

Running Head: SEVENTEEN DAYS

Seventeen Days: A Teen Pregnancy Prevention Program for

Hispanic Adolescent Females in Portland, Oregon

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**Abstract**

Adolescent pregnancy and childbirth are the second leading cause of death for teen girls worldwide. In Multnomah County, as throughout the United States, teen pregnancy rates are high and disproportionately affect the Hispanic community. Hispanic adolescent females have a teen pregnancy rate over two times higher than white adolescent females. The purpose of the Seventeen Days program is to reduce risky sexual behavior of sexually active Hispanic teen girls through sexual health education. The main goal of Seventeen Days is to reduce teen pregnancy and sexually transmitted infection rates using interactive education on sexual health, condom use, and risk reduction. Using a free mobile device application offered in both English and Spanish, participating young women will work their way through a series of videos and utilize cognitive rehearsal to develop safer sexual practices. Though these young women will be completing the program privately, clinicians will have access to a monitoring system to track participant progress and record significant program milestones. This program is targeted toward sexually active, 14-19-year-old Hispanic females in Portland.

## **A.1 Rationale**

A rationale for a sexual health education program to reduce adolescent pregnancy in Portland, Oregon

Adolescent pregnancy is an issue that requires global and national attention. According to the US National Library of Medicine (2015), adolescent pregnancy is defined as pregnancy in girls 19 years old or younger. There are hundreds of thousands of babies born to women across the world every day, and almost 11% of those births are to adolescent girls. Of the approximately 17 million adolescent girls that give birth every year, over 1 million are under the age of 15 (World Health Organization [WHO], 2014). While reproduction is a very natural part of human nature, having a child early in life can have serious consequences for individual girls, their communities, and society at large (Hoffman, 2012). According to the World Health Organization, complications during pregnancy and childbirth are the second leading cause of death for 15-19 year-old girls (WHO, 2014). There are also about 3 million girls who get unsafe abortions each year, which exposes them to additional health risks (WHO, 2014).

The United States has the highest rate of teen pregnancy of any industrialized nation in the world (Kearney & Levine, 2012). Though the overall numbers continue to decrease, the United States teen birth rate in 2013 was 26.5, which is measured in births per 1,000 females ages 15-19 (Office of Adolescent Health, 2015). Just as these rates vary immensely between countries, they also vary between states. The states of Massachusetts and New Hampshire recorded the lowest teen birth rates at 12.1 and 12.6, respectively. In comparison, the teen birth rate for Oregon is almost double that, though still slightly lower than the national average, at 21.6 births per 1,000 females. (Office of Adolescent Health, 2015). According to the Oregon Public Health Division, the most populous county in Oregon, Multnomah County, is also the county that has consistently recorded the highest total number and one of the highest rates of teen pregnancies in the state since 2006 (Oregon Public Health Division, 2016).

Adolescent pregnancy rates are closely related to risky sexual behavior, engaging in sex for the first time at a young age, alcohol consumption, and lack of knowledge about safe sexual practices. Young

women who have these experiences are more likely to become pregnant than those who have not (Brahmbhatt et al., 2014). Adolescent pregnancies also disproportionately affect poor, uneducated, and rural communities because the young women from these communities encounter the above experiences more often than other women (WHO, 2014). In addition, females of different racial backgrounds are disproportionately affected by teen pregnancies. In 2013, black adolescent girls had a birth rate of two times that of white adolescent girls, and Hispanic adolescent girls had a birth rate that was 2.2 times that of white adolescent girls (Office of Adolescent Health, 2015). The racial-ethnic minority population in Portland that is most affected by teen pregnancies is Hispanic girls (Oregon Public Health Division, 2016).

Potential consequences of adolescent pregnancy are numerous for the mother, the child, and the communities in which they live. In the United States, only 51 percent of teen moms receive their high school diploma, compared to the 89 percent of high school females that did not have a baby during adolescence (Shuger, 2012). A young woman without a high school diploma has limited employment options, which hurts society in the form of lost productivity and increases the likelihood that her child will be raised in poverty. Low income also pushes many adolescent mothers to rely on public aid in order to provide for themselves and their children, which puts an extra financial burden on taxpayers. According to a study in 2012, the average teen mother depends on public assistance for about a third of her parenting years (Hoffman, 2012).

Healthy People 2020 is a national health promotion and disease prevention initiative through the federal Office of Disease Prevention and Health Promotion. This ten-year plan includes family planning health objectives, many of which focus on addressing the sexual health of adolescents and the reduction of the country's adolescent pregnancy rates (Healthy People, 2010). Objectives that aim to indirectly target teen pregnancy include reducing unintended pregnancies, increasing sexual health education, and increasing regular condom use in adolescents (Healthy People, 2010).

As previously mentioned, teen pregnancy rates in the United States have been slowly declining, and this decline is thought to be due to the combination of the increased use of contraceptives by teens and an

increased number of teens delaying initiation of sex (Office of Adolescent Health, 2015). Sexual health education can influence both of these factors, but there are two distinctly different ways to teach the information: abstinence-only or comprehensive sexual health education. Strong evidence suggests that comprehensive sexual health programs cause positive changes in young adult sexual behavior, including increased condom use and delayed initiation of sex (Kirby, 2008). Teens who receive comprehensive sex education have been shown to have a lower risk of pregnancy than teens who receive abstinence-only or no sex education (Kohler et al., 2008). In contrast, there is insufficient evidence to support the efficacy of abstinence-only programs and their ability to reduce teens' sexual risk (Kirby, 2008). For this reason, many call for the use of comprehensive sexual health education to ensure that adolescents are fully informed on pregnancy risks, correct use of contraceptives, variety of contraceptive methods available, and risk and prevention of sexually transmitted infections. A sexual health program that covers all of these topic areas is needed in Portland to combat the health issue of adolescent pregnancy.

## **A.2 Needs Assessment**

Data have been collected on the number of adolescent pregnancies in Multnomah County and the subsequent outcomes of those pregnancies, such as live births and abortions. Background evidence on adolescent pregnancies has been presented in addition to the effects of these pregnancies in terms of morbidity, mortality, and cost to society. There is local information available broken down by geographic area as well as by race and ethnicity. The background data will help identify the need for teen pregnancy prevention education for the target population and highlight the needs of the community that currently are not being met.

In order to successfully implement a teen pregnancy prevention program, we need to conduct an anonymous survey of Portland's teen female population regarding sexual health knowledge and beliefs. This survey will ask fact-based questions about sexual health concepts teens should know at their age, including contraceptive methods, sexually transmitted infections, and proper reproductive health. Answers to these

questions will help identify where the knowledge gap lies and give direction to the information that should be included and emphasized in the program. The second part of the survey will address the current health beliefs of the target population regarding pregnancy risk, current level of sexual activity, and related topics. Knowing what this population believes to be true about their sexual practices and risks will help us attempt to dispel myths and establish a realistic and informed adolescent female population. Finally, the survey will include demographic identification questions, such as race, age, and resident zip code, which will be checked against the background data to ensure that the appropriate demographics are being targeted.

A separate self-report questionnaire will be given to parents of teenage girls in Portland because parents have great influence on the sexual health knowledge and beliefs of their children. This survey will be similar to the second part of the adolescents' survey that addresses health beliefs about different aspects of their children's sexual health. It will also include questions regarding their beliefs about sex and contraception, what resources their children have available to access accurate sexual health information, whether sex is talked about openly in their household, and other similar questions. The goal of collecting this information from parents is to better understand what barriers exist for children in families that cannot openly talk about sexual health.

Both of the above surveys will be self-reported and therefore inexpensive to administer (McKenzie et al., 2013). Due to the technological proficiency of adolescents, the teen survey will be administered both on paper as well as online in order to reach a larger number of girls. The parent survey will only be administered on paper. The costs associated with this data-gathering process would include staff to distribute the paper survey, software to create the online version, and possibly stamps to mail surveys if that is how we choose to deliver them to parents. By keeping answers anonymous and confidential and having teens and parents complete the surveys independently of each other, we hope the answers given will be honest.

The Office of Adolescent Health created a sexual health education and teen pregnancy prevention program called Seventeen Days (Downs et al., 2015). This program was implemented in clinics and

originally pilot tested on young African American women who were ages 14-19 and sexually active. We hope to examine the effectiveness of this program in increasing sexual health knowledge and reducing teen pregnancy, and we plan to adapt this program for Hispanic adolescent girls ages 14-19 in Portland. Census data from the U.S. Census Bureau can be used to determine how these young women are geographically distributed throughout Portland and how many should be counted as part of the target population. This data will allow us to focus our efforts on target areas where young Hispanic females are more heavily concentrated.

Though the state of Oregon requires comprehensive, medically accurate sexual education in public schools, additional sexual education programs at schools, clinics, and other areas frequented by adolescent females will be looked at and examined for effectiveness. Programs similar to the one we are looking to implement will be researched thoroughly to ensure that resources are not being wasted on implementing a new program that is already in place elsewhere. In addition, reasons for the termination of ineffective or unpopular programs in the area will be taken into consideration when adapting the evidence based intervention listed above. The information that will be most helpful are the locations of current and former programs, the names of business or organizations that sponsor[ed] these programs, community reception, and the number of adolescents reached. The locations and sponsors of current and former programs will be researched thoroughly, while community reception will be revealed in town hall meetings.

In order to facilitate the success of our program, it is critical that we gain the support of the Portland community. The community needs to acknowledge the issue of teen pregnancy as important and want to make a change. For that reason, the values of the community and any organizations that join in partnership with the Seventeen Days program will be fully taken into consideration. A possible way to collect data on community perceptions before starting program implementation would be to hold open parent meetings at schools and pediatric health clinics. By recording the opinions, thoughts, and concerns of parents, physicians, teachers, and other stakeholders, we would be able to better address the issue in a way that will be most beneficial for this particular community.



## **B.1 Evidence Based Intervention (EBI) Description**

### **Chosen Program**

Seventeen Days is a program designed to prevent pregnancy and the spread of sexually transmitted infections in sexually active teenage girls. This interactive program is delivered through a DVD or the recently released mobile device application, and participants individually move through the video privately and at their own pace. Through the vignettes, mini-documentaries, and condom demonstration, participants learn valuable sexual health information on a variety of topics, including reproductive health, contraceptives, risk reduction, and sexually transmitted infections. The video uses the concept of cognitive rehearsal to allow young women to practice making decisions in potentially risky sexual situations and develop their ability to confidently create safer outcomes in their sexual activities. In addition, helping adolescent girls learn how to properly use a condom allows them to feel more comfortable using them regularly with their partners.

This evidence based intervention program is centered around a few key health theories. Parts of the Health Belief Model and the Theory of Planned Behavior were pieced together to create the backbone of this program. The Health Belief Model takes into account a person's perceived threat of a health problem, perceived benefits of and barriers to preventive action, cues to action, and self-efficacy to determine that person's likelihood of taking the recommended preventive health action (McKenzie et al., 2013). The Theory of Planned Behavior links a person's beliefs and behavior by focusing on the relationship between someone's attitude toward a specific health behavior, their subjective norm, and their perceived behavior control (McKenzie et al., 2013). By considering all of these elements in relation to adolescent pregnancy risk factors, one could determine the most effective and efficient ways to target teen girls' knowledge and behavior to reduce their risk of becoming pregnant.

In 2004, this program was evaluated using a randomized control trial of girls at risk of teen pregnancy. Three hundred sexually active girls ages 14-18, who were primarily African American, received the program in an urban health clinic setting. These girls were split into three groups, two of which were

control groups and the third being the experimental group. All three groups received the same information, but the first control group read it in book form, the second read it in brochures, and the experimental group used the interactive video. The goal of the trial was to evaluate the effectiveness of delivering information about sexual health and risk reduction in an interactive video format, and the results showed that young women who viewed the video had the most significantly positive health outcomes. They were more likely to abstain from sexual activity, less likely to get a sexually transmitted infection, and experienced fewer condom failures (Downs et al., 2004). Since this research showed the video to be effective in reducing risky behavior and increasing sexual health knowledge, the Seventeen Days program may be successful in addressing teen pregnancy in Hispanic adolescent females in Portland.

## **Program Description**

### Core Elements

- The program video must include a condom demonstration, decision vignettes, and mini-documentaries.
- The topics covered by the program must include negotiating safer outcomes in sexual situations, risk reduction, reproductive health, gynecological exams, sexually transmitted infections, and contraceptives.
- Participants must be given choice and flexibility with regards to pace of completing the program and video segment selection. Interactivity is key.
- Due to the interactive nature of the program, it must be offered in a setting that allows for participant privacy while watching videos.
- Participating staff must be properly trained prior to implementation of the program.
- A system must be in place to track participant progress and alert staff when milestones are reached.

### Key Features

- The vignettes and mini-documentaries can be tailored for the target population. This includes, but is not limited to, culturally appropriate images and additional language options.
- The program's mode of delivery can be through the DVDs, the mobile app, or a combination of the two, provided the setting is still private.
- The program can be adapted for a variety of settings, including clinics, schools, or at home.
- The length of the program can be adjusted to meet the needs and available resources of the community in which it is implemented.
- Materials used to train staff can be adapted depending on the program setting and the staff's expected level of involvement.
- The way participant progress is monitored will change depending on the mode of delivery. For example, the mobile app tracks progress automatically, but using the DVDs requires that the participant disclose her progress.

### **Support Components**

Staff training and technical support materials are available through the Seventeen Days parent program at Carnegie Mellon University. Staff will be trained in the areas of participant recruitment, program components, progress tracking, and troubleshooting techniques before program implementation. Attendance at monthly refresher trainings will be required for all staff to keep them up-to-date with current technology and ensure the quality of the program. Major technical issues with the mobile app or Educator Portal will be referred to the staff at Carnegie Mellon.

### **Other Program Needs**

In order for Seventeen Days to operate properly, personnel and private space are needed. The program will require educated professionals in the public health and medical fields to facilitate the program at each health care clinics involved in implementation. A program coordinator will be responsible for

program and staff oversight. Two providers at each of the four participating clinic sites will be required to get participants started with the program and use the companion Educator Portal to track participant progress. A local technology consultant will provide small scale technical assistance as needed. The aforementioned clinics need to have the space and privacy to accommodate participants as they begin the program as well as for follow-up.

### **Setting and Clients**

Seventeen Days was previously implemented with sexually active, primarily African American females ages 14-18. These young women were recruited at urban Pittsburgh healthcare clinics found in a children's hospital, community health centers, and a women's teaching hospital. Since Portland is also an urban area, we would be able to reach our target population about as well as earlier implementations if we were to deliver the program through these settings previously used. However, with the cultural and technological adaptations we will propose, we expect to have even better results.

### **B.2 Adaptation Plan**

Adaptation of the Seventeen Days program to fit the needs of the target population in Portland, Oregon will mostly be cultural considerations. The initial target population was young, sexually active women ages 14-19. Urban versus rural settings were not addressed in the original literature. Race and ethnicity were intentionally kept nonspecific to allow for cultural adaptations. While we are still looking to target young, sexually active females, our target population will shift focus to Hispanic adolescents, which is why cultural adaptations need to be made. Currently, all electronic and print materials are only offered in English and will need to also be offered in Spanish to accommodate potential language barriers. The mini-documentaries, vignettes, and demonstration video must be culturally sensitive in both word and picture. Some videos may need to be modified to include more culturally relevant images and actors.

The other significant adaptation that will be made is in regards to program setting. The chosen EBI was initially developed for and evaluated in clinics. However, the original program implementation report states that the program can be adapted for home-based delivery as it still allows for private viewing. Due to the development of the free mobile device version of the program in combination with the technological competence and reliance of today's urban youth, we will eliminate the use of the DVD and make this mobile app the main mode of delivery for the program. Since the mobile app allows providers to track progress and monitor when a user reaches specific program milestones, there will still be a connection between our program and clinicians in order to ensure user progress.

### **B.3 Mission, Goals, and Objectives**

#### **Mission Statement**

The mission of Seventeen Days is to reduce adolescent pregnancy rates by increasing sexual health knowledge for adolescent Hispanic girls in Portland, Oregon.

#### **Goals**

- Educate adolescent girls on reproductive health, contraception, and sexually transmitted infections
- Promote safe sexual behaviors among adolescent girls
- Reduce the occurrence of unplanned adolescent pregnancies
- Reduce rates of sexually transmitted infections

#### **Objectives**

##### **Process Objectives**

1. Prior to the start of program, all providers will be fully trained. A session in cultural competence and cultural sensitivity shall be included in this training to ensure proper implementation of the program to the target population.

2. Mobile app functionality shall be assessed regularly to account for changes in mobile device technology. This will occur at least once a month, but may be done more frequently as new operating systems are released.

**Impact Objectives: Learning**

1. Attitude/Awareness: At least 80% of program participants will be able to acknowledge that they, as sexually active young women, are at risk of becoming pregnant or contracting sexually transmitted infections.
2. Knowledge: Two-thirds of adolescent girls who participate in the program will improve their score on their follow-up sexual health knowledge assessment by 10 points compared to their preprogram knowledge assessment results.

**Impact Objectives: Behavioral**

1. Within six months of completing the program, the frequency of regular and proper condom use by participants will have increased by 25%.
2. In the post-program follow-up, 50% of participants will report having negotiated safer outcomes in a risky sexual situation.

**Impact Objectives: Environmental**

1. Economic: Condom distribution hotspots will be set up at the four clinics participating in the program to allow adolescents access to free condoms and promote their consistent use.

**Outcome Objectives**

1. By the year 2020, there will be a 25% reduction of unplanned adolescent pregnancies among Hispanic girls in Portland.

2. One year after beginning program implementation, rates of sexually transmitted infections will have decreased by 25% in adolescent girls.

## **C.1 Implementation**

### **Timeline Breakdown**

The program implementation process will take a full two years to complete. The first step will be to hire the program coordinator who will oversee program development, implementation, and evaluation. After the coordinator is hired, he or she must select four clinics in Portland that will participate in the program. While this will be largely determined by the number of Hispanic adolescent females that receive care at each of the clinics, any clinics with great interest in and enthusiasm for the program will also receive strong consideration. Once clinics are chosen and enter into partnership with Seventeen Days, two providers from each location will be hired as clinic facilitators. The local technical support consultant will be hired on at this time as well. All ten staff members must be hired by the end of February to allow adequate time for training. The program coordinator will train the staff on the program components, participant recruitment, progress tracking, and troubleshooting techniques. Training will be complete by the end of March.

April will mark the start of the three-month pilot test, explained below, to identify any initial problems. Based on the results of the pilot program, the program coordinator will determine any revisions to the program that need to be made before full implementation. During this time, clinic facilitators will be actively advertising the Seventeen Days program and recruiting participants through July and August. As young women join the program, they will each complete a preliminary sexual health knowledge assessment questionnaire and submit it to their clinic facilitator. Over the course of two weekends in September, there will be a kick-off event for parents, community members, clinic staff, and other stakeholders at each of the four participating clinics. This kick-off event includes information about the program, a viewing of the Seventeen Days original DVD, a question-and-answer session with staff, and light refreshments.

Once these steps are complete, implementation can begin in October (Year 1) and will occur concurrently with monthly staff refresher trainings. Program implementation will continue for a full twelve months before final program evaluation. During October (Year 2), the final participant questionnaires will be administered, collected and interpreted. Program staff will take the rest of the year to complete the full evaluation plan and draft a final report on the program. The program coordinator will be able to use this final report to determine the program's efficacy and decide if it should be continued.

Table 1. Implementation Timeline

Task	Year 1				Year 2			
	Jan.- Mar.	April- June	July- Sept.	Oct.- Dec.	Jan.- Mar.	April- June	July- Sept.	Oct.- Dec.
Choose clinics and develop relationship	✓							
Hire staff	✓							
Train all staff (new and clinic providers)	✓							
Pilot test		✓						
Revise program based on pilot			✓					
Recruit participants			✓					
Administer and collect questionnaires			✓					
Prepare for kick-off event			✓					
Full implementation				✓	✓	✓	✓	
Staff training refreshers				✓	✓	✓	✓	
Administer and collect final questionnaires								✓
Evaluation								✓
Final report								✓
Continue program if determined beneficial								✓

### Pilot Program

As mentioned, this program will be executed first as a pilot program in one specific clinic to discover any unanticipated issues and see how well it is received before fully implementing it in all four



Portland clinics. Running the full program for three months with only 10-15 participants will allow program personnel the opportunity to closely control a test run of the program and identify any weaknesses in areas of staff training, participant expectations, expected timeline of completion, supplemental resources, and technical assistance. Both the staff and the pilot test participants will be given the opportunity to provide qualitative feedback on their experiences during the program. One to two months will be given to the program coordinator to evaluate the results of the pilot test and determine what, if anything, needs to be adjusted before full implementation.

## **C.2 Evaluation**

### **Process Evaluation**

A process evaluation will be used to ensure that the program is being implemented and executed properly. The first part of the evaluation will involve confirming that all staff were fully trained before the start of the program. Record of these training sessions, staff attendance, and material covered must be submitted to the Portland Department of Public Health. One of the sessions must include information on cultural competence and cultural sensitivity because the target population is a racial-ethnic minority and it is important that the program appropriately addresses their needs. Throughout the program, the functionality of the mobile app must be assessed once a month by the local technical consultant to account for changes in mobile device technology. If new phone operating systems are released between these monthly checks, the consultant must complete an additional assessment to make sure participants always have access to a working application. Record of these assessments must be submitted to the program coordinator and the Department of Public Health.

### **Impact Evaluation**

The goal of the impact evaluation is to measure participant changes in attitude, knowledge, and behavior, as well as clinic provision of free condoms. Assessing participant changes will be done using a

non-experimental pre-test/post-test evaluation design. Before program implementation, all participants will complete a two-part questionnaire. The first section will address participants' preprogram attitudes about their personal risk of becoming pregnant or contracting sexually transmitted infections, their ability to negotiate safe outcomes in sexual situations, and their behavior choices regarding things like condom use. The second section will be a basic sexual health knowledge assessment that asks questions about topics covered in the program, such as contraceptives and reproductive health. Immediately following program completion, all participants will complete the same two-part questionnaire and their responses will be compared. In addition, another part of the impact evaluation is assessing whether or not clinics have free condom distribution sites set up and how well they are being utilized. The program coordinator will visit each clinic within the first month of beginning program implementation to confirm that the distribution hotspots are present and in an easily accessible location. Every month, the number of condoms taken from each clinic will be recorded to monitor distribution site utilization.

### **Outcome Evaluation**

An outcome evaluation will be used to determine if the program met its intended goals and mission statement using data collected by the Portland Department of Public Health. To evaluate if the program has had an effect on lowering teen pregnancies among the target population, rates of unplanned adolescent pregnancies among Hispanic girls for the year before program implementation (2017) will be compared to rates from two years after program completion (2020). We chose this timespan because it will take time for behavior change to occur and we do not want to assess the data before participants have had a chance to modify their behavior. Similarly, we will compare preprogram rates of sexually transmitted infections of Portland's adolescent female population to the rates one year after program completion. The sexually transmitted infection rates will be assessed in the entire Portland adolescent female population because access to and proper use of condoms by program participants will theoretically affect infection transmission among a larger network of people than just participants and their partners.

**Budget**

Table 2: Program Budget

<b>Category</b>	<b>Base Salary (100% FTE)</b>	<b>% FTE</b>	<b>Total Salary</b>	<b>Benefits Costs</b>	<b>Number of personnel</b>	<b>Sub Totals</b>
<b>Personnel</b>						
Program Coordinator	\$75,000	0.50FTE	\$37,500	\$11,250	1	\$48,750
Clinic Facilitator	\$60,000	0.15FTE	\$9,000	\$2,700	8	\$93,600
Local Tech Support Consultant	\$50,000	0.25FTE	\$12,500	\$3,750	1	\$16,250
				<b>Personnel Sub Total =</b>		<b>\$158,600</b>
<b>Materials &amp; Equipment</b>	Per unit costs				Units/Number	Sub Totals
Mobile app Educator Portal licensing fees	\$300				1	\$300
DVD	\$200				1	\$200
Adaptation: Translation	\$250/hour				3.5	\$875
Condoms	\$400/case of 1,000				1	\$400
Staff training materials	\$150/training session				12	\$1,800
Technology support from parent program	\$3,000				1	\$3,000
				<b>M &amp; E Sub Total =</b>		<b>\$6,575</b>
<b>Office Space</b>	Per sq. foot	Square footage	# of months			Sub Total
Office for Coordinator	\$1.50	100	12			\$1,800
<b>Other Direct Costs</b>	Per unit costs				Units/Number	Sub Totals
Participant incentives	\$100				150	\$15,000
				<b>Office Sub Total =</b>		<b>\$16,800</b>
		<b>Grand Total =</b>			<b>\$181,975</b>	

**Budget Justification**

The following budget justification provides the general budgeting guidelines for one year of implementation for the Seventeen Days teen pregnancy prevention program. This includes salaries and benefits for program staff, access to program materials, the cost of making adaptations to the provided program materials, staff

training, access to technical support, office space, and participant incentives that reward young women who remain in the program.

**Program Coordinator (50% FTE):** Twelve months of salary will be requested for the program coordinator and will include fringe benefits at the current rate of thirty percent. The coordinator will be responsible for direct supervision of the clinic facilitators and local tech support consultant, as well as leading the monthly staff trainings and answering inquiries about the program from parents, participants, and other community members. These duties will require fifty percent of his or her time dedicated to the program over the full calendar year.

**Clinic Facilitator (15% FTE):** Eight facilitators (two at each of the four participating clinics) will be required for twelve months, with fifteen percent of their time devoted to the program. Each facilitator must be a clinic provider and will be responsible for direct oversight of program participants. There will be two facilitators at each of the four participating clinics, so each provider will track the progress of half of the participants at his or her specific clinic. They are required to attend each of the monthly training sessions and will receive fringe benefits at the current rate of thirty percent.

**Local Tech Support Consultant (25% FTE):** In addition to the technical support from the parent program at Carnegie Mellon University, there will be one local tech support consultant responsible for assisting with day-to-day technical difficulties experienced by participants or facilitators. This consultant will be a contracted consultant and the duties will require twenty-five percent of his or her time for twelve months.

**Mobile App Educator Portal:** A core element of the Seventeen Days program is having a system in place to track participant progress. The mobile app Educator Portal includes extensive tracking tools that will allow providers to monitor progress and milestones for registered users.

**DVD:** The kick-off event at the start of program implementation will include a showing of the original DVD to increase community interest and buy-in of parents, community members, and other stakeholders.

**Translation Services:** Currently, program materials are only offered in English, but this implementation of Seventeen Days will also offer all materials in Spanish to accommodate potential language barriers in the target population. Translation services are a one-time cost.

**Condoms:** In order to facilitate safer sexual behaviors among program participants, condom distribution areas will be set up at the participating clinics to allow access to free condoms.

**Staff Training Materials:** All staff are required to partake in training sessions once a month throughout the duration of the program. These refresher courses will help staff maximize the benefits of the mobile app and Educator Portal and keep them up-to-date on the current technology.

**Technology Support:** The parent program at Carnegie Mellon University provides overarching technology support resources. There is a one-time fee prior to program implementation that will allow our organization to benefit from ongoing technical support for the app and Educator Portal.

**Coordinator Office Space:** The office space will be used by the program coordinator for daily program maintenance activities as well as the monthly training sessions. This location will be the main point of contact for the program.

**Participant Incentives:** Using a participant incentive is intended to serve as a retention strategy.

Participants who complete the full program will be rewarded with a voucher for a free gynecologist visit, the cost of which is about \$100 per girl. Providing a free gynecologist visit will also help promote participant health.

## References

- Brahmbhatt, H., Kågesten, A., Emerson, M., Decker, M. R., Olumide, A. O., Ojengbede, O., ... Delany-Moretlwe, S. (2014). Prevalence and determinants of adolescent pregnancy in urban disadvantaged settings across five cities. *The Journal of Adolescent Health, 55*(6), S48–57.  
<http://doi.org/10.1016/j.jadohealth.2014.07.023>
- Downs, J., Murray, P., Bruine de Bruin, W., Penrose, J., Palmgren, C., & Fischhoff, B. (2004). Interactive video behavioral intervention to reduce adolescent females' STD risk: a randomized controlled trial. *Social Science & Medicine, 59*(8), 1561–1572.  
<http://doi.org/http://doi:10.1016/j.socscimed.2004.01.032>
- Downs, J., Murray, P., Fischhoff, B., & Bruine de Bruin, W. (2015). *Seventeen Days*. Retrieved from <http://www.seventeendays.org>
- Healthy People 2020. (2010). U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Washington, DC. Retrieved from <http://www.healthypeople.gov/2020/topics-objectives/topic/family-planning/objectives>
- Hoffman, S. D. (2012). *Kids having kids: Economic costs and social consequences of teen pregnancy (2nd Edition)*. Washington, DC: Urban Institute Press.
- Kearney, M. S., & Levine, P. B. (2012). *Why is the Teen Birth Rate in the United States so High and Why Does It Matter?* (Working Paper No. 17965). National Bureau of Economic Research. Retrieved from <http://www.nber.org/papers/w17965>
- Kirby, D. B. (2008). The impact of abstinence and comprehensive sex and STD/HIV education programs on adolescent sexual behavior. *Sexuality Research & Social Policy, 5*(3), 18–27.  
<http://doi.org/10.1525/srsp.2008.5.3.18>
- Kohler, P. K., Manhart, L. E., & Lafferty, W. E. (2008). Abstinence-only and comprehensive sex education and the initiation of sexual activity and teen pregnancy. *The Journal of Adolescent Health, 42*(4), 344–51. <http://doi.org/10.1016/j.jadohealth.2007.08.026>

- McKenzie, J. F., Neiger, B. L., & Thackeray, R. (2013). *Planning, Implementing & Evaluating Health Promotion Programs: a primer* (Sixth). New York City: Pearson Education.
- Oman, R. F., Merritt, B. T., Fluhr, J., & Williams, J. M. (2015). Comparing School-Based Teen Pregnancy Prevention Programming: Mixed Outcomes in an At-Risk State. *The Journal of School Health*, 85(12), 886–893. <http://doi.org/10.1111/josh.12343>
- Oregon Public Health Division. (2016). *Teen pregnancy* [Data file]. Retrieved from <https://public.health.oregon.gov/BirthDeathCertificates/VitalStatistics/TeenPregnancy/Pages/index.aspx>
- Shuger, L. (2012). *Teen Pregnancy and High School Dropout: What Communities Can Do to Address These Issues*. Washington, DC: The National Campaign to Prevent Teen and Unplanned Pregnancy.
- The Office of Adolescent Health, U.S. Department of Health and Human Services. (2015). *Trends in Teen Pregnancy and Childbearing*. Retrieved from <http://www.hhs.gov/ash/oah/>
- US National Library of Medicine. (2015). *Adolescent pregnancy*. Retrieved January 13, 2016, from <https://www.nlm.nih.gov/medlineplus/ency/article/001516.htm>
- World Health Organization. (2014). *Adolescent pregnancy*. Retrieved from <http://www.who.int/mediacentre/factsheets/fs364/en/>