December 17, 2004

TO: The Honorable Mark R. Warner
Governor of Virginia

The Honorable Vincent F. Callahan, Jr.
Chair, House Appropriations Committee

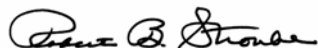
The Honorable John H. Chichester
Chair, Senate Finance Committee

The Honorable Lacey E. Putney
Vice Chair, House Appropriations Committee

FROM: Robert B. Stroube, M.D., M.P.H.
State Health Commissioner

Enclosed please find the ninth annual report to the Governor and the General Assembly on the results of the evaluation of the Virginia Department of Health (VDH) Teen Pregnancy Prevention Initiative (TPPI) as required by Item 313B of the 2003 Appropriations Act.

If you are in need of further information or have any questions, please feel free to contact me at 804-864-7001.



Item 313B of the Appropriations Act

Teen Pregnancy Prevention Initiative

Annual Report FY04

Submitted by:
Virginia Department of Health

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Executive Summary

Background

Since 1994 there has been a consistent decline in the teenage pregnancy rates in Virginia. The rate per 1,000 population age 10 – 19 females was 38.7 in 1994 and in the preliminary data report for 2003 the rate is 27.4. This reflects a decrease in rate of 11.3 over the past 10 years.

Through the Teenage Pregnancy Prevention Initiative (TPPI) the Virginia Department of Health funds seven health districts to implement pregnancy prevention strategies. These health districts have been identified as those that have pregnancy rates that are higher than the state rate. The seven health districts are Alexandria, Crater, Eastern Shore, Norfolk, Portsmouth, Richmond and Roanoke. A variety of programmatic strategies are implementing in school, community and clinical settings.

Results

Sixty-six percent of the overall TPPI participants received a minimum of 75% of the program dosage. This is an improvement in participation over the previous year (when 42% of participants received a minimum of 70% of the program dosage).

During FY03 the seven TPPI funded sites revamped their programs and evaluation plans to include monitoring the goal of 10 or more hours of intervention. In FY03, only 36% of participants received 10 or more hours of program intervention. The increase to 56% in FY04 should strengthen the probability that program participation will have a positive effect on teen pregnancy prevention.

With the exception of Richmond, each of the TPPI funded localities has seen a reduction in the teen pregnancy rate since the program's inception. Roanoke has experienced the greatest decrease in the teen pregnancy rate from 1994 to 2002. While Alexandria has experienced an apparent increase from 2002 to 2003, the overall decrease since 1994 is almost 10%.

The City of Richmond has seen the least amount of change in teen pregnancy rates during this period. It should be noted that it appears that Richmond experienced a significant increase in the rate of teenage pregnancies in 2003. This is preliminary data that reflects a change in the reporting criteria related to the residence of the person completing an application for pregnancy related services in the City of Richmond. These preliminary data reflect not only City of Richmond residents but also persons who actually reside in one of the surrounding counties but obtained services in the City of Richmond, thus the rate is inflated. This change in reporting criteria affects all localities in Virginia, but among the TPPI sites, it appears to disproportionately impact the City of Richmond.

Recommendations

The VDH TPPI has to strike a balance between meeting the needs of the program participants while grappling with changing sources of and limitations to funding. The program would be well served to consider the following:

- **Continue to respond to best practices and evaluate programs based on outcomes to provide accurate and reliable data to support the continued efforts of the VDH TPPI.**

- **Continue to monitor each site for incorporation of the recommendations included in the individual program evaluations.**

- **The VDH should work closely with the local sites to develop and promote community-wide coalitions.**

- **Continue to develop programs based on best practices and demonstrated curricula, and**

- **Conduct an overall TPPI evaluation to measure the following:**
  - **Readiness to participate in program evaluation,**
  - **Commitment and participation of program staff,**
  - **Support of local school systems (and other agencies),**
  - **Competing programs,**
  - **Staff turnover, and**
  - **Any other barriers to program implementation and evaluation.**

- **Continue to reinforce the need for rigorous data collection consistent with Institutional Review Board requirements,**

- **Consider the feasibility of implementing an electronic data collection system to streamline data and make reporting more timely,**

- **Merge the local evaluation team into an evaluation consortium that pulls research, methodology, theory, best practices, and shares knowledge with evaluators from other programs to create new energy and positive forward momentum, and**

- **Continue to monitor program goals and objectives to assure that they are being met; make changes to the logic model as needed to maintain the impact of the program on participants.**

Introduction

Despite a steady decline in the rate of teenagers giving birth in the United States since 1991, the U.S. teen birth rate is still one of the highest among developed nations. The Virginia Department of Health's (VDH) Teen Pregnancy Prevention Initiative (TPPI) began addressing this problem following the 1993 General Assembly as a result of receiving a $600,000 general fund appropriation. The purpose of the funding was to establish teen pregnancy prevention programs in the health districts of Alexandria, Norfolk, and Richmond. These health districts had consistently higher than average or rising teen pregnancy rates, in comparison to state teen pregnancy rates, which had begun to decline after years of increases.

At the start of FY94, each of the three identified health districts received $200,000 to develop a teen pregnancy prevention program. In response to the General Assembly appropriation, the Maternal and Child Health (MCH) Council's Subcommittee on Teen Pregnancy Prevention formed an interagency advisory committee to establish general guidelines for the three pilot teen pregnancy prevention programs. The interagency advisory committee established seven guidelines adopted by the subcommittee during the early part of FY94. One of those guidelines stipulated, "VDH, in consultation with the interagency advisory committee, would contract with an external program evaluator to conduct program evaluation. A portion of the appropriated funds should be set aside for this purpose".

The Department of Medical Assistance Services (DMAS), through an administrative agreement with VDH, provided matching federal dollars in addition to the general fund dollars in FY95. The VDH TPPI then had an established base budget of $1.4 million for FY95. The General Assembly authorized the additional funds to be used to assist in starting four additional teen pregnancy prevention programs in the health districts of Crater, Eastern Shore, Roanoke, and Portsmouth.

In FY03 the General Fund appropriation was replaced by an allocation of Temporary Assistance to Needy Families (TANF) funds from the Department of Social Services. In the 2004-2006 biennium, the funds available to support the VDH TPPI through this allocation totaled $910,000 per year.

A percentage of the base budget is withheld each year from the health districts to fund evaluation activities in response to the guidelines adopted by the Subcommittee and the charge to VDH to evaluate the programs. In order to ensure that the prevention methodologies were successful and transferable to the other health districts, evaluation was given priority status.

Methodology

The ultimate objective of the VDH TPPI is to develop effective and replicable community-based teen pregnancy prevention programs. Evaluation contributes to the attainment of this objective by:

1. Providing data for use in management planning and resource allocation,
2. Measuring performance at each stage of program development,
3. Measuring performance of programs using outcome measurement, and
4. Providing information and feedback to VDH regarding effective teenage pregnancy prevention strategies.

In FY96, VDH and Virginia Commonwealth University's Survey and Evaluation Research Laboratory (SERL) staff developed a statewide system of evaluation. Since the initial evaluation plan was developed, there have been several adaptations made to overcome a variety of challenges.

Currently, the statewide system of evaluation consists of two primary uniform data collection and reporting components as well as a local site evaluation component. All components of the statewide system of evaluation are interrelated and feed into the Logic Model for Program Evaluation.

<u>Uniform Data Collection and Reporting Components</u>

1. Quarterly Implementation Progress Reports (QIPR)

   The QIPR is a quarterly compilation and reporting of the progress that each local program has made toward meeting their stated goals and objectives. The QIPR includes a description of barriers encountered and strategies developed to overcome those barriers. A standard format for the development of local program goals and objectives is provided to program staff at each location. The QIPR includes four areas of development: coalition building, assessment and planning project implementation, program continuation, and outcome evaluation. The QIPR is completed by each local site and submitted directly to VDH.

2. Attendance Log

   Attendance logs for each program offered at the seven localities provide a count of project participants. Participant information is collected only for projects providing intensive educational sessions utilizing a series of classes where the participants are expected to return to each session.

<u>Local Site Evaluation Component</u>

As part of the overall evaluation of TPPI, each local site provides a plan for evaluation that includes collecting attendance data as well as local project-specific data collection in the form of program evaluation. Each of the seven sites identifies a Local Site Evaluator (LSE) to design and implement a local evaluation plan. The evaluation plans are

centered on a logic model designed by the LSE and are specific to each of the site's programs while maintaining continuity with VDH program goals and objectives. The LSE works with the site, VDH, and the Local Evaluation Team (LET) to assure that the measures that are provided in the evaluation plan are 1) appropriate to VDH goals and objectives, 2) appropriate to local program goals and objectives and, 3) appropriate for providing the highest quality of program evaluation.

Logic Models

A logic model is a succinct series of statements that link together the program mission, the methods used to address it, and the expected results. The VDH TPPI program evaluation logic model included the following components:

1. **MISSION:** the problem or issue that the program is to address falls within a setting or situation from which priorities are set,
2. **INPUTS:** the resources, contributions and investments that are made in response to the situation. Inputs lead to Activities,
3. **ACTIVITES:** what the program does with the inputs to fulfill its mission. Activities lead to Outputs,
4. **OUTPUTS:** the services, events, and products that reach people and users. Outputs lead to Outcomes, and
5. **OUTCOMES:** the results, changes or benefits for individuals, groups, agencies, communities and/or systems.

The logic model feeds directly into program development. Program development is an ongoing systematic process that is used to plan, implement and evaluate prevention programs. The process can be applied on a small scale to an individual workshop, on a larger scale to a comprehensive community initiative or to a county or statewide program of action. The scope may be different but the principles of program development remain the same.

The outcome statement established by VDH for TPPI is: *"No teenage pregnancies in the seven designated health districts"*. The logic model developed for program evaluation stresses both formative and summative evaluation.[1] The current year was used to revise the logic model for program evaluation at each of the localities using a standard logic model. Locality-specific logic models are in the Attachment A – G.

[1] Formative evaluation: produces information to be fed back during development of programs to help improve them
Summative evaluation: produces information about program effectiveness for decision-makers

Results

This is the ninth annual report to the Governor and the General Assembly on the evaluation results of the VDH TPPI. During the past year all seven of the TPPI funded localities have collaborated with staff at VDH, SERL and with staff from other programs to accomplish process evaluation and to participate in the uniform data collection and reporting components of the statewide evaluation. The results are:

- All VDH TPPI local site coordinators and evaluators revised their evaluation plans to incorporate the "outcome funding" model as supported by VDH.

  The model stresses:

  - Use of ***investor targets*** to define the overall quantitative and qualitative results the investor (VDH) expects to achieve; multiple implementers contribute to investor targets, but when aggregated, investor targets define what constitutes success

  - Use of ***implementer performance targets*** to set annual objectives that focus on the desired behavior change of clients receiving services (as opposed to focusing on the services provided by the site)

  The model as implemented for VDH TPPI is based on the following assumptions:

  1. Programs are developed based on needs assessment data that is current (within 5 years). All programs should be able to be justified based on data.

  2. Programs are more effective if they have community buy-in. Receiving input and connecting with partners, collaborators, and stakeholders is important to the success of teen pregnancy prevention.

  3. Funding for programs will not last forever. Programs need to work toward sustainability and adopt various methods of viability to continue to provide services.

  4. Programs that offer short-term interventions, i.e., those that last only a few hours, do not have a measurable impact on knowledge, attitudes, or behavior of teens.

  5. Programs are effective and successful when most participants minimally receive a critical dose of the intervention thought to be efficacious.

  6. Successful teen pregnancy prevention programs focus on multiple approaches to reach high-risk youth.

7. Each of the seven TPPI sites should have a clear, understandable underlying theory of change that program staff can articulate and follow.

8. VDH has adopted five typologies for teen pregnancy prevention programs based on national evaluation and research. They are:

   a. Curriculum-based educational projects – use of a pre-developed curricula,

   b. Life skills/youth development projects – improved educational and career opportunities for youth can help reduce teenage pregnancy,

   c. Adolescent reproductive health care projects – focus on increasing access to preventive health care services,

   d. Secondary prevention projects – work with teenage mothers and fathers to prevent second or additional pregnancies, and

   e. Social marketing projects – rely heavily on traditional commercial marketing techniques to promote health-related behavior or attitudes with the goal of specific behavior change.

VDH determined that it would fund only projects falling into one of the five typologies and it would fund no more than three projects per site (unless adequately justified).

The VDH outcome statement: *"No teenage pregnancies in the seven designated health districts"* was used during this process year to assist in developing evaluation plans.

- Several VDH specific investor targets were established in support of this outcome:

    - Participation in each of the seven programs will be increased to a point where the participants are receiving a minimum of 75% of the dose of each project (the dose in each program to equal 75% varies based on the curriculum used).

    - Participation will be increased to a point where participants are receiving 10 hours or more of program intervention (this assures participation at a level that should show an impact on knowledge, attitudes, and behaviors).

During FY 04, the following results were achieved for these two targets:

VDH Teen Pregnancy Prevention Initiative Dosage Results for FY04			
Program Location	Number of Participants	Number of Participants Receiving **75**% of dosage	Percent of Participants Receiving **75**% of dosage
Norfolk	404	279	69%
Portsmouth	369	326	88%
Roanoke	367	99	27%
Alexandria	392	103	26%
Crater	292	231	79%
Richmond	2287	1816	79%
Eastern Shore	294	36	12%
TOTAL	**4405**	**2890**	**66%**

Sixty-six percent of the overall TPPI participants received a minimum of 75% of the program dosage. This is an improvement in participation over the previous year (when 42% of participants received a minimum of 70% of the program dosage).

The measure of 10 or more hours of program intervention was developed and implemented for FY04 as a method to monitor the amount of intervention each participant receives as compared to their change in knowledge, attitude, and behavior. This comparison will be extremely beneficial to the pre and post test survey work to be done during FY05 to see the amount of change that takes place from the pre to post test administration. Results from FY04 participation in 10+ hours of program intervention are:

VDH Teen Pregnancy Prevention Initiative 10+ hours of Intervention Received			
Program Location	Number of Participants	Number of Participants Receiving **10+** hours of program	Percent of Participants Receiving **10+** hours of program
Norfolk	404	253	63%
Portsmouth	369	315	85%
Roanoke	367	185	50%
Alexandria	392	227	58%
Crater	292	276	95%
Richmond	2287	973	43%
Eastern Shore	294	235	80%
TOTAL	**4405**	**2464**	**56%**

During FY03 the seven TPPI funded sites revamped their programs and evaluation plans to include monitoring the goal of 10 or more hours of intervention. In FY03, only 36% of participants received 10 or more hours of program intervention. The increase to 56% in FY04 should strengthen the probability that program participation will have a positive effect on teen pregnancy prevention.

- Pregnancies in the seven health districts should be no more than 101.1 per 1000 females ages 15-19 by 2004.

The table below shows the teen pregnancy rates for localities served by VDH TPPI programs from 1993 to 2003 for population ages 10-19 per 1000. [2]

Teen Pregnancy Rates per 1000 by Locality from 1993 to 2003 for Population Ages 10-19

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003*
Virginia	**38.9**	**38.7**	**37.4**	**36.2**	**34.8**	**34.1**	**33.6**	**31.5**	**29.7**	**27.6**	**27.4**
Alexandria	70.8	73.1	81.6	59.6	60.8	63	54.2	56.4	61.4	55.5	63.3
Norfolk	70.4	66.9	64.9	62.6	60.1	62.1	58.9	58.7	56.2	58.5	52.5
Richmond	75.8	69.8	62.6	70	73.7	67.4	65.7	67	68.8	65.1	80.6
Crater	\	52.7	53.5	54.9	55.5	51.7	51.9	50	47.3	45.7	46.0
Eastern Shore	\	49.8	53.1	58.7	48	42.1	53.2	44.4	42.3	42.2	38.4
Portsmouth	\	71.7	74.6	70.3	67.7	60	60.9	58	56.4	54.1	51.9
Roanoke	\	79.7	72.8	71.8	71.8	64	54.9	57.2	47.6	54.5	48.9

** 2003 teen pregnancy rates are still considered preliminary and subject to change prior to official release by the VDH Center for Health Statistics. The rate for Richmond reflects a change in the Code of Virginia reporting criteria related to the place of residence of person seeking pregnancy related services.*

The chart below shows the change in the teen pregnancy rates for the state of Virginia and for VDH TPPI programs per 1000 population age 10-19 from 1994 to 2003:

Location		1994 Rate/1000	2003 Rate/1000	Change
Virginia		38.7	27.4	-11.3
Alexandria		73.1	63.3	-9.8
Norfolk		66.9	52.5	-14.4
Richmond		69.8	80.6	+10.8
Crater		52.7	46.0	-6.7
Eastern Shore		49.8	38.4	-11.4
Portsmouth		71.7	51.9	-19.8
Roanoke		79.7	48.9	-30.8

With the exception of Richmond, each of the TPPI funded localities has seen a reduction in the teen pregnancy rate since the program's inception. Roanoke has experienced the greatest decrease in the teen pregnancy rate from 1994 to 2002. While Alexandria has experienced an apparent increase from 2002 to 2003, the overall decrease since 1994 is almost 10%.

The City of Richmond has seen the least amount of change in teen pregnancy rates during this period.[3] It should be noted that it appears that Richmond experienced a significant

[2] Alexandria, Norfolk, and Richmond were the original three Phase I programs and have data represented from 1993. Crater, Eastern Shore, Portsmouth, and Roanoke are the Phase II programs and do not have data represented from 1993.

increase in the rate of teenage pregnancies in 2003. This is preliminary data that reflects a change in the reporting criteria related to the residence of the person completing an application for pregnancy related services in the City of Richmond. These preliminary data reflect not only City of Richmond residents but also persons who actually reside in one of the surrounding counties but obtained services in the City of Richmond, thus the rate is inflated. This change in reporting criteria affects all localities in Virginia, but among the TPPI sites, it appears to disproportionately impact the City of Richmond.

Adolescent Sexual Health Programs Evaluation Conference

During FY04 VDH hosted the second annual adolescent sexual health evaluation conference in Richmond. This conference served a dual purpose: to bring together individuals throughout the state who work with adolescents on the topic of sexual health, and to reinforce the importance of program evaluation. Though originally intended to disseminate the results of evaluation studies to all TPPI stakeholders, it was decided that the conference would be more effective if it included stakeholders from all VDH-sponsored adolescent sexual health programs.

Sixty-nine individuals attended the conference. The attendees were primarily program staff from VDH funded programs that address adolescent sexuality and reproductive health issues (i.e., Teen Pregnancy Prevention Initiative, Better Beginnings Coalitions, and Virginia Abstinence Education Initiative). Attendees were asked to give feedback by completing an evaluation of the conference. This information will be used in planning future staff development programs.

The conference publicity section, which included the initial announcement and conference program, was given an above average rating by 90% of those who answered the survey, while 10% found it to be average. The overall conference planning and facilities ratings were 91% above average, 7% average, and 2% below average.

Individual speakers all received an overall above average rating, and attendees indicated some of the most useful information to be the abstinence education workshop, abstinence education evaluation results, HIV/STD teen trends, updates on risk behavior patterns, breakout sessions, pregnancy data, and how to implement effective programs.

Suggestions for future conferences included: give copies of slide presentations at conference, hear from "model" programs that seem to be working, provide more opportunity for roundtable discussion forums, provide opportunities for attendees to speak with people who have implemented community-based programs that are working so that grass roots individuals will have some guidance with how to begin, and provide more information about programs (e.g., what works and what doesn't).

[3] The City of Richmond did not receive TPPI funding for two consecutive years.

Detailed Evaluation

EVALUATION

A detailed FY04 evaluation report for each locality is included in Attachment H.

RECOMMENDATIONS

The VDH TPPI has to strike a balance between meeting the needs of the program participants while grappling with changing sources of and limitations to funding. The program would be well served to consider the following:

- **Recommendation**
  - **Continue to respond to best practices and evaluate programs based on outcomes to provide accurate and reliable data to support the continued efforts of the VDH TPPI.**
  - **Continue to monitor each site for incorporation of the recommendations included in the individual program evaluations.**

According to the guidelines set by the MCH Council's Subcommittee on Teen Pregnancy Prevention, each locality is to form a community-wide coalition that includes representation from public and private organizations. The coalition is to determine program type and direction. Previous assessments combined with input from the seven TPPI localities have provided information that shows the local coalitions have not been, and are not, as active and directive as originally intended.

- **Recommendation**
  - **The VDH should work closely with the local sites to develop and promote community-wide coalitions.**

The VDH TPPI program sites have experienced varying levels of decreasing pregnancy rates and some have seen less-than-expected results. Many variables factor into the results at each site, such as:

- Number of participants served by project(s) at each site,
- Commitment and participation of program staff,
- Support of local school systems,
- Competing programs offered by other initiatives, and
- Attrition of program staff.

- **Recommendations**
  - **Continue to develop programs based on best practices and demonstrated curricula, and**

- Conduct an overall TPPI evaluation to measure the following:**
    - **Readiness to participate in program evaluation,**
    - **Commitment and participation of program staff,**
    - **Support of local school systems (and other agencies),**
    - **Competing programs,**
    - **Staff turnover, and**
    - **Any other barriers to program implementation and evaluation.**

In FY04, the VDH TPPI put in place a plan of action that will assist the local sites in moving forward with programs that are providing the means for participants to demonstrate a change in knowledge, attitudes, and behavior. These short term and intermediate changes are the first steps to producing system-level changes that can in turn lead to changes in the population. Each of the health districts was originally chosen due to higher than average teen pregnancy rates. While each district continues to struggle with teen pregnancy rates, the statewide teen pregnancy rate for females age 10-19 is decreasing. The seven TPPI funded sites have been given the guidance and assistance needed during FY04 to develop solid evaluation plans to assist them in providing the results that are required by VDH and other funding sources.

Demonstrating a measurable impact is vital to showing program success. In order to meet the goals of the VDH TPPI, each of the local sites will need to participate fully in the data collection process as well as the evaluation process.

- **Recommendations**
  - **Continue to reinforce the need for rigorous data collection consistent with Institutional Review Board requirements,**
  - **Consider the feasibility of implementing an electronic data collection system to streamline data and make reporting more timely,**
  - **Merge the local evaluation team into an evaluation consortium that pulls research, methodology, theory, best practices, and shares knowledge with evaluators from other programs to create new energy and positive forward momentum, and**
  - **Continue to monitor program goals and objectives to assure that they are being met; make changes to the logic model as needed to maintain the impact of the program on participants.**

FUTURE DIRECTIONS – FY05

In FY05 all VDH TPPI local site coordinators and evaluators will be following the "outcome funding" model as supported by VDH. Evaluation plans and instruments were designed with this model in mind.

The SERL has developed a Master Evaluation Protocol (MEP) for evaluation in conjunction with the local evaluators. The MEP will be developed from existing approved evaluation plans as well as other best practice instruments and measures. The

MEP will include survey questions as well as focus group questions for various evaluation methodologies to include:

- Consent forms targeted at the sixth grade reading level for both surveys and focus groups (Consent & Assent),
- Scripts for focus groups,
- Letters to parents for surveys and focus groups,
- Pre/post survey questions,
- Pre/post focus group questions, and
- Key informant interview questions.

SERL shall continue to submit participant level data based on the performance measures established by VDH on a quarterly basis to VDH.

The two performance measures as outlined by VDH are:

1) Attendance for each program supported by TPPI funding – tracking participants in each program that receive 10+ hours of an on going, approved program intervention; and

2) Exposure to minimum dose for each program supported by TPPI funding – tracking participants in each program that receive the minimum dose according to the specific program (minimum dose defined by VDH as 75% of each curriculum).

In lieu of a conference, VDH will sponsor a training event focused on the topic of data collection and management in Richmond. Based upon the feedback obtained from local evaluators and the challenges experienced by some of the localities in data collection the training event will include the following:

- Obtaining and maintaining parental and youth consent,
- Survey administration,
- Overcoming barriers to evaluation, and
- Presentation of data from FY04 TPPI programs

The VDH and SERL will continue to provide technical assistance around data collection to program staff, provide technical assistance and guidance to the local evaluators, and coordinate technical assistance and evaluation support to the local site coordinators. Both VDH and SERL will work to provide an outline for an evaluation for the overall TPPI. The goal of the outline is to establish an ongoing evaluation plan for the overall program that will allow a measure for efficiency and effectiveness of the TPPI funds.

ATTACHMENT A

City of Richmond

Teen Outreach Program Logic Model

Empowering youth to become healthy, responsible individuals and contributing members in their communities.

INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES		
Resources dedicated or consumed by the program.	What the program does with the inputs to fulfill its mission.	The direct products of program activities. # of …..	Benefits or changes for individuals or populations during or after participating in program activities.		
			Initial	**Intermediate**	**Longer-term**
Educational materials Program manager Program educator(s) Community Site Coord. Facility Planned Parenthood administrative staff (shared resource) Housing Funding Van for transportation Volunteers Parents Partnerships with public and private organizations Support of school system Middle/High schools identify participants	Program provides activities in the following: * Life Skills Training Weekly classroom-based activities and discussion using the TOP changing scenes curriculum – provided in middle and high schools selected by the City of Richmond. * Community Service Weekly participation in community service work – organized by the community with transportation provided. * Service Learning Structured reflection on community service experience discussion, writings, and research. Creative presentations on community service. * Program staff, volunteers contacts additional high schools and advocate for the expansion of TOP in future years.	Students at selected middle and high schools participate in the program. - A minimum of 20 hours of life skills training is provided to selected students. - A minimum of 20 hours of community service is provided to selected students. - A minimum of 6 hours of reflection activities is provided to selected students. - A minimum of 6 hours of sexuality education is provided to selected students.	Program participants gain knowledge and information about life skills training, community service, reflection, and sexuality issues.	Program participants will acquire valuable life skills, (i.e. respect for self, respect for others, involvement in community) and demonstrate practical application of those skills during the service-learning component. **Current evaluation funded at the initial and intermediate level of outcomes	Teens are healthy, responsible individuals who have delayed parenthood and are contributing members in their community

ATTACHMENT B

Alexandria TPPI: Pro-Teen/Pro-Youth & Project Step Out

Mission Statement: The Alexandria Teen Pregnancy Prevention Program (ATPPP) is dedicated to nurturing and fortifying the emotional and mental development of young people. Its sole purpose is to protect the well being of the child. The ATPPP attempts to instill all the qualities and life skills necessary to make youth more prepared for and aware of the future. The ATPPP strives to create a moral compass in every child that can be used to steer them through the uneasy transition from adolescence to adulthood.

I. INPUTS Resources dedicated or consumed by the program.	**II. ACTIVITIES** What the program does with the inputs to fulfill its mission.	**III. OUTPUTS** The direct products of program activities. # Of …..	**IV. OUTCOMES** Benefits or changes for individuals or populations during or after participating in program activities.		
			A. Initial	B. Intermediate	C. Long-term
IA. Staff 1. Two FTE 2. 6 Part Time IB. Volunteers 1. Parents 2. GMU Students 3. High School Students IC. Community Leaders 1. Individuals 2. Alex. Campaign on Adolescent Pregnancy (ACAP) ID. Resources 1. VDH funding in the amount of $120,125 2. Gifts 3. Computers 4. Audio-visual equip. 5. *Life Planning Education curriculum* 6. Health Clinic 7. Dental Health Services	IIA. Staff 1. (a) Manage budget, personnel and other resources, oversee reporting; (b) Coordinate program functions 2. Provide instruction at program sites IIB. Volunteers (IB.1,2,3) 1. Assist IA.2 & attend periodic meetings with staff person 2. Assist IA.2 3. Assist IA.2 IIC. Community Leaders 1. Make presentations (IC.1) 2. Conduct community awareness campaigns (IC.2) IID. Resources 1. Pay staff (IA.1, IA.2), fund field trips, and supplies 2. (ID.2) provide incentives to participants for attendance and cooperation 3. (ID.3) develop lesson plans and instructional materials; generate reports 4. (ID.4) visual display of	IIIA. Staff 1. Scheduled reporting to VCU and VDH, including attendance data, progress reports and evaluation reports 2. Seventeen (17) instructional sessions at each site IIIB. Volunteers support Staff IIIC. Community Leaders 1. Verbal presentations and handouts (IIC.1) 2. Community awareness trailers at movies and printed media on mass transportation related to teen pregnancy prevention (IIC.2) 3. Brochures on teen pregnancy prevention distributed at churches and schools 4. Mayor's television program on Com Cast	IVA-A. Participants demonstrate increased: ***1. Knowledge in:*** a. Health and nutrition related to personal growth and healthy lifestyles b. STDs and substance abuse, and their relationship to teen pregnancy c. Study skills d. Normal sexual development 2. ***Awareness and appreciation*** of: a. the influence of the media on their lives b. diversity and pro-social values c. personal goals related to education and careers	IVB-A. Relative to their non-participant counterparts, the Participants: 1. Reveal a significant delay in the early onset of sexual intercourse and marked reduction in teen pregnancy rates 2. Graduate from high school at a higher rate 3. Exhibit a more positive life-style that includes avoidance of tobacco, substance abuse and sexual intercourse 4. Demonstrate greater self-assurance and self-control	**Participants are engaged in productive and self-fulfilling work.**

I. INPUTS Resources dedicated or consumed by the program.	II. ACTIVITIES What the program does with the inputs to fulfill its mission.	III. OUTPUTS The direct products of program activities. # Of …..	IV. OUTCOMES Benefits or changes for individuals or populations during or after participating in program activities.			
			A. Initial	B. Intermediate	C. Long-term	
					Community remains supportive of its children	

ATTACHMENT C

Crater TPPI: Makin' Your Future Program Logic Model

INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES		
Resources dedicated or consumed by the program.	**What the program does with the inputs to fulfill its mission.**	**The direct products of program activities. # of …**	**Benefits or changes for individuals or populations during or after participating in program activities.**		
			Initial	**Intermediate**	**Longer-term**
Educational materials (Sex Can Wait, Reduce the Risk, Social Skills Building) Program manager Program educator(s) Community Site Coord. Facility Administrative staff Funding Volunteers Parents Partnerships with public and private organizations Support of school system Middle schools identify participants	Program provides activities in the following: * Critical Thinking and Social Skills Training Bi-weekly classroom-based activities and discussion using the MYF curriculum and social cognitive theory – provided in 2 middle schools (to include sexuality issues) from October – May. The following constitute core program topic areas: Relationships Communication Anger management Sexuality Alcohol & Substance Abuse * Other Program staff contact additional middle schools and advocate for the expansion of MYF in future years and for the inclusion of additional schools to serve as "control groups" for future evaluation efforts.	Students at 2 selected middle schools participate in the program. 21 hours of training are provided to approximately 125 selected students. The majority of students receive a minimum of 14 hours of training. Additional hours of one-on-one training are provided to students selected by school and program staff.	Program participants gain knowledge and information about critical thinking and social skills related to 5 program topic areas.	80% of students receiving minimum dose will demonstrate knowledge of at least 2 consequences of teen pregnancy. 80% of students receiving minimum dose will demonstrate knowledge of at least 3 of the most common STD's affecting young people. 80% of students receiving minimum dose will demonstrate knowledge of abstinence as a lifestyle choice. 80% of students receiving minimum dose will demonstrate knowledge of at least 3 contraceptive methods. 70% of students receiving 14 hours will pledge to not become pregnant or be involved in a teen pregnancy by June 30, 2004. 70% of students receiving 14 hours will be able to clearly convey their own values regarding sex and sexual behavior to others. 70% of students receiving 14 hours who are having sex will pledge to use contraception each time.	Program participants use program skills to build good character that makes them resilient despite environmental influences. Program participants choose a safe and healthy lifestyle that does not include teen pregnancy.

ATTACHMENT C

Crater TPPI: Passport to Manhood Logic Model

Empowering male youth to become healthy, responsible individuals and contributing members in their communities.

INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES		
Resources dedicated or consumed by the program.	**What the program does with the inputs to fulfill its mission.**	**The direct products of program activities. # of …**	**Benefits or changes for individuals or populations during or after participating in program activities.**		
			Initial	**Intermediate**	**Longer-term**
Educational materials (curriculum and training manuals) Program manager Program educator(s) and/or Mentors Facility Crater Health District Administrative staff (shared resource) Funding Parental support Partnerships with public and private organizations Support of Boys & Girls Club Support of Virginia Department of Public Health Participants (identified by B & G Club)	Program provides activities in the following: - Weekly sessions administered at the B & G club site - Working on a service project - Field trips for participants - Graduation ceremony	Students will participate in the program – students are chosen by B & G Club for participation A total of 14 sessions of the curriculum, *Passport to Manhood*, will be delivered – one session per week for approximately 1-1.5 hours A service project will be developed and completed. Field trips will be scheduled and attended. A graduation ceremony will be held at the end of the program for those who complete the program.	Program participants gain increased knowledge and information about preventing adolescent sexual involvement, reducing drug use and gang involvement, preventing premature parenting and how to become productive, becoming independent contributors to family and community life, career and employment opportunities, a code of ethics, personal decision making, diversity and conflict resolution. *An average of 75% will be used to measure the impact of the program for outputs* 75% of the participants who received the minimum dosage of 10 contact hours will demonstrate the following by the program year end of 6/30/2004: - demonstrate competency in at least 3 areas of appropriate knowledge, skills, and attitudes to avoid pregnancy - demonstrate a decrease in at least one behavior which places them at risk for pregnancy - demonstrate an increase in at least on protective factor	Program participants will acquire valuable decision making skills that allow then to change their attitude toward drug use, diversity, community involvement, conflict resolution, becoming a teen parent, and improving their educational and economic well being. Participants will acquire decision-making skills that provide them with appropriate tools to prevent fatherhood and improve their relationships with girls.	Program participants become responsible individuals who have delayed parenthood and are contributing members in their community. Participants have improved their educational and economic well-being by avoiding conflict, becoming contributing members of their community, avoided substance abuse, and responded positively to relationships with girls.

ATTACHMENT D

Norfolk TPPI: Real Alternatives to Pregnancy (RAP) Program Logic Model

RAP's goal is to reduce teenage pregnancy through action at the level of the individual teen and his/her family, school and community based groups, members of the advisory board and the city's system of agencies and organizations. Through RAP's efforts, positive health messages about preventing teen pregnancy are provided. RAP's staff as well as trained peer leaders and youth service workers throughout the city work together to achieve this goal. RAP will continue to place emphasis on expanding its school programs by targeting the area's middle and high schools that allow RAP's staff to conduct sexuality and life skills education sessions during regular school hours. RAP will also continue to collaborate with various community based youth service organizations/agencies in order to provide Norfolk's youth the structured, life skills building activities. Some sessions will be held during the critical after school hours when youth are most often unsupervised and therefore at greater risk for pregnancy.

INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES		
Resources dedicated or consumed by the program.	**What the program does with the inputs to fulfill its mission.**	**The direct products of program activities. # of ….**	**Benefits or changes for individuals or populations during or after participating in program activities.**		
			Initial	**Intermediate**	**Longer-term**
2 MSW Social Workers (Female) (100% of time) 1 Health Educator (Male) (25% of time) Student interns from Norfolk State University TPPI funding is sole funder of program 3 Curriculum- based programs (LPE, PSI, FMO) One-to-One Program (OTO), a one-on-one reproductive health care program Office space at Norfolk Department of Public Health	Deliver in-school and after- school curriculum-based programs Provide community-based curriculum-based programs One-to-one crisis counseling City-wide recruitment for program at public middle/high schools and community organizations Advisory board meetings Training of staff in pregnancy prevention issues Pretest and posttest assessment of program effectiveness and implementation Year-end community conference	@350 middle and high school students at in-school programs @40 students at after-school programs @200 adolescents at community programs @35 adolescents in one-to-one counseling @400 adolescents and adults at the community conference	Increased knowledge of abstinence/safe-sex practices Increased confidence in decision making Increased positive feelings about oneself Increased responsibility for sexual behavior Correction of misperceptions regarding sexuality and STDs Increased positive attitudes towards delaying pregnancy	Decrease in sexual risk-taking Increase in protective behavior Higher levels of healthy lifestyle behaviors Decrease in sexual activity (for those already sexually active) Increase in safe-sex practices	Decrease in teen-pregnancy rate in Norfolk Decrease in STDs among adolescents in Norfolk Increase in community and political support for teen pregnancy prevention in Norfolk

ATTACHMENT E

Portsmouth TPPI: Becoming A Responsible Teen Project Logic Model

Becoming A Responsible Teen (BART) is a prevention curriculum that works. BART presents accurate, useful information about HIV and AIDS and involves teen participants in building the skills they need to clarify their own values about sexual activity and to make decisions that will help them avoid the risks inherent in such activity through better choices regarding healthier living and positive behavior changes.

INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES		
Resources dedicated or consumed by the program.	What the program does with the inputs to fulfill its mission.	The direct products of program activities. # of …..	Benefits or changes for individuals or populations during or after participating in program activities.		
			Initial	Intermediate	Longer-term
Program funding of BART project. One facilitator/trainer. Other general TPPI Program staff support. Project curriculum and associated training materials (pencils, paper, handouts, videos, activity worksheets, snacks, etc.). Video equipment, display boards, and other presentation materials. Training sites.	Finalize project training curriculum and related training materials. Determine training schedule. Secure training locations. Recruit guest speakers as appropriate. Recruit participants. Obtain informed consent from parents and participants as appropriate. Train 150 total participants over six to eight cycles of the 16 project contact hours.	Conducted in both community and school settings beginning summer, 2003, and continuing through spring, 2004. Conducted with male (approx 15%) and female (approx. 85%) youth, ages 12 - 18. Racial composition is expected to be 90% African-American, 5% Caucasian, and 5% Other. Conducted covering 10 topic areas including: 1) understanding values; 2) responsible decision-making; 3) assertive communication; 4) dating and relationships; 5) human anatomy; 6) contraceptives; 7) sexually transmitted diseases and HIV/AIDS; 8) condom use; 9) alcohol, tobacco, and other drugs; and 10) child abuse and neglect.	Participants who satisfactorily complete the Becoming A Responsible Teen (BART) training project will have acquired an increased knowledge of the ten topic areas covered, indicate an increased ability to employ project learned resistance skills, and indicate an increased sense of social support.	Participants incorporate their newly acquired knowledge and skills into their daily living adopting health affirming attitudes and positive behaviors while remaining free of infection from sexually transmitted diseases.	Participants lead healthy lives free of the risks of infection from sexually transmitted diseases.

ATTACHMENT F

Roanoke TPPI: For Males Only Logic Model

Empowering young males with the knowledge and skills required to make responsible choices as they pertain to avoiding risky behaviors.

INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES		
Resources dedicated or consumed by the program.	**What the program does with the inputs to fulfill its mission.**	**The direct products of program activities. # of ….**	**Benefits or changes for individuals or populations during or after participating in program activities.**		
			Initial	**Intermediate**	**Longer-term**
Staff Time Money Curricula Volunteers Technology Equipment Educational Materials	Using the FMO curriculum the program is taught in: High schools Middle schools Alternative schools After school programs. The program enrolls young teens ages 12-19. The program goal is to have at least 75% of program participants receive ten teaching contacts.	The FMO program targets middle and high school males. The program addressees the consequences of poor decision making, teenage pregnancy, enhancing positive values and belief systems, avoiding risk taking behavior and the prevention of sexually transmitted diseases.	Improved knowledge regarding the responsibilities associated with early sexual activity and potential parenthood. Improved knowledge regarding the behavior and situations that put teens at risk for pregnancy. Improve attitudes supporting healthy behavior that includes positive future orientation. Decreased behavior that put participants at risk for pregnancy and STD's.	Foster a long-term approach to responsible sexual behavior, healthy life-styles and positive decision-making. Increase in the number of students who indicate an intention to complete high school and go on to attend college or trade school.	Reduce the Roanoke Teen Pregnancy Rate. Reduce the incidence of sexually transmitted diseases in the youth of Roanoke. Increase a life long approach to healthy decision-making.

ATTACHMENT F

Roanoke TPPI: Roanoke Adolescent Health Partnership Logic Model

Improve the lives of teenagers by making comprehensive health care accessible. Parents, teens, health care providers and others work together to address the emotional and physical needs of each young person.

INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES		
Resources dedicated or consumed by the program.	**What the program does with the inputs to fulfill its mission.**	**The direct products of program activities. # of …..**	**Benefits or changes for individuals or populations during or after participating in program activities.**		
			Initial	**Intermediate**	**Longer-term**
Staff Time Money Volunteers Technology Equipment Educational Materials	RAHP operates one community-based and two school-based health care clinics for adolescents ages 10-19 years of age RAHP offers a variety of services focusing on prevention to improve health and reduce risk-taking behavior. Services include: Family Planning. Health Education services. Mental Health. Minor illness and injury treatment. Immunization. Drug, alcohol, smoking education. Violence prevention. Sports physicals.	RAHP goal for FY05 is to target 3,500 patient visits at its three teen health centers. All teens attending for family planning services will receive one-to-one health education and sexual health counseling, pregnancy testing and a consult with a physician or family nurse practitioner. RAHP school based THC are open Mon-Fri, term time; Hurt Park THC is open Mon-Fri year round. Health education services available Mon-Fri in both school based THC and Mon-Thurs at Hurt Park THC. Clinicians are available for consultation on: Flemming/Ruffner 4 1/2 days per week; Patrick Henry 4 days per week. Hurt Park 3 1/2 days per week.	Improved knowledge regarding the responsibilities associated with early sexual activity and potential parenthood. Improved knowledge about basic reproductive health, pregnancy prevention and at least one community source they would go for information or services for pregnancy prevention. Increase compliance with birth control methods.	Foster a long-term approach to responsible sexual behavior, healthy life-styles and positive decision-making. Improve parent-child communication.	Reduce the Roanoke Teen Pregnancy Rate. Reduce the incidence of sexually transmitted diseases in the youth of Roanoke. Increase a life long approach to healthy decision-making.

ATTACHMENT F

Roanoke TPPI: Teen Outreach Program Logic Model

The Top philosophy is that each young person has something to contribute to the community, and its mission is to help young people identify their talents and interests so that they can find their place in society.

INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES		
Resources dedicated or consumed by the program.	What the program does with the inputs to fulfill its mission.	The direct products of program activities. # of …..	Benefits or changes for individuals or populations during or after participating in program activities.		
			Initial	**Intermediate**	**Longer-term**
Staff Time Money Curricula Volunteers Technology Equipment Educational Materials	Best practice activities using the Changing Scenes curriculum. School programs After-school programs Life skill training. Community service learning. Role modeling Family involvement	Top targets both male and female teens who are high risk academically. Top's goal is to have at least 75% of the 90 youth enrolled in TOP receive the minimal dose of 10 hours life skill training and 10 hours of community service learning.	Improved knowledge regarding the responsibilities associated with early sexual activity and potential parenthood. Improved knowledge about basic reproductive health. Improved knowledge about the means and behaviors that help teens avoid pregnancy. Improved attitudes supporting healthy behaviors, including personal responsibility and improved self-respect.	Decrease course failure rate and increase school attendance by increasing the commitment to learning. Foster a long-term approach to responsible sexual behavior.	Reduce the Roanoke Teen Pregnancy Rate. Reduce the incidence of sexually transmitted diseases in the youth of Roanoke. Increase a life long approach to healthy decision-making.

ATTACHMENT G

Eastern Shore TPPI: Young Voices for Better Choices (YVBC)

The Eastern Shore Teen Pregnancy Prevention Initiative (ESTPPI), also known as the Young Voices for Better Choices (YVBC), began its ninth year of implementation during the 2003- 2004 state funding period. The YVBC program evolved out of a community-based model and has functioned on the philosophy that the community identifies it own needs and its own strategies to address those needs. Since its inception, Eastern Shore's TPPI has expanded its coordination of programs to include churches, a health clinic, and community-based youth groups. Many of these groups have been with the YVBC program for four to six years.

INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES		
Resources dedicated or consumed by the program.	**What the program does with the inputs to fulfill its mission.**	**The direct products of program activities. # of ….**	**Benefits or changes for individuals or populations during or after participating in program activities.**		
			Initial	**Intermediate**	**Longer-term**
Sex Can Wait Program Bethel AME Church (Staff= .25 FTE)	Church based educational activities that are curriculum based	80 contact hrs of services per participant (2 hr sessions twice per wk for 12 wks, 16 hr lock in, 6 hrs of field trips, and 8 hrs of fun night)	75% of participants will increase knowledge and proper attitudes toward teen pregnancy	75% of participants will have decreased risk taking and increased protective behaviors	Decrease in teen-pregnancy rate in Eastern Shore Decrease in STDs among adolescents in Eastern Shore Increase in community and political support for teen pregnancy prevention in Eastern Shore
Sex Can Wait Program St. John's United Methodist Church (Staff= .25 FTE)	Church based educational activities that are curriculum based	35 participants receive 62 contact hrs of services per participant (2 hr sessions twice per wk for 15 wks)	100% of participants will improve knowledge, values, self-esteem	Improved communication between parents and youth	
Postponing Sexual Involvement Program New Mt. Calvary Baptist Church (Staff= .25 FTE)	Church based educational activities that are curriculum based	35 participants receive 70 contact hrs of services per participant (2 hr sessions twice per wk for 15 wks)	75% of participants will improve knowledge conducive to avoiding teen pregnancy	75% of participants will improve interaction with parents and increase responsibility	
Sex Can Wait Program St. Luke AME Church (Staff= 3.6 FTEs)	Church based educational activities that are curriculum based	35 participants receive 75 contact hrs of services per participant (3 hr sessions twice per wk for 12 wks)	100% of participants will receive knowledge conducive to avoiding teen pregnancy	100% of participants receive computer skills training and 75% improve decision making skills	
Sex Can Wait Program Northampton County Extension Office's Teens	Community based educational activities (educational sessions that are curriculum based through a	40 participants receive 75 contact hrs of services per participant	75% of participants will increase knowledge conducive to avoiding	75% of participants have positive parent relationships and 60%	

Reaching Youth Program (Staff)	county extension service)	(2 hr sessions twice per wk for 18 wks)	teen pregnancy	decrease one high risk behavior	

ATTACHMENT H

Locality Specific Evaluation Reports

Alexandria

The program sites targeted for outcome evaluation for 2003-04 were among the sixteen programs conducted by the Alexandria Health Department's Teen Pregnancy Prevention Initiative (TPPI) for children and adolescents living in the Alexandria Health District. The sites included five of the *Pro-Teen/Pro-Youth* (PT/PY) programs that served primarily African-American and Latino children and adolescents last year. Three of the sites (Cora Kelly, Crestview, and Ramsay) provided teen pregnancy prevention education to youth living in the surrounding African-American community. The other two sites (Bruce Street and Grace Episcopal) are located in Latino communities. In total, the 231 youth who participated in the PT/PY programs represented 60% of the 384 children and adolescents serviced by the TPPI.

Pro-Teen/Pro-Youth (PT/PY)

Program Description

The *Pro-Teen/Pro-Youth* program is a teen pregnancy prevention program for children (age 9-12) and adolescents (age 13 – 17). This project operates under the assumption that the causes of teen pregnancy are complex, thus requiring multifaceted intervention strategies aimed at the following objectives: (1) provide the target population, their parents and guardians general information regarding teen pregnancy that will enable them to make informed choices; (2) reduce sexual activities; (3) promote male responsibility; (4) stimulate growth in youths' self-awareness and improvement in their self- esteem; (5) increase the number of youth who adopt postponement or abstinence as their mode of sexual conduct; (6) promote sound judgments to use safe sex practices by youth who persist in their sexual activities; (7) increase parental investment and involvement in project goals and activities; (8) provide access to health care; and (9) promote good health.

The Latino sites became part of PT/PY two years ago, and provided services to 107 youth during the year, nearly a 50% increase over the previous year. The majority of the participants were between the ages of 10-14, though one site, Grace Episcopal Church, serves adolescents as old as 16. Pro-Teen/Pro-Youth is an after-school program, and uses the curriculum, *Life Planning Education* (Clark, 1992). The program includes informal education, community resource referrals, and individual interactions with program participants. The intensity of intervention varies by sites as a function of the age of the participants and program staffing conditions.

All of the programs are located in an urban setting characterized by considerable ethnic and cultural diversity. Many of the families in the areas served by the programs are recent immigrants from Central and South America, Africa, and the Caribbean. African-American families are represented in significant numbers as well. Pretest data showed that 65% of the program participants came from single-headed households, and 15% from two-parent

families. The remaining children and adolescents were being cared for by grandparents and older siblings.

Outcome Evaluation

Data Collection

The survey instrument used in the outcome evaluation was developed and administered last year. The tool has two versions, a shorter one containing 63 items pertaining to life skills, curriculum-based knowledge of physical hygiene, human maturation, self-efficacy, achievement motivation and substance abuse. This version, administered to the younger participants, contains less explicit inquiry related to personal sexual behaviors and decision-making skills. The longer survey does inquire about these matters with 20 additional items, for a total of 83 items that were administered to the adolescents.

Data collection and analysis was conducted this year using the survey instrument. A total of 71 participants were administered the pretest at the five program sites, down 13 percent from last year. Moreover, official attendance data indicated that a total of 231 children and adolescents participated in the programs offered by these five sites. Therefore, only 30.7% of participants took the pretest.

Findings

The shrinkage in the available data for outcome evaluation was dramatic by posttest; only 24 posttest surveys were available for the outcome evaluation analysis. Given this serious constraint, the only option was to rely, for the most part, on simple statistical comparisons and graphing procedures that sought trends and offered tenuous interpretations, at best.

Results are reported separately for the younger children. The younger children's gain in curriculum-based knowledge was examined first. The participants' understanding of such matters as hygiene, sexually transmitted infections, and maturation differences between boys and girls, was examined by analyzing the scores on 16 true-false items. An example of one of the items is, *"Puberty means that a boy and girl have started dating. (False)*. Scores were summed across the 16 items and the means for the pre-and posttest scores were compared. The gain from pre- to posttest mean scores was determined to be statistically significant ($t = 2.712$; $df = 14$; $p < .05$), although the accompanying effect size ($\Delta = 0.67$) may be viewed to be modest.

Individual items were also examined for changes from pre to post survey administrations. The number of participants agreeing with the statement, *"I will not have sex until I am married, "* increased dramatically from the number of endorsements at pretest. The number of children that gave a positive endorsement to the statement at pretest increased from 4 to 14.

The results for the adolescents attending Grace Episcopal were examined using attendance data as a measure of dosage. Unfortunately, only nine participants took both the pre-and posttests. To gain some insight into the growth in knowledge acquired over the year, the nine participants' summed scores on the six posttest items that focused on the physiology of sexual reproduction were examined as a function of the number of hours of curriculum

exposure they experienced. The mean test scores increased as the dosage increased, with the exception of the one student who was exposed to at least 82 hours, who did not fare a well as others with less exposure. Of course, only one datum at this level renders interpretation meaningless. Examination of trends among the other variables, either from pre-to-posttests, or as a function of dosage, did not prove fruitful, given the very small sample size.

Limitations
The major limitation was the high attrition rate from pretest to posttest.

Recommendations for Next Year
Technical assistance for the current 2004 – 2005 program year includes assisting staff to understand the program theory associated with the Pro-Teen/Pro-Youth program, using a logic model that was developed last year. Program evaluation in FY05, similar to the current year, should focus on PT/PY's impact on participants' attitudes, skills such as prosocial decision-making, and coping with peer pressures, knowledge, and behaviors related to issues about teen pregnancy prevention. It is envisioned that at least one comparison group will be available through a local public grade school so that stronger evidence of causal connections between program interventions and outcomes can be gathered. In addition, an extensive process evaluation will be undertaken to explicate the program theory that influences daily decisions by staff, and to assess program fidelity on key interventions.

Crater

Crater Health District originally received funds to initiate a teen pregnancy prevention program in 1995 in Phase II of the Virginia Department of Health Teen Pregnancy Prevention Initiative (TPPI). The Crater Teen Pregnancy Prevention Initiative is unique among the VDH TPPI programs due to the diverse and expansive geographic area covered by the health district. Crater provided three curriculum-based programs through TPPI this year, through several subcontrators.

Making Your Future (MYF)

Program Description
Making Your Future is a school-based bi-weekly program developed by Petersburg's sexual education coordinator. It is the youth behavioral risk component of the Appomattox Pregnancy Issues Council. The program's primary goal is to educate young people ages 10 to 19 to make decisions based on critical thinking. This model is based on social cognitive theory, which considers environmental models and attitudes as the basis for risk-taking behavior. Program goals include improved skills in anger-management and conflict resolution, increased knowledge about pregnancy, STDs, contraception and abstinence, and an increased awareness of one's own sexual values. Although the program was provided to 5th-10th graders at two schools in the City of Petersburg (urban), the evaluation focus was on 5th graders. These two schools were both evaluated as program schools and a third school was to provide comparison data.

Outcome Evaluation

Data Collection

A total of 130 pretests were administered, 79 from program schools and 51 from comparison schools. Of the 55 respondents who submitted both pre and posttests, 29 (52.7%) were male and 26 (47.3%) were female. At pre-test, 96% self-reported as Black or African-American, 1 as White, and 1 as biracial. At post-test, 98% self-identified as Black or African-American, 1 as "other."

Findings

Research questions for the evaluation were organized around four main areas. The findings are discussed in relation to those questions.

1. Knowledge

   a. Risks and consequences of sexual behavior

      All five of the questions showed significant change in students' responses from pretest to posttest.

      Having sex, as a teenager would make it harder to stay in school, harder to have a good marriage and family, harder to get a good job; having a baby during high school is a problem, unlikely to finish.

   b. Risks of sexual behavior

      Significant change in knowledge was demonstrated between pre and post on 3 of the 11 questions:

      Curability of Herpes
      Possibility of a woman becoming pregnant the first few times she has sex
      Who can contract AIDS

   c. Understanding abstinence

      Students' responses showed significant change from pre to post.

   d. Identify, articulate use of contraception

      There was no significant change in respondents' knowledge of this issue from pre to post as measured by their responses to one question about whether or not condom use effectively prevents the spread of STDs.

2. Interpersonal skills

   a. Refusal skills

      Of the four questions used to assess this construct, only one showed significant change from pre to post. Respondents reported an increase in their level of comfort in saying "no" to someone who made a pass at them.

   b. Communication skills

      There was no significant change in respondents' responses from pre to post on this measure.

3. Healthy behaviors

Only 1 of 8 questions used to assess internal locus of control showed a significant change from pre to posttest in the predicted direction. Respondents showed an increase in their belief that they are responsible for what happens to them.

On 3 questions, respondents showed significant change in the OPPOSITE direction from what was predicted.

Limitations

The primary challenge posed to the evaluation is the absence of comparison group post-tests. Although the program provider was requested to administer a post-test on several occasions by both the local evaluator and program coordinator, in writing as well as orally, she independently made the decision not to administer the post-tests. Although 51 comparison group pre-tests were administered, they are essentially worthless to the evaluation without the post-tests.

For some of the changes that moved in the opposite direction, the absence of the comparison group's post-tests prevents us from ascertaining the extent to which this is a common change among children in this age-group in the general population.

Postponing Sexual Involvement (PSI)

Program Description

Postponing Sexual Involvement is the most widely used abstinence education program in United States. It consists of a series of skill-building programs designed to help youth ages 10 – 17 manage social and peer pressures that might lead to sexual involvement. The goals of the series is to give all youth an opportunity to think and talk more about the consequences of sexual choices and learn skills that will enable them to behave in ways that are in their personal best interests. By helping teenagers learn to manage their sexual feelings and behaviors and acquire skills that let them communicate their choices to other people effectively, teenagers can have futures in which they are in control of their lives and free to realize their potential. The series provides intensive reinforcement and support for young people who have not become sexually involved so that they will want to continue to delay sexual intercourse and avoid other risky sexual behaviors. These series is also aimed at helping youth who are experimenting with sex understand that they can delay further sexual involvement and there are some very real benefits to their future if they do. The three series include: Preteens (5th & 6th grades), Young Teens (7th & 8th grades) and Teens (9th through 12th grades). The objectives of Postponing Sexual Involvement are to reduce the number of teenage births, increase school attendance, improve academic performance and grades and increase high school completion rates. Crater offered the program to 8 sites – 6 school-based (1 in the high school and 5 in middle schools), 1 in an alternative school, and 1 community-based in Emporia (rural). All were expected to be year long programs but start and end dates varied.

Outcome Evaluation

Data Collection

There was no comparison group for the PSI program. Altogether, there were 123 pretests and 68 posttests. There were 68 participants who completed both a pretest and posttest. No race or gender variables were entered from the surveys. Evidently this page was inadvertently removed from the surveys. However, demographic variables are available for the process evaluation.

Findings

Research questions focused on 3 main areas from the Implementer Target Areas. Those items that reflected a significant change from pre- to posttest are indicated below:

1. Knowledge

Pregnancy knowledge test

Students' responses on 5 items related to pregnancy knowledge were combined by adding the number of correct responses into one variable. The mean level of knowledge of pregnancy increased significantly from pre- to posttest.

Media comparison

This group of questions assessed students' reports how their own lives compared to those of others portrayed in media.

Life like movies/TV - at posttest, respondents showed a significant increase in their agreement that their life is like the lives of characters portrayed in movies or on television.

Information base

This group of questions assessed students' reports of their sources of information about sex.

Friends - at posttest, respondents showed a significant increase in their view of friends as a source of information about sex.

Friendship information sources

This group of questions assessed students' reports of their sources of information about friendships.

Radio - at posttest, respondents showed a significant increase in their identification of radio as source of such information.

2. Skills

Confidence in ability to control romantic/sexual interactions

This construct includes 5 questions. Of these, only one showed a significant change from pretest to posttest. Respondents reported stronger levels of agreement at posttest with the statement, "When I think about my sexual behaviors, I know for sure what is right and wrong sexually for me."

Saying no
Correct scores for nine questions related to the various meanings of saying no to sex were added together to create this variable. There was a significant increase in respondents' correct responses to these questions.

Acceptable behaviors
Respondents were asked to identify which of several types of physical contact were acceptable to them. Although acceptability increased from pretest to posttest for all behaviors, only "putting arms around each other" showed a significant increase.

3. Locus of control
There was no significant change on these measures from pre- to post-test.

Limitations
The main limitations were the absence of a comparison group and of demographic data.

Passport to Manhood (PTM)

Program Description
Passport to Manhood is a program for boys ages 11-14 provided through the Emporia Boys and Girls Club (rural) that provides the following activities: weekly sessions administered at the B & G club site, participants' keeping a diary/passport, working on a service project, field trips for participants, and a graduation ceremony. The program teaches and promotes responsibility.

For most adolescent males, the passage from boyhood to manhood is a challenging one, since it requires them to understand and manage a variety of issues and transitions: physical changes in their bodies; altering relationships with authority, friends and members of the opposite sex; greater freedom and responsibility for personal decisions; new expectations for acting more like adults in how they conceive and plan for the future; preparation for life's roles particularly related to education and careers; and greater pressures from peer, authority and popular culture in how they respond to drugs and other controlled substances, and sexual relations.

The program is delivered in fourteen one-hour weekly sessions. Topics include decision-making, ethics, substance abuse, and relationship with girls, fatherhood and employment. Desired outcomes include helping young boys develop sound character and positive behavior as they embark on their journey into manhood. Goals of the program include increasing program participants' knowledge and information about preventing adolescent sexual involvement, reducing drug use and gang involvement, preventing premature parenting and how to become productive, becoming independent contributors to family and community life, career and employment opportunities, a code of ethics, personal decision making, and diversity and conflict resolution. The program was provided to 2 groups this year, one in the fall and one in the spring. Expected enrollment for each was 15-20, and each was evaluated.

Outcome Evaluation

Data Collection

There were two groups of PTM: fall and spring. The fall group included nine participants, the spring, ten. All 19 participants completed pre- and post-tests. All participants were African-American males. Four were in the 5th grade, 12 in the 6th, and 3 in the $7^{th.}$

Findings

Those items that reflected a significant change from pre- to posttest are indicated below:

1. Knowledge

    Consequences and risks of teen sexual activity

    Students' knowledge increased on only 1 or 12 items, i.e. "If I have sex at my age, I can get someone pregnant." Their responses changed in the unexpected direction for all other items.

    Understanding meaning of the abstinence

    For 4 of the 6 items, participants' understanding of abstinence improved from pre- to post-test.

2. Interpersonal skills

    Anger management, conflict resolution

    Respondents' scores decreased from pre- to post-test, reflecting a move in the unexpected direction.

    Communication

    This was measured by one item, "When a girl says no to sex, she really doesn't mean it." Respondents agreed with the statement MORE at post-test than at pre-test, which is the wrong direction.

3. Internal locus of control

    Respondents' scores decreased on all measures except for one: "I am responsible for what happens to me."

4. Protective behaviors

    Future orientation

    Educational values

    Scores on both of these items decreased from pre- to post-, indicating that they were less important to the teens at the end of the program.

Limitations

The small sample size for this program limits our ability to interpret a great deal from the results. Additionally, this program targets at-risk teens that are dealing with a number of challenges in their lives that any given program would have difficulty addressing. Plans are to continue to work with program staff on improving the evaluation instrument and emphasizing critical program components during delivery.

Recommendations for Next Year
Based on the problems encountered with MYF's evaluation, we were not able to assess its effectiveness as an unapproved program (i.e. not evidence-based). Therefore, VDH has recommended that Crater no longer provide this program but choose a program that has been shown effective among 5th graders in urban settings. The program educator in Petersburg who did provide MYF has been required to undergo formal training on an approved curriculum. The staff has selected PSI. Since it will be the first time Petersburg has implemented PSI, they will also designate two comparison school sites. VDH has approved Crater's continued provision of both PSI and PTM in the same Emporia locations as last year. The team will revise the surveys to better address the identified outcomes and conduct pre/post evaluations again for 2004-2005 among at least four distinct groups in Emporia.

Eastern Shore

The Eastern Shore Teen Pregnancy Prevention Initiative (ESTPPI), also known as the Young Voices for Better Choices (YVBC), began its ninth year of implementation during the 2003-2004 state funding period. The YVBC program evolved out of a community-based model and has functioned on the philosophy that the community identifies it own needs and its own strategies to address those needs. Since its inception, Eastern Shore's TPPI has expanded its coordination of programs to include churches, a health clinic, and community-based youth groups. Many of these groups have been with the YVBC program for four to six years.

Young Voices for Better Choices (YVBC)

Program Description
The YVBC program is offered in rural Eastern Shore, a two-county health district. Teenagers, ranging in ages from 10 to 17, are the target population that were reached through funded projects based at churches, government agencies, civic, and social service organizations. The two main goals/objectives of the funded projects are to (1) provide a culturally appropriate and sensitive educational and social intervention to the Eastern Shore community, and (2) assure a consistent abstinence-based message delivered to youth and parents by YVBC programs.

Progress toward Outcome Evaluation
Although no outcome data were available at the time of the writing of this report, there are some descriptive data available on the programs provided. Approximately 460 contact hours were provided to 207 youths by the five funded projects. The population consisted of 98 males and 109 females. Racial composition was 174 (84.1%) African-American, 4 (1.9%) White, and 31 (15%) unknown race. Age composition was 9 (3.5%) were 9 years old or younger, 103 (51.2%) were between the ages of 10 to 14, 77 (37.2%) were between the ages of 15 to 17, and 26 (12.6%) were between the ages of 18 to 19.

Outcomes to be measured next year include the effectiveness of the education and social interventions based upon changes measured by pre and post test survey performance,

continuation of youth program alumni interviews, and the effectiveness of training in the consistency in utilizing curriculum-based interventions. Current activities underway include.

- The evaluation plan for FY 2004 - 05 is in progress.
- The evaluation instruments for the youth survey and youth program alumni will be the same instruments used in the 2004 fiscal year.
- Plans for the administration of the youth survey and interviews are projected to be similar in approach for the new year as they were for last year.
- Data from pre and post-test surveys were collected, are under current analysis, and were not ready for submission at the time of this report. The delay is due in part to extended medical problems experienced by the local evaluator.

Recommendations for Next Year
There should be more involvement of the local evaluator with the ESTPPI coordinator and project staff to encourage planning in the use of curricula based programs to avoid duplication of content for returning youths. Efforts should focus on increasing more earnest participation of youth in completing the surveys. Mechanisms should be put in place that assure a more timely receipt of youth surveys from all projects. The local site evaluator should take proactive steps to have the year-end outcome evaluation report ready for submission in a timely manner.

Norfolk

Norfolk's primary TPPI intervention effort is Real Alternatives to Prevention (RAP). RAP is a comprehensive community-based pregnancy prevention program that has been in operation in the Norfolk community since 1993 as part of the Virginia Teen Pregnancy Prevention Initiative (TPPI). RAP targets its services to adolescents, their parents, and the surrounding community. This effort offers three science based prevention programs. They are Life Planning Education, Postponing Sexual Involvement, and For Males Only. RAP also offers one program that is not science based, the One to One Program. The three overall objectives of the RAP are to provide education in area schools and the community, provide short term counseling/crisis intervention for at risk teenagers, and sponsor an annual pregnancy prevention community conference for teenagers, parents, community leaders, and other health professionals.

Real Alternatives to Pregnancy (RAP)

Program Description
The RAP utilizes four different education programs as follows. (1) "Life Planning Education (LPE)" is a 10-week abstinence-based curriculum that is conducted within various Norfolk middle and high schools, both during school time and in after-school programs, as well as in various local community groups (e.g., churches, community centers, etc.). The program, which deals with issues such as self-esteem, understanding puberty, and developing decision-making, is offered continuously throughout the school year. (2) "Postponing Sexual

Involvement (PSI)" is a 5+ hour abstinence-based, curricular program. (3) "For Males Only (FMO)" is a 5+ hour curriculum based education program that is geared to male adolescents. (4) The "One to One program (OTO)" is a one on one 10-hour adolescent reproductive health care program. The short-term counseling/crisis intervention is provided to high-risk youth either in the client's own home or at a location where they feel comfortable. The clients are usually referred to one of the other programs (LPE, PSI, FMO). From July 2003 to January 2004 a total of 195 adolescents participated in RAP programs. The majority of adolescents (72%) received the Life Planning Education (LPE) program followed by the For Males Only (FMO) program (22%) and PSI program (6%).

Progress toward Outcome Evaluation

There is currently no evaluation plan in place for 2004-2005 due to the IRB closing out Norfolk's protocol. Since Norfolk is still working out personnel issues a revised protocol has not yet been created. Once Norfolk has rectified its personnel issues new protocols will be created and staff will be retrained on data collection procedures.

Recommendations for Next Year

The first recommendation for next year is to fully follow data collection guidelines. Staff should pay careful attention when distributing and collecting informed consent forms and surveys. Participant IDs should be carefully recorded in the database and all surveys should be sorted properly. Only Norfolk TPPI staff should be collecting data from participants. Staff should fill out implementation checklists immediately after each session. Data should be given to the local evaluator immediately after it has been collected and it should be in a sealed envelope.

The second recommendation is to have the program coordinator maintain regular contact with the local evaluator. The program coordinator should maintain regular contact with the local evaluator by phone and/or email (at least once a week). The program coordinator should let the local evaluator know immediately if there are any problems with data collection or other issues related to the evaluation. The program coordinator should make sure all of their staff comply with the IRB protocol and properly collect data. In addition, the program coordinator should assure adequate personnel are in place to support appropriate data collection. Staff is responsible for properly distributing and collecting informed consent forms and surveys as well as ensuring the creation of a comparable control group. Identified personnel need to work closely with the local evaluator to ensure that data collection goes smoothly.

The third recommendation is to seek additional funding/resources. Norfolk is currently attempting to do many things (4 programs) on a very small budget and with minimal staff and resources. Additional funding and resources should be obtained in order to maintain the program after TPPI funding is gone. Now that standardized, research-based programs (i.e., Life Planning Education, Postponing Sexual Involvement, and For Males Only) with appropriate program theory are in use, granting agencies may be more likely to award funding. Alternatively, the site should consider limiting its program scope to a more realistic menu of projects given the current funding.

The fourth recommendation is for RAP to use one standard survey for all programs. This will make things more uniform and less confusing and cumbersome for program staff.

The final recommendation for next year is to increase utilization of the advisory board. Norfolk has an advisory board that is comprised of individuals with a diversity of backgrounds and specializations. The RAP coordinator should attempt to utilize these individuals more for conference planning, seeking additional resources, and obtaining volunteer staff.

Portsmouth

Portsmouth TPPI, through its Becoming a Responsible Teen (BART) Project tackles difficult teenage pregnancy issues by providing male and female youth ages 12-18 the knowledge and range of skills that will help them carry out the decision to postpone having sexual intercourse until they reach a more mature age. The BART Project is a component of the Portsmouth Teen Pregnancy Prevention Initiative programming effort that includes the following additional projects and services. Adolescent Outreach Project is a case management service that is an “Adolescent Reproductive Health Care” (ARHC) service based in the Portsmouth Community Health Center and works with 11 – 19 year old youth focusing on pregnancy prevention through family planning, education and extra-curricular activities. Comprehensive Health Investment Project (CHIP) is a case management service that is a “Secondary Prevention Project” working with 11-19 year old youth matching them with a medical home and promoting self-sufficiency. Girls Inc. Will Power/Won’t Power is a “Curriculum-based Education Project” and works with 12-14 year old girls in area middle schools focusing on issues in sexuality and promoting healthy relationships.

Becoming a Responsible Teen (BART) Program

Program Description

The BART Project addresses teenage pregnancy issues by providing male and female youth ages 12-18 the knowledge and range of skills that will help them carry out the decision to postpone having sexual intercourse until they reach a more mature age. The BART Project is a component of the Portsmouth Teen Pregnancy Prevention Initiative programming effort and was developed in 1998 as a community-based education and skill-training curriculum by Janet S. St. Lawrence, PhD, ETR Associates, Santa Cruz, CA. It has since been used in classroom settings as well. The project is based on a body of scholarly work associated with social learning theory and self-efficacy theory indicating that to alter risky behavior teens require accurate information regarding sexual activity and the dangers involved, the motivation to act on that knowledge, a belief in themselves, and the conviction that they can successfully take self-protective action. These theories explain how people act in terms of personal biological, emotional, cognitive factors and the environment.

The BART curriculum organizationally incorporates four major components to reflect this. First: information that increases adolescents’ knowledge and their awareness of risk. Second: training, through modeling and role-play, in the skills needed to translate the

information into action. Third: opportunities to practice and receive corrective feedback, using the skills in a safe environment before the challenge of using them in risky situations presents itself. Fourth: social support for the desired behaviors to help make them seem to be the norm in the youth's social environment.

The BART Project cycle typically is conducted over 16 training contact hours covering 10 topic areas including: 1) understanding values; 2) responsible decision-making; 3) assertive communication; 4) dating and relationships; 5) human anatomy; 6) contraceptives; 7) sexually transmitted diseases and HIV/AIDS; 8) condom use; 9) alcohol, tobacco, and other drugs; and 10) child abuse and neglect. BART is conducted in both community and school settings 6 to 8 times through the year targeting 150 total participants. It was selected for outcome study particularly since it has a well-developed and highly replicable curriculum and a relatively stable participant population throughout the term of the training.

The project target population is expected to be male (approx. 15%) and female (approx. 85%) youth, ages 12 - 18. Racial composition is expected to be 90% African-American, 5% Caucasian, and 5% Other. Six to eight cycles of the 16 contact hour project conducted in community and school settings were planned to be covered in the study, beginning summer, 2003, and continuing through spring, 2004. Project participants must attend a minimum of 10 contact hours to be considered to have satisfactorily completed the training. The actual population served was 32 participants, 13 male and 19 female youth, ages 12 – 18, representing 6th through 11th grade. Racial composition was 100% African-American. Five cycles of the 16 contact hour project were conducted in community settings, 4 of which were covered in the study, beginning summer, 2003, and continuing through winter, 2004. The average duration of any project cycle providing 16 contact hours was 3 weeks instead of the intended 8 to 10.

Outcome Evaluation

Data Collection

The outcome study testing included 11 male (out of 13 total male project participants) and 12 female (out of 19 total female project participants) youth, ages 12 – 18, representing 6th through 11th grade. Racial composition was 100% African-American. Five cycles of the 16 contact hour project were conducted in community settings, 4 of which were covered in the study, beginning summer, 2003, and continuing through winter, 2004. The average duration of any project cycle providing 16 contact hours was 3 weeks instead of the intended 8 to 10.

Project participants must have attend a minimum of 10 contact hours to be considered to have satisfactorily completed the project training and must have completed both the pre-test and post-test to have been included in the outcome study. The participants completed identical 3-part pre-/post-test surveys assessing knowledge of the project topic areas, self-confidence/resistance skills, and social support.

The Pre-test/Post-test survey is a single instrument in three parts assessing knowledge of the project content areas, self-confidence/resistance skills, and sense of social support. The knowledge section consists of multiple choice and true/false question drawn directly from the project curriculum. The self-confidence/resistance skill section consists of standardized

statements with scaled response options of “strongly agree”, “agree”, “disagree”, and “strongly disagree”. The third section consists of standardized true/false statements. Raw scoring is straightforward totaling of sums. For the knowledge section the highest possible score is equivalent to the total number of questions. Improvement on the post-test would show an *increase* over the pre-test score. The self-confidence/resistance skill section has a scale range from 8-32 where the *lower* the score the more likelihood of higher self-confidence and ability to resist. Improvement on the post-test would show a *decrease* from the pre-test score. The social support section had a scale range of 7-14 and the *lower* score here as well indicated a better sense of social support. Improvement on the post-test would show a *decrease* from the pre-test score.

Study participants completed identical surveys just prior to the start of a project cycle and at the end. All surveys were labeled with an ID code to ensure confidentiality of the test taker. Project facilitators distribute, collect, and forward the surveys to the Portsmouth TPPI Program Coordinator for transfer to the local evaluator. Only the generated ID numbers of subjects in the study were available to the evaluator.

Findings
Limitations not withstanding, 22 of 23 study participants did show an overall average 57 % increase in scores on the knowledge measure of the testing (one participant scored lower on the post-test than the pre-test), with approximately equal percentage increases when broken down by both males and females, or younger and older. This seems to indicate that the project curriculum does “fit” the target population sought relative to the content of the topic areas covered by the training. Scores on self-confidence/resistance and social support measures remained constant, most likely due to the short duration of the training cycles.

Limitations
For the study, a Non-Equivalent Control Group Pre-test/Post-test design was to be used, where the control group, though not matched with the participant group, is similarly situated across several relevant demographic and academic categories including racial composition, gender, school grade and class, and academic performance. However, due to project implementation constraints and obstacles arising which impeded the selection and testing of sufficient control group members the above design had to be abandoned and substituted with the Before-and-After-Design, where only the participant group takes a pre-test, goes through the training, and takes a post-test. This design offers only severely limited interpretation of testing results as related to behavior or attitude shifts but does allow relative assessment of changes in knowledge related to the curriculum content.

Therefore, the outcome study was hampered by the obstacles arising to defeat efforts to select and test a comparison group of non-participant youth requiring a change to a study design significantly limited in making assessments of overall project effectiveness. Another difficulty resulted from the project’s implementation constraints which reduced the intended average training cycle duration of 8 to 10 weeks to an average of 3 and total number of project participants to 32. Since the second and third parts of the study survey are dependent upon on the expected two months span in duration of the training period for reasonably

reliable measurement of shifts in behavior and attitude, they are of little value for addressing any such potential shifts other than in a general way.

Recommendations for Next Year
It is recommended that this year's study be repeated employing the original Non-Equivalent Control Group Pre-test/Post-test design. For the outcome evaluation to be completed successfully, the BART project must be implemented as a series of 8-10 week cycles and maintain 150 participants. Increased efforts to assemble and pre/posttest a non-participant comparison group need to be made.

Richmond

The purpose of the City of Richmond Teen Pregnancy Prevention Program (TPPP) is to deliver and support abstinence-based, primary prevention programming to Richmond youth ages 10 to 19 through targeted, comprehensive programming offered in elementary, middle, and high schools as well as community recreational sites in two zip codes (23223 and 23224). These two zip codes produced 47% of the teen births in Richmond for 2000. The City of Richmond TPPP targets high schools in the two zip codes by providing the Teen Outreach Program (Level IV) to five schools: Armstrong, Kennedy, Franklin Military, Huguenot, and George Wythe. The Superintendent of Richmond Public Schools has granted permission for the TOP program to be provided in these schools. Programs in the high schools are offered in collaboration with the Virginia League for Planned Parenthood.

Postponing Sexual Involvement (PSI)

Program Description
The Postponing Sexual Involvement Program (PSI) is used nationwide in various ways. Three of the seven sites in Virginia that are funded by the TPPI have been approved to provide the PSI program to participants at their localities. The three sites are: the City of Richmond, the City of Norfolk, and the Crater Health District. In an effort to evaluate the impact that the PSI program will have on the participants' knowledge, attitudes, and behaviors, an evaluation tool was developed. The evaluation booklet attempts to evaluate the PSI program. The information collected from participants is NOT intended to be research. Information collected at each site will be delivered to the sites' local evaluator who will analyze the data. Each local evaluator will then send the data to the SERL for analysis across the three sites. Again, the information collected and analyzed is meant to show what impact, if any, the PSI program has had at the three sites that are approved to offer the program through TPPI funding.

The curriculum developed for the Postponing Sexual Involvement program is designed to provide young people with tools to help them bridge the gap between their physical development and their cognitive ability to handle the implications of such development. The PSI program is aimed at youth in junior high or middle school. Younger students do not have the social or cognitive readiness to maximally use such a program. Older youth have moved beyond the more concrete directive approaches contained in the program and generally are ready to deal with behavioral issues relating to sex on a more complex level.

Progress toward Outcome Evaluation
Due to human subjects violations (i.e., failure to obtain parental consent before administering youth surveys) the PSI surveys had to be destroyed, and thus this program's outcome evaluation results were not analyzable. PSI is also not slated for evaluation next year.

Teen Outreach Program (TOP)

Program Description
The TOP program is a nationally recognized method of educating teenagers about pregnancy and pregnancy prevention. It combines classroom based and real-world experiences to meet its goals. The classroom component, called "The Changing Scenes" curriculum, is designed to engage students via structured discussions, group exercises, role-playing, talks by guest speakers, and traditional lectures and presentations. The curriculum involves very little programming directed specifically to the targeted behaviors rather, the curriculum focuses on life-skills building, such as personal growth and self-understanding, decision-making, and building communication skills. In addition, participants are required to participate in a minimum of 20 hours per year of community-based volunteer service. The volunteer component helps students to take on adult roles and build personal responsibility.

The goal of the Changing Scenes curriculum at Level IV is to prevent primary teen pregnancy and help young people make consistent progress in school. TOP principles rest on four "pillars" or touchstones of the program: (1) Youth Development: encourages adults to value young people as assets and resources, (2) Community Involvement: strong community –wide partnerships promote broad-based community involvement to insure program continuity, (3) Learner Centered: TOP participants receive learner-centered education, and (4) Academic Extensions: links learning gained through the service experience to the classroom and vice versa.

Outcome Evaluation
Data Collection
Data collection for the TOP program consisted of pre/post tests. A total of 239 participants had appropriate consent to take the pre/post tests. Out of the 239 participants, there were 74 who had matching pre/post tests that could be analyzed. Out of the 239 participants, 207 were African-American, 9 were White, 2 Latino/Hispanic, 2 Bi-racial, 3 Asian and 16 missing racial identity. The participants ranged in grade level from 9th – 12th as follows: 9th grade = 16, 10th grade=15, 11th grade=89, 12th grade=72 and the remainder did not indicate a grade level. For the matching pre/post test survey participants, the following demographic breakouts were found:

73 African-American, 1 White
3 Ninth graders
7 Tenth graders
36 Eleventh graders
22 Twelfth graders
3 unknown/did not answer

Findings
When looking at the participants' answers from a pretest to a posttest, the data suggests that there is no significant change in a majority of the measures. The only measures to show significant positive change ($p<.05$) are:

- Having sexual intercourse isn't something you can plan – it just happens ($p=.019$)
- I ask for help if I need it ($p=.000$)
- I plan to have sexual intercourse whenever the opportunity come along ($p=.032$)
- If someone were to offer you cigarettes during the next year, would not use them ($p=.029$)
- It is alright to demand sex from a girlfriend or boyfriend – not alright ($p=.003$)
- There are times when I think I'm no good at all ($p=.032$)

The data actually showed an increase in skipping school and classes, a decrease in desire for higher education, an increase in tendency toward use of drugs and alcohol, and no significant change overall in the remainder of the measures.

Given the population and modifications that were made to adapt the curriculum to the youth involved in the program this year, the results are not surprising. This population of participants was already identified with behavior and other disciplinary problems. The population in general is more likely to engage in risky behavior or to show no change during a program. It is recommended that future doses of the program to this population be more intense, longer, and more tailored to the population if it is used for this population.

Limitations
The City of Richmond decided to change the program offered from TOP to Reducing the Risk. The local evaluator was not familiar with the Reducing the Risk program or the evaluation instrument used by Doug Kirby and ETR Associates. The local evaluator was not informed that the program would be changed until the new program year had begun – two weeks before program implementation. The local evaluator obtained a copy of the Reducing the Risk survey and compared it to the TOP survey. While similarities existed, there were several questions relevant to the Reducing the Risk program that was not asked on the TOP survey. The TOP survey was modified to include these questions and checked to assure that questions from the Reducing the Risk survey were adequately covered by the TOP survey.

Recommendations for Next Year
The City of Richmond staff needs to be sure to follow guidelines for consent/assent and survey distribution among participants. The City of Richmond TPPI Coordinator should maintain contact with the local evaluator on a weekly basis to provide progress reports and updates as to the status of the data collection and efforts. Any questions/issues/barriers to data collection should be resolved before the beginning of the program year.

It is also recommended that the City of Richmond provide programming to the high school students originally identified in the needs assessment. The results from programming for an at-risk group with behavioral problems will differ (in general) from those who are not faced with the challenge of behavioral problems.

Roanoke

The Roanoke Teen Pregnancy Prevention Initiative (TPPI) and the Better Beginnings Coalition of the Roanoke Valley (BBC) is a partnership of the Virginia Department of Health (VDH), Division of Child and Adolescent Health; Carilion Health Systems; and the City of Roanoke, Department of Human Services. The Roanoke TPPI effort includes three programs. For Males Only (FMO) provides community education on family life, sexuality and related topics to young men. The Roanoke Adolescent Health Partnership (RAHP) provides family services to young women. The Teen Outreach Project (TOP) provides school based and after school teenage pregnancy prevention services to academically high-risk adolescents.

For Males Only (FMO)

Program Description

The objective of For Males Only (FMO) was to provide community education on family life and sexuality and related topics to young men. The curriculum focus is to increase understanding about responsibility and decision-making; to gain knowledge about the causes and consequences of teenage pregnancy and birth control methods

Outcome Evaluation

Data Collection

The following analysis is based on data gathered from survey data from FMO participants, two key informant interviews, and two focus groups with FMO participants. Two focus groups were conducted; one with Patrick Henry High School students and one with students from the Roanoke County Career Center. The sample for the FMO survey included 68 matched pre-test and post-test surveys.

Findings

The results for this year's evaluation pretest and posttest data as well as results of focus two focus groups revealed the following:

- Overall, 97% of participants were not involved in a pregnancy.
- The percentage of young men correctly identifying whether a specific birth control method was effective or not effective averaged 80% on the post-test, and the percentage doing so increased significantly from pre-test to post-test for many birth control methods.
- FMO participants' sexual knowledge increased significantly; out of six sexual knowledge questions, the average number answered correctly increased from 3.5 on the pre-test to 4.3 on the post-test ($F = 10.04$, sig. = 0.002).
- The percentage of FMO participants who agreed that birth control is the responsibility of both the man and the woman increased from 79% on the pre-test to 91% on the post-test.

- The percentage of survey respondents who reported they planned to use birth control the first/next time they had sexual intercourse increased from 68% on the pre-test to 76% on the post test.
- The percentage of survey respondents strongly agreeing with the statement *"If I became a father while I was a teenager, it would interfere with my future"* increased from 53% on the pre-test to 60% on the post-test.
- Focus group participants were unanimous in feeling that the program should be expanded so all male students could participate.

Limitations
The FMO curriculum was offered to 91 youth at three schools in Roanoke (Patrick Henry High School, James Madison Middle School, and the Roanoke County Career Center). FMO participants ranged in age from 11-17 years old (average age of 14.6 years old), and were predominantly White (75%) or African-American (19%). Staff reported that inconsistent attendance by some young men made it difficult for them to deliver the minimum dose of 10 one-hour teaching contacts. FMO rescheduled classes with the schools' approval in order to increase the number of potential teaching contacts.

Roanoke Adolescent Health Partnership (RAHP)

Program Description
RAHP provided services to 2,338 youth in Roanoke City and provided family planning services to 256 young women. The Roanoke Adolescent Health Partnership (RAHP) Centers play a crucial role in addressing the problem of teen pregnancy and other teen health issues in Roanoke.

Outcome Evaluation
Data Collection
Data collection efforts included multiple approaches such as program records and focus groups from teenagers from Fleming High School and Patrick Henry High School who received services from the Fleming/Ruffner Teen Health Center and the Patrick Henry Teen Health Center, and key informant interviews with school based health professionals familiar with RAHP.

Findings
Outcome data revealed:
- RAHP continued to increase the number of students served by its health centers. In the 2003-2004 fiscal year, RAHP provided services to 2,338 youth in Roanoke City, 201 more than in the previous year.
- RAHP was visited by these youth 4,234 times, substantially exceeding RAHP's performance goal for the year of 3,500 patient visits (74% females and 55% African Americans).

- RAHP provided family planning services to 256 young women. These young women had 1,056 family planning visits.
- 96% of the 256 RAHP family planning patients did not become pregnant during the first three quarters of the 2003-2004 fiscal year, exceeding its goal of 90.
- The 256 RAHP family planning patients had a 98% compliance rate with their birth control methods.

Limitations
RAHP services were provided with few significant problems. RAHP continued to operate with only one nurse practitioner covering its three sites. In addition, RAHP health educators faced barriers providing some classroom sessions – Roanoke City schools will not allow certain topics on sexual health. Snow days also caused many cancellations.

Teen Outreach Program (TOP)

Program Description
TOP was implemented both in schools and in after-school programs. A total of 136 students participated in TOP in seven separate programs. TOP targets academically high-risk adolescents with the goal of preventing teenage pregnancy.

Outcome Evaluation
Data Collection
Data for the TOP evaluation came from pre-post survey data from middle school and high school students, three focus groups with high school students aged 15-18 years (two were conducted with students from William Byrd High School and one with students from Fleming High School), two key informant interviews, and staff-completed program activity logs. There were 73 matched surveys from two high schools (Fleming High School and the Roanoke County Career Center alternative school). The focus of the key informant interviews was to explore knowledgeable professionals' assessment of TOP's impact on teens, the strengths of the TOP program, and ways in which TOP can be improved. Activity logs completed by TOP staff members provided another source of data regarding the implementation and impact of TOP. Staff used the logs to record data regarding program activities, fidelity, implementation barriers and the impact on TOP teens.

Findings
Data revealed the following:

- TOP enrolled 136 students in the 2003-2004 school year – 96 high school students and 40 middle school students.
- Overall, 86% of the participants received at least twenty hours of curriculum and community service.
- Overall, 99% of TOP participants were not involved in a pregnancy during the program.

- On average 86% of TOP high school participants demonstrated correct knowledge about basic reproductive health, and the percentage of students correctly answering sexual knowledge questions increased significantly on four out of six questions.
- The percentage of surveyed high school participants agreeing that it is possible to get a sexually transmitted disease from sexual intercourse increased from 72% on the pre-test to 89% on the post-test.
- The percentage of surveyed high school participants agreeing that birth control is the responsibility of both a man and a woman increased from 89% on the pre-test to 94% on the post-test.
- Among surveyed high school participants, agreement with the statement *"If I became a parent while I was a teenager it would interfere with my future"* increased from 57% on the pre-test to 68% on the post-test.
- Among surveyed high school students, the percentage who reported they planned to go on to graduate or professional school increased from 30% on the pre-test to 43% on the post-test.

Limitations
Due to the small sample size for the survey data, results should be viewed with some caution. Further problems with the implementation of the survey were encountered when many key knowledge, attitude and behavior items were eliminated from the survey by various schools.

Recommendations for Next Year
Participants felt the program should be expanded so all male students could participate. Some suggested having FMO meet more often and that there should be a girls group.

Students and the key informants interviewed suggested RAHP could strengthen its mental health counseling component. Also, students continue to desire expanded hours and capacity for RAHP Centers. Increasing the accessibility of services is the only consistent concern students express year-to-year.

The overwhelming feeling among TOP focus group participants and the key informants was that TOP is just fine and does not need to be improved. Students in one group did suggest offering TOP more often. All students in the focus groups felt TOP should be offered to all students.