FACILITATORS OF SUCCESS:IMPLEMENTING MULTI-COMPONENT TEEN PREGNANCY PREVENTION PROGRAMS TO SCALE

The Office of Population Affairs' Teen Pregnancy Prevention (TPP) Program funds medically accurate and age appropriate programs to prevent teen pregnancy and reduce disparities. In 2015, the Office of Adolescent Health (OAH, now merged with the Office of Population Affairs, OPA) awarded grants to 50 organizations in 31 states and the Marshall Islands to replicate evidence-based programs (EBPs) to scale in communities with the greatest need. Projects used a community-wide, multi-component strategy and were required to include four key elements:

Evidence-based programs. Deliver EBPs to scale with fidelity in at least three different types of settings.[1]

Community mobilization. Engage the community around a shared vision to increase the community's ability to prevent teen pregnancy and improve adolescent health. Community Advisory Groups (CAG) and Youth Leadership Councils (YLC) inform the effort.

Linkages and referrals. Recruit a network of youth-friendly, accessible service providers, develop a referral system, and connect youth to needed services.

Safe and supportive environments. Ensure programs are implemented in safe and supportive environments: integrate a trauma-informed approach (TIA), assess LGBTQ inclusivity, and put positive youth development (PYD) characteristics into action.

Data sources for this brief

Results are based on data collected during the first two years of full implementation:

- Semi-structured telephone interviews with all 50 grantee project directors and a purposive sample of 93 grant partners.
- Multi-day site visits to five grantees to develop case studies. Visits included interviews with grantee staff, grant partners and other stakeholders, observations, and youth focus groups.
- Multi-day site visits to 12 grantees that were candidates for a federal impact evaluation. Visits included interviews with grantee staff and grant partners geared toward understanding project implementation and evaluation feasibility.

This brief summarizes facilitators (grantee actions and community conditions and resources that supported implementation) of the community-wide, multi-component strategy to reduce teen pregnancy during the first two years of full implementation.

[1] "Setting" refers to the setting types identified in the OAH grant guidance, such as high school, middle school, out of school/community-based, clinic, or juvenile detention.

Implementation Facilitators

There are four categories of facilitators that cut across the key program elements described above: community capacity and context, program infrastructure and support, partnerships, and evidence-based programs. This section briefly introduces each category. The remainder of the report presents the facilitators, organized by category, for each element of the multi-component strategy.

Community capacity and context includes the extent to which local service delivery settings and systems, policies, networks and collaborations, and social norms and attitudes were supportive of the project.[2] **Program infrastructure and support** refers to the organizational structure of the grantees, partners, and the project itself; capacity, skills and competencies of organizations and staff; and support (e.g., training) provided to project staff and other stakeholders. The **Partnerships** category includes collaborative skills and relationships that partners bring to the project, including partners' roles and histories within the community. Finally, **Evidence-based programs** refers to characteristics of the EBPs (e.g., length, content, focus), how communities chose them (e.g., involvement of stakeholders), and whether they are a good fit for the community and setting.

Delivering Evidence-Based Programs to Scale

Delivering EBPs appropriate for the target populations with fidelity across multiple settings required substantial support of school and community partners, and high organizational capacity among grantees and partners. Frequent, clear communication and a sense of trust between the grantees, implementing partners, and settings were commonly cited as key to successful implementation. To deliver EBPs to high proportions of the eligible population, projects needed to implement within larger systems.

Community Capacity and Context

- **Key stakeholder champions facilitated EBP implementation in new settings.** The proactive support of decision-makers or influencers expanded a project's reach to new locations or setting types, or allowed them to start implementation more quickly. Some found that champions within settings (e.g., a school superintendent or Parent Teacher Association head) and champions among front-line staff within sites (e.g., teachers within schools) met different needs and were both necessary. A few grantees found that champions at the school district level helped them to integrate EBPs into district-level curriculum plans, increasing the likelihood of sustaining the programs after the grant period.
- **Local policies were an important factor in EBP implementation.** School system policies and state and local standards that presented a need for evidence-based sex education or health curriculum encouraged collaboration between grantees and local systems. In contrast, some local governments or school districts had policies limiting what can be taught. While some grantees who encountered such barriers did not continue to pursue delivering the EBPs in the area or system, others were able to make approved

[2] A "system" is a set of service delivery sites connected by a common governance structure, e.g., a school district, or a health care agency operating a group of clinics. "Site" refers to a specific service delivery location such as an individual school, clinic, or a community center.

adaptations to the EBPs, choose a different EBP, or worked with the community to change the curriculum requirements.

- **Partnering with settings with relatively large and stable youth populations was essential to reach high proportions of youth.** These types of settings were most commonly schools, juvenile detention, and out of home care; community-based/out of school time sites were less likely to have large numbers of consistent youth participants.

Program Infrastructure and Support

- **Experience delivering or hosting EBPs helped ensure implementation as intended.** This included the experience of health educators and sites such as schools and community centers that hosted the EBPs.[3] Experienced health educators were best equipped to set expectations for both the participants and the sites, and familiarity with the EBPs allowed them to maintain fidelity and anticipate challenges. Sites with experience hosting the EBPs were more likely to be aware of coordination needs, approaches to parent and community engagement, and how to engage youth in the material.
- **High capacity partners helped grantees increase reach and serve large communities.** High capacity partners were those with the knowledge, experience, and organizational structure to coordinate with service delivery sites, manage attendance, and deliver EBPs with fidelity. Grantees covering large geographic areas, working in many setting types, and/or delivering multiple EBPs relied heavily on partners. Some grantees found that partner capacity was less than expected, making it difficult to implement EBPs as planned unless they made changes to partnerships and partner roles.
- **Grantees designed training and other supports to increase program quality, fidelity, and community buy-in.** Some projects provided ongoing technical assistance and training for EBP facilitators to increase their skills and keep knowledge fresh after the initial training. Communities of practice (e.g., regular meetings of health educators to discuss what worked well and challenges they had faced) helped them form best practices, increase confidence, and maintain EBP fidelity. Some projects used data from fidelity monitoring and local evaluations to manage performance and fidelity in real time and make improvements. Some projects trained site staff on the EBP curriculum, even if these staff were not responsible for delivering the programs themselves. This training increased their ability to answer questions from youth participants or community members, and increased their motivation to coordinate and maintain EBP delivery schedules.
- **Backbone organizations coordinated EBP planning and implementation to ensure that EBPs were delivered as planned without duplication.** Grantees frequently identified coordination and continuous communication with site staff as essential to full implementation, especially in larger implementations involving several partners and multiple service delivery systems. Some projects designated an organization to serve solely as coordinator and liaison between the project and each site, which helped standardize implementation and reduce burden on health educators and implementation sites.

Partnerships

- **Grantee and partner history and roots in communities facilitated adoption of the EBPs.** Where grantees or their partners had historically collaborated in the community and

[3] "Health educator" refers to any trained professional delivering an EBP, such as community-based organization staff, classroom teachers, or other school staff.

built strong relationships based on trust and mutual benefit, settings and sites were likely to be interested in continuing to collaborate. Grantees often brought on partners, at least in part, because of those partners' strong relationships with particular settings or other key stakeholders.

- **Recruiting and engaging a broad multi-sector CAG around shared goals helped communities reach scale.** Engaged CAG members helped projects identify and recruit new EBP setting types and sites, or improved community awareness and support from previously uninvolved sectors such as the business community. CAG members also helped remove barriers to EBP implementation by troubleshooting with key decision makers.

Evidence-Based Programs

- **Using EBPs that were a good fit helped build buy-in and support for program delivery.** Fit encompassed a wide array of characteristics, including number and length of sessions, curriculum content, focus, and cultural appropriateness. Curricula needed to be of appropriate lengths in order to fit into school schedules and to ensure all sessions could be completed. Well-suited curricula were also engaging for the target population, and aligned with the preferences of the community and settings.
- **Adaptations helped grantees further integrate EBPs into settings.** Many grantees found that approved adaptations to structure (e.g., number or length of sessions, number of participants) or content allowed them to deliver EBPs in key settings.

Community Mobilization

Community mobilization required initial and continual engagement of community members, primarily through CAGs and YLCs, and shared goals among project staff, partners, and community allies. Overall awareness of teen pregnancy in the community, a backbone organization coordinating communication and community mobilization activities, and well-managed and involved CAGs and YLCs were also important facilitators.

Community Capacity and Context

- **Existing networks with complementary goals provided a foundation on which to build mobilization efforts.** Many grantees used existing teen pregnancy prevention coalitions to build CAGs or YLCs. This strategy helped ensure quick startup and engagement with the subject matter, but did not always have the potential for building a multi-sector coalition unless grantees recruited new members. Other grantees joined with existing coalitions focused on related issues, such as substance abuse prevention and school drop-out prevention. Grantees were able to capitalize on community infrastructure focused on improving the health and wellness of its residents and expand coalitions to include teen pregnancy prevention.
- **Community-wide recognition of teen pregnancy facilitated stakeholder participation and support.** Public awareness tended to increase community willingness to host EBPs, participate on CAGs and YLCs, or otherwise support the project. Where the public and key stakeholders did not see teen pregnancy as an issue despite high teen birth rates or disparities, grantees spent time cultivating champions and increasing understanding of the issue through targeted outreach or dissemination.

Program Infrastructure and Support

- **A backbone organization or designated staff member helped ensure a coherent community mobilization strategy and message.** Allocating resources to a central

organization or staff member positioned community mobilization as a core part of the grant strategy. Having individuals with a high level view of each part of the project and related efforts in the community helped clarify mobilization objectives among all stakeholders, curb mission drift, and keep CAGs and YLCs engaged.

Partnerships

- **Fostering engagement for the CAG and YLC was important in mobilizing the community.** Projects fostered engagement by encouraging the CAG and YLC membership to take ownership, being purposeful about meeting facilitation (including using experienced meeting facilitators at the inception of the project), and providing training and development opportunities for members. To help ensure engagement, avoid "committee fatigue," and facilitate scheduling, grantees made sure CAGs had concrete tasks or created empowered topic-oriented working groups. Factors related to YLC success included viewing the group as an essential partner, fostering professionalism through a formal application process, training, or leadership development, and supporting the YLC in developing its own direction.

Linkages and Referrals

Projects that provided strong linkages and referrals tended to have pre-existing easily accessible youth-friendly service providers in the communities, and health educators or setting staff who were able to connect youth with services as part of their routine. Other methods included leveraging complementary community initiatives and assigning a dedicated staff member to support implementation of this element.

Community Capacity and Context

- **The availability of pre-existing youth-friendly services drove the strength of linkages and referrals.** The presence of youth-friendly service providers pre-dating the grant project helped some communities make linkages and establish a referral process relatively quickly and smoothly. The availability of youth-friendly health services and other services for youth was fairly mixed, both between and within grantee service areas. For example, grantees serving multiple counties sometimes reported that one county had multiple options, whereas youth-friendly options were limited in another county. Where availability was limited, health educators had few options for referrals and not enough available and willing providers with whom to cultivate youth-friendly practices.
- **Public transportation, other local supports for transportation, and conveniently located service providers helped strengthen linkages and referrals.** Many grantees noted that locations near youth residences and schools or that were accessible by public transportation were essential for ensuring that services were youth-friendly. Sometimes youth-friendly services existed, but transportation options were limited. Some grantees were able to provide transportation support; one grantee facilitated the move of a key healthcare provider to a more accessible location. However, lack of transportation remained an intractable barrier for many communities.
- **Local norms were important considerations for enhancing linkages and referrals.** Especially in small or close-knit communities, the potential lack of privacy was a challenge to youth seeking services. For example, healthcare provider or pharmacy staff may be neighbors to youth or their family members, making privacy more difficult to achieve and youth less likely to access services.

- **Interactive teen-friendly websites, education campaigns, and well-curated resource guides helped connect youth to services when direct referrals were not possible.** Carefully designed materials and resources, often with the help of the YLC, were particularly important strategies in communities or settings where project staff were not able to make one-on-one referrals to services.

Program Infrastructure and Support

- **Some grantees leveraged existing initiatives to better serve youth and increase linkages.** The grantees whose communities had the most well-connected and teen friendly services tended to be those that joined with related initiatives already underway in the community. For example, several communities already had efforts in place to enhance the youth-friendliness of health service providers through training and technical assistance, fund services youth could not otherwise afford, or fund systematic assessments of youth-friendliness. Grantees incorporated these efforts into the community-wide strategy.
- **Grantees with previous experience providing technical assistance to increase youth friendliness or referring youth to services were better equipped to provide linkages and referrals as part of this project.** Furthermore, projects with a designated staff position focused on implementing linkages and referrals were best able to build networks of actively involved providers or practitioners who were interested in increasing youth friendliness and improving referral processes.
- **Some grantees sought to make "youth-friendly" a desirable status for providers.** These projects focused on making "youth-friendly" a high-status designation by creating professional networks of youth-friendly providers, bringing them together for peer support and professional development, and including them on a publicly available guide only after they passed an assessment. To fully implement this project element, service providers had to be willing to support the assessment of their youth friendliness, make associated changes to practice, and support referrals. For some grantees, establishing formal relationships with service providers through memoranda of understanding helped start a conversation about youth needs.

Safe and Supportive Environments

Providing safe and supportive environments (SSE) for youth involves trained and experienced health educators and partners with understanding and respect for the experiences youth might be facing. Recruiting health educators with a history of working in the EBP settings, leveraging similar initiatives in the community, and creating classroom management policies facilitated safe and supportive environments.

Community Capacity and Context

- **Existing initiatives in the community helped projects support TIA and inclusive environments.** Prior to the start of the grant project, some communities and partner organizations already had experience addressing trauma and supporting inclusivity. For example, all school staff in one grantee's service area school district had already undergone TIA training as part of a broader city-wide initiative and were thus familiar with the concept and rationale.
- **Some grantees needed to consider local policies and norms when planning how to provide SSE.** Communities with norms or rules that limited or precluded certain topics made it difficult to discuss some situations that might arise for youth.

Program Infrastructure and Support

- **Health educator experience and ongoing training helped establish SSE.** Experienced staff or those with a connection to the target community were often best equipped to fully and consistently integrate TIA and inclusivity into how they delivered the EBPs. Their experiences gave them insights into the types of traumatic experiences participating youth may have faced. A nuanced understanding of participants' backgrounds, experiences, and cultures also helped educators incorporate inclusive language and examples in a way that youth were likely to understand and respect. Professional development on these topics and standard training for health educators helped ensure that all staff, regardless of experience, had sufficient knowledge and skills and could apply them consistently toward assuring SSE.
- **Training for setting partners helped create continuity for youth.** Many grantees offered training to setting partner staff, such as teachers, administrators, juvenile court staff, or community-based program staff, because they were in a position to reinforce SSE principles and ensure that youth felt supported outside of the EBP sessions. Other common strategies included communities of practice for health educators, and informal peer support and mentoring on SSE for other setting staff and parents. One grantee raised community awareness and reinforced SSE by opening up training to the general public, including parents as well as people with a formal role in serving youth.
- **Classroom policies and practices set the tone for SSE.** Most health educators routinely set out guidelines at the beginning of class that students did not have to participate in an activity/discussion if they were uncomfortable or stressed. Others designed specific practices or exercises to help youth feel safe and help keep information they shared confidential.
- **Many projects used the YLCs to promote positive youth development for YLC members.** These efforts included providing professional development and training for youth, supporting them in making decisions about the direction of the YLC, and encouraging them to serve as ambassadors of the project to their peers and adults. For example, training could include instruction and support on public speaking, leadership training, and training in disseminating information and results through a variety of media.

Evidence-Based Programs

- **Projects made curricula more trauma-informed, inclusive, and supportive by making adaptations or providing health educators with additional training.** For those EBPs that did not address TIA or inclusivity, grantees implemented minor adaptations to update materials and examples and provided supplemental health educator training on both topics.

Conclusion

This brief provides a summary of key actions grantees took and conditions they used or cultivated in their communities to support the successful implementation of a multi-component, community-wide approach to reducing teen pregnancy in high-need communities during the first two years of full implementation. While each community was unique and grantees tailored implementation approaches accordingly, their collective experiences offer insights into what it takes to prepare communities for long term successful implementation.

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