Whitfield County Pregnancy Prevention Program (WCPPP):

A Health Promotion Intervention for Combating Adolescent Pregnancy Rates

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Whitfield County Pregnancy Prevention Program

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Mission Statement:

The Whitfield County Pregnancy Prevention Program (WCPPP) seeks to decrease teen pregnancy rates, increase sexual education knowledge, and provide community resources and support for the teens. Furthermore, this program focuses on incorporating comprehensive educational materials in classroom settings for male and female participants throughout the county, with goal of increasing sexual self-efficacy of the students.

Goals and Objectives:

- **Goal 1**: This program will be administered to the majority of students (9th and 10th graders) in Whitfield County.
  - **Objective 1A**: By July 2020, this program will have been administered to at least 80% of all 9th and 10th grade students at Whitfield County High schools as evident by class enrollment data.
  - **Objective 1B**: The program will encourage high participation rates (minimum of 80% of the program sessions attended), indicated by attendance records taken during each session.

- **Goal 2**: This program will encourage healthier sexual decisions.
  - **Objective 2A**: By the senior year of each cohort (2-3 ears after the program), 75% of students who are engaging in sexual intercourse are practicing “safe-sex” measures set by the program, data measured from questions in the follow-up survey.
  - **Objective 2B**: By the end of the program, the majority of the participants will be able to recognize risky sexual behaviors as indicated by a statistically significant measure from pretest to post-test.

- **Goal 3**: This program will increase the sexual self-efficacy of the participants.
  - **Objective 3A**: The majority of the participants will be able to demonstrate increased knowledge of pregnancy prevention practices and sexual education resources throughout the community, as evident by a statistically significant improvement from pretest to post-test.
  - **Objective 3B**: The majority of the participants will know where and how to gain access to sexual health testing and contraceptives, at least 75% of the program participants will be able to correctly identify where to find these services as evident through the program evaluation.

- **Goal 4**: Create a partnership with the local health department along with community health resource personnel.
  - **Objective 4A**: The program will provide and encourage community health organization/personnel relationships with students by providing a minimum of 3 community guest speakers over the course of the program.
• **Goal 5:** This program will decrease the social and economic effects of teenage parenthood by decreasing adolescent pregnancy and birth rates in Whitfield County through comprehensive sexual education.
  
  o **Objective 5A:** By July 2020, there will be a statistically significant decrease in the teenage pregnancy rate in the cohorts who received the program compared to the previous years before the program.
  
  o **Objective 5B:** When the first cohort is in their senior year of high school, school records will be analyzed again to determine if the program produced a statistically significant decline in the overall teenage pregnancy rates through the years.

**Needs Assessment:**

**Background:**

The American Academy for Pediatrics has considered preventing unplanned adolescent pregnancies a top priority for many years, and although both adolescent pregnancies and birth rates have declined over the years, it is still a significant public health problem (Klein, 2005). According to the CDC (Centers of Disease Control and Prevention), the teen pregnancy rate in the U.S is substantially higher than in any other western industrialized nation (Centers of Disease Control and Prevention, 2017). In fact, the adolescent teen pregnancy rate in the United States is nearly twice that of Canada and Great Britain and approximately four times that of France and Sweden (Chen, Ward, Williams, & Abdullah, 2013). The CDC also considers teen pregnancy prevention as one of the most “winnable battles” in public health, however, in 2015 the birth rate for women aged 15-19 was at a national rate of 22.3 births per 1,000 women (Centers of Disease Control and Prevention, 2017). However, in the rural state of Georgia, the rate is even higher than that, averaging around 30 births per 1,000 women aged 15-19 years old (Georgia Department of Public Health), and counties like Whitfield county have an even higher teen birth rate compared to the rest of the state at 57.8% (Georgia Family Connection Partnership, 2012). In 2010, teen pregnancy and childbirth accounted for at least $9.4 billion in costs for U.S taxpayers, along with being a significant contributor to excessive high school dropout rates (Center for Disease Control and Prevention, 2011). Overall, teen pregnancy is a significant issue as it attributes to social, economic, and health implications throughout society.

**Risk Factors:**

Health disparities are the primary risk factor associated with the high prevalence of teen pregnancies, as disparities can limit the ability of the adolescent to access resources and poses a barrier to future success for young mothers (Murimi & Harpel, 2010). Health disparities related to adolescent pregnancy living in poverty, limited maternal education, having a mother who gave birth before the age of 30, coming from a single parent home, living in a home with frequent family conflict, early sexual activity, early use of alcohol and drugs, low self-esteem, and the teen’s race and ethnicity (Youth.GOV, 2015). Some of these risk factors are behavioral choices, which are important to consider when deciding the type of program needed. Creating
programs with certain behavioral changes in mind, like increasing self-efficacy and decreasing drug and alcohol use, can be used to indirectly decrease teen pregnancy rates. Although teen childbearing is the result of these individual behaviors, many findings suggest that community-level factors such as income and income inequality may contribute significantly to differences in teen birth rates (Chen et al., 2013). However, risk factors like family income level and race and ethnicity cannot be changed and are not in the teen's control whatsoever. Demographical risk factors are important to target directly. By targeting programs directed at populations that are at the greatest risk or have the greatest history of teen pregnancy, the prevention program is more likely to be successful. Risk factors for teen pregnancy can be very broad, thus identifying these factors, along with protective factors, within specific communities is critical to guiding teen pregnancy prevention program planning and implementation (Youth.GOV, 2015). Protective factors can be used as well to implement prevention efforts and build upon. Research shows that protective factors such as open communication with parents and/or adults about accurate contraception use, parental support and healthy family dynamics, peer use of condoms, positive attitudes towards condom use, and accurate knowledge of sexual health, HIV infection, sexually transmitted infections, and health outcomes of pregnancy (Youth.GOV, 2015).

Consequences:

Teenage mothers often are unaware of the negative consequences associated with teen pregnancy, both to themselves and their unborn child (Killebrew, Smith, Nevels, Weiss, & Gontkovsky, 2014). Compared with women who delay childbearing until their 20s, teen mothers are more likely to drop out of school and have low educational attainment, to face unemployment, poverty, and welfare dependency, to experience more rapid repeat pregnancy, to become single mothers, and to experience divorce- if they marry (Santelli & Melnikas, 2010). The infants of teen mothers are more likely to be premature and experience infant mortality (Baker & Haeri, 2014). Additionally, children often preform lower on indicators of health and social wellbeing than do children of older mothers, are more likely to have lower school achievements, higher incarceration rates, and substantially more health problems (Santelli & Melnikas, 2010) (Center for Disease Control and Prevention, 2011). Later in life, daughters of mothers who began childbearing before they were 18 years old are more likely to bear children during adolescence themselves, perpetuating the cycle of teen motherhood (Killebrew et al., 2014). Because the children of teen parents are more at risk to become teenage parents themselves, teenage pregnancy has proved to be cyclic in nature and this is one of the reason for continually high teenage birth rates.

Teenagers are also at a higher risk for health complications during pregnancy and adverse birth outcomes (Baker & Haeri, 2014). Pregnant teens have an increased risk of low birth weight and preterm infants, and in fact those infants are 40 times more likely to die within 28 days than normal birth-weight infants (Killebrew et al., 2014). Adolescents are also more likely to experience gestational diabetes, hypertension, anemia diseases, and depression, all of which can cause a drastic decline in health for both the mother and child, leading to lifelong effects (Baker & Haeri, 2014).
Program Focus:

Some Georgia schools have recently begun to implement comprehensive prevention programs to combat their teen pregnancy rates, however, these programs are typically limited to large schools in more urban and advanced areas, like Atlanta. For example, in 2014, DeKalb County adopted the FLASH curriculum for their K-12 health courses. FLASH is an “interactive and comprehensive science-based sexual health education curriculum designed to prevent teen pregnancy, STDs, and sexual violence” (“FLASH,” 2017). It is rooted in the Theory of Planned Behavior, and is a relatively new program to the area. However, Atlanta has proven to have success with this program so far when compared to the previously taught abstinence-centered program “Choosing the Best”, which was/is taught in 47 states, including Georgia ("Choosing the Best," 2017). There is still a significant need for programs, like FLASH, that are inclusive to rural smaller schools in Georgia for students aged 15-19. Intervening earlier on in the teen years is key for sustaining prevention programs, and schools are ideal places to intervene. Per the Georgia board of education, students may be exempted from sex education and AIDS prevention lectures, but may not be exempted from drug and alcohol courses. Georgia education standards also say that risky sexual behaviors must be taught/discussed, but it does not specifically address to what extent nor mentions pregnancy prevention efforts (Georgia Department of Education, 2009). The board of education also provides guidelines to teach “the reasons for remaining sexually abstinent” (Georgia Department of Education, 2009). Whitefield county Georgia has 4 comprehensive public high schools that are required to follow these outlined guidelines, not requiring anything more in depth than the minimum requirements (Whitefield County Schools, 2017). While basic STI risks and HIV prevention is important, research has shown that there is a general lack of understanding of basic anatomy which is important to understand how various contraceptives work and how pregnancy occurs (Langley et al., 2015).

Currently, Georgia law mandates that sexual and HIV education emphasize abstinence until marriage, but does not inhibit providing students with comprehensive knowledge and skills for avoiding sexually transmitted disease and pregnancy (Georgia Department of Education, 2009). However, it is left up to the local school systems to decide how and what information to share, and unfortunately, more school systems follow programs like “Choosing the Best” over a more comprehensive program (Georgia Department of Education, 2009).

However, there is proof that evidence-informed comprehensive and community-based teen-pregnancy prevention programs that promote community connections, engage the boys and not just target the girls, and provide communal support are more successful at lowering teen pregnancy rates than the minimum guidelines set by the state of Georgia (Kozhimannil et al., 2015). Research has also shown that teens need access to contraceptives, knowledge on where and how to access contraceptives, comprehensive sexual education courses, sexual screenings, and confidentiality among the health environment (Mueller et al., 2017).

Based on past research and the current sexual education requirements, there is currently a need for courses on knowledge, attitudes, and behaviors related to teen pregnancy along with incorporating evidence-informed curriculum, competent and engaged staff who can implement the program with fidelity, and a supportive community with access to contraceptives. The WCPPP will incorporate the standards that previous research identified while using a public health theory to effectively implement the program.
**Figure 1: Logic Model**

| PROGRAM: The Whitfield County Pregnancy Prevention Program (WCPPP) |

**Goal: Target sexual education classes to decrease teen pregnancy rates in Whitfield County Georgia**

<table>
<thead>
<tr>
<th>INPUTS ➔</th>
<th>ACTIVITIES ➔</th>
<th>OUTPUTS ➔</th>
<th>OUTCOMES ➔</th>
</tr>
</thead>
<tbody>
<tr>
<td>What we invest</td>
<td>What we do</td>
<td>Who we reach</td>
<td>Direct products of program</td>
</tr>
<tr>
<td>School Faculty members (teachers)</td>
<td>Conduct in school health classes focusing on preventing pregnancy and sexual well being</td>
<td>Parents of teens, Teenagers 15-19 years old (male and female students)</td>
<td>Minimum of 90 minutes a week devoted to program materials</td>
</tr>
<tr>
<td>School Counselors and Nurses</td>
<td>Comprehensive Sexual education courses</td>
<td>Health professionals, influential community members</td>
<td>Minimum of 80% of all 9th and 10th graders anticipated to participate</td>
</tr>
<tr>
<td>Time- Two calendar years</td>
<td>Develop curricula</td>
<td>School faculty and staff</td>
<td>Participants must attend at least 80% of course</td>
</tr>
<tr>
<td>Money- $300,000 grant</td>
<td>Facilitate access to contraceptives and health checks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research findings</td>
<td>Work to increase sexual self-efficacy for teens</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educational Materials- Videos, PowerPoints, pamphlets, books</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community partnerships (Health department, community guest speakers, etc.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual supplies (i.e. Condoms)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Assumptions**
- Health classes are mandatory for all students
- Curriculum is approved by Board of Education
- Health workers will be able to be in the classroom
- Guest speaker will choose to participate and have the time
- Some students will be apathetic or inactive in the sessions

**External Factors**
- Peer judgment/support
- Learning atmosphere of the classroom
- Class scheduling issues
- Students transferring/moving schools or in/out of the class
- Attitude of the community towards the school and the activities being promoted
**Figure 2: Program Budget:**

*Project Title:* Whitfield County Pregnancy Prevention Program (WCPPP)  
*Period of Performance:* June 1st 2018 to July 31st, 2020

<table>
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<tr>
<th>Personnel</th>
<th>Salary</th>
<th>% effort</th>
<th>Calendar Months</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Total</th>
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<td>Project coordinator</td>
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<td>16,185</td>
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<td>8,578</td>
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<td>Nurse (RN)</td>
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<tr>
<td>Counselor</td>
<td>49,555</td>
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<td>9,911</td>
<td>10,208</td>
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<td>5,410</td>
<td>10,663</td>
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<td>Liscenced Clinical Social Worker</td>
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<td>Data Analyst</td>
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<td>16,704</td>
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<td>Domestic (in state milage)</td>
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<td>16,704</td>
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<td>Supplies</td>
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<td>Postage for Parent forms</td>
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<td>Printing/Photocopying</td>
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<tr>
<td>Contraceptives (condoms)</td>
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<td>Teacher Training</td>
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<td>15,000</td>
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<td>Marketing (Flyers/Posters)</td>
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<td>Bi-Weekly Meetings (Rent/Snacks)</td>
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<td>Indirect Costs @ 30%</td>
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<td>33,560</td>
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<td><strong>Total Costs</strong></td>
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<td>145,429</td>
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<td>299,808</td>
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Budget Justification:

PERSONNEL

Project Director – 2.4 calendar months (20% effort) in Years 1 – 2

For this program, we will need a project director who is trained in sexual health education and has a minimum of a Master’s Degree in Public Health (MPH). On top of that, they will have a minimum of three years working with high school-age children and local health organizations. Having experience in these areas will make the project director very well qualified to help lead and organize this intervention program.

The project director’s duties will include:

- **Year 1:** The project director will provide a communication link between the school officials throughout the counties, along with the teachers, program staff, and community health organizations to obtain support for the program. They will also be in charge of training the program staff (i.e. the coordinator, nurses, counselor’s, etc.) in program protocols. The project director will also oversee approving supply purchases and will lead the project team meetings.

- **Year 2:** Throughout year two, they will continue to lead and oversee team meetings, trainings, and communication links. They will also work closely with the project coordinator in assessing the progress of the program as well as implementing changes to insure success. They will also supervise the data analyses for the project to prepare it for distribution, working closely with the analyst. The project director will also oversee maintaining IRB status and that the program follows all ethical standards.

Project Coordinator – 4.3 calendar months (36% effort) in Years 1 – 2

The project coordinator will have a Master’s degrees in Social Work and/or Public Health, and has experience working with adolescence. They will need to have training in sexual health education with/for adolescence. Ideally, they will have experience overseeing a public health intervention dealing with the community. They will also be responsible for overseeing day-to-day project activity including the intervention delivery and supervision of project counselors, nurses, and teachers. They will also oversee the collection and data analyses along with the project director. They will manage student enrollment numbers along with tracking progress updates and outcome evaluations. They will also be tasked with writing the results up, as well as participating in the bi-weekly meetings.

Registered Nurse (RN) – 3.0 calendar months (25% effort) in Years 1 – 2

There will be a Registered Nurse of staff that will be licensed in the state of Georgia, along with having a minimum of 5 years’ experience. They must also have worked with high school aged children and be familiar with comprehensive sexual education courses, as well as basic screening procedures, accurate sexual medical knowledge, and resource information. The nurse will serve as a go-to for students with personal questions and concerns regarding their sexual health, as well as a clinical health personnel they can take medical concerns to. The
nurse will help to provide medical terminology and information regarding different sexual practices and contraceptive methods that will be taught in the class.

**Counselor – 2.4 calendar months (20% effort) in Years 1 – 2**

There will be a counselor on staff with a Master’s degree in Social Work or Education that has experience working diverse student populations. They must also have training and knowledge on the intervention subject. They will help serve as a liaison to the students and other community members as well with providing students with sexual resources if needed. They will be able to be reached for scheduled appointments and be onsite at the schools. They will also participate in the meetings.

**Licensed Clinical Social Worker- – 1.2 calendar months (10% effort) in Years 1 – 2**

There will be a licensed clinical social worker on our team as well in order to assist with developing the nest methods for delivery sexual health information to adolescence. They must have experience with psychology, social work, and education, as well as working with adolescence. The social worker will also assist the nurse and/or counselors in being a resource go-to and health advisor for the students. They will also be required to attend the bi-weekly meetings.

**Data Analyst – 1.2 calendar months (10% effort) in Years 1 – 2**

The data analyst must have a Master’s degree in Public Health with a concentration in Biostatistics or Statistics, and have experience working on qualitative and quantitative data for community based projects. They will help to create the evaluation methods and tools and will be responsible for updating the project coordinator as results and progress ensues. They will also be present and assist in giving updates at the bi-weekly meetings and assist the coordinator with the final write up.

**TRAVEL**

**In-State Travel to and from the Schools in Whitfield County** ($8,352 each year, Years 1 – 2)

- In Years 1 and 2, we will request funds to reimburse team members for travel to schools and community meetings from UGA to Whitefield county at the rate of $.60 per mile. This will allow the team to travel to and from Whitfield county (145 miles) twice a month for the biweekly meetings.

**EQUIPMENT & SUPPLIES**

**Teaching supplies** ($6,500 for year 1 and $2,000 for year 2)

- We are requesting funds to purchase teaching supplies in the form of videos, books, and pamphlets for the students. There will be an additional $2000 allotted for year two due to potential damage or loss, as well as implementing newer materials.

**Postage** ($500 each year, Years 1 – 2)

- We request $500/year to cover the cost of postage throughout the project. The project will require mailing information about the program home to parents and community members (school board) and our goals and objectives of the intervention, as well as...
detailing how any personal information gathered through the program will be confidential.

**Printing/Photocopying costs ($500 each year, Years 1 – 2)**
- We request $500/year to cover the cost of printing and photocopying throughout the project. We will need to produce project information documents, training workbooks for our project members as well as handouts for the participants.

**Contraceptives ($800 each year, Years 1-2)**
- The nurse, social worker, and counselor will have access to providing students with condoms and contraceptive pamphlets if the student wants them. They will be at all the high schools at all times in order to normalize safe sex.

**OTHER EXPENSES**

**Teacher Training ($10,000 Year 1 and $5,000 Year 2)**
- The project will train all health and/or wellness teachers as well as administrative staff (school counselors, principle, vice principle, etc.) for two weeks before the intervention starts. They will be trained 3 days a week for a total of 6 days, during the already existing “teacher training” days the school has. Additionally, all high school teachers will attend a three-hour seminar about the importance of sexual health and an over view of the program at the end of the two weeks. The budget allows them to be reimburse for gas/mileage along with providing snacks and a small monetary stipend, the amount will depend on the number of people.

- **Year 2:** The project will train new teachers and staff members just like the previous year. However, teachers who have already completed the training will not be required to participate in the two weeks training, but a small 1 day re-training session to refresh them on techniques and share with them if anything in the program has changed.

**Marketing ($300 each year, Years 1 – 2)**
- Informational brochures and posters will be created and disseminated throughout the high schools, and at high school-focused events throughout the year. Marketing costs will cover color printing, poster board size printing and printing on specialized papers.

**Bi-Weekly Meetings ($4,840 each year, Years 1 – 2)**
- As part of the maintenance plan for this project, the team will host bi-weekly meetings across the 3 high schools within the county. This will allow a budget of $220 per meeting for renting a community space, providing light snacks for participants, and disseminating information about the progress of the program along with any concerns or suggestions going forward. These meetings will allow the team to provide continued health education training to program providers, along with provide information about the intervention to parents/guardians that have chosen to attend. These meetings will primarily serve as progress check points and planning time for the project, however, because sexual education is a controversial topic, the meetings will be open to the
entire school board and parents of the children so that they may ask questions. During the summer, these meetings will shift to once a month, for a total of 22 meetings a year.

All salary pay is based on the average pay in Georgia based on the degree/position, if applicable, the average was based out of Whitefield County for local personnel hired (i.e. nurse and school counselor). The total personnel costs are $83,387 in year 1 and $85,889 in year 2, and include annual fringe benefit rates of 43% for personnel making $50,000 or more, and 53% for personnel making under $49,999 (the University negotiated benefit rate for TIAA-CREF), while year 2 includes annual salary increase of 3%. The indirect cost for using the school buildings is estimated at 30% of total cost per a year.

Marketing, Recruitment, and Retention Plan:

Target Population:
The WCPPP will engage high school students of Whitfield county that attend one of the four high schools in the county, as all four public high schools will be included in the program. The program will also incorporate both boys and girls that range from 15-18 years old, but there will be exceptions made for student in high school that are aged 14 or 19. If students are outside of this age range, they will be permitted to participate in the program, but their data will not be included in our final data set. Because the program targets teen pregnancy, it must account for students who have already experienced teen parenthood, as a solution, those students will be allowed to participate as well, but, they will be asked to fill out an additional pre-test and post-test survey. Students who attend school in Whitefield county, but do not reside in Whitefield county, will be included in the data set. However, students who move school systems during the length of the program will not be included. This included data from students who began the program and later moved, and students who moved into the program midway.

Recruitment/Marketing:
Students will be recruited through the high schools. Per state law, all students must have been enrolled in a health education class before graduation; our program will target students who are beginning to enroll in this class, as the program will be delivered as part of it. An informative email will be sent to the parents/guardians of the students explaining the purpose of the program, what it will entail for the students, and an opt out form (an example is provided in figure 3). The opt out form will only be signed and returned if the parent/guardian, nothing will be returned if they give permission. The opt out form will also detail what their student will be doing on days that the program is taking place if they aren’t granting permission to participate. This way, even students with the opt out form will be offered alternative assignments related to sexual health education. To accommodate for guardians who do not use email, the same information will be sent to the last physical address on file. Because a health class is mandatory, marketing programs geared towards taking the class are not necessary. An example of the email is provided in figure 3.
Retention:

Again, because a health class is mandatory for all students before graduation, retaining them in the class will not be a huge issue. However, to account for some students dropping out of school, we anticipate that at least 80% of the students who start the program will also finish the program each semester. Attendance will be recorded each day that the program is being administered, and in order to complete the program, students will have to attend a minimum of 80% of the program classes. Progress will be monitored by a mid-point evaluation in the middle of each semester (October for fall and March for spring) as well as an end of the semester evaluation. Although the health class is mandatory, we do want students interested in the program and excited to participate in it. For this reason, the curriculum includes “fun” learning activities in the form of games as well as guest speakers to break up the monotonous lectures. Small prizes (candy, pencils, etc.) will be provided to the winner of each game on those days, as well as a reward for participation and answering questions at the discretion of the teacher. Although those may seem like minor rewards for participation, the budget does allow for a larger reward to be given less frequently. For an example, if the class has at least 85% attendance by the mid-point check, the class will get a pizza party, and the student with the highest grade will get a lunch of their choosing brought to them (maximum price at $15). These incentives will likely encourage students to show up and participate throughout the class/program, which will help us meet our goal of 80% of the students attending at least 85% of the classes.
Figure 3: Email to Parents

To: WhitfieldCountyHighSchool Parents Listserv
Cc:
Subject: Pregnancy Prevention Program in Health Classes
From: Tori Fabacher – fabacher@uga.edu

Dear parents, guardians, and whom it may concern:

This year, all four of the Whitfield County high schools will be participating in a teenage pregnancy prevention program (WCPPP) set up and run through the University of Georgia. The program will focus on combating the teenage pregnancy rate in our county through an educational program that will be administered through our existing health classes. The program will teach a comprehensive sexual health education and bring in guest speakers from the community.

If you do not wish for your child to participate, you can fill out the information in the link provided below. If your child is not participating in the program, they will be sent out of the classroom while the program is being administered. They will be required to complete other health related work in the meantime to be turned in for a grade

- Link: www.WCPPPhealthclass.com/donotparticipate

If you are giving your child permission to participate, you do not need to do anything further. All students enrolled in the health classes will automatically be enrolled in the program unless specified in the link above.

For additional information on the program, you can visit our website at www.WCPPP.com/parentinformation

Sincerely,

Whitfield County School System
Theory:

The Health Belief Model

The goals and objectives of this program will encourage healthier behaviors through a more comprehensive sexual education course. In order to do this, the program will focus on established knowledge, attitudes, and beliefs of the individual, with hopes to change them in order to decrease teenage pregnancy. The WCPP will be developed and implemented using the Health Belief Model, which will cover those aspects as well as additional objectives of the program.

The Health Belief Model is derived from a body of social psychology theory that relies heavily on cognitive factors oriented towards goal attainment (i.e. motivation to prevent pregnancy) ("Explaining Health Behaviors," 2017). Its constructs emphasize modifiable factors, rather than fixed variables, which enable realistic interventions to reduce public health problems (i.e. unintended teenage pregnancy)(Hall, 2012). Overall, the Health Belief Model’s adaptability and encompassing nature enable applications to diverse contexts like preventing teen pregnancy with changing complex behaviors like engaging in risky sexual behaviors. The constructs of this theory include perceived threat (perceived susceptibility/perceived severity), perceived barriers, perceived benefits, cues to action, and self-efficacy. The end goal of the theory being a behavior change through an increase of self-efficacy, and the end goal of the program being preventing teenage pregnancy through increased sexual self-efficacy ("Explaining Health Behaviors," 2017).

Perceived threats (susceptibility and severity) of an unwanted teenage pregnancy and its consequences (i.e. birth, abortion, parenthood) provides the incentive to use contraception and/or other resources to prevent the pregnancy and everything it entails. This construct considers personal feelings of the severity of becoming pregnant as well, based upon subjective assessments and includes factors like fear of the financial obligations associated, pregnancy complications, judgment from peers, body changes, not having a stable partner, or worry of quitting school or not attaining long-term goals. For this program, the perceived barriers are negative implications of not participating in risky sexual behaviors. More often than not, these are centered around social ideals- i.e. wanting to please their partner, risk of losing a reputation, and wanting to fit in/social acceptance from their peers. However, this dimension also includes factors such inconveniences like having to remember to take a daily pill or having to stop apply a condom, not having a ride to a STI/ wellness checkup, or having to obtain parental consent for a medical procedures and/or prescriptions. Perceived benefits relate to the perceived effectiveness, feasibility and other advantages of engaging in healthy sexual behaviors. Through a cost-benefit analysis, the perceived ratio of the benefits to its barriers helps determine what action an individual will take. This construct may also include increasing the knowledge of all benefits that the individual was initially unaware of.

Cues to action are internal and external motivations that prompt an awareness of the perceived pregnancy threat and help to launch action to remedy that threat (Hall, 2012). This may include symptoms like a missed period after intercourse (internal stimuli) or healthier sexual behavior communication from the media, a healthcare provider, or someone the individual looks up to (external stimuli). For the WCPPPP, we will focus on interacting with modifying/ enabling factors that have a direct implication on the individual’s perceptions of
teenage pregnancy, like demographics for groups of people that are at a higher risk. For an example, adolescents of racial/ethnic minority are more likely to experience an unintended pregnancy, as well as adolescence of rural residence, with low income levels. The WCPPP will target all constructs in order to increase the individual’s confidence (self-efficacy) to make healthy informed sexual decisions, in hopes of decreasing the teen pregnancy rate in Whitfield County. The organization of the Health Belief Model makes it a perfect model for this program to be based on.
Figure 4: Health Belief Model Diagram

- **Demographics**: Age, socioeconomic status, race/ethnicity, family relationship, knowledge, personality

- **Perceived Severity/Susceptibility**: Consequences of teen pregnancy-body changes, financial obligations, losing long term goals, not having a stable partner, having to drop out of school, and having pregnancy complications

- **Perceived Benefits/Barriers**: Using contraceptives, community sexual resources, and educational programs can help promote healthier sexual decisions and protect against teen pregnancy

- **Preventative Health Behavior**: Making healthier sexual decisions, decreasing their risk of becoming a teen parent

- **Perceived Threat**: Becoming a teenage parent

- **Cues to Action**: Internal: Missed period, diagnosed with STI, friend gets pregnant. External: educational resources-community members, videos, handouts; Sexual resources-health professional, contraceptives

- **Self Efficacy**: Has the confidence to make knowledgeable sexual decisions, Has the confidence to seek sexual resources throughout the community
Program Description:

- **Target Population:**
  - The program will enlist high school students through public school system in Whitfield County
  - Along with the participants, the program will also partner with community health resources throughout the community
  - Boys and Girls throughout the high schools will be enrolled in a mandatory health class per GA state law
    - The WCPPP will be implemented through this class

- **Program Logistics:**
  - The program will be administered through the health class at a min. of 90 minutes per week
    - How this is done is up to the administrator, it can be done with a set day a week only focusing on the program or administrating a small portion of the program each day.
      - Whatever way is chosen must be consistent throughout the semester
      - Each week of the program will focus on a different topic or have a different guest speaker (full day will be allotted for guest speaker weeks)
  - Participants must attend at least 80% of the program classes to be considered in the long-term data
  - The program will last two years, meaning each group of students will receive 1 semesters worth of the program, as well as any students transferring in. Then the second year, a new group of students will come in for 1 semester
    - In total, there will be 4 cohorts of students throughout the program (1 per semester)
  - The summer months will be used for logistics, supply purchases, and training programs

- **Evaluation:**
  - All participants will take a pre-test survey to gauge their knowledge level as well as sexual behaviors and perceptions/attitudes
  - At the end of each semester they will take an additional post-test to evaluate the program, they will also be allowed to provide teacher feedback here
  - All educational material will be provided in class in the form of videos, handouts, and PowerPoint presentations
  - All visual educational materials dealing with or pertaining to the body will be anatomically correct and factual
  - Participants will be offered the chance to speak one on one with the school counselor or nurse regarding any personal sexual behavior or health screening questions
Both the nurses and school counselors will have contraceptives and informational pamphlets on campus

**Table 1: Program Curriculum Overview:**

<table>
<thead>
<tr>
<th>Week</th>
<th>Topics</th>
<th>Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 1</td>
<td>Introductory Class</td>
<td>Pre-Class Survey</td>
</tr>
<tr>
<td>Week 2</td>
<td>What is Sexual Health?</td>
<td><em>Mental, Physical, and Emotional Sexual Health</em> handout</td>
</tr>
<tr>
<td>Week 3</td>
<td>Teen Pregnancy in the U. S</td>
<td>Video</td>
</tr>
<tr>
<td>Week 4</td>
<td>Consequences of Teen pregnancy</td>
<td><em>Economic Impact of Pregnancy</em> handout</td>
</tr>
<tr>
<td>Week 5</td>
<td>1st Nurse visit, School counselor visit/lecture</td>
<td>Guest lecture</td>
</tr>
<tr>
<td>Week 6</td>
<td>Contraceptives</td>
<td><em>How to Use, Where to Find</em> handout</td>
</tr>
<tr>
<td>Week 7</td>
<td>Sexually Transmitted Infections</td>
<td><em>Signs, Symptoms, Treatment, and Transmission</em> handout/lecture</td>
</tr>
<tr>
<td>Week 8</td>
<td>Community Resources</td>
<td>Resource PowerPoint</td>
</tr>
<tr>
<td>Week 9</td>
<td>Safe Sexual Practices</td>
<td><em>Beyond Condoms- Sexual Risk Avoidance</em> Video and classroom demonstrations</td>
</tr>
<tr>
<td>Week 10</td>
<td>OBGYN lecture</td>
<td>Guest Lecture- <em>What Happens to Your Body during Sex/Pregnancy</em></td>
</tr>
<tr>
<td>Week 11</td>
<td>Pregnancy Misconceptions</td>
<td><em>Facts, Fiction, and Myths</em> interactive game/ PowerPoint</td>
</tr>
<tr>
<td>Week 12</td>
<td>Teen Pregnancy Health Outcomes</td>
<td><em>The Adverse Effects of Teen Parenthood-</em> video and handout</td>
</tr>
<tr>
<td>Week 13</td>
<td>Healthy Relationships</td>
<td><em>Sexual Abuse- It’s Not Always What It Seems</em> lecture</td>
</tr>
<tr>
<td>Week 14</td>
<td>2nd Nurse Visit, Health department visit/lecture</td>
<td>Guest lecture</td>
</tr>
<tr>
<td>Week 15</td>
<td>Risky Behaviors</td>
<td><em>Are you at Risk?</em> handout/lecture</td>
</tr>
</tbody>
</table>
Explanation of Curriculum:

Each week of the class will emphasize different aspects of sexual health, that will all tie into preventing teen pregnancy and increase sexual health competency. The different topic will increase overall sexual knowledge comprehension in multiple areas of sexual health. These are all intended to increase sexual self-efficacy of the participant. The curriculum is aimed at providing knowledge and resources in order to change the attitudes and beliefs of the participants in order to accomplish the goals of the program. This will be completed through educational handouts, lectures, guest speakers, classroom demonstrations, educational videos, as well as knowledge reinforcing games. This curriculum is designed to keep the participant engaged and interested while delivering all aspects of the program.

Pre/Post program surveys:

The first week of classes will focus on introducing the WCPPP and all that it entails. The administrator (teacher) will go over goals and objectives for the class, as well as expectations from the participants (students). Class materials, such as books, will be assigned to the students. Class materials will not be taught yet to compensate for the potential dropping/adding of students. Pre-test will be administered during this week to gauge initial beliefs, attitudes, and knowledge regarding the topics that will be addressed throughout the semester. The last week of class will be used as a progress check and feedback point. Students will complete the course post-test, which will gauge how their beliefs, attitudes, and knowledge has changed over the course of the program. They will also fill out teacher evaluations for the administrator to gauge training techniques. There will also be class discussions for feedback/ideas going forward in the program. The feedback from year 1 will be used during the training moths to make changes to the program to be implemented in year 2.

Handouts:

Handouts will be printed and provided for students, however, some information for certain lectures may directly come from their textbooks, so they will be required to have them on those days. All handouts will provide factual information to the topic at hand and pose deeper level thinking questions at the end of them. Those questions are to be completed by each individual student and turned in. The handouts will also have some form of visual aspect.
to them to keep students interested and engaged while going through them. Each week that a handout is given, there will be a corresponding lecture over that topic given by the teacher.

**Video/ Classroom demonstrations/Games:**
Class room demonstrations and games will be used as a collaborative learning tool to keep students engaged. For an example, one of the games includes a jeopardy based format that will ask questions about pregnancy and sexual facts, fictions, and myths. Students will be divided into teams and play against each other as a way of engaging the students as well as keeping the attention focused on the program. Each game played will be directly related to the topic of the week. The classroom demonstrations will be an interactive way for students to learn about contraceptives and other resources. On days like these, a short educational video will be played to demonstrate the “how to’s” - i.e. how to put on a condom, how to use female condoms, and other how to’s of that nature. Then students will be invited up to “practice” correctly doing these things on props. By familiarizing students with how to protect themselves from things like STI’s and pregnancy, more student will most likely feel confident to engage in healthier sexual behaviors.

**Guest Lectures:**
Guest lecturers will be carefully selected throughout the community. They will have a background in the health field and will be proficient in sexual resources as well as sexual behaviors and pregnancy. We will have the nurse on staff who will come in to answer any questions the students may have, as well as set up appointments to meet with them one on one to discuss anything information or concerns. On the first nurses visit, the nurse will introduce why they are there and then begin taking appointments, while the school counselor will lecture about all of the sexual health resources offered at the school. On the second nurses visit, the nurse will be pulling students out for their meetings while a guest from the local health department comes in to speak about different resources and sexual services the health department can provide them with (i.e. support groups, birth control, STI/HIV testing, pregnancy tests, etc.). We will also have an OBGYN specialist (doctor, physician’s assistant, or nurse practitioner) come in to detail exactly what happens to a women’s body during pregnancy and delivery. They will also discuss what happens during an abortion and how sex in general can affect someone. All guest lecturers will be local community members.

**Project Timeline:**
This program will be conducted over 2 calendar years (24 months). However, the year will begin in June and end in May to accommodate the school year calendar. For years 1 and 2, training and program prep as well as scheduling will take place in June and July (non-school months), as well as purchasing supplies for the program. The actual implementation of the program will run the length of the school calendar, August- May. There will be a midpoint progress check around the semester change (December- January), where logistics will be evaluated as well as the need for more materials/supplies. The program evaluation will take place from May-July after year 1, and then just data evaluation for year 2. Marketing and program recruitment efforts will be targeted around class registration times, July- August and
December-January in hopes to recruit more participants for the class. For a visual representation, see image below.
Figure 5: Project Timeline

WCPPP Timeline (Year 1 and 2)
**Evaluation Plan:**

Evaluation measures will be distributed to all program participants in order to examine the efficacy of this program. Additionally, evaluation measures will be conducted among the nurses, counselors, teachers, and program staff to assess their opinions and perceptions of the program in conjunction with any challenges they endured during the program to better adapt and implement the program in the future. The program coordinator along with the data analysts will perform the program evaluation in order to determine sustainable solutions for future program implementation strategies. A diverse set of quantitative and qualitative data will be collected and analyzed to effectively assess this program through several evaluation measures. The outcome evaluation will be used in hopes of monitoring the long-term goals and achievements of this program throughout follow-up periods beginning three years after implementation.

**Formative Evaluation:**

Previous data collection methods (surveys, questionnaires, other program evaluation techniques, pilot tests, etc.) have determined some of the main barriers/limitations within programs like the WCPPP. Some of them included excluding valuable populations (i.e. boys) from the program, focusing too much on abstinence only and not comprehensive sexual health, and sessions being too long and boring to engage participants (for more information on this, please see Needs Assessment) (Kozhimannil et al., 2015) (Mueller et al., 2017). The WCPPP has been designed to help cut down on these limitations in order to increase sexual self-efficacy and decrease teen pregnancy rates. The WCPPP includes many design elements similar to previous interventions that have been conducted, but the implementation of the program classes as well as the educational lessons and training techniques must be individually targeted, simplified, and interesting and easy for the participants to engage in. Attitudes of participants towards the program will be measured via survey intake (pretest/post-test). This will help direct modifications throughout the program and future programs.

Initial pre-test surveys will be administered on the first day of the class each semester in order to analyze how students already feel about content that will be discussed in the program and to determine where their sexual self-efficacy already stands, measured by using a 5 point Likert scale. Additional planning with the individual schools and teachers will be conducted in order to make sure other health topics set by the Board of Education are covered and how to maximize the time distribution for each class/session of the program.

There will also be training surveys administered to the staff that has participated in training before the program has begun. This is to ensure that the staff feel confident that they can appropriately teach the program. This will also be used as a feedback point to change anything the staff feel is not helping the feasibility or appropriateness of the program before it begins.

**Process Evaluation:**

In order to examine the number of participants, attendance rates, and efficacy within
the population, we will record data at each session. These data will be examined at the conclusion of the program and compared to results from other comprehensive pregnancy prevention programs. First, attendance will be taken at each session. The program aims for students to attend 80% of the programs sessions/classes. At the conclusion of the program, the project coordinator will examine the attendance rates to see whether students attended the correct number of classes, and if not, what materials/days were missed the most in order to determine what content of the program was most often not received. Additionally, the number of participants in the program will be recorded in order to determine if the program is effective and representative of the school system in order to determine if the program should continue to seek grant funding in future years. It will also be reordered to determine if the program met its recruiting goal of including at least 80% of 1st and 2nd year students (9th and 10th graders). Basic demographics will be collected of each participant at the first session including age, race, and ethnicity to determine which sample of the population decided to utilize this program and will also be used to determine which group of these students is at highest risk for experiencing teen pregnancy by comparing it to previous school data. The program will be altered to target these groups in future years and methods for reaching different populations will be developed in order for these populations to have an increased chance to receive the program and decrease their chances of becoming a teen parent. Since the program is to be implemented across 4 schools, the measures and data collection must be divided to look at the individual and school characteristics, and outcomes as well, and individual school characteristics include measures assessed by the Georgia Department of Education. These include attendance and suspension rates, enrollment, teaching experience, and student and school performance records.

Mid-point evaluation surveys will be administered to gauge teaching techniques and implementation strategies as well. These surveys will be distributed to everyone in the classes as well as the principle of the school, the school counselors involved, the nurses, and the teachers. This data will then be analyzed and discussed in the next program staff meeting where this input will be accounted for and changes to the program will be made based on it. This will hopefully keep the program on track while making it more efficient and tailored specifically to students and what they want/need. These changes will be effective immediately and will be altered as the program sees fit through the remainder of the semester.

**Summative Evaluation:**

*The following table(s) provide a brief description of summative evaluation measures pertaining to each goal/objective of the program. A further explanation of each section is discussed below each table.*
Table 2: Impact Evaluation Measures

<table>
<thead>
<tr>
<th>Goal</th>
<th>Objective</th>
<th>Evaluation Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>This program will be administered to the majority of students (9th and 10th graders) in Whitfield County.</td>
<td>By July 2020, this program will have been administered to at least 80% of all 9th and 10th grade students at Whitfield County High schools as evident by class enrollment data.</td>
<td>School records will be analyzed to determine if the program has been taught to at least 80% of the number of 9th and 10th grade students enrolled at the school, this will not include students who are repeating either grade. Process evaluation will also be used to measure this goal/objective.</td>
</tr>
<tr>
<td>This program will be administered to the majority of students (9th and 10th graders) in Whitfield County.</td>
<td>The program will encourage high participation rates (minimum of 80% of the program sessions attended), indicated by attendance records taken during each session.</td>
<td>At the end of each semester (post-program), attendance records will be stratified by the individual students enrolled in the course to determine what percentage of students received at least 80% of the course. Process evaluation will also be used to measure this goal/objective.</td>
</tr>
<tr>
<td>This program will increase the sexual self-efficacy of the participants.</td>
<td>The majority of the participants will be able to demonstrate increased knowledge of pregnancy prevention practices and sexual education resources throughout the community, as evident by a statistically significant improvement from pretest to post-test.</td>
<td>Pre-test/Post-test data will be analyzed once the program has been completed for each cohort (that way changes can be made from one cohort to the other if needed) to determine if there was a statistically significant change in the number of students who had increased knowledge, attitudes, and overall self-efficacy. Formative evaluation will also be used to measure this goal/objective (see formative evaluation section for more information).</td>
</tr>
</tbody>
</table>
This program will increase the sexual self-efficacy of the participants. The majority of the participants will know where and how to gain access to sexual health testing and contraceptives, at least 75% of the program participants will be able to correctly identify where to find these services as evident through the program evaluation. Pre-test/ Post-test data pertaining to questions about sexual resources and their availability will be analyzed to determine if at least 75% of the students who completed the pre-and posttest survey were able to correctly identify where they could find particular services/resources once the program was completed.

Impact evaluation will be measured in order to help predict whether or not the program will be successful in decreasing teen pregnancy rates by measuring attitudes/beliefs and knowledge addressed in the form of the pre/post-test surveys as well as the overall attendance records for the program. These will be examined at the end of each cohort’s program semester as well as the overall end of the program.

**Table 3: Outcome Evaluation Measures**

<table>
<thead>
<tr>
<th>Goal</th>
<th>Objective</th>
<th>Evaluation Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>This program will encourage healthier sexual</td>
<td>By the senior year of each cohort (2-3 ears after the program), 75% of</td>
<td>Follow-up survey data with questions pertaining to sexual behaviors will be analyzed to determine 1). How many students are engaging in sexual intercourse and 2). What percentage of those students are practicing “safe-sex” practices taught/encouraged by the program.</td>
</tr>
<tr>
<td>decisions</td>
<td>students who are engaging in sexual intercourse are practicing “safe-sex”</td>
<td>Pre-test/post-test data will be analyzed after each cohort and at the conclusion of the program to determine if more participants are able to recognize more risky sexual behaviors. Formative evaluation will also be used to measure this goal/objective (see formative evaluation section for more information).</td>
</tr>
<tr>
<td></td>
<td>measures set by the program, data measured from questions in the follow-up</td>
<td></td>
</tr>
<tr>
<td></td>
<td>survey.</td>
<td>This goal/objective will be evaluated by 1). The number of community guest speakers</td>
</tr>
<tr>
<td>This program will encourage healthier sexual</td>
<td>By the end of the program, the majority of the participants will be able</td>
<td>Pre-test/post-test data will be analyzed after each cohort and at the conclusion of the program to determine if more participants are able to recognize more risky sexual behaviors. Formative evaluation will also be used to measure this goal/objective (see formative evaluation section for more information).</td>
</tr>
<tr>
<td>decisions</td>
<td>to recognize risky sexual behaviors as indicated by a statistically</td>
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<tr>
<td></td>
<td>significant measure from pretest to posttest</td>
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<tr>
<td>Create a partnership with</td>
<td>The program will provide and encourage community health</td>
<td></td>
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</table>
the local health department along with community health resource personnel. organization/personnel relationships with students by providing a minimum of 3 community guest speakers over the course of the program.

<table>
<thead>
<tr>
<th>This program will decrease the social and economic effects of teenage parenthood by decreasing adolescent pregnancy and birth rates in Whitfield County through comprehensive sexual education.</th>
<th>By July 2020, there will be a statistically significant decrease in the teenage pregnancy rate in the cohorts who received the program compared to the previous years before the program.</th>
</tr>
</thead>
<tbody>
<tr>
<td>School data records will be analyzed before the program begins to determine the number of 9th and 10th graders that had become pregnant and then again after the program to compare the rates between the teens who received the program and the teens who did not receive the program. This summative evaluation is helping to determine if we reached our overall goal of decreasing teenage pregnancy rates.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>This program will decrease the social and economic effects of teenage parenthood by decreasing adolescent pregnancy and birth rates in Whitfield County through comprehensive sexual education.</th>
<th>When the first cohort is in their senior year of high school, school records will be analyzed again to determine if the program produced a statistically significant decline in the overall teenage pregnancy rates through the years.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beginning two years after the programs conclusion, school records will be analyzed again to determine the number of students who became teenage parents or experienced a pregnancy in the cohorts that received the program 2 years ago. This data will be compared to the individual school’s history of teen pregnancy data. This summative evaluation is helping to determine if we reached our overall goal of decreasing teenage pregnancy rates.</td>
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</table>

Outcome evaluation will also be measured beginning two years after the program begins and will continue for 2 years. This is to measure whether or not the program decreased teen pregnancy rates within the Whitfield County School system when the first group of students becomes seniors and gets ready to graduate, and it will continue through the second
cohort’s senior year. This evaluation will be in the form of a follow-up survey, and its data will be compared to the post test survey data gathered at the end of each cohort’s semester. It will address the following questions:

1. Since completing the program, have you become pregnant or produced a pregnancy?
2. Have you accessed resources the WCPPP provided for you (i.e. health screenings, providing condoms, etc.)
3. Are you currently engaging in sexual activity, and if so, approximately how many times since the program have you engaged in unprotected sexual activity?
   - A. 0-3 times
   - B. 4-7 times
   - C. 8-11 times
   - D. More than 11 times

This survey will be completely anonymous and students will complete it online during the school day. It should take them no more than 20 minutes to fill out and will only be administered to students who completed the program by the standards laid out in the goals and objectives. A school counselor and a member of the program staff will proxy the survey test taking. This data will then be used to compare it to the student’s previous answers on the posttest completed immediately after the program. A retrospective review will also be conducted to examine the pregnancy rates within the senior class from the year the program began and every year after to determine whether or not pregnancy rates for the students who received the program were lower than that of the students who did not receive the program. Ultimately, this will help us measure our end goal of decreasing teenage pregnancy rates.
References


Choosing the Best. (2017). In *The Leader in Abstinence- Centered SRA Education*.


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