Because it is intended for all programs, the primary questionnaire avoids questions that are highly sensitive or that address behaviors that are rare among the teen population in general.

The questionnaire can be self-administered, group-administered, or administered individually by an interviewer. It has four sections: demographic background, nonbehavioral outcome measures, behavioral outcome measures, and sample intervention-measurement items. The short nonbehavioral section is devoted to attitudes, values, plans, and intentions, the intermediate variables through which many programs attempt to change behavior. However, the greatest emphasis is given to the behavioral measures in the third section because behavioral outcomes are, ultimately, the ones that prevention programs have to affect if pregnancy and STD/HIV/AIDS are to be avoided. Behaviors covered include the exercise of refusal/negotiation skills, sexual activity, contraceptive use, pregnancy and parenthood, STD/HIV protection, and STD/HIV infection. Table 1 provides an outline of the primary questionnaire.

The supplementary modules. In contrast to the primary questionnaire, the supplementary modules focus on topics that might apply to some programs but not to others. The modules fall into the same four sections that comprise the primary questionnaire. That is, some modules focus on demographic background measures that expand the coverage of the primary questionnaire. Among these modules, for example, are ones on education, religiousness, and drug use. Other modules address nonbehavioral outcomes (e.g., knowledge of sexuality, abstinence attitudes) and others address behavioral outcomes in more

TABLE 1
Outline of PMEDS Primary Questionnaire

A. Background and related information. The questions in this first section assess basic demographic characteristics of participants (e.g., age, year in school, race/ethnicity). In previous research, these items have shown reliable relationships with fertility- and STD-related outcomes. Constructs covered:

1. Gender
2. Age
3. Birthdate
4. School completed
5. School enrollment
6. Race/ethnicity
7. Mother's education
8. Living arrangement

B. Nonbehavioral criterion measures. This second section probes teens' refusal/negotiation skills, intentions, expectations, values, and attitudes concerning abstinence, sexual activity, contraceptive/prophylactic use, and pregnancy. The questions are suitable for use with all teen pregnancy and STD/HIV/AIDS prevention programs. However, we particularly recommend them for programs serving younger teens ages 15 and below, for whom questions about actual behaviors may be inappropriate. Constructs covered:

1. Values, attitudes
 - a. Best age to marry
 - b. Youngest age to marry
 - c. Number of children wanted
 - d. Best age to have first child
 - e. Youngest age, first child
 - f. Best age, first sex
 - g. Youngest age, first sex
 - h. Sex before marriage all right?
 - i. Responsible person for contraception
 - j. Having baby in high school
 - k. Sexual attitudes
2. Intentions, expectations
 - a. Number of sexual partners in teen years
 - b. Plans for sexual intercourse
 - c. Plans for contraceptive use
 - d. Methods intend to use

C. Behavioral criterion measures. This third section includes measures of specific behaviors regarding sexual activity, contraceptive/prophylactic use, pregnancy, and parenthood. As noted above, these items may not be appropriate for some groups, particularly younger teens. Constructs covered:

1. Refusal/negotiation skills
 - a. Communicating about sex
 - b. Saying "no"
 - c. Stopping sex
 - d. Communicating about contraception
 - e. Insisting on contraception

(continued)

TABLE 1 Continued

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- 2. Sexual activity
 - a. Sexually experienced?
 - b. Frequency, 6 months
 - c. Number of partners, ever
 - d. Number of partners, 6 months
 - e. Age at first sex
 - f. Frequency, 4 weeks
 - 3. Contraceptive use
 - a. Method used, first intercourse
 - b. Method used, most recent intercourse
 - c. Consistent use, 6 months
 - 4. Pregnancy and parenthood
 - a. Ever pregnant
 - b. Number of pregnancies
 - c. Number of live births
 - d. Age at first pregnancy
 - e. Pregnant now?
 - 5. STD protection
 - a. Method, first intercourse
 - b. Method, most recent intercourse
 - c. Consistent use, 6 months
 - 6. STD/HIV infection
 - a. STD infection, ever
 - b. STD infection, 6 months
 - c. HIV infection, ever
 - d. Know someone with HIV infection

D. Examples of treatment/intervention elements and dosage. In any evaluation study, it is essential to measure the actual intervention to which teens are exposed. Because the questions will vary with the nature of the intervention, each program will need to construct its own set of items. This fourth and final section provides a sample structure for writing measures of the actual program activities as well as the amount of exposure teens receive. Constructs covered:

- 1. Number sessions attended
 - 2. In program last year?
 - 3. Components received
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detail (e.g., first birth control use, high-risk sexual behaviors). Items of greater sensitivity are also found in the supplementary modules. For example, some modules address behaviors (such as anal sex) that are likely to be relevant only for some subpopulations. The supplementary modules are also designed to reflect the varying approaches or short-term outcomes that programs may take. For example, some

modules focus on sexuality education, abstinence, parent-child communication, sexual values education, and peer influence. Table 2 provides a list of the constructs covered in the supplementary modules.

AVAILABLE FORMATS

Recognizing that PMEDS may be used for evaluating a diverse array of interventions and by individuals with varying amounts of evaluation-related experience, the instrument is offered in two formats: paper and floppy diskette. These formats vary in the degree to which they allow for customization of the instrument and provide background information about evaluation research in general and development of the PMEDS tool in particular.

ILLUSTRATIVE USES

To illustrate the varied ways in which PMEDS can be used, four case studies are presented.

Vallejo Teen Age Pregnancy Prevention (TAPP) Program. In the fall of 1996, the city of Vallejo, California, received a 5-year state grant to implement and evaluate pregnancy prevention activities for youth. Located in the northern tip of the San Francisco Bay area, Vallejo has been cited as having a significantly higher incidence of adolescent births, relative both to the state of California and to the county in which it is located. The TAPP project team selected two well-known programs for the intervention: SMART Moves and Postponing Sexual Involvement (PSI). SMART Moves will be implemented by a local boys club that provides academic enrichment and recreational opportunities after school. The full, 10-day PSI curriculum will be implemented in 6th-, 8th-, and 10th-grade public school classrooms.

To adapt PMEDS for the TAPP evaluation, we needed to incorporate measures relating to SMART Moves' emphasis on alcohol and drug prevention as well as academic achievement. Values and attitudes toward abstinence are also essential to the project's objectives and, consequently, the evaluation survey. In addition, project staff

TABLE 2
Outline of PMEDS Supplementary Modules

A. Background and related information
Module 1: Socioeconomic status
Module 2: Education
Module 3: Sex education
Module 4: Religiousness
Module 5: Dating behavior
Module 6: Risk taking
Module 7: Tobacco, alcohol, and other drug use
B. Nonbehavioral measures for programs focusing on teens' refusal/negotiation skills, intentions, values, and attitudes
Module 8: Knowledge
Module 9: Abstinence
Module 10: Communication skills or parent-child communication
Module 11: Sexual and contraceptive attitudes and values education
Module 12: Peer influence
C. Additional measures of behaviors regarding sexual activity, contraceptive/prophylactic use, pregnancy, and parenthood. Special measures of high-risk behaviors are also included.
Module 13: First birth control use
Module 14: STD/HIV prevention-related behaviors
Module 15: High-risk behaviors

determined that a simplified instrument would be more appropriate for the younger teens. In consultation with the TAPP team, we drafted separate instruments for 6th-, 8th-, and 10th-grade students. Pilot testing of these instruments revealed that they were too complex and lengthy for many respondents. For example, elementary and middle school students had trouble answering items with more than five response choices or that asked them to estimate the frequency of particular behaviors using percentages. Additionally, we found that rates of sexual activity, pregnancy, STD infection, and drug use among the youngest respondents were so low as to be negligible. Using this information, we simplified and shortened the surveys considerably. The final, 39-item sixth-grade survey contains no measures of sexual behavior or sexual history. In contrast, the addition of these items, along with additional measures of drug use, increased the length of the 10th-grade survey to 68 questions. Project staff feel confident that these revised instruments will be more suitable for their teens.

PASHA field test. PMEDS is being used extensively in conjunction with the PASHA. As described previously, PASHA is a diverse

collection of 23 promising teen STD/HIV/AIDS prevention programs. All programs included in the collection have been selected for their demonstrated, positive impact on fertility- or sexuality-related behaviors in teens. For the PASHA field test, we are reevaluating the effectiveness of these interventions when they are implemented in new settings and with new groups of teens. Eighteen participating sites, located in all areas of the country, include junior and senior high schools, after-school programs, family planning clinics, juvenile detention facilities, hospitals, and community-based organizations. The evaluation will include pretest, posttest, and 6-month follow-up assessments of participating teens together with an assessment of the implementation process. Comparison data will be obtained from a synthetic comparison group formed from the AddHealth data set (Kelley, Peterson, & Peterson, 1997; Udry, 1996).

At the start of the project, we determined that it would be cumbersome to use each of the 23 separate original evaluation instruments (those used in the original demonstration of program effectiveness) for the reevaluation studies. Many of these instruments are complex, time-consuming, and more appropriate for the comprehensive, scientist-directed studies in which they were originally used. In contrast, the PASHA reevaluations required a straightforward instrument that would be appropriate in a wide range of situations—that is, for pregnancy and STD/HIV/AIDS prevention programs, with older and younger teens, with high- and low-risk youth, and with strategies that vary from promoting abstinence to developing negotiation skills to providing and encouraging the use of contraception. We also required an instrument that would be easy for program leaders to implement and for teens to complete. PMEDS seemed well-suited to meet these kinds of logistical and conceptual challenges.

To date, Basic PMEDS (the primary questionnaire) has worked best when used with the groups of teens for which it was originally developed, notably, youth between the ages of 13 and 18 who attend school, can read and write in English, and live in a family setting. With such youth, staff report that the respondents appreciate knowing that their opinions and beliefs are valued, and the youth are able to complete the survey within a single class period (e.g., about 45 minutes). At the same time, we note that Basic PMEDS has proved difficult for teens who are less than 13 years old or who have limited English skills.

Additionally, we have found several items in Basic PMEDS to be inappropriate or objectionable to gay, lesbian, or bisexual teens, college students, incarcerated youth, and those in residential care. For such groups, we have modified the survey by incorporating additional items from the full PMEDS instrument. Questions on high-risk sexual encounters, for example, have been used in test sites working with gay, lesbian, and bisexual teens.

A longer term solution would be to develop specialized versions of PMEDS that are tailored to specific subgroups. Already, we have created PMEDS Jr. for use by programs aimed at younger teens or emphasizing abstinence, and response to this instrument has been quite favorable.

California's Community Challenge Grant Program. PMEDS is also currently being used as part of a new statewide teenage pregnancy prevention initiative, the California Community Challenge Grant program. As part of the governor's initiative titled "Partnership for Responsible Parenthood," 112 lead community agencies have received funding to establish a wide range of community-based adolescent pregnancy prevention strategies. Using over 660 collaborating agencies, communities are implementing programs that range from those focused on abstinence-only education to program efforts directed at youth development. As part of the infrastructure of the evaluation, PMEDS is being adapted for use in measuring a wide range of program outcomes. Sites are being encouraged to collect similar data across sites, depending on the modules that are most responsive to their proposed interventions. Given the variability in interventions being tested and the necessity of creating a flexible but standard cross-site data collection approach, PMEDS has been especially useful in assuring a level of standardization across sites. However, as a result of multiple target groups and multiple outcomes sought by the evaluation, the number of potential combined packets of questionnaires has risen from 112 to over 180 different types of evaluations being conducted. This has created challenges to the evaluation team whose initial evaluation budget was not developed to process and analyze the level and variability of data being collected across the state. In an effort to share some of the printing costs associated with each of the packets, master copies of the instruments have been shared with sites.

However, many of the sites have failed to photocopy the instruments appropriately, including not copying the back side of pages and/or printing the surveys out of order, thus creating poor data quality and requiring elimination of the data from the evaluation. Furthermore, many of the programs have had problems with achieving an adequate level of positive parental consent forms being signed, thus diminishing the capacity of the evaluation to gather data from an unbiased sample. Finally, the visibility of the statewide project has required the implementation of the data collection instruments in sites that have had limited programmatic experience. As a result, even with the availability of a strong tool, the programmatic intervention represented by these challenge grants may not be of sufficient strength to measure effects.

Girls Incorporated of Orange County. In California, Girls Incorporated of Orange County has drawn on PMEDS in the development of tools to assess the effectiveness of their Will Power/Won't Power and Taking Care of Business programs. The program director reviewed and adapted their existing curriculum and selected a number of PMEDS items to better respond to the modifications that were made in the original program curriculum. The program is now being provided to a primarily Hispanic/Latino population, ages 11 to 18. The use of PMEDS will enable the sharing of this site's experience with others aimed at a similar population. In reviewing PMEDS, the program director had to accept the fact that she was unable to ask a number of questions pertaining to sexual activity in the school sites where the program is being provided. However, alternative items that pertain to knowledge, attitude, and behavioral intent within PMEDS allowed her to develop a tool that was responsive to the social context of her program.

SUMMARY AND CONCLUSIONS

As community practitioners and their funders respond to the national call to improve adolescent pregnancy prevention efforts, they recognize that such efforts can be helped by evaluations that show what works, for whom, and under what circumstances. In this

environment, PMEDS can be a helpful tool for those who are committed to evaluation research, regardless of their program role, funding perspective, or level of technical expertise.

Several features have the potential for making PMEDS attractive to diverse stakeholders in the teen pregnancy prevention field, including practitioners, funders, policy makers, evaluators, and communities. First, PMEDS' modular system allows program directors and staff members, who must evaluate a variety of programmatic efforts with limited time and resources, to select from well-tested questionnaire items those that (a) focus on intervention approaches similar to those chosen by their program and (b) are applicable to a broad array of interventions sharing common short- and long-term objectives. Practitioners need not spend significant time and effort developing questionnaire items from scratch. Rather, they can concentrate on program development using the PMEDS evaluation tool to ascertain whether their goals and objectives are being met. Over time, locally collected evaluation feedback from PMEDS enables programs to fine-tune and improve their interventions.

PMEDS' modular system can be expanded as new research measures and related topic areas emerge; for example, questions related to AIDS prevention and communication skills have recently been added to PMEDS. Two additional tools, PMEDS Jr. and PMEDS Jr.+, have also been developed for users who prefer a scaled-down assessment tool. PMEDS Jr. is intended for use in evaluating programs that promote abstinence. With just 28 questions, it provides a brief, ready-to-use instrument that is also suited to evaluating programs aimed at younger teens. PMEDS Jr.+ is somewhat broader in focus; in addition to the 28-item core questionnaire, it offers 11 supplementary modules, so that the instrument can be tailored to fit most pregnancy and STD/HIV/AIDS prevention programs.

By encouraging the development of standardized data collection across different interventions, PMEDS enables practitioners to compare their results with those of other similar programs. This provides sources of comparison data when establishing a local comparison group may not be feasible (Schott, Peterson, & Card, 1993). With PMEDS, the field can more readily assess the robustness of the effectiveness of a particular program. Is a program shown to be effective

with a middle-class suburban high school population also effective with Hispanic/Latino youth, Asian youth, rural youth? The next generation of programs will greatly benefit from the results of evaluations that use similar items and then contribute their results to a shared data repository. Through such a repository, evaluators can use existing research to develop multiple comparison standards (Card & Reagan, 1989).

PMEDS potentially enables funders and policy makers to make wiser use of limited resources, raising expectations for a minimum level of program accountability and evaluation that results in better decisions about which interventions to fund. In turn, locally based evaluation data may help other community stakeholders, such as parents and advocates, to call for the funding of programs shown to be effective in meeting local needs. Given increasingly competitive demands for resources, all stakeholders—from providers to policy makers to community members—share a responsibility for making wise investments. PMEDS promises to contribute greatly to these important programmatic and policy decisions.

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