



OFFICE OF
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Taking Evidence-Based Teen Pregnancy Prevention Programs to Scale in High-Need Communities

Early Implementation of a Multi-Component Approach

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EXECUTIVE SUMMARY

Background

In 2010, the U.S. Department of Health and Human Services, Office of Population Affairs (OPA) launched the Teen Pregnancy Prevention (TPP) Program to fund medically accurate and age appropriate programs focused on preventing teen pregnancy and reducing disparities. OPA supports and evaluates evidence-based (Tier 1) and new or innovative (Tier 2) TPP program models. In 2015, OPA awarded a second round of grants, including the “Tier 1B” grant program, which supported 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 strategy that integrated EBPs into multiple settings and stages of adolescence, mobilized stakeholders around a shared vision, and increased access to youth-friendly services. While implementation varied, all were required to use a multi-component approach that included four key elements:



Evidence-based programs. Deliver EBPs with fidelity in at least three different types of settings.



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 TPP programs are implemented in safe and supportive environments: integrate a trauma-informed approach, assess LGBTQ inclusivity, and put positive youth development characteristics into action.

The Tier 1B Early Implementation Study: Documenting Project Startup

To understand how grantees and their community partners applied the key elements of the Tier 1B strategy, Abt Associates documented the early planning and implementation phase of all Tier 1B grants. The study team conducted 143 semi-structured telephone interviews (all 50 grantee project directors and a purposive sample of 93 community partners) between October 2016 and March 2017. The findings reflect plans and progress made mid-way through the second grant year and first year of full implementation.

Grantees, Communities, and Key Strategies

Grantees and their communities ranged widely. Almost two thirds were non-profit organizations, while most of the remainder were state and local government agencies. Nearly half were located in the southern U.S., and nearly half were serving a large central metro area.

Capacity and reach varied substantially. More than half of the grantees were previously funded by OPA. At the same time, many had no previous federal funding for TPP, and most had never attempted a community-wide approach. Projects received between \$500,000 and \$2 million annually and planned to reach between 700 and 17,550 youth per year, depending on size and funding level.

Community size and grantee capacity shaped project structure. About a third of grantees were solely intermediaries, providing structure and distributing funds to partner organizations to deliver EBPs. About a third acted as both intermediaries and direct service providers, and the remaining third delivered all EBPs themselves. In projects with large areas, sub-awardees were often responsible for implementing in an entire community. Grantees used formal and informal partnerships to add capacity, credibility, and expertise with numbers of formal partners ranging from three to 200 (median of 11 per grantee).

Projects used community advisory structures to widen outreach or ensure that project strategies were appropriate for the community. The most common CAG role was to provide guidance and input for project activities and represent the voice of the community; they also led the community mobilization efforts. The most common YLC role was to raise community awareness and provide input on key project activities. About half of projects formed multiple CAGs and YLCs to represent dispersed communities or support wide participation.

Most projects interpreted “scale” as increasing the number of youth served directly by EBPs, mostly focusing on schools. Scale was primarily accomplished by establishing new, and leveraging existing, partnerships to (1) saturate school districts with EBPs, (2) serve additional youth in non-school settings, and (3) expand to new communities. Projects implemented in an average of four setting, and most delivered EBPs in at least some school settings (i.e., traditional middle and high schools, or alternative schools).

Projects built linkages and referrals through community outreach, and supporting and assessing providers. Common approaches included developing and disseminating resource guides, expanding partnerships to increase referral options, and building the capacity of providers to make them youth-friendly. Several projects engaged the YLC to assess the youth-friendliness of area providers.

Early Conclusions

- While the grant program required a multi-component, community-wide approach, the most practical and effective ways to implement each key element varied based on community readiness, needs, and resources.
- Engaging key community members early, continually, and strategically was important for launching the projects.
- Selecting curricula and strategies that worked for the community meant balancing youth characteristics, community norms, and logistical practicalities.
- Tier 1B grantees successfully built on prior efforts and expanded EBPs to multiple settings using a community-driven, multi-component approach.

1. INTRODUCTION

Despite great progress in reducing rates of teen pregnancy and births in the U.S., large disparities exist across racial and ethnic groups, socioeconomic status, urbanicity, and geographic location.¹ In response, in 2010 the Office of Population Affairs (OPA) launched the Teen Pregnancy Prevention (TPP) Program to fund medically accurate and age appropriate programs focused on preventing teen pregnancy and reducing disparities. OPA supports and evaluates evidence-based (Tier 1) and new or innovative (Tier 2) TPP program models.² In 2015, OPA awarded a second round of grants including the “Tier 1B” grant program, which supported 50 organizations in 31 states and the Marshall Islands to replicate evidence-based programs (EBPs) to scale in communities with the greatest need.

The Tier 1B grants were grounded in a place-based strategy that moved beyond funding and evaluating single program models in single settings to building community capacity to reduce teen pregnancy and birth rates. The community-wide strategy incorporated EBPs into multiple settings, mobilized stakeholders around a shared vision, and increased access to youth-friendly services. By taking programs to scale, OPA intended grant recipients not only to reach greater numbers of youth and families, but also to maximize impact by serving communities and populations with the greatest need, carefully selecting EBPs that best fit the target population, and by making the programs accessible to youth. Replicating to scale also meant saturating the community by implementing the selected intervention(s) in multiple settings through existing systems or networks, ideally reaching youth repeatedly over the course of their adolescence.

1.1 Moving to a community-driven approach

To achieve collective impact (i.e., engaging multiple community sectors to decrease teen pregnancy and births for whole communities), OPA expected Tier 1B grantees to use a community-driven, multi-sector approach for TPP programming.³ While the community context influenced the specific ways a grantee translated the grant requirements, all grantees were required to include the key elements shown in Exhibit 1. Appendix A contains the full logic model depicting the resources, strategies, and pathways through which the elements expected to lead to improved community outcomes. For more detail on the grant requirements, please see the Funding Opportunity Announcement (FOA).⁴

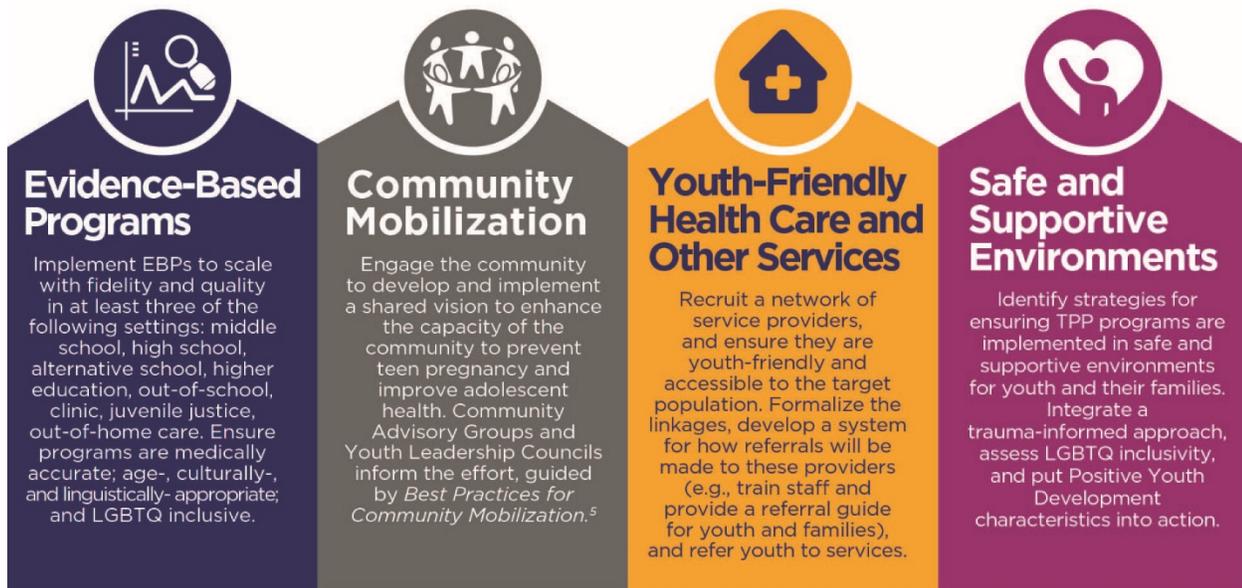
¹ Cox, S., Pazol, K., Warner, L., Romero, L., Spitz, A., Gavin, L., and W. Barfield. (2014). Vital Signs: Births to Teens Aged 15-17 Years – United States, 1991-2012. Center for Disease Control and Prevention, Morbidity and Mortality Weekly Report, April 8, 2014.

² Tier 1 is split into Tier 1A and 1B. Tier 1A grantees build the capacity of youth-serving organizations to implement, evaluate, and sustain evidence-based teen pregnancy prevention programs.

³ The collective impact framework recognizes that no single organization can accomplish large-scale social change alone. The framework emphasizes five factors necessary for success: a common agenda, shared measurement, mutually reinforcing activities, continuous communication, and a backbone organization. Kania, J., and M. Kramer. (2011). "Collective Impact." *Stanford Social Innovation Review* 9, no. 1: 36–41.

⁴ Available at <https://www.hhs.gov/ash/oah/sites/default/files/tier1b-foafile.pdf>

Exhibit 1. Key Required Elements of the OPA Tier 1B Grant Program



Definitions

Project. For this report, a “project” refers to the overall effort under the grant for each grantee.

Setting. The type of environment in which a grantee implements an EBP. For example, “in-school middle school” and “community-based” are settings. Tier 1B grants are required to provide EBPs in at least three different settings.

Site. The specific location of the implementation within a setting. For example, for an “in-school middle school” setting, the site would be a specific middle school.

Community Advisory Group (CAG). There may be one or more CAGs for a given project. These groups may include community leaders, members of organizations working to prevent teen pregnancy and promote healthy adolescent development, and other community stakeholders.

Youth Leadership Council (YLC). There may be one or more YLCs for a given project. These groups are made up of youth in the target population.

⁵ Available at <http://www.advocatesforyouth.org/publications/publications-a-z/2398-strategies-guided-by-best-practice-for-community-mobilization>

1.2 Report overview

This report documents the early planning and implementation phase of the 50 Tier 1B grants, with an emphasis on how grantees and their community partners applied the multi-component approach to lay a foundation for scaling prevention activities over the grant period.

The study team conducted 143 semi-structured telephone interviews with the 50 Tier 1B grantee project directors and with a purposive sample of their implementation partners between October 2016 and March 2017—during the first year of full implementation (July 2016-June 2017) following the planning year (July 2015-June 2016). Typically, for each grantee, we interviewed respondents from two partner organizations—one that delivered EBPs (if applicable) and one that was involved with the CAG, community mobilization, overall coordination, or other components of the project.

Grantee interviews covered the planning and implementation of the multi-component approach of the Tier 1B grant, including: how the grantees were implementing each element; who was involved in these processes (e.g., who was consulted, who made decisions, and what each organization or entity provided and to whom); reasons or goals for each implementation choice and how these decisions evolved; challenges grantees had encountered with each step; and lessons learned up to that point. Each grantee interview lasted about two hours. Partner interviews were tailored to the level of involvement and knowledge of each partner organization, covered all applicable topics, and lasted about 90 minutes.

To supplement the interviews, the study team gathered additional data from the following sources: (1) grantee documentation of the number of formal and informal partners and their roles, and the composition and structure of the CAGs and YLCs; (2) four-page profiles the grantees provided to OPA in late 2016; and (3) a systematic review of the 50 awarded Tier 1B grant applications.

Using data from these four sources, the report describes how the grantees were implementing each element of the project. Section 2 describes the communities and populations participating in the projects. Section 3 describes the development of partnership structures necessary to implement these community-wide projects. Section 4 summarizes grantees' strategies for scaling the EBPs to reach the community as a whole—and what it meant to bring the project to scale. Section 5 presents the settings in which projects were delivering EBPs, the EBPs that projects chose for their communities, and the decision-making processes behind the selections. Section 6 describes strategies projects use to ensure safe and supportive environments for youth. Section 7 presents community mobilization structures and strategies, including the CAGs and YLCs. Section 8 presents community strategies and experiences with linkages and referrals to youth-friendly health services. Lastly, Section 9 describes grantees' early efforts to ensure sustainability, and their plans for future efforts.

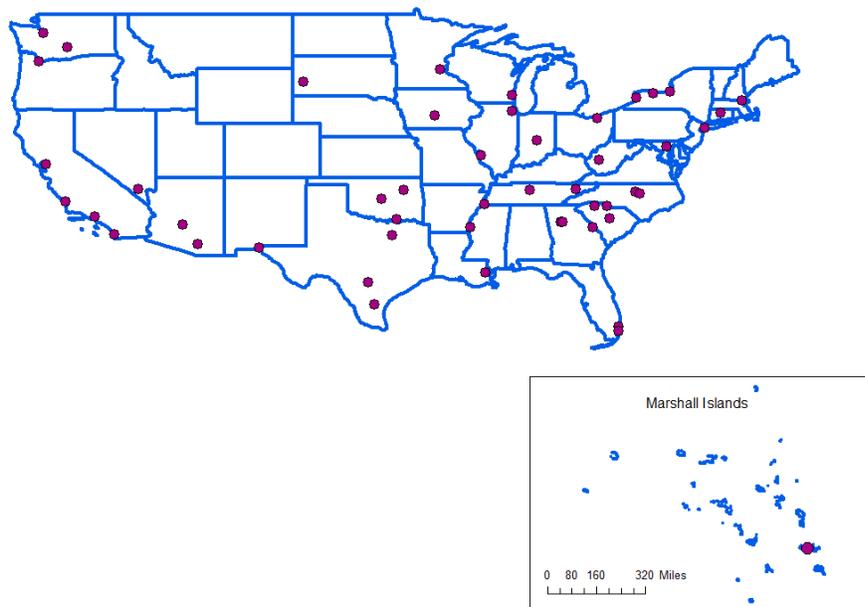
Appendix B contains profiles created for this report that summarize the key characteristics of each grantee's project.

2. THE COMMUNITIES AND POPULATIONS PARTICIPATING IN TIER 1B TPP EFFORTS

Grantees and their community partners were free to designate a single community or multiple communities to be the focus of the grant. Each community must be defined by a geographic boundary that allows grantees to reliably track teen birth rates over time, and have a demonstrated need—at a minimum, teen birth rates above the 2013 national average of 26.6 per 1,000 women aged 15-19. Nearly a third of grantees noted that they also chose communities based on where they or their partners had previously worked and had connections. These pre-existing relationships were important in helping to gain early community buy-in and support for the TPP projects. A substantial number of grantees had previous experience implementing OPA-funded TPP programs (29 grantees) between 2010 and 2015.

The areas in which TPP Tier 1B projects operated varied substantially in terms of geographic region, size, population density, and demographics. There were Tier 1B projects in 31 states and the Marshall Islands, with almost one-half in the southern U.S. Exhibit 2 shows the location of each of the 50 grantees. Typically, grantees were headquartered in or near their target communities for the Tier 1B grant; however, in the case of some grantees, target communities served by an individual grantee were dispersed across multiple counties or states, and grantee locations did not necessarily represent the center or focal point of these communities.

Exhibit 2. Locations of TPP Tier 1B Grantees



Note: Points on the map represent approximate locations where the 50 grantees are headquartered. As stated above, some projects had service areas spanning counties, or operated across multiple states. In addition, some grantees were headquartered near—but not in—their Tier 1B service areas.

All grantees served communities with teen birth rates above the national average. In 2013, the national average was 26.5 births per 1,000 women age 15-19, while the average grantee's target community had a teen birth rate of 51.7. Thirty percent of grantees had target communities with a teen birth rate more than double the national average, and several had rates that were more than triple the national average.

Almost half (24) of the grantees defined their communities as counties (see Exhibit 3 Graph A). The remainder targeted smaller, more densely populated areas, often defined either by city and town boundaries or by ZIP codes. The Graph B shows that most grantees focused on multiple communities—for example, among those focused on counties, the number of counties per grantee ranged from 1 to 53, with an average of six counties. For those that served ZIP codes, grantees worked in an average of 11. Only 13 grantees focused on a single geographic area.

Teen Birth Rates (2013)

U.S.A.: **26.5**

Grantees (average): **51.7**

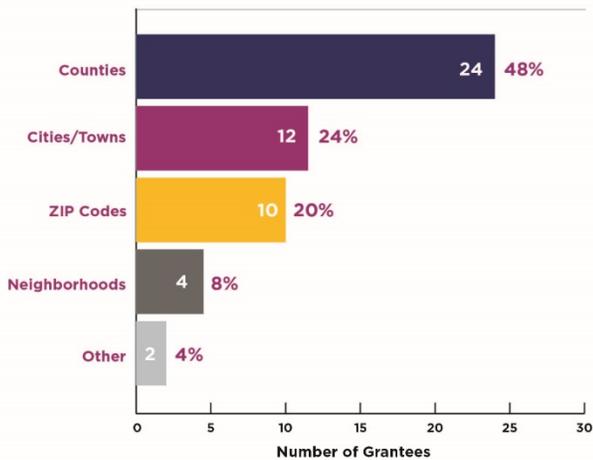
Range among grantees: 31.4-101.5

Note: Teen birth rates are per 1,000 women age 15-19.

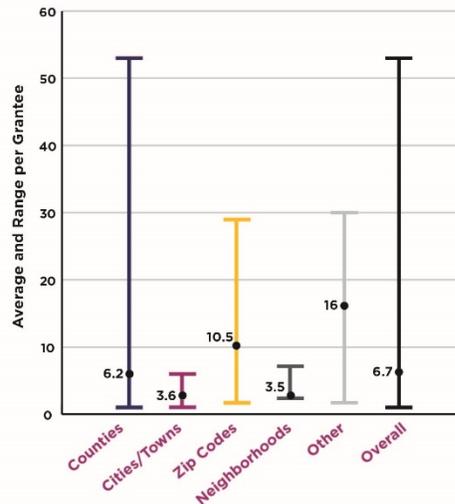
Source: U.S. data is from Martin JA, Hamilton BE, Osterman MJK, et al. Births: Final data for 2013. National vital statistics reports; vol. 64 no 1. Hyattsville, MD: National Center for Health Statistics. 2015. Grantee service area data are estimates derived from averaging teen birth statistics provided in grantees' funding applications. These data are primarily for 2013, with some variation in source and year based on the availability of community-level data.

Exhibit 3. Geographies of the Target Communities

A. How do grantees define their communities?



B. How many geographic areas make up each community?

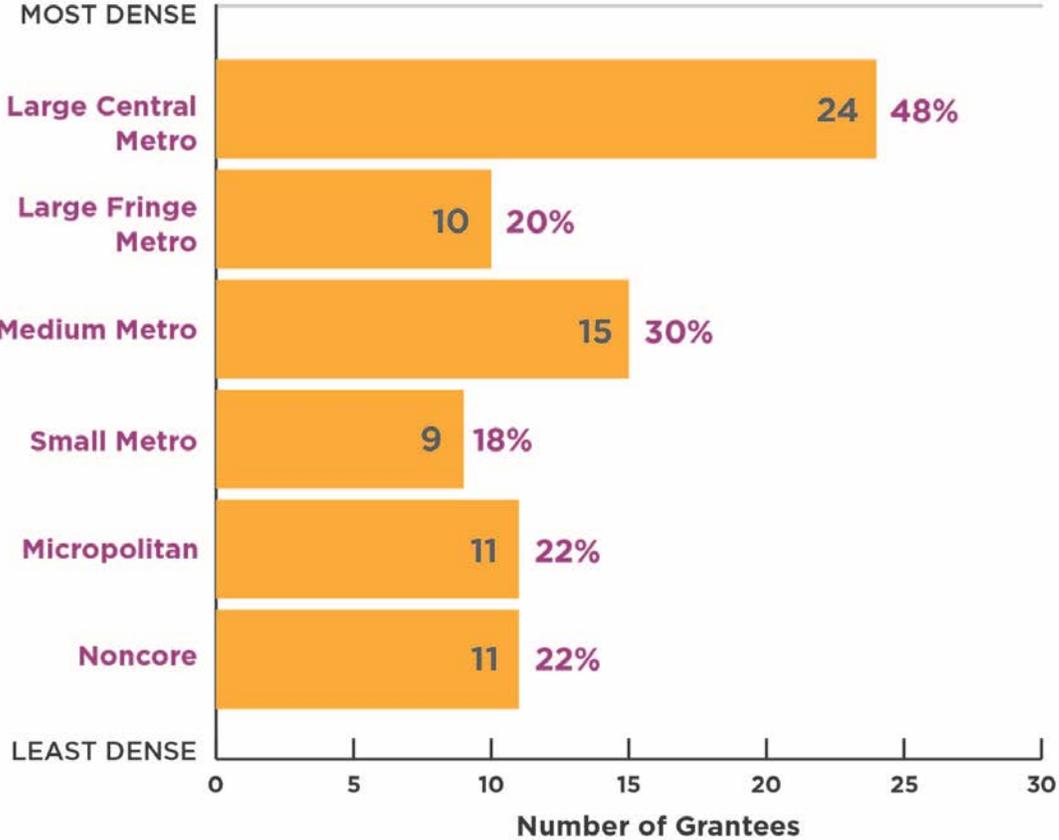


Source: Data provided to authors by grantees, 2016.

Note: "Other" includes Medical Service Study Areas in California and Primary Care Areas in Arizona.

Grantees focused their efforts in both urban and rural communities. While almost one-half of the grantees served urban areas with population centers of one million people or more (large central metro), 32 percent focused their efforts, at least in part, on areas with no large cities or only rural areas (micropolitan or noncore)(see Exhibit 4). Thirty percent of grantees worked in areas that included a mix of urban-rural categories.⁶

Exhibit 4. Urban-Rural Characteristics of Communities



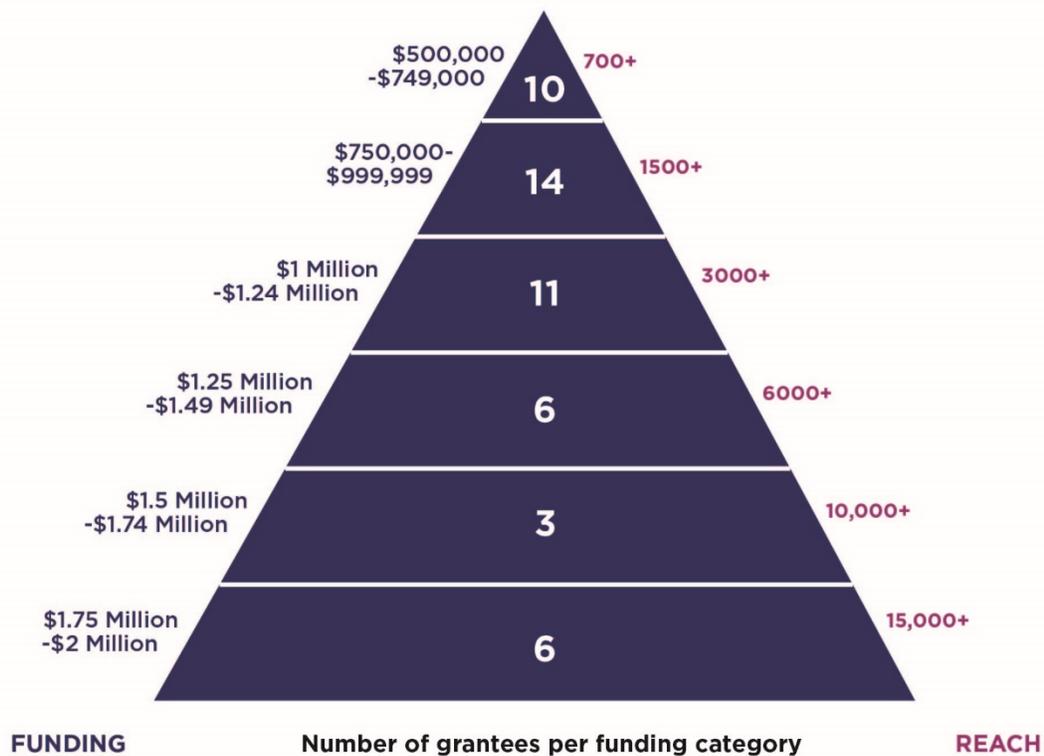
Note: Total is greater than 50 because some grantees’ service areas spanned more than one urbanicity classification. See Footnote 5 and Appendix B for details of the urbanicity classifications.

⁶ The urbanicity classifications are based on the CDC National Center for Health Statistics 2013 Urban–Rural Classification Scheme for Counties. The full definition of each classification is included in the introduction to Appendix B and in the classification report: https://www.cdc.gov/nchs/data/series/sr_02/sr02_166.pdf

2.1 Program reach and target populations

In their grant applications, grantees proposed the number of participants they would reach each year with EBPs.⁷ The proposed reach corresponded to one of six grant funding tiers ranging from \$500,000 to \$2 million. The 50 projects each planned to reach an average of 4,899 unique youth per year (ranging from 700 to 17,550 across grantees), a grand total of nearly 250,000 youth per year across all grantees and communities. About half (24) of the projects received between \$500,000 and \$1 million per year, and aimed to reach between 700 and 3,000 youth per year. These totals do not include youth who may have been exposed to TPP messages through other project elements without participating in an EBP. The numbers of grantees in each reach and funding tier are illustrated in Exhibit 5.

Exhibit 5. Number of Grantees Funded by Annual Reach and Funding Tier

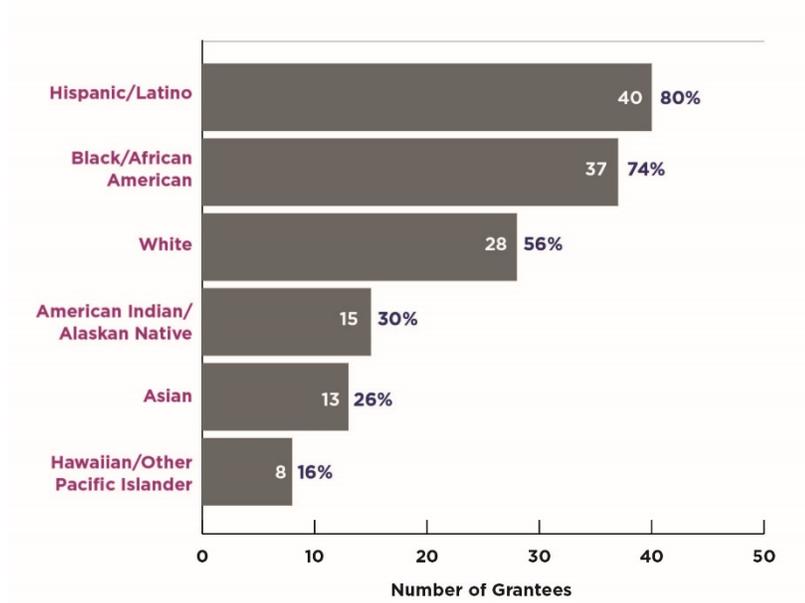


Within each community, grantees often focused on reaching specific populations, defined by either race/ethnicity or status as a member of a vulnerable population, with disproportionately high teen birth rates. Eighty percent of projects focused on Hispanic/Latino youth, and about three quarters focus on black/African American youth. About two-thirds of projects (33 of 50) identified both Hispanic/Latino and black/African American youth as target populations (see Exhibit 6).

⁷ Reach is defined as the number of participants attending at least one session of an EBP during a 12-month period.

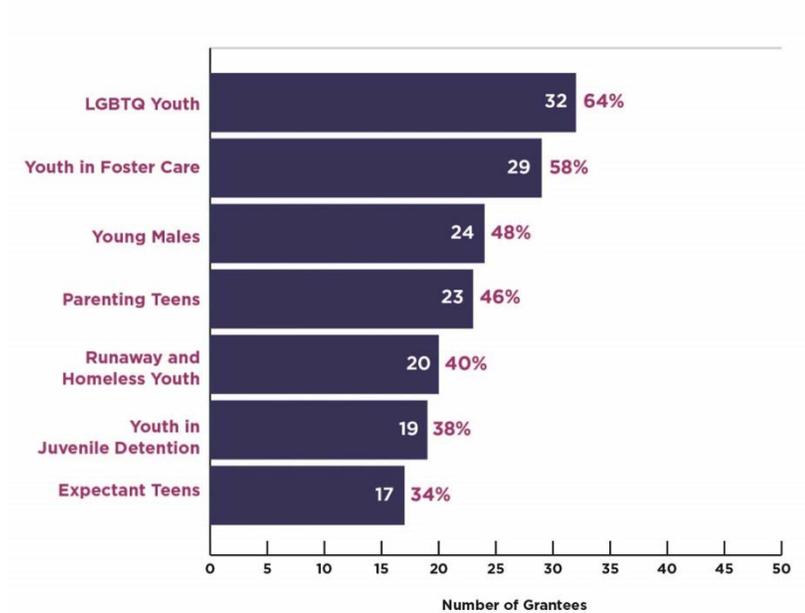
Exhibit 7 shows the proportion of grantees focusing on specific vulnerable populations. Almost two-thirds of the projects had an intentional focus on LGBTQ youth, and almost as many directed their efforts toward youth in foster care. Nearly half of projects focused on boys, and approximately the same number focused on parenting teens.

Exhibit 6. Racial and Ethnic Populations Included in Target Communities



Source: Data provided to OPA by grantees, 2017. Total is greater than 50 because grantees served more than one type of population.

Exhibit 7. Vulnerable Populations Included in Target Communities



Source: Data provided to OPA by grantees, 2017. Total is greater than 50 because grantees served more than one type of population.

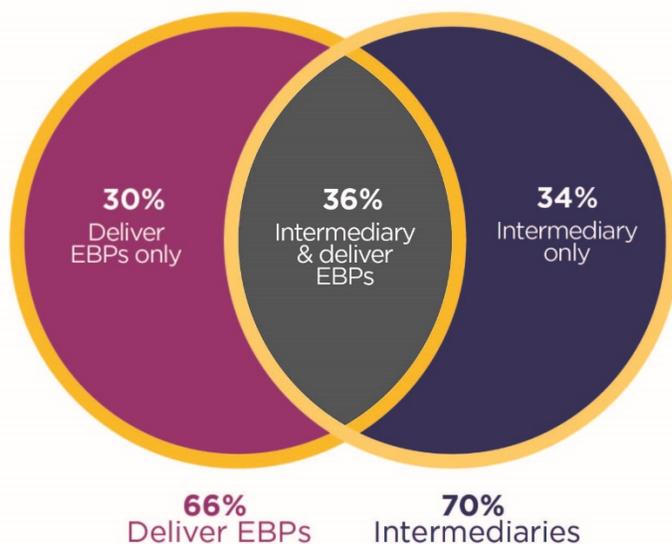
3. DEVELOPING PARTNERSHIP STRUCTURES FOR A COMPLEX INITIATIVE

Complex, community-driven initiatives like the Tier 1B TPP programs require formal and informal partnerships with other organizations. These collaborations add capacity, credibility, and expertise that no single organization could provide alone. The following section describes the varied ways grantees and partners organized themselves to execute the project goals.

3.1 Grantees had varied roles—as intermediaries, direct service providers, or both

The majority of grantees (64 percent) were non-profit community-based organizations operating in or around the target communities. Others were state, local, or tribal governments or agencies (24 percent), universities (6 percent), hospitals or clinics (4 percent), or faith-based organizations (2 percent). While grantees typically served a coordinating role and always served as the entity with fiduciary responsibility, about one-third were solely intermediaries, and distributed funds to partner organizations to deliver the EBPs. Roughly another third delivered the EBPs directly to youth themselves and did not have partners serving in this role (see Exhibit 8). Grantees that delivered the EBPs without additional sub-awardees noted that it was important that they do so because it allowed them to harness their credibility and relationships within the community, and maintain control of the relationships with program delivery settings or over program quality. On the other hand, grantees using the intermediary model believed it is important to have partners within the community deliver the EBPs to build community capacity and ensure that the project was sustainable.

Exhibit 8. Grantee Roles Implementing the Project



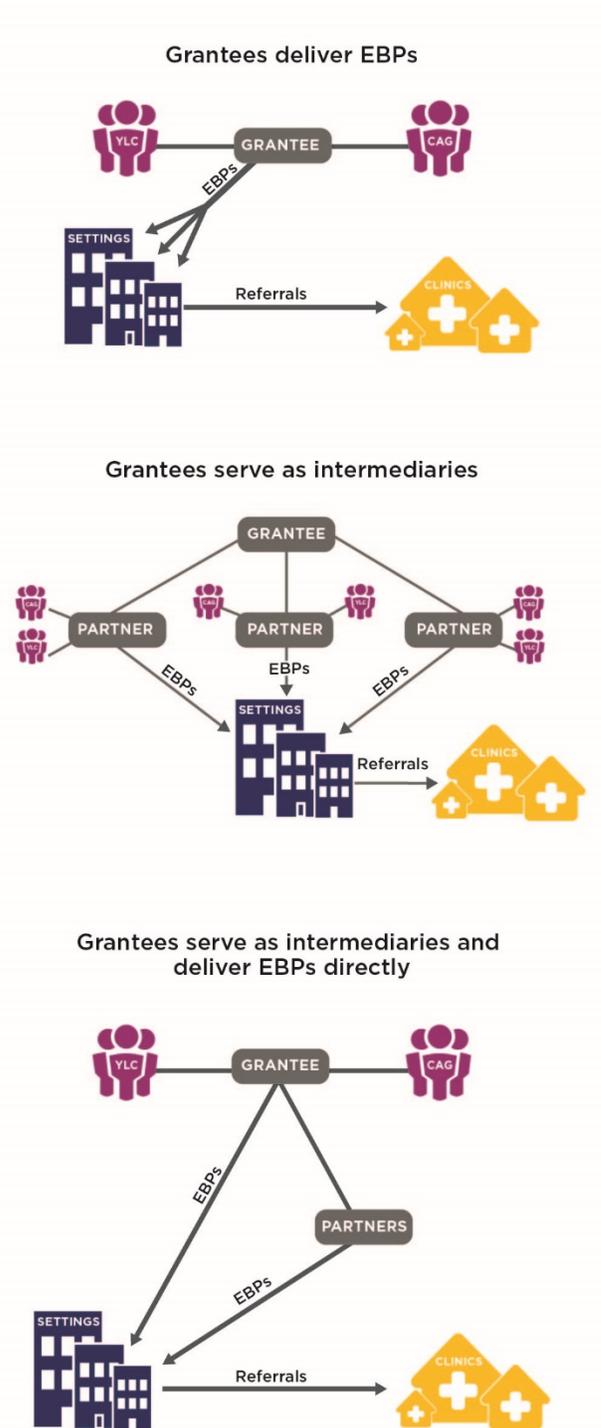
Source: Grantee funding applications.

In addition, nearly half of grantees (all of which serve as intermediaries) described training or technical assistance as part of their role in the project. This typically involved curriculum training for EBPs, refresher training to promote program fidelity, training on adolescent health topics, or inclusivity training to help ensure safe and supportive environments. Several grantees regularly convened implementation partners that delivered the EBPs, to troubleshoot issues, provide training, and establish best practices among health educators.

The three most common implementation structures for Tier 1B projects are illustrated in Exhibit 9.

- A. **Grantees deliver EBPs**, coordinate with multiple settings that host EBPs, generate linkages and referrals to youth-friendly services, and run the CAG and YLC.
- B. **Grantees serve as intermediaries**, working with partners who deliver EBPs in multiple settings, while grantees and/or partners generate linkages and referrals to youth-friendly services. In large geographic areas, partners often are responsible for discrete communities, running separate CAGs and YLCs for each. In smaller areas, it is more common to have a single CAG and YLC facilitated by the grantee or partner.
- C. **Grantees serve as intermediaries and deliver some EBPs directly**, with grantees and partners coordinating multiple settings for EBPs, co-coordinating the CAG and YLC, and generating linkages and referrals to youth-friendly services.

Exhibit 9. Three Common Implementation Structures

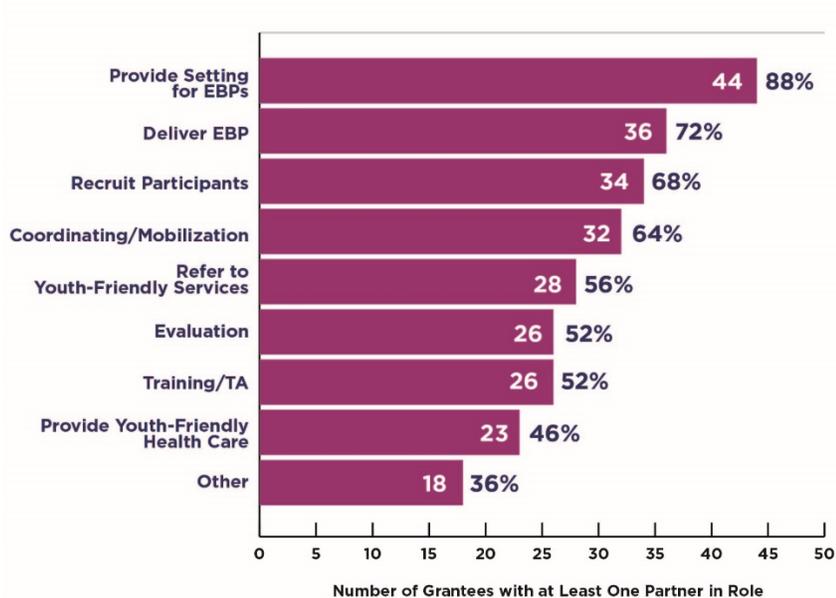


3.2 Partner organizations provided settings for EBPs, delivered EBPs, and helped mobilize the community

Some grantees relied heavily on formal partners, while others undertook most project tasks alone or chose not to formalize relationships with partners.⁸ The number of formal partners per project ranged from three to, in one case, almost 200, and the median number of formal partners was 11.

Formal partnerships with organizations to deliver EBPs were common among grantees (72 percent). These included sub-grants and memoranda of understanding (MOUs). Most grantees (88 percent) had MOUs with one or more partners that provided settings for EBP delivery. Most often, these settings were schools or school districts, and these partners also helped recruit EBP participants. About two-thirds (64 percent) of grantees had partners that supported community mobilization or coordination for the project. These roles included CAG leadership, coordinating with related coalitions, recruiting or managing partners who provide settings or participants for the EBPs, and strategic planning. Several grantees had one or more key partners who co-wrote the grant application with them and took on a strong leadership role, serving as co-grantees in all but name. Exhibit 10 shows the range of roles played by formal partners.

Exhibit 10. Common Roles of Formal Partners



Source: Data provided to authors by grantees, 2016

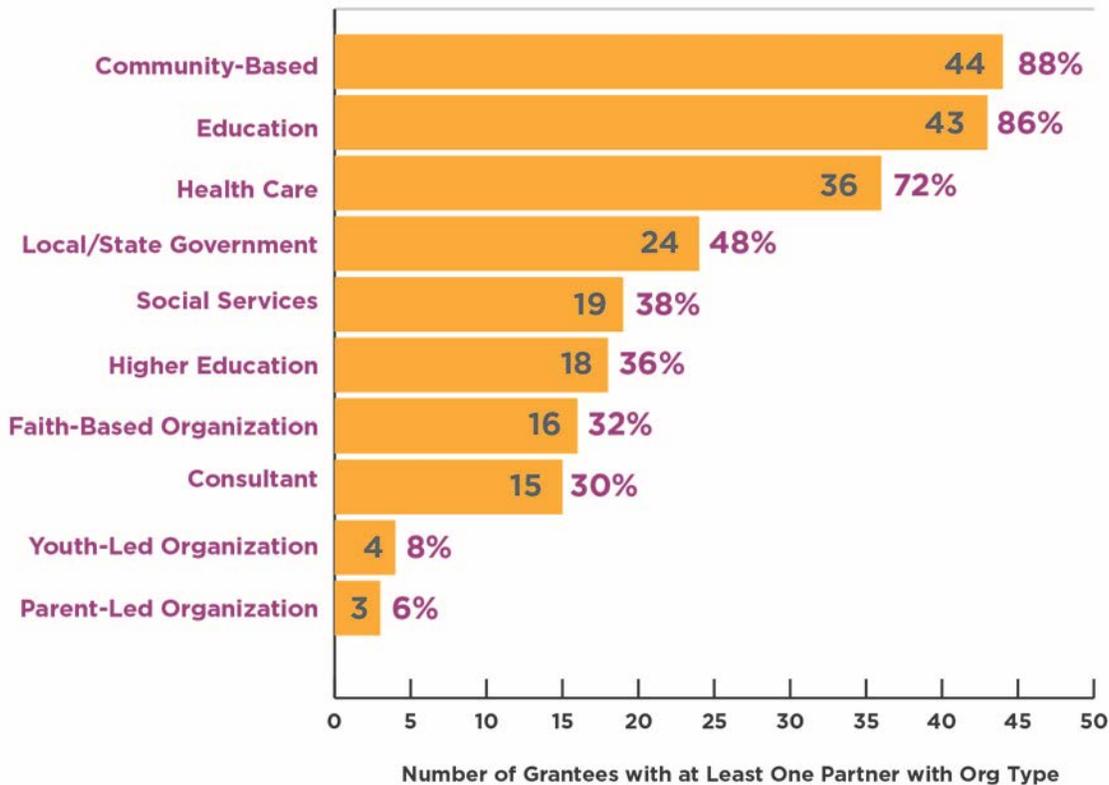
Note: "Other" category includes internal communication support, providing in-kind goods or services, support or resources for dissemination (e.g., providing air-time), and database or IT support and development.

⁸ Formal partners are those that have a formal, documented relationship with the grantee under the grant. Usually, this includes a sub-grant/sub-award, MOU, or other written partnership agreement.

3.3 Grantees most often partnered with community-based organizations, schools, and health care service providers

Grantees engaged with organizations representing a range of community sectors. Most grantees had formal partnerships with community-based organizations (88 percent) and schools or school districts (86 percent; see Exhibit 11). Community-based organizations played a range of roles for the projects and made up most of the formal partners that deliver EBPs. School and school system partners typically provided settings for EBPs and helped recruit participants. In some cases, they were also involved in community mobilization efforts (typically through CAG participation) and, in a few cases, provided EBPs directly to youth. Health care services organizations were also common—almost three quarters (72 percent) of grantees have a formal partnership with at least one. These organizations provided youth-friendly health care and may have provided settings for EBPs, training or TA, or mobilization/coordination support through the CAG or other community involvement. Exhibit 11 shows the range of sectors represented by formal partners across grantees.

Exhibit 11. Formal Partner Organization Types



Source: Data provided to authors by grantees, 2016.

3.4 Informal partners helped establish and operate the projects

It was very common for grantees (70 percent) to have at least one informal partner that played a mobilizing, coordinating, or leadership role for the project. Some grantees had over a dozen partners that did not have a formal contractual relationship with the project but that were nevertheless important to its success. Examples of informal partner roles included CAG leadership and participation, using influence and networks to build support for the project (such as obtaining permission to provide EBPs in settings), informally coordinating other partners, and participating in discussions and decision-making related to the project's overall strategies and goals.

Almost half the grantees (46 percent) had at least one informal partner providing youth-friendly health care services essential to the project. In some cases, these providers also served on the CAG or provided referrals to youth for additional services that they were unable to provide. Forty percent of grantees used informal partners to provide training or technical assistance on topics such as ensuring safe and supportive environments, providing services to LGBTQ youth, or improving the availability and quality of youth-friendly health care services in the community. Less common roles were providing settings, recruiting EBP participants, and referring youth to youth-friendly services.

3.5 Grantees considered multiple factors when selecting partners

Most grantees chose their partners for a combination of strategic reasons that allowed them to work smoothly together and to strengthen the community effort. Factors that grantees considered when forming their partnerships included:

Pre-existing positive relationships between partners and grantees. About one-third of grantees mentioned that they had previous positive working relationships with their partners and knew that it would work well to partner with them again. These relationships allowed them to ensure collaborative partnerships, coming from a point of trust and confidence in the partners' abilities. In addition, these existing relationships helped both the partners and the grantees make progress quickly and work together smoothly, without a lot of hiccups and false starts.

"We had an existing network, and it was easy to dig into [it] and get specific outreach to the ZIP codes of the TPP grant. We tend to convene people pretty regularly, like every month, through additional workshops. So that helps for communication purposes. People are accustomed to hearing from us."—Grantee

Teen pregnancy prevention experience in the targeted communities. About one-third of grantees mentioned that they wanted partners who had experience doing TPP work in their communities successfully. Furthermore, partners with TPP experience were attracted to the project because they wanted to scale up their previous work with the help of federal grant resources and the support of the grantee.

"We look at their mission [and] vision, their target audience, and their purpose. We essentially use that to determine a good fit. And oftentimes it has been my experience that there is some commonality there that we can work with because at the end of the day, they want children to succeed."—Grantee

Shared mission and commitment to improve outcomes for youth. About one-third of grantees mentioned the importance of potential partners having a vested interest in and willingness to take on TPP work. This was sometimes sufficient reason to take on a partner even if the partner in question did not have prior experience in TPP work, though this was less often the case for partners that have responsibility for delivering the EBPs.

Access to youth or specific capabilities. Given the focus on scaling, several grantees recruited partners specifically because of their access to large numbers of youth (often school districts or large youth-serving programs) or a specific youth sub-population. Grantees also chose partners because of specific skills or experience those partners brought to the table, including community mobilization and convening organizations.

Participation in existing collaboratives. In some cases, grantees chose partners from a pool of organizations that were members of an existing network or consortium already established in the community to address issues around teen pregnancy prevention or youth health and well-being more generally. For example, a grantee that belonged to a regional partnership to support youth noted, “We have partners who serve on different strategy teams, so it was easy to pick out those partners who are youth serving agencies, looking at ages 13-19 and then [see] if they are working with teen pregnancy.”

Fresh perspectives. Notably, some grantees wanted to go beyond their typical base of partners, especially in forming and growing the CAG. Relying on partners who had historically worked on TPP limited the sectors of the community they could mobilize. Because traditional TPP partners often came with pre-established ideas of how to provide TPP programming in the community, they may also have been less open to new strategies, or may not have been fully engaged.

“Our current CAG is really ‘safe’ so we need to continue to build on that and invite business partners to the table and diversify ourselves a little more.”—Grantee

Entrée to a community. Helping to build community buy-in was an essential asset that partners brought to the table. Grantees often recruited partners whose community relationships could help the project gain access to particular settings and community champions. These connections allowed the TPP effort to build on an established foundation of trust and credibility rather than being seen as an outsider.

3.6 Expanding reach and engaging the community required new partnerships

In most cases, grantees decided to include partner organizations with which they had not worked previously on teen pregnancy prevention. A key purpose of these new partnerships was to serve more youth with the EBPs than the grantees or communities had served previously. Specific reasons for establishing new partnerships were to incorporate new settings, expand service delivery capacity, and launch a new effort.

Many grantees engaged new partners to add settings for EBPs. The majority of grantees formed new partnerships with entities that could provide additional places for evidence-based programming in an effort to serve more youth than they had previously with TPP or other initiatives. These were often schools or school districts, clinics, community-based organizations, or local government entities. Community-based organizations and government

partners typically were those with access to youth in the juvenile justice system or homeless youth. In many cases, partners who provided settings for the EBPs helped recruit or assemble EBP participants, and may have participated on the CAG to provide settings' perspectives, but did not serve any additional roles on the Tier 1B project.

Some grantees formed new partnerships to expand service capacity. Grantees also took on new partnerships to add staff capacity to deliver the EBPs. Others continued to work with pre-existing partners who had either hired new staff to help scale the EBPs, were centering more of their existing resources on EBPs than they have previously, or were previous partners in other capacities.

Some grantees required new partnerships to launch a new effort. For the minority of grantees with little history of TPP work in the target communities, establishing new partnerships was a major part of starting the project. In one example, the grantee identified and recruited local organizations and individual stakeholders already doing this work, and engaged them heavily in the process of designing the project and forming different elements of the strategy. Even those grantees who already had a history of providing TPP programming in their target communities often needed to establish a CAG for the first time, which may have meant forging new informal or formal partnerships with over a dozen organizations. Moreover, even when the CAG was a pre-existing body, new partnerships were often needed to recruit members beyond those who usually conducted TPP or youth development work in the community.

4. SCALING THE PROJECTS TO SERVE WHOLE COMMUNITIES

Implementing EBPs to scale means expanding the reach of programs with the aim of increasing impact. That is, the goal is not to simply serve greater numbers, but to have the greatest impact by selecting high-need communities and populations, ensuring the EBPs are a good match to the communities, and breaking down barriers to participation (FOA, p.15). OPA guidance specifies that, to successfully bring the effort to scale, youth should ideally receive EBPs repeatedly over the course of their adolescence, and the information provided should be “sequential, consistent, and reinforcing” (FOA, p. 21). The requirement to provide the EBPs in multiple settings can allow grantees to reach the same youth multiple times, if the settings are selected with this in mind.

For many grantees and their selected communities, the Tier 1B project was the first grant they had with the explicit goal of scaling up programming to impact community-level teen pregnancy and birth rates. Most grantees’ prior experience with TPP was limited to serving specific classrooms or community programs with EBPs or other curricula. The following section describes how grantees and partners interpreted the OPA guidance to bring programs to scale, which is closely tied with how they see the goals of the project itself, and early challenges related to scaling up.

The ways that grantees interpreted and applied the meaning of scale in the early stages of the grants fell along five key overlapping dimensions: expanding reach, saturating settings, serving multiple settings and time points, community mobilization and outreach, and program fit and fidelity.

4.1 Most projects defined “scale” as expanding program reach

Grantees and partners interpreted scale most often as increasing the numbers of youth they plan to serve directly through the EBPs. To accomplish this, they expanded via three primary mechanisms:

- **Many projects established new partnerships to serve more youth with EBPs.** As described above, in some cases, this meant expanding reach within a setting by adding more locations (sites), including new school districts or schools, or adding new community sites or clinics. In other cases, this meant targeting new settings such as juvenile courts. New partnerships could also add staff capacity to deliver EBPs.
- **Some projects served youth in new and expanded areas where the grantees or core partners had not previously worked.** Expanding their service areas for the project usually also meant that the grantee and other organizations with a leading role in the project needed to make new connections, either by taking on new partners with experience working in the new area or by connecting with new setting partners. In some instances, the target geographic areas had shifted from where grantees had previously been working because the teen birth rates in those areas were no longer above the national average. In a few cases, local communities or school districts heard about the project and reached out to the grantees or partners to request that they be allowed to participate.

- **Several grantees leveraged relationships with existing partners to reach more youth.** How this looked in the community varies from project to project. Projects that were extensions or expansions of previous projects that provided EBPs were serving more youth than they have previously, yet the majority of grantees were partnering only with organizations with which they have worked in the past. To serve more youth, many grantees were either working with more partners at a time to deliver EBPs than they have previously, asking partners to take on a higher workload, or working with partners in a different capacity than they have previously.

4.2 Many projects planned to saturate a setting or service delivery system to achieve scale

Another approach to achieving scale was to deliver EBPs to all sites within a setting type or service delivery system. For example, saturating a middle school setting means serving all youth in 6th and 8th grade in all middle school sites in the target community. Most projects sought to saturate at least one setting type.⁹ In practice, grantees found this ideal difficult to realize, especially when they served large areas or multiple school districts or service delivery systems within the target communities. During the first year of full implementation, approximately one-third of grantees had program delivery in place to fully saturate key settings (this almost always meant school settings). A slightly smaller share had not yet reached saturation in key systems, but felt that they were still somewhat likely to achieve it by the end of a five-year grant period. Nearly half of grantees said they were unlikely to achieve full saturation in key settings or service delivery systems.

The most common challenge to achieving saturation of a setting type was gaining approval to implement in all of the sites or components of the service delivery system—for example, a resistant school board or superintendent. Several projects also found that, while they had approval at the highest level to provide the EBPs system-wide, individual schools, principals, and teachers had yet to buy in. Challenges gaining access to schools were common, even for projects that have ultimately been able to implement in all of the intended schools.

***"One of the things that we have noticed is that we have an MOU at the superintendent level, but the teachers play a huge role in recruitment and retention and they don't want to give up a full day a week for us to come in. They might not want to give up instruction time, so they are hesitant at times."*—Grantee**

In some cases, grantee and partner organizations may have been seen as outsiders, and school decision-makers were either unwilling to give them a chance or simply did not want any outside agencies providing services to their students.

A second challenge was limited capacity to serve large areas and systems. Several grantees indicated that saturation was likely not possible, given the size of the service delivery systems in their communities and the resources they had available. A few tried to overcome this by training classroom teachers to provide the EBPs, but most of them had not fully implemented these plans at the time of the interviews. Many did not plan to have teachers deliver EBPs during the grant period but did plan to train teachers on the EBPs as a long-term strategy to aid sustainability and saturation. A serious but less common challenge was cuts to school

⁹ Grantees almost always mentioned saturation in the context of in-school settings rather than other service delivery systems such as clinics, after school programs, or the juvenile justice system.

resources, resulting in fewer time slots for EBPs or fewer school staff to support the effort. At least one grantee had not been able to implement in schools in particular parts of the targeted community for this reason.

4.3 Implementing in a variety of settings was seen as more essential to scaling than reaching youth repeatedly

A key mechanism of scaling described by OPA involved reaching youth at multiple points in time. The FOA to which grantees responded in applying for this grant stated explicitly that:

“To have a lasting effect on reducing rates of teen pregnancy and disparities, youth should receive evidence-based TPP programs at multiple times over the course of their adolescence, and the information provided should be sequential, consistent, and reinforcing. Implementation of a single evidence-based TPP program at a single point in time is likely insufficient to prevent teen pregnancy, STIs, and HIV for the long-term.” (pg. 13)

However, while OPA encouraged grantees to serve youth repeatedly throughout adolescence, this was not a requirement. Thus, approaches to reaching youth in multiple settings and multiple points in time varied. Grantees described three main strategies: (1) delivering EBPs in multiple grade years in schools, (2) using non-school settings to reach different youth, and (3) using non-school settings to reinforce the message with the same youth.

Less than half of the grantees reported that their implementation plan was specifically designed to reach youth repeatedly throughout their adolescence. Of those that did, most aimed to do so by delivering the EBPs in multiple grade years in middle and high school. For projects that have fully saturated school systems or school feeder patterns, this strategy ensured that youth received the EBPs multiple times, depending on their age at the beginning of the grant. The longer the project or EBPs were in continuous operation, the more likely it was that youth would be reached repeatedly. Providing the EBPs in multiple grade years also made it more likely that highly mobile youth would receive the program at least once. A grantee who planned to integrate the EBPs fully within the school system and deliver it in 6th, 7th, and 8th grade plus 9th and 11th grade explained the strategy:

“I heard from one of our high schools in the previous round [of funding] that high school was too late, so felt like we had to hone in on a middle school approach and see the sequential approach. We saw there was knowledge lost in the subject matter over time. So we wanted to see the sequence for them of dosage in 6th, 7th and 8th grade and a different curriculum in 9th and 11th grade. So that’s how we envisioned it.” —Grantee

Grantees generally used settings other than schools as a way to reach youth who had dropped out of school, had been incarcerated, or were otherwise unreachable in a school setting, rather than to reach the same adolescents in different settings. These grantees focused on using multiple settings to reach as many youth as possible with limited resources. Several grantees specifically noted that while they hoped some of the same youth received the EBPs in multiple settings, this was not an intentional strategy.

“We are aware that some of the youth are only going to get the intervention one time. In theory, we are hoping youth will get the intervention at the middle school level, high school level, and they can get it again in the community.”—Grantee

"Youth should get this information in 9th grade health [through the project's EBPs], but also after that and in youth centers they go to after school. It's important to be embedded into structures where students learn and where they experience things."—Grantee

A few grantees saw serving youth in multiple settings as closely tied to reaching the same youth repeatedly. These grantees aimed to reach the same youth in different community contexts to reinforce the messages of the EBPs. For these grantees, reaching youth both in and out of school was an intentional strategy to ensure that the programs would touch different parts of participants' lives.

4.4 Mobilizing the community or raising awareness about the importance of TPP was a key aspect of scale

Another dimension of scale articulated by grantees was community mobilization; grantees had a range of views on its role in the scale-up process. For some, engaging the community allowed them to ensure that the EBPs were a good fit for the community. Others focused on how increasing community engagement is necessary to reach youth in new settings. Engaging the community fully and reaching scale also meant building community capacity to provide EBPs and other services, which sometimes included fully integrating the EBPs within systems (for example, institutionalizing EBPs through schools or in all clinics). Other grantees saw community mobilization as a necessary part of changing community norms and ensuring that youth feel safe and supported in reaching out for resources or making positive choices.

For some projects, community mobilization strategies focused primarily on building capacity of the CAG or other coalitions or networks in their areas, but many discussed direct outreach to individual stakeholders, or engaging health educators and partners to harness their own networks, attend public stakeholder events, and forge community connections. A grantee explained the health educators' broader role:

"[In addition to reaching a large number of youth in the community with the EBPs with fidelity], it [bringing to scale] means bringing teen pregnancy numbers down and approaching it with a community view. It's not just implementing a program. ... It's addressing the overall problem, taking a community approach—what kind of community norms do we need in order to change the way people look at teen pregnancy? And, ultimately, change the rates [of teen pregnancy], having youth feel more supported, and knowing about resources that are friendly to them and usable."—Grantee

"Bringing to scale means going into communities, not just to be an educator, but you are now the community's ambassador of knowledge, of information, of bringing medically accurate information. Being present at community events, school advisory committee meetings, parks and rec, different things happening in the community. Connecting to [...] committees."—Grantee

In addition to mobilizing the community through the CAGs and YLCs, many projects worked to reach community members who are not participating in EBPs, through direct contact. This included three types of outreach strategies:

- **Focus on engaging parents to increase impact.** Projects engaged parents not only to participate in community-level support, multi-generational programming, and parent-focused EBPs, but also to help recruit youth for EBPs; and encouraged parents to communicate with and support their own children. Some respondents noted that parents have historically been a source of sex education for youth, so engaging them was essential to reach youth and ensure that parents are comfortable with their children’s participation in the EBPs.
- **Using “youth ambassadors” to share information and recruit participants.** Respondents from a few projects mentioned cultivating “youth ambassadors,” through the YLC or other leadership groups, to serve as peer educators and provide information about the project to other youth in their schools and communities. For example, these youth may have spoken at school assemblies, referred other youth to community settings to participate in EBPs, or served as sources of medically accurate information for their peers.
- **Providing information outside of the EBPs and using community events to recruit participants.** Respondents for several projects described reaching out to youth directly outside of the EBPs through providing information at tables or booths at health events and festivals. These events served not only to help recruit youth to participate in EBPs and/or the YLC, but also to raise awareness of issues around teen pregnancy, teen pregnancy prevention, and how youth can access resources. For example, one project came to a Head Start program to reach young parents and provided food and toys.

“When we try to reach parents, we are also trying to reach youth. That’s why we want community champions to meet and make contact with parents in their neighborhoods, to get their children involved in the program.”—Partner organization

4.5 Ensuring fit and fidelity was an essential part of scaling for many grantees

Lastly, for about a third of grantees replicating the EBPs to scale meant not just serving more youth or serving youth in different contexts, but serving them most effectively through ensuring good program fit, compassionate and engaged facilitation, and/or fidelity to the curriculum. For these grantees, replicating to scale meant not just reaching more youth, but delivering the full breadth and depth of the information in the curricula with accuracy. Grantees’ strategies for ensuring fidelity are described in Section 5.9.

“[Replicating the EBPs to scale means] replicating the EBPs, doing it with fidelity. Making sure we are following the curriculum will give the youth that we are targeting the information they will need to make informed decisions about their bodies and about their health.”—Grantee

Most Partner Organizations Viewed the Project as Having Multiple Goals Beyond Expanding Reach

The majority of partners saw the goal as more nuanced than serving more youth with the EBPs. Most partners saw other key strategies—such as saturation, or delivering the EBPs to more youth with fidelity—as part of the goal.

In general, partners tended to view project goals in terms of their own roles or tasks. For example, partners whose sole or primary role was delivering the EBPs to youth were likely to see the goals of the project most strongly in terms of equipping individual youth with skills and knowledge to make positive choices. Partners who were members of clinics, county health departments, or youth-serving organizations focused on youth and child health were more likely to include helping youth access services beyond the EBPs (primarily reproductive health care) as goals of the project.

4.6 Scaling challenges and early lessons

Projects faced a range of hurdles in launching their scale-up efforts. As noted above, many were either not allowed to implement in key settings or sites, or encountered local culture or structures that were cautious or insular. Both of these types of challenges much more commonly affected efforts to implement the EBPs in school settings rather than in other types of settings in the community. Other challenges centered on the scope of the project, partner capacity, finding the right EBP, and retaining participants in non-school settings.

The Tier 1B project had a more extensive scope than some grantees have previously experienced. Coordinating all of the elements of the strategy, partners, and settings required a steep learning curve for some grantees. In a few cases, grantees were not initially aware of the extent of what was required by each of the elements of a Tier 1B project.

In addition to the multiple elements, the sheer size of the implementation presented coordination and oversight challenges. For example, one grantee noted that just one of their many partners was implementing in nearly a dozen middle schools, so keeping actively engaged and aware of each partner's recruitment and attendance targets in each site and setting was demanding. This coordination and communication was particularly challenging for communities with high reach targets, or communities in rural areas or that were otherwise geographically spread out.

"It is just pulling together the strings, making sure everything is where it is supposed to be. It is difficult and challenging, but we are dedicated to make this happen. [...] We are making sure everyone is on board and communicating. There are so many parts."—Grantee

"With hindsight of the pilot year, we understood through the RFP that replication was not just reaching more youth but also the community engagement piece. We didn't understand how extensive that was, and have gotten a sense of this from OPA as the year went on. The health care linkages piece is a challenge for school-based settings."—Grantee

Limited partner capacity made implementation more difficult for some grantees.

Grantees covering large geographic areas, working in many settings, and/or delivering multiple EBPs relied heavily on partners. A minority of grantees faced substantial challenges with the capabilities of their partners, which delayed or threatened their ability to reach full scale. In a few cases, key partners dropped off entirely, usually because of internal difficulties within the partner agencies. This required those grantees to act quickly to engage new or existing partners to fill the gap, or to shift resources among their own staff. One grantee dropped a few partner organizations during the planning year because of “their [lack of] infrastructure and willingness to maintain fidelity.” Other grantees that had not lost or let go of partners nevertheless faced capacity challenges with some of their partners, and spent time providing them technical assistance. Another grantee said that some of their setting partners did not understand the importance of structure and punctuality for the EBPs, which has made scheduling and implementation of the EBPs difficult.

“To do this with fidelity, the people in the setting have to get there on time. Some partners are not aware of the need for timing. ...Our internal educator acts as lead and tries to corral people.”
—Grantee

A handful of grantees also noted that staff turnover within partner or grantee organizations posed a challenge, because it meant they must offer ongoing EBP training to ensure quality and continuity for the new staff—additional training for which some grantees had not planned.

Finding the right EBP fit takes time. Several projects also found during the planning year that the EBPs they had initially chosen to scale up were not the right fit for the settings because of logistical or scheduling considerations. Changing or adapting EBPs set them behind schedule in cases where grantees had intended to use the planning year to ramp up the EBPs prior to the first full year of implementation (rather than simply to pilot the EBPs and other project components for fit). For example, a grantee noted that several sites were unable to accommodate the EBP they had initially selected, which was a 12-16 week intervention. They had to move to different curricula that they had not originally planned because these curricula either were preferred by community stakeholders or allowed them to engage with school- or faith-based settings that would otherwise not be willing to participate.

Recruitment and retention of youth in community settings. Several projects mentioned that retention in some non-school settings posed a substantial challenge to implementing at scale. This was especially the case in settings where the EBPs were not tied to other programs or services that had a steady set of participants, but instead had different youth dropping in on an unpredictable basis. Retention was also typically difficult to achieve in settings that serve the most vulnerable youth, such as those experiencing homelessness.

“With the high-risk side of it, some of the barriers they are experiencing is a lot of turnover—kids are in and out or sent elsewhere.”—Grantee

Projects also experienced retention problems in certain in-school settings where student mobility is high. Providing transportation or incentives could sometimes help retain participants in EBPs, but in a few cases projects faced with seemingly unsurmountable challenges to recruitment and retention switched focus to higher-yield, more reliable settings.

5. DELIVERING EVIDENCE-BASED PROGRAMS IN MULTIPLE SETTINGS

As a requirement of the grant, Tier1B projects had to provide EBPs across at least three different types of settings. As discussed above, reaching youth and families in multiple settings has a few different purposes:

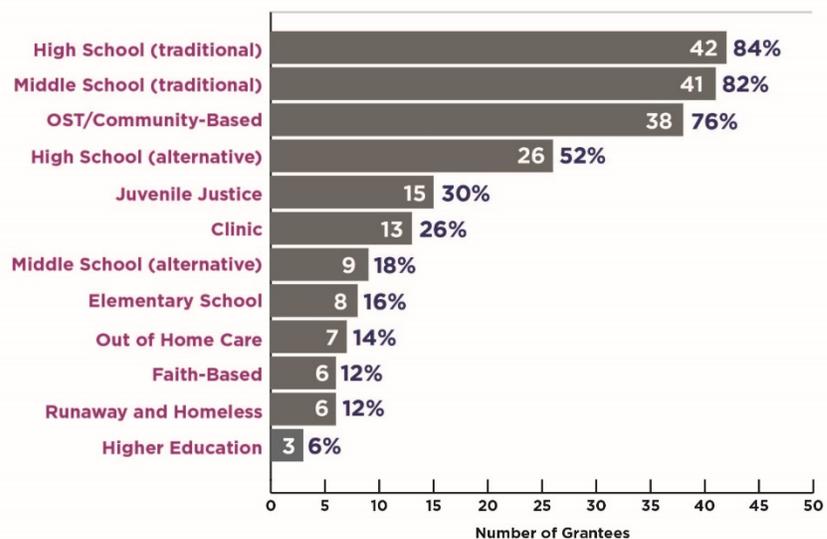
- (1) To reach youth repeatedly, at different developmental stages during adolescence
- (2) To reach youth in multiple contexts with a consistent reinforcing message
- (3) To reach all youth, especially those who would not necessarily be accessible or willing to participate in a single setting

While some projects selected setting types with the first two aims in mind, most chose settings primarily as a way to expand opportunities to reach more youth with EBPs. Below, we describe the most common settings, how grantees chose settings, and challenges associated with selecting and implementing in particular settings. The section closes with an overview of the range of EBPs selected by grantees and their partners, processes for choosing them and improving fit, and approaches to ensuring fidelity and quality at scale.

5.1 In-school settings were the most common, followed by out-of-school time/community-based

Exhibit 12 shows the setting types defined by OPA and the percentage of grantees that chose each, based on their plans as of summer 2017. Most projects delivered EBPs in traditional public or charter in-school settings – middle schools (82 percent) and high schools (84 percent). Out-of-school time/community-based, which included after-school and community-based settings, was also a popular choice. Grantees implemented in an average of four setting types, ranging from two to up to eight different settings.¹⁰

Exhibit 12. Grantees Delivering EBPs in Each Setting



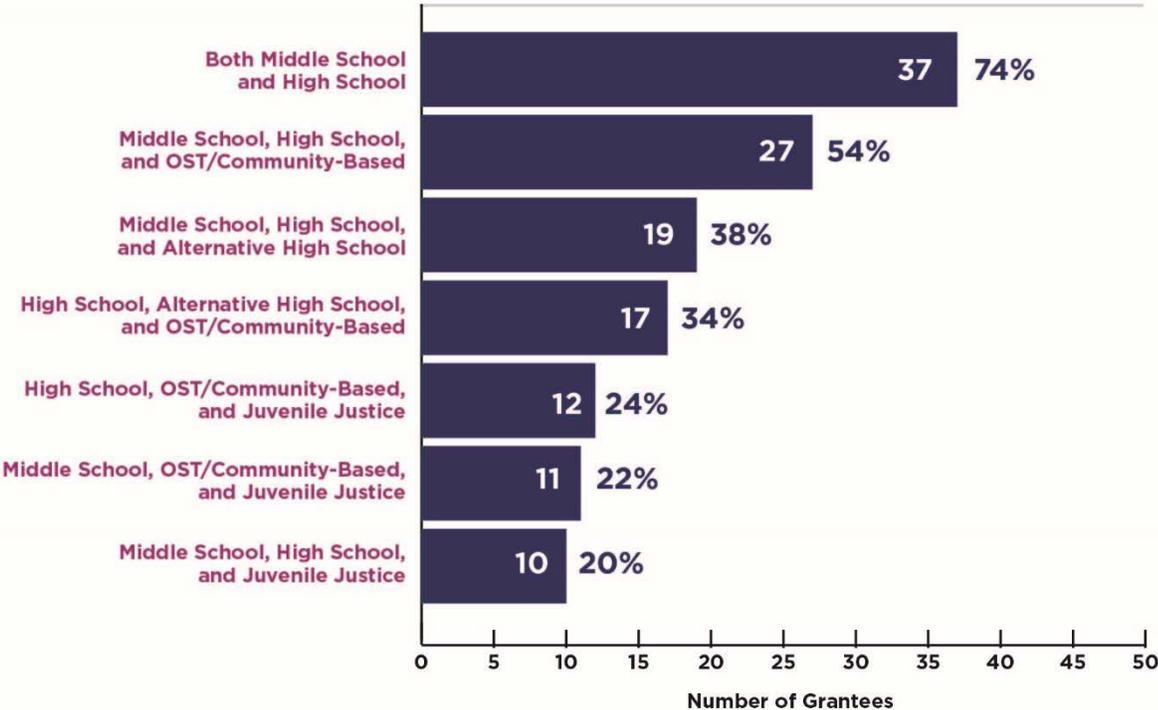
Source: Data provided to OPA by grantees, 2017.

Note: "OST/Community-Based" denotes Out-of-School Time and Community Based settings (e.g., an after-school setting on school grounds, or a local community-based nonprofit organization).

¹⁰ Three grantees served less than the required number of settings because "OST/Community-Based" combines a few settings types or because they experienced a slower scale-up period.

Some combinations of settings within communities were also more common than others. Exhibit 13 shows the most common combinations. Almost all projects (92 percent) delivered EBPs in either traditional middle schools or traditional high schools, and about three-quarters (74 percent) delivered EBPs in both settings. More than half of projects (54 percent) delivered EBPs in all of the most popular three settings—high schools, middle schools, and out-of-school time/community-based. Other common setting combinations included: high school, middle school, and alternative high school; and high school, alternative high school, and out-of-school time/community-based. Projects serving youth in juvenile justice settings often also served youth in traditional school and out-of-school time/community-based settings.

Exhibit 13. Common Setting Combinations



Source: Data provided to OPA by grantees, 2017.
 Note: "OST/Community-Based" denotes Out-of-School Time and Community Based settings (e.g., an after-school setting on school grounds, or a local community-based nonprofit organization).

Below, we discuss grantees' and their communities' reasons for choosing settings, and their experiences working within these settings.

5.2 Previous relationships and access to large numbers of the target population were the most common reasons for choosing a setting

Grantees and partners recruited settings with which they had prior relationships and where they knew the setting partners had an established interest in hosting EBPs. In some cases, grantees or partners had pre-existing MOUs with settings, which decreased barriers to entry. Schools were usually selected as at least one of the settings, since they are the easiest way to recruit the largest number of youth once in the door. Because youth are required to attend school regularly, it can also be easier to retain youth from session to session of the EBP when they are receiving it in school.

"We had been in these settings before. It made it easier to get buy-in because we already had partnerships and they wanted more. We were just limited in funding [before the Tier1B grant]."—Grantee

Projects in rural areas where transportation was a concern had difficulty getting youth to out-of-school locations, which makes school settings an obvious choice. Likewise, for out-of-school settings, many chose settings where youth were already going for existing community programs. Other reasons for choosing particular setting types included:

To fill gaps in services. Several projects chose settings to reach youth who were not already receiving EBPs. For example, projects often chose to serve community settings to reach youth that they would not otherwise reach through the schools, or to reach youth more than once.

To adapt to the lack of receptivity of public schools. Several respondents specifically mentioned that they chose community, clinic, or charter school settings because of an inability to gain access to the public school districts in some or all parts of their target communities. In these cases, grantees would have preferred to be able to implement in the schools throughout the whole community and the desired age groups, but it was not an option for them.

"Working in the district was not going to be an option moving forward. That is why we brought in clinic-based education because that's where we thought we could have the greatest impact on the community and reach the most young people without having access to the schools."—Grantee

To reach special populations, including youth they could likely not reach in other settings. Others chose settings in order to reach specific special populations—either youth in specific demographics, or vulnerable populations at elevated risk for teen pregnancy or STIs, such as youth in the criminal justice system, youth who are homeless, or youth in foster care. Often, these were youth who the grantees would not reach through traditional in-school settings.

Geographic proximity to high teen birth rates. For respondents from the majority of projects, the geographic area was integrally tied to their choices of sites within settings (e.g., specific schools within the greater universe of high schools in a district) and subsets of settings (e.g., specific school districts within a constellation of local school districts). Many zeroed in on sites by starting from data sources pinpointing school attendance zones or areas serving the communities most in need. They then chose school sites or districts based on high teen birth rates or specific demographics.

In a few cases, where service areas were limited to a small set of ZIP codes with high teen birth rates, projects served school districts outside of their target ZIP codes but that are heavily attended by students who reside within the targeted ZIP codes.

"They looked at the school demographics and paired that with health maps the county developed that outlined where there were pockets of young people who had STIs, high pregnancy rates, free or reduced [price] lunch."—Partner

5.3 Changes to settings in the planning year were typically based on new opportunities or demand

Just under half of projects decided to adjust setting types or sites (locations) within settings from those originally planned. Most often, projects added a setting type because they found interested partners willing to host EBPs beyond those they had originally planned or expected. Several added a school setting. For example, one grantee expanded from high schools to middle schools because they found several willing middle school partners. Others added community-based settings because of new partnership opportunities that grantees discovered or developed during the planning year.

Sometimes a setting had to be dropped because of difficulty in working with a partner who: controlled access to the setting (e.g., juvenile detention facilities); or delivered EBPs in a setting (e.g., a community-based provider who also runs programs); or recruited youth in the site or sites within the setting where the project planned to deliver EBPs. Several grantees were in the process of developing new settings in response to recruitment challenges in an existing setting.

5.4 Most grantees experienced challenges establishing or maintaining partnerships with schools and school districts

Grantees described problems in establishing and maintaining partnerships with organizations that provide settings for EBP delivery, particularly schools and school systems. The most common challenges were gaining approval from schools, and the capacity of schools to fully participate.

Obtaining approvals from schools. In most cases, grantees expected schools to serve as settings and recruit youth for the EBPs. Depending on the school district or school structure, getting final approval to deliver the EBPs in the schools took many attempts, from the district level down to the teacher level. While grantees typically established agreements in principle with settings and individual sites during the grant application stage (or in previous projects), schools often required additional levels of approval to formally solidify their commitment and allow the project to proceed with EBPs. In addition, many grantees hoped to deliver EBPs in

settings or specific sites that had not yet agreed to host EBPs at the time of the application, or that had declined to participate in earlier activities.

Insufficient time or capacity among school partners. Some projects found that principals or teachers were hesitant to let the health educators into the school or were unable to start scheduling because they had concerns about taking time away from the other curricula. In some of the projects that relied on classroom teachers to deliver the EBPs (which only included a few projects), schools that had agreed to participate were unable to release teachers for the training or professional development necessary to implement the EBP, or delayed doing so, making it impossible to implement in these sites or settings during the first full grant year.

Grantee Strategies for Addressing Challenges with Settings

Be flexible. Accommodate school staff needs and requests as much as possible. In some cases, this meant obtaining approval for small adaptations of the timing of EBP sessions.

Communicate. Clear and continuous communication is essential to navigating setting challenges. Regular communication could prevent confusion, help identify problems early, and help build trust.

Cultivate a committed liaison. Having staff members from the settings who were committed to the projects as liaisons helped avoid common scheduling and retention challenges. This could come in the form of personal or professional commitment as a dedicated liaison between the setting and project.

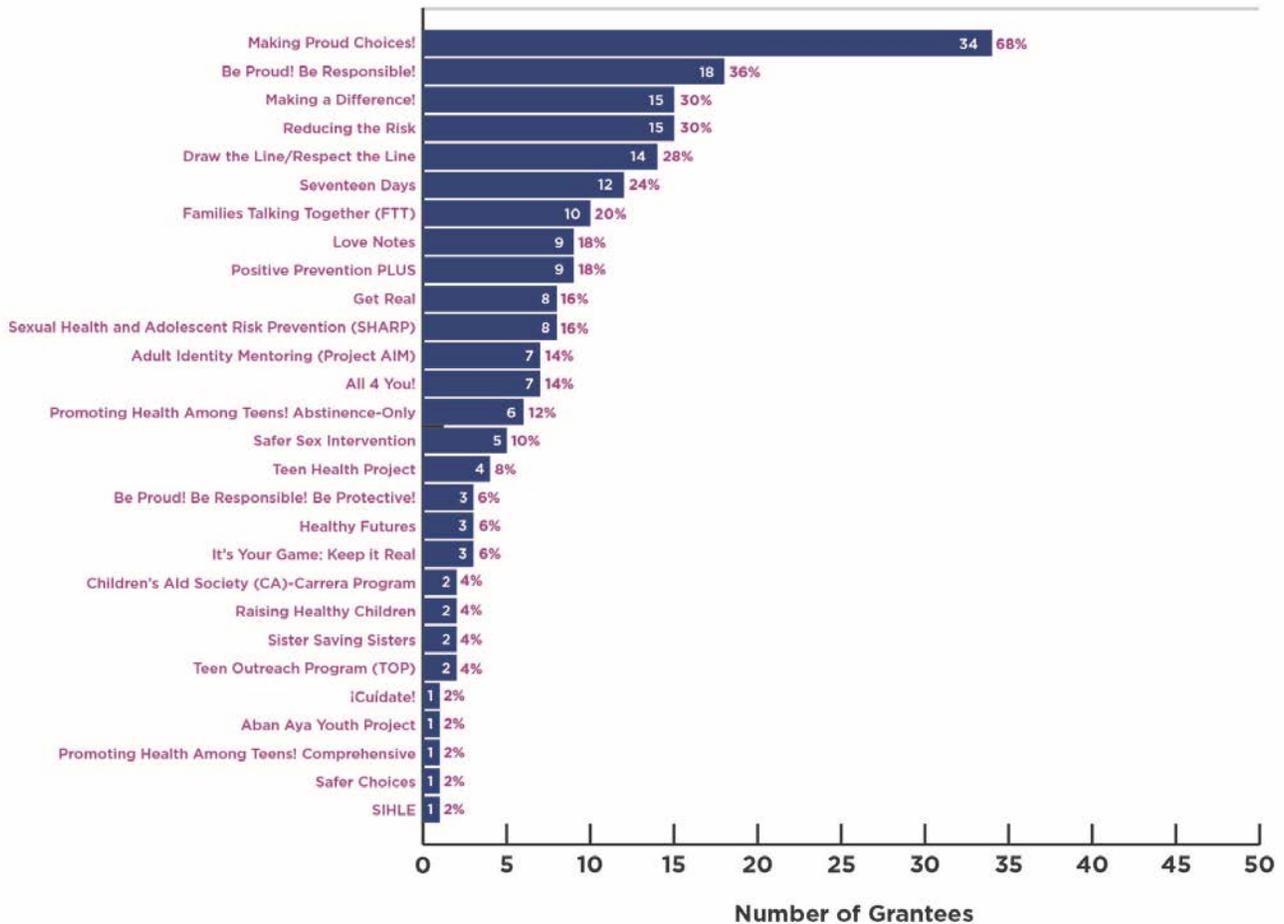
Provide transportation. Providing transportation or incentives to participants could be essential for recruitment and retention in some community or after-school settings where youth were not required to be there. Incentives could come in the form of meals, field trips, gift cards/prizes, or connection with additional resources.

“They [the grantee] said ‘this is what we need’ and we looked at scheduling for the best time to implement. I have to commend the campus administrators and the program staff. They make it a collaborative effort and find the best time to deliver services.”—Partner (school district staff)

5.5 Grantees implemented a wide variety of evidence-based programs

Grantees implemented 28 different EBPs in total. Exhibit 14 shows the full range and how many grantees implemented each in at least one setting. *Making Proud Choices!* was, by far, the most popular choice. More than two thirds of grantees (68 percent) chose to implement it in at least one setting. *Be Proud! Be Responsible!* (36 percent), *Making a Difference!* (30 percent), and *Reducing the Risk* (30 percent) were also commonly selected EBPs, each chosen by about one-third of grantees. Other common choices were *Draw the Line/Respect the Line* and *Seventeen Days*, each chosen by about one quarter of grantees.

Exhibit 14. Evidence-Based Programs by Number of Grantees Implementing in One or More Settings



Source: Data provided to OPA by grantees, 2017.

Making Proud Choices! was implemented in all types of settings. It was the most common choice for out-of-school/community-based time settings and for youth in out-of-home care, and was also common for traditional high school settings and youth in the juvenile justice system. *Reducing the Risk* was implemented almost exclusively in traditional high school settings. *Be Proud! Be Responsible!* was also primarily chosen for traditional high school settings, but some grantees also implemented this EBP in other settings, including out-of-home care settings, settings serving homeless youth, and faith-based organization settings. *Making a Difference!* and *Draw the Line/Respect the Line* were each primarily implemented in middle school settings. Some grantees also chose *Making a Difference!* for faith-based organizations and out-of-school time settings. *Seventeen Days* was primarily implemented in clinic-based settings and it was also the most common EBP chosen for those settings. Some grantees also implemented *Seventeen Days* in institutions of higher education.

5.6 Grantees and partners chose EBPs based on program fit for the community, population, or settings

During the planning year, grantees were expected to ensure that the EBPs they had preliminarily chosen at the grant application stage were appropriate for their communities, settings, and target populations. In assessing fit, some used a formal process or tool, but also relied on a “gut feeling” or input from their partners to make a final decision.

A formal process for assessing fit. More than a third of the projects used a formal process or tool (Getting to Outcomes was the most common) to assess fit. Others created their own criteria and checked off elements as they reviewed the EBPs, used the Health Educational Curriculum Analysis Tool (HECAT) or Sexual Health Educational Curriculum Analysis Tool (SHECAT), or looked for EBPs that aligned with the findings of their needs assessments.

Some grantees and implementation partners noted that they did not need to use a formal selection process because they already had a clear idea of what type of program they wanted to implement, and chose the EBP that best fit that vision. In these cases, there was usually a particular criterion that the partner or grantee wanted to meet: an abstinence curriculum; or an EBP that was similar to another curriculum they had used in the past, familiar to their staff, or designed for specific populations.

The grant guidance emphasized the importance of investing considerable time to ensure that the EBPs were a good match for the implementation context, and projects weighed many factors when making the final decisions about which EBPs would be implemented. Indeed, the majority of projects selected a particular EBP because it was a “good fit” for the target population or was the most practical option given community constraints or concerns.

“[EBPs] were mostly chosen based on the population that we’re working with. Making a Difference was reviewed as a good curriculum for Hispanic and African American populations, but I think after reviewing the curriculum it was just a really good fit for us [in addition to fitting the target population demographics].”—Grantee

Preferences and constraints of the settings hosting the EBPs. About half of projects chose EBPs based upon what the setting would allow them to use. Traditional public schools and faith-based settings were the most common types of settings that imposed substantial constraints based on content. In some instances, that parameter narrowed their choices down to one, two, or three possible EBPs. A grantee explained:

“With Draw the Line/Respect the Line [we] knew a number of school districts they [implementation partners] work with had already approved the curriculum. There was a sense the district already went through the process to recognize this program was good for students.”—Grantee

Previous experience. Projects tended to settle on EBPs the grantee or partners had implemented in the past, especially if these EBPs seemed to be working well and had already been approved by community decision-makers. About a third of projects chose EBPs that they had implemented in the past under previous funding. In some cases it was the grantee or implementing partner who had experience with the EBP, while in others it was the setting partner itself. For example, a partner explained that they chose an EBP with which the community was familiar:

“Making Proud Choices was chosen because it’s been successful in our community for so long and it’s approved by our school board to be used in schools without additional parental permission.”—Grantee

5.7 Finding “a good fit” required attention to content, feasibility, and past successes

Grantees and their partners cited a range of criteria for what made an EBP a good fit, and most projects reported more than one criterion. These included content compatible with community needs and context, logistics, and past implementation success in the community.

Content appropriate for the community and demographics of target youth.

Appropriate curricula were those that are clear and effective for the specific population. Appropriateness was also often defined as alignment with the preferences of the community or settings hosting the EBPs.

“In terms of the overall community, it was like when the community felt that it was a good fit and there was public will and the parents said yes, and it was appropriate for the target population based on the needs assessment that was gathered, that was really how we determined it was a good fit.”—Grantee

For some, the EBPs needed to be applicable for youth of multiple ages across middle and high school. Others explained that the curriculum needed to include a module on anatomy because students had not been taught basics of reproduction. Some said the curriculum needed to be culturally appropriate for a specific population, or to emphasize delaying or avoiding sexual activity.

Logistically possible to implement. Projects also often found that a “good fit” includes logistical fit, meaning that the EBP was a workable length and could easily be scheduled in the chosen settings, that the curriculum was age-appropriate, or that students liked the program and responded well to the material.

Success in similar communities. Especially for communities where an EBP had been delivered in the past, respondents said that if the EBP had historically been successful in the community and was perceived as contributing to lower teen birth rates, they viewed that as a strong indicator of fit. Other indicators of fit were that the facilitators would be able to deliver the program with fidelity, and that the EBP was inclusive for all students and culturally and linguistically appropriate, met all state laws and standards, and ensured a safe space, including a trauma-informed approach (TIA).

Who Was Involved in Selecting EBPs?

Implementation partners. Grantees most often involved partners that provide EBPs; settings; and/or the CAG in the process, though the grantee typically made the final decision.

Other stakeholders. A smaller number of projects involved additional stakeholders, including: the YLC, partners providing technical assistance, or other stakeholders such as a school health advisory committee, parents, the local school district, the health department, other local coalitions, or other youth stakeholders.

Single-purpose group. In a few cases, the project convened a new group of stakeholders solely for the purpose of selecting the EBPs.

Partner-led. In communities where the project was partially devolved to anchor partners, each in their own geographic areas, those partners usually led the process of choosing the EBPs for their respective communities.

5.8 EBP selection challenges included community constraints, changes to evidence-based programs, and length

Grantees and partners encountered three types of challenges in selecting the EBPs, and about one-third changed their EBPs due to these concerns. Usually, either the initial selection was a poor fit for their youth, or it became apparent that another EBP would be a better fit than what they had initially been using. These types of changes were expected as part of the planning year.

Community constraints. Challenges related to community constraints ranged widely, based on the specific communities and youth populations targeted. Almost a quarter of projects (10) needed to be responsive to policies or norms that limited what could be taught. This affected which EBPs these projects ultimately chose to implement, at least in some of their sites and settings. Several grantees and partners factored in which approaches resonated with students better than others. A small number of respondents expressed concern that the content of certain EBPs was too extensive for youth to learn well or to remain engaged.

Changes to evidence-based programs or changes to program models. Some grantees experienced challenges finding new EBPs that fit their communities after rigorous testing of their first choices did not show those curricula to be effective for certain populations. For others, EBPs that projects had originally identified as a good fit were not possible to train on in a timely fashion because the developers were in the process of revising the curriculum and there were delays in its release.

Length or scheduling. Some respondents saw a challenge in finding an EBP that had appropriate content and format for their target community and population and was a manageable length for the setting. The ease or difficulty of integrating EBPs within settings (particularly school-based settings) was an important element of fit. In many cases, EBPs fit well for the community, settings, and populations in principle, but the large number of sessions made scheduling the EBPs infeasible. The most popular EBPs require at least eight sessions, and the regular school curriculum and state testing schedules made it challenging to fit in these sessions.

"Where we run into some challenges is with the lengthy [EBP] curriculum ... figuring out how to balance the scheduling and what classes do they push into for implementation. We have to look at what is required as a district for young people to graduate and balance all of the competing demands of what we have to be able to implement in terms of curriculum and instruction. Every year we run into issues with how we are going to make this work."

—School District Partner

Common Adaptations to Improve Fit of EBPs

Adding new information or content. This included adding local statistics, information on anatomy and reproduction, a definition of abstinence, or supplementary information about STIs and birth control methods.

Changing wording or adding a module. Changing names or titles to be less heteronormative (for instance, using names that were gender non-specific or using “partner” instead of “boyfriend” or “girlfriend”), and ensuring more inclusion of LGBTQ students. Other adaptations were made to be more inclusive of faith communities or to be more culturally appropriate.

Adapting the session spacing or grouping to accommodate scheduling. Sometimes a setting required fewer sessions, so modules were combined; in other cases, more sessions needed to be added so facilitators could get through all of the material.

Adapting the condom demonstration. About one quarter of projects adapted the condom demonstration (e.g., they replaced the demonstration with a “condom line-up” exercise that explained the steps for proper use, showed a video of a condom demonstration, or used a sock instead of a real condom), at least in some settings, or removed the demonstration from the EBPs entirely.

There were also several less common types of adaptation. These included removing content from EBP that was outdated or not relevant to the youth being served, changing the setting for which an EBP was intended, updating the EBP so the material was more relevant to students, making changes to ensure medical accuracy, and altering class size to accommodate space and time constraints. A few projects also reorganized the content within the EBPs in some way, added information about healthy relationships, or changed the language in which the EBP is delivered.

5.9 Assuring fidelity and quality at scale was resource-intensive

All projects were required to conduct regular fidelity monitoring of the EBPs to ensure that they were delivered as intended in accordance with the tested model. Many respondents associated the importance of implementing with fidelity with bringing the project to scale and having an impact on the community. At the same time, as an implementation grew in scale across more locations and program facilitators, fidelity could be more difficult to maintain. Tier 1B projects were required to observe and assess fidelity of 5 percent of EBP sessions. Many projects used fidelity logs after each session to confirm whether each lesson was covered or whether there were any deviations from the planned curriculum.

Other efforts to ensure fidelity included arranging regular training or booster sessions on the EBPs as the projects progressed, discussing fidelity challenges and solutions in regular meetings with facilitators, and developing supplemental materials to accompany the initial curriculum training, such as written guidance on adaptations to ensure that partners did not make inappropriate adaptations on their own.

Most projects encountered common challenges to fidelity such as school schedules that were not conducive to the prescribed dose and duration of the program, or the tension between fidelity and being able to engage youth. There were two concerns related specifically to maintaining fidelity at scale:

Monitoring fidelity across multiple partners could be resource-intensive. Fidelity monitoring for 5 percent of sessions may not have been sufficient for some projects with multiple partners that delivered the EBPs across many different locations. Some reported that they aimed to observe more sessions to ensure fidelity across organizations, and to keep in communication with facilitators. For others, the percentage of required observations was too high (this was typically for projects or partners with high target numbers of youth to serve and a high volume of sessions), and grantees or implementation partners were worried about their capacity to fulfill this requirement.

Maintaining and sustaining fidelity was difficult with staff turnover. New staff had to be trained just as thoroughly as existing staff were originally trained, and grantees did not always anticipate the level of turnover they faced. Many raised concerns about sustaining fidelity at scale past the end of the grant period. Even stakeholders who had been trained on the EBPs may leave the system or the area over time.¹¹

Strategies for Ensuring Quality in Delivering EBPs:

- **Gave implementation partners regular training** on a variety of professional development topics to support quality, such as classroom management and adolescent health.
- **Convened regular meetings with implementation partners to discuss any issues that have arisen**, and to share best practices and other strategies that had emerged. Sometimes these were referred to as “communities of practice” or “educator networks.”
- **Ensured frequent and open communication between project leadership and facilitators to trouble-shoot emerging concerns.** This communication could come in the form of e-mails, regular conference calls or meetings, or just the clear understanding that either party should feel free to pick up the phone and call the other if there were questions.
- **Collected feedback from youth at the end of a program cycle** about their experience with and feelings about the EBP. The projects then used this feedback to assess what was working well and what required more work to engage youth (or potentially an adaptation or a change of program).

¹¹ While only a few grantees currently had teachers or other school staff delivering EBPs, several had trained some teachers in the EBP curriculum in order to support school engagement and investment in the project and to equip teachers to address questions from parents and other members of the community.

6. STRATEGIES FOR ENSURING SAFE, SUPPORTIVE ENVIRONMENTS FOR YOUTH

OPA expected grantees to provide programs for youth in safe and supportive environments, which included—but was not limited to—ensuring inclusivity of all youth, including LGBTQ youth, applying Positive Youth Development practices when interacting with youth, and using a trauma-informed approach (TIA). “Inclusivity” means making sure youth feel included in the discussion and curriculum, that their identities and opinions are respected by peers and health educators alike, and that they feel as comfortable as possible raising questions.¹²

The OPA guidance further defined a TIA to facilitation and services as one that takes into account the trauma that some participants may already have experienced in their lives because of sexual or other abuse, assault, bullying, witnessing violence, or trauma from other sources. A TIA gives health educators the tools to avoid re-traumatizing youth who have experienced trauma and recognize when youth need additional support or referrals.¹³ Grantees were free to interpret and apply these principles in ways that made sense for their local contexts.

The projects differed in their processes for ensuring safe and supportive environments and the aspects on which they focused. The following section describes the most common ways projects tried to ensure safe, supportive environments for youth.

Adjusting EBPs for inclusive, trauma-informed language and content. Several projects started by assessing the curricula for inclusivity and use of a TIA. Some found that the curricula needed adjustments and received approval from OPA to add more-inclusive language with regard to gender, culture, language, or content to make the curriculum more trauma-informed, or to add a module geared toward LGBTQ issues. One project was in the process of developing a trauma-informed module to add to their curricula.

Professional development on inclusivity and TIA. At least half of the projects provided inclusivity training to facilitators, and at least a third provided training specifically relating to LGBTQ youth. More than a quarter of projects promoted classroom policies designed to help facilitators interact respectfully with youth, to address questions, and to generally help youth feel free to speak. Examples of these practices included providing a way to submit anonymous questions to the health educator, a policy where youth who felt uncomfortable could leave the classroom with no questions asked, and ensuring that students were not forced to participate in activities or discussions at any time. One grantee expressed the importance of “making sure the staff that is delivering the EBPs is aware that we don’t know the situation of every young person that we may be working with. It’s just an important factor in delivering the program.”

Most educators received specific trauma-informed care training through the project. On the whole, training in trauma-informed care tended to be slightly more common among projects than formal inclusivity training. In some cases, health educators were already receiving trauma-informed care training through their organizations because of pre-existing projects or agency requirements, and did not receive additional TIA training specifically for the Tier 1B project. Other grantees believed that training on safe, supportive, and inclusive environments

¹² OPA guidance on creating safe and supportive environments can be found at <https://www.hhs.gov/ash/oah/resources-and-training/tpp-and-paf-resources/creating-safe-and-supportive-environments/index.html>

¹³ Ibid.

was integrated into the initial curriculum training for the EBPs, and, in some cases, did not provide additional training or resources beyond this curriculum training.

Hiring appropriate staff and building trusting relationships. Another important approach to safe and supportive environments was having frontline staff who understood the youth and could develop a caring relationship with them. For example, a grantee project director described the specific efforts that educators for her project extended to build rapport and trust with students:

“Our educators have a history with the schools. They don’t just go in, teach the curriculum, and then leave. The educators still stop by the school and let students know they can talk to them even if the class is over, sit in the lunch room, so students are used to seeing their faces, and they develop rapport.”—Grantee

Quality improvement and feedback. Some grantees also built in observations and assessments to monitor and improve supportive practices. Others established and shared best practices for safe and supportive environments and interaction with youth by discussing their experiences, concerns, and successes in regular group meetings with EBP facilitators.

6.1 Projects saw few challenges in ensuring safe and supportive environments

Most respondents did not find this aspect of the Tier 1B strategy challenging; however, there were some concerns. A few noted that the curricula they were using currently were not inclusive of LGBTQ youth. Others expressed concerns that classroom teachers may not have felt comfortable being inclusive of LGBTQ students in how they delivered or co-delivered the curriculum or answered questions.¹⁴

One grantee said that local laws limited how they could present LGBTQ issues and relationships in the schools. Grantees and partners usually worked to address these issues through training and support of staff, observations and feedback, or assessing who is a good fit for the health educator role.

Grantees and partners were not aware of any challenges in incorporating a trauma-informed approach into their work. Most often, they addressed the need for trauma-informed care by ensuring that health educators were trained or by hiring or engaging staff who were familiar with the types of stressful or traumatic experiences the youth they were serving were likely to face.

Grantees and partners tended to address positive youth development through the curricula they chose, through encouraging facilitators to connect the curricula to youth goals and opportunities for future growth, and through their approach to the Youth Leadership Councils. They did not tend to see any explicit challenges to making these connections.

“Being a church, we have unique issues. There is a strain between churches and the LGBTQ community. One thing I talk to staff about all the time is that, no matter what your beliefs are, or where you stand, we are here to provide service. We are here for everyone that goes through the program.”

—A faith-based organization that delivers EBPs

¹⁴ This concern was raised most often when schoolteachers delivered the EBPs or when the EBPs were being provided in faith-based settings.

7. COMMUNITY MOBILIZATION APPROACHES

A cornerstone of the grant strategy was the involvement, support, and leadership of a broad base of community stakeholders in preventing teen pregnancy and improving adolescent health. The community mobilization approach was guided by *Best Practices for Community Mobilization*, which describes a number of features associated with a successful mobilization effort.¹⁵ Key best practices include, but are not limited to:

- A formal structure and strong leadership/backbone organization
- Shared vision, decision-making, and authentic participation
- Diverse, multi-sector representation
- Authentic and productive roles for youth
- Strategic plan
- Community education, awareness, and outreach

Grantees were expected to convene a CAG and a YLC to develop a shared vision and action plan and inform community mobilization efforts. This section describes how CAGs and YLCs were formed, the range of roles and early contributions, and key challenges of recruitment and facilitation of the groups. We close the section with a discussion of how grantees were planning to bring education and awareness to the broader community, with the ultimate goal of building public will and broad support for TPP efforts.

7.1 Community Advisory Groups (CAG) were a mix of pre-existing and new entities, and involved a diverse cross-section of stakeholders

To form the CAGs and YLCs, projects could re-purpose existing coalitions, committees, or collaboratives in their communities, where available, or create entirely new groups for the Tier 1B initiative. Each project could choose to have one CAG and one YLC for the whole community, or could have multiples of either body, particularly where the Tier 1B service area covered more than one community.

Half of the grantees formed new CAGs for the project, and almost half had multiple CAGs. Grantees typically recruited new groups, formed specifically for the Tier 1B-funded project, when there was no viable pre-existing group, or when they wanted to engage new sectors of the community and focus specifically on TPP. Some projects (28 percent) leveraged pre-existing groups in their communities to act as CAGs, instead of forming new groups (Exhibit 15). This was usually done for efficiency reasons, for instance if there was a TPP-related advisory group already in existence, or in an effort to integrate teen pregnancy prevention with other salient youth issues being addressed by established groups. In some cases, projects needed to create new CAGs for some of their target communities but not others—for example, if some counties they served had ongoing TPP efforts and some did not.

¹⁵Available at

http://advocatesforyouth.org/storage/advfy/documents/Factsheets/strategies%20guided%20by%20best%20practice_8-11-14.pdf

Grantees were roughly split between those with one CAG (48 percent) and those with more than one (52 percent) (Exhibit 16). Grantees with multiple CAGs had an average of just under 4 CAGs (3.7). Since many projects were implementing in several distinct communities and geographic areas, many had several CAGs to represent these diverse or dispersed areas.

Exhibit 15. Grantees with New and Pre-existing CAGs

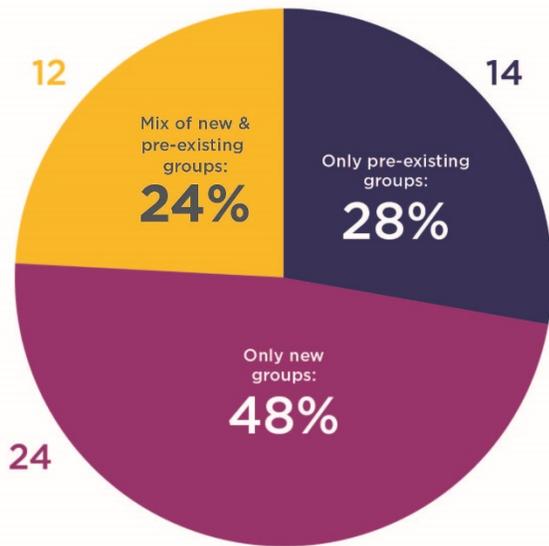
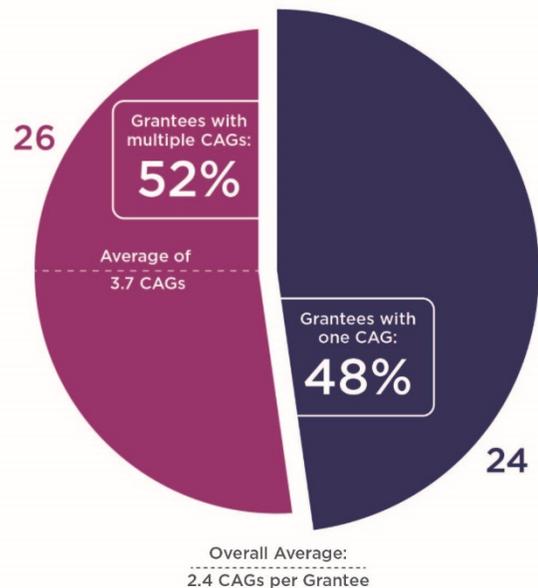


Exhibit 16. Common CAG Structures



Source: Data provided to authors by grantees, 2016.

CAG membership cut across sectors, including many agencies that provided services to youth. The Tier 1B projects assembled CAGs with participants representing multiple stakeholder groups in an effort to coalesce a broad base of support around the shared mission of reducing teen pregnancy. When considering whom to recruit for the CAGs, grantees focused on those providing services to youth either within or outside of the Tier 1B project, and also on community members with a strong interest in and passion for the project, and who had influence.

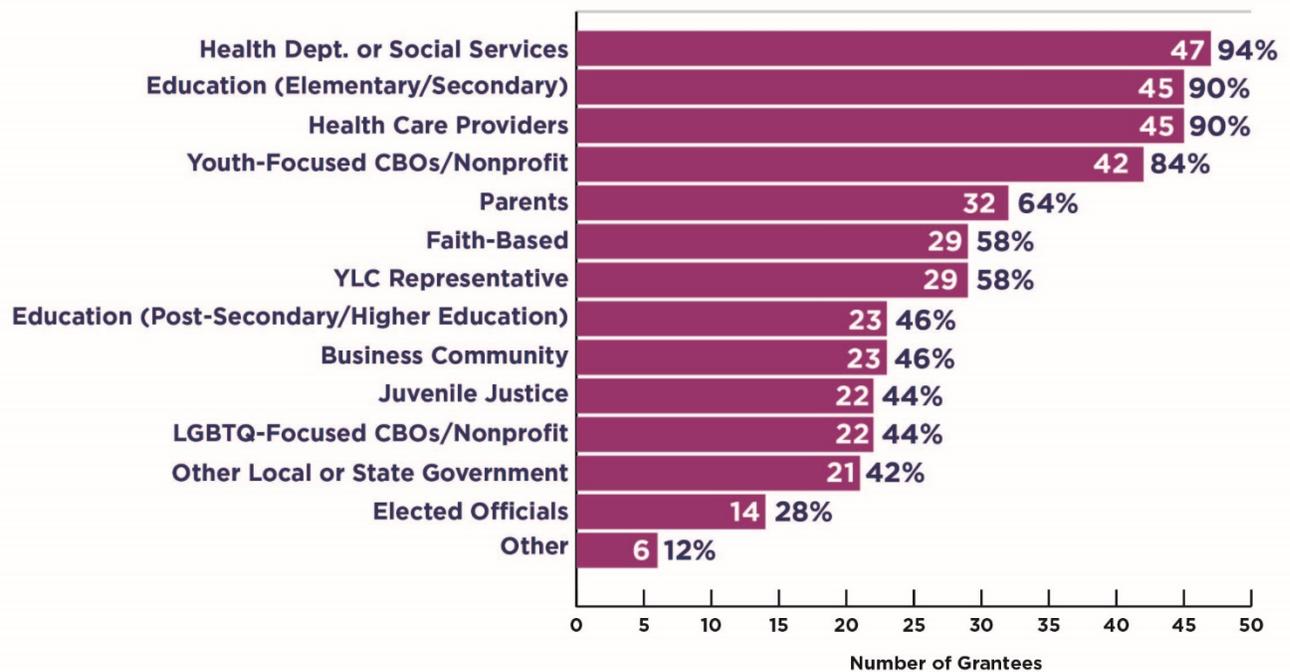
Some grantees also said that including school representatives on the CAGs (as representatives of a key EBP setting) helped ensure that the project incorporated the schools’ needs; or that school staff better understood the projects’ goals, key elements, and needs.

“The champions—these are the heavy hitters in the communities who know everybody. We’ve identified people in each county that people listen to and we want these to be our front people.”

—Grantee

CAG members were most commonly representatives of government or community-based organizations that provided services directly to youth. Most grantees had representatives of a local health department or social services department, elementary or secondary education, health care providers, and youth-focused community-based organizations on their CAGs (Exhibit 17). More than half of grantees had a representative of their YLC also participating in the CAG, which OPA specifically recommended.

Exhibit 17. Composition of the CAGs



Source: Data provided to authors by grantees, 2016.

7.2 The most common role of the CAG was to provide guidance and input

CAGs most often provided general guidance for the project, and represented the voice of the community. Respondents from most projects (including grantees and partners who are involved with the CAG) also said that their CAGs served in an advisory capacity, providing input as representatives of the community. CAG members were often tasked with participating in and providing input on needs assessments, strategic plans, EBP implementation, evaluation, communication and dissemination plans, and sustainability efforts. CAGs also commonly reviewed EBP curricula to assess fit, LGBTQ inclusivity, medical accuracy, and the need for any adaptations. For some projects, the CAGs provided ongoing guidance on how best to address challenges that emerged as the project progressed.

One grantee noted that the CAG's role was to "hold us accountable." This included making sure the project was reaching across all relevant sectors in the community, was engaging with other TPP-related

"The CAG serves as an advisory and planning committee for the project. They help us map out strategy and approaches and serve as a sounding board. Additionally, they provide much of the volunteer power for events and community outreach efforts."

—Grantee

"They give advice and suggestions on how to improve the program, what will work and what will not work in the community. We are very fortunate to have that."

—Grantee

efforts and resources within the community, and was providing due diligence in implementing the key elements of the grant strategy.

CAGs provided community mobilization leadership. Most often, the CAGs also led or were entirely responsible for the community mobilization effort in the Tier 1B communities. What this meant varied somewhat in practice. The role could be general (e.g., help increase awareness of and support for the Tier 1B project and teen pregnancy prevention among community members and the community as a whole), or more targeted (e.g., work to garner support for the EBPs; linkages to services). CAG members disseminated information about the project and teen pregnancy through their networks, by being present at parent meetings, or through local op-eds. Some CAG members identified additional partners to serve as members of the CAG, provided settings for EBPs, or advocated for teen pregnancy prevention within their sectors, agencies, or professional networks outside of the CAGs. For example, additional advocates may have been engaged within a school district, a mayor's office, or a parent group.

"[The CAG's role is] to mobilize and engage other key stakeholders from various walks of life, including youth, to build forth a movement that is community led. [...] They've been paramount, they are the movement. They're the people who opened the doors that we couldn't."—Grantee

CAGs were tasked with supporting and ensuring sustainability. At the beginning of the first full year of implementation, many projects had started to brainstorm and plan for sustainability efforts, and considered the CAG to be a key part of this process. CAG roles in achieving sustainability beyond the grant period included identifying fundraising strategies; leveraging CAG member connections to help gain support through funds, services, or other resources; and assessing other opportunities for sustainability, including embedding EBPs in community systems. Several projects tasked their CAGs with primary responsibility for drafting a sustainability plan.

CAG members provided training and technical assistance to the project. In some projects, CAG members provided training on topics such as trauma-informed care, safe and supportive environments, and LGBTQ inclusivity, or provide facilitator training for EBPs. They provided these trainings either to their fellow CAG members to ensure full understanding of the EBPs, their contexts, and youth needs, or to health educators who delivered the EBPs to youth participants.

Some organizations could not speak to the CAG's contribution to the project, as they were still in the beginning stages of building up and convening the CAG during Year 2 of the grant. The level of CAG involvement in the Tier 1B projects also varied substantially between grantees. Many grantees acknowledged that their CAGs met infrequently, or had met only once or twice, or that the grantees shaped the agenda for the CAGs and CAG meetings.

7.3 Most respondents believed the CAG had a shared vision

Establishing a shared vision and mission was a best practice for community advisory groups, because members often came from varied backgrounds and home agencies with their own missions.¹⁶ Most respondents for projects with fully established CAGs perceived their CAGs as having a shared vision and purpose. Grantees and partners believed there was agreement on the purpose of the CAG as well as an understanding of the goals of the project among the members.

"The shared mission/vision is to provide health services and information to youth, and they know the importance of an evidence-based curriculum and understand that it can't just stand alone—you need someone to drive services for the whole community, not just this one entity." —Grantee

Respondents from about a third of projects reported that they are still working on establishing a shared vision and purpose among the CAG. Often this was due to the CAG being relatively new or not fully up and running at the time of the interview. For some projects, CAG member turnover had also posed a challenge, as new members must be brought up to speed on the mission and goals of the project. Some respondents indicated that, while including diverse and non-traditional sectors in the CAG can be helpful for mobilizing the community, the more diverse the composition of the CAG, the longer it may take to reach a shared vision:

"The [new] people they are bringing in don't have a TPP background so it will take some time to do training and get them to understand the issues to begin with."—Partner

7.4 The most common challenge facing CAGs was engagement and retention of members

Since projects were in varying stages regarding the development of the CAG, most respondents mentioned current barriers, while others anticipated what the barrier would be in facilitating an effective CAG. Most described some degree of difficulty in keeping the CAGs motivated and invested, signified by inconsistent attendance and low participation in meetings. One factor contributing to these challenges may be that CAG members were all volunteers:

"That is always going to be a struggle because people have their own lives and their obligations and as much desire as they have to be involved in the TPP program, they have to prioritize and sometimes the thing not bringing in any money is not your priority." —Grantee

Staff turnover (including turnover of grantee staff involved in the CAG and turnover in partner staff participating in the CAG) made it harder to retain CAG members in some communities, and it could take time to bring new members up to speed with the previous work of the project and the CAG.

¹⁶ Ibid.

Many projects found that scheduling for the CAG meetings was a serious barrier to success. Trouble finding a time for meetings that worked for all members was primarily reported by partners who were heavily involved in the CAGs rather than by the grantees. As one partner stated, “The main barrier to forming any CAG group is people’s time: getting people to meetings, getting a common time for people to meet, a place that works for everyone.”

Other common challenges included ensuring multi-sector diversity and establishing the CAG’s role. Some grantees had a hard time recruiting parents, representatives serving the LGBTQ community, school-based representatives, and representatives of the business community. These challenges were the greatest for projects seeking to engage sectors of the community that have not historically been involved in teen pregnancy prevention and youth health and well-being initiatives in their communities. During the first full year of implementation, some projects were still trying to determine the best groups to recruit for their CAGs. Many projects struggled with defining the CAG role, what they want from CAG members, and how to be more supportive so that members can take ownership of tasks.

“A part of the CAG is getting those strategic people to the table ... diversity is key—not having people in the same industry and area. It allows them to come with a plan of action that is well-rounded, not just tunnel-visioned.”

—Grantee, on the importance of broad sector representation on the CAG

7.5 Strategies to improve the effectiveness of CAGs included fostering ownership and improving meeting facilitation

Many respondents spent the planning year as well as the first year of full implementation learning what works for developing CAGs into effective groups. The specific strategies they suggested fall into three broad categories:

Foster ownership of the project to support engagement and productivity. Strategies to promote ownership included:

- Use shared decision-making between the CAG and project leaders (e.g., the CAG helps select EBPs and specifies details for piloting EBPs). Giving the CAG decision-making power was also important for incorporating the community’s needs and perspectives into the project.
- Foster an environment where CAG members feel free to share opinions and know that their ideas are valuable to the project and its leaders.
- Make it continually clear how different issues of interest to the CAG members relate to teen pregnancy and teen pregnancy prevention (e.g., infant mortality, school readiness, economic development).

“We are the content experts and the community members [on the CAG] are the context experts.”—Grantee

Be purposeful in meeting facilitation and coordination.

- Use a trained facilitator.
- Make sure each meeting has a clear agenda and purpose (if possible, driven in part by CAG input). Once in the meeting, the facilitators must be mindful of time.
- Keep meetings focused primarily on specific project goals and actions (e.g., by sticking with items in the strategic plan). Break into sub-groups for specific tasks.
- Adjust the format of meetings to make them more inclusive and interactive.
- Schedule meetings as far in advance as possible and provide calendar invitations and reminders.
- Provide incentives, including food at meetings. Some projects also provide gift card or monetary incentives.

Where appropriate, build on existing groups. This can ensure that members are already engaged and avoid “committee fatigue” sometimes caused by community members being asked to participate in too many different groups.

7.6 Youth Leadership Councils (YLC) were a mix of pre-existing and new groups, usually recruited by partner organizations

Each project was expected to have one or more YLC to incorporate youth perspectives into decisions made by the project and lead the overall community mobilization effort with the CAG. The YLCs should include members of the target population and provide opportunities for authentic participation and decision-making. One of the YLC’s key intended functions was to ensure that programs and strategies are a good fit for the needs of the community. The specific roles played by YLCs varied across projects as well as within projects that had multiple YLCs.

About half of the projects formed entirely new YLCs, and half managed more than one. In a similar pattern to that of the CAGs, half of projects had YLCs that were entirely new groups formed for the Tier 1B project (54 percent), while more than a quarter of projects adapted pre-existing groups to serve as the YLC(s). Typically, respondents for projects that used pre-existing youth advisory or working groups to form the YLCs said that they did so in order to capitalize on the experience and leadership these groups possessed. Projects that formed new groups usually did so because a youth advisory group with a similar mission did not already exist in the community, or in some of the distinct communities in the service area, or because existing groups would be stretched too thin by adding this new role. In many cases, the existing groups were already involved in TPP, teen health, or teen leadership projects. In some cases, these groups were involved with or had originally been formed by the grantee or partner organizations. As with the CAGs, grantees were split between those with one YLC (48 percent) and those with more than one. Grantees with multiple YLCs have an average of just under 4 YLCs. Similar to reasons for having multiple CAGs, projects with multiple YLCs typically had a YLC for each geographic area or region within the target service area. On projects where partners were often responsible for running the program within a specific area, those partners were sometimes responsible for running and recruiting their own YLCs.

Exhibit 18. Grantees with New and Pre-existing YLCs

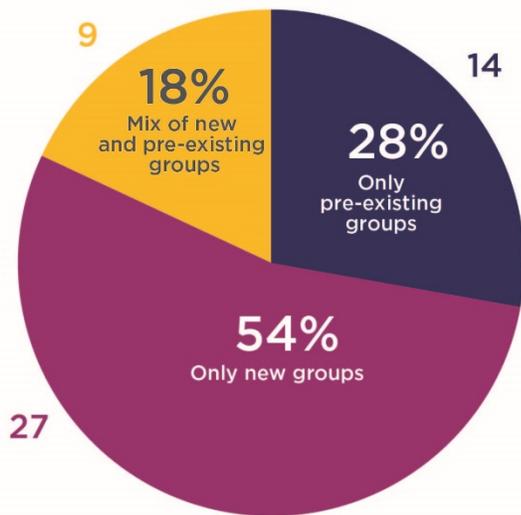
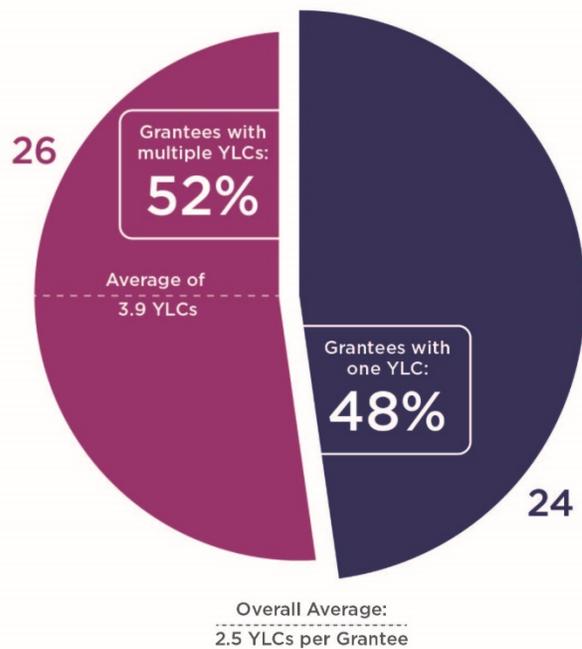


Exhibit 19. Common YLC Structures



Source: Data provided to authors by grantees, 2016.

YLC participants were intended to represent the target population, and were usually recruited by partners who provide EBPs. Projects tried to ensure that the youth comprising the YLCs were from the target community and were representative of the Tier 1B project’s target populations. For the majority of projects, partners (rather than grantees) recruited youth for the YLC. Partners usually used their connections to programs, services, and groups in the community to identify and recruit youth, or recruit youth from their own programs or schools. A smaller number of grantees reached out to youth directly, or used current and former YLC members to help recruit new members for the YLC.

Many saw YLCs as providing an opportunity to develop leadership skills in youth who might not already have them, sometimes purposefully recruiting youth who would not normally be on an advisory group in order to gain their perspectives and develop skills for which these youth were not receiving support elsewhere.

7.7 YLCs raised awareness and provided input on key project elements

Respondents described a range of roles either planned for currently played by the YLCs, but most projects expected them to provide perspective and feedback on one or more elements of the project. The main roles of the YLCs are described in more detail below.

Most commonly, YLCs developed and disseminated media or public awareness campaigns. This could take multiple forms, both formal and informal, but typically the YLC helped design information about the program and teen health and spread this more broadly to their community and peers. Modes included word of mouth and media campaigns, including social media campaigns, television or radio ads, or messages in other media, such as

advertisements on bus shelters. Engaging youth to plan or execute a social media campaign was a particularly popular strategy. Many YLCs' members had been tasked with serving as peer mentors in their communities, to help pass on information they had learned through YLC participation or through reviewing or participating in the EBPs.

The majority of YLCs helped review EBPs for fit. Often, this was a review for program fit after the curricula have already been selected, but a few projects had youth review the curricula in collaboration with CAG members before EBPs were fully in place. Some respondents noted that youth perspectives on the EBPs, particularly with regard to inclusivity and age- or cultural appropriateness, were essential in determining whether adaptations were required, or whether a new curriculum would be more appropriate for the youth in the community.

Many YLCs were involved in assessing the youth-friendliness of health care. For about one quarter of projects, the YLC was helping identify youth-friendly health care options in their communities. This most often takes the form of serving as "secret shoppers" to assess clinics, though some YLCs also provided feedback to clinics directly.

Some YLCs' members served as community advocates. This role generally entailed YLC members serving as "youth ambassadors" in their schools and communities, participating in public speaking opportunities to promote the project and to discuss issues surrounding teen pregnancy prevention or youth health. Some projects provided YLC members with leadership training or encouraged them to speak publicly (e.g., at open school district meetings) on issues that mattered to them as a group, whether they related directly to TPP or not.

Youth-Adult Partnerships Are Challenging to Foster

While projects aimed to have the CAG and the YLC engage with one another, this was often difficult to do in practice due to scheduling conflicts and transportation needs.

Few projects had had joint CAG-YLC meetings or events at the time of the interviews. On a couple of those projects, CAG and YLC members worked on shared committees (e.g., to select EBPs).

Interaction between the two groups more commonly flowed through one individual who attends meetings of both. For example, a YLC member sits in on CAG meetings, or an adult who supervises or attends YLC meetings fills in the CAG on YLC activities and discussions.

7.8 Some projects had not fully established some or all of their YLCs at the time of the interviews

The most common barrier to launching a YLC was difficulty in recruiting members. Transportation needs and difficulty finding a time that worked for most or all potential members were issues, particularly in rural areas or those with limited public transportation. In addition, projects were more likely to have trouble identifying and recruiting YLC members when they had to rely on the community to identify participants, or relied on more distant partners who were not otherwise fully invested in the project. Another challenge mentioned by

a small number of grantees was recruiting YLC members who were representative of the target population.

The most common barrier to *maintaining* a YLC over time was keeping the YLC members engaged. Grantees and partners expressed the importance of gaining the YLCs' trust, and noted that that can be particularly challenging with members of vulnerable populations. Respondents also mentioned the importance of keeping the YLC organized with tasks and of empowering them to take ownership of certain aspects of the project. In this respect, the challenge of keeping YLC members engaged was similar to challenges respondents saw in keeping CAG members engaged. Many grantees and partners had not worked with a youth leadership group before, and were less familiar with giving these groups substantial responsibilities over which they can take ownership.

Lessons Learned for Launching and Maintaining YLCs

In the course of launching and coordinating YLCs, grantees and partners identified a few successful strategies:

Launching a YLC

- Start planning early, so all the procedures will be in place to start recruiting youth.
- Establish strong ties in the community to help recruit youth and advocate for participation.

Maintaining YLCs

- Provide clear, open, and honest communication with the youth about the project's expectations.
- Increase engagement by using expert facilitators (adult experts or experienced youth participants), provide incentives (including food, gift cards, and field trips), and provide leadership development through opportunities for hands-on contributions and other side projects that interest the youth.

7.9 Educating the community and raising awareness: most projects had an education effort planned or already launched

To ensure TPP programs had the greatest impact, OPA expected grantees to engage in strategic dissemination and communication activities to raise general awareness of the importance of preventing teen pregnancy and promoting positive youth development, and to raise specific awareness of the program. At the same time, a key aspect of community mobilization was to generate awareness, motivate action, and keep the community focused on the issue at hand. These activities were meant to focus on building public understanding of the issue and support for the community effort over time. During the first full year of implementation, projects' communications and awareness campaigns were in various stages of development, but most projects made at least initial plans for strategic dissemination in their communities, and the majority had some type of education campaign in the planning stages. About half of projects that planned a public media campaign had not yet implemented it at the

time of the interviews. Many of the community education efforts were small in scale or in early stages.

The most common approach was a media campaign, including social media, newsletters, or web campaigns. In addition, respondents for more than a third of projects described community events or forums that the project hosted to conduct outreach about teen pregnancy prevention. Many held meetings and presentations or produced and distributed handouts and flyers to promote the project. In many cases, projects engaged youth (typically through the YLC) to help conduct outreach to the public, either through public presentations and community event tabling, or through leading a social media campaign. Less common strategies included billboard or bus shelter poster campaigns and programs on local television and radio stations.

Most community education efforts aimed to raise awareness of the TPP project. In addition to promoting awareness of the local effort, many projects also aimed to elevate the importance of the discussion around teen pregnancy prevention more generally and increase knowledge about resources. Educating the community about teen pregnancy included sharing local statistics on teen pregnancy and births in order to help community members understand the magnitude of disparities between their communities and others, or within their community.

Community education had a key role in ensuring that youth, parents, teachers, and other community members were aware of the services available in the community and how to access them. Some projects also included communication and healthy relationships as part of their community education efforts (other projects typically focused on that goal through the EBPs only).

"First and foremost [the goal is] to make sure that people are aware of the issues, factual numbers and pockets of STIs and teen pregnancy rates and start conversations as to why. And also make them aware of resources in the community and direct individuals to other organizations and resources. ... Make them aware of what we are doing and why we are doing it and how we are doing it."

— Grantee

The vast majority of respondents did not see any challenges to community education. Of those who did recognize challenges, the most common concern is how information relating to pregnancy and sexual activity would be received by the community. Respondents for more than a quarter of projects were concerned that engaging the public in positive dialogue is more challenging than disseminating a message. In a few cases, respondents mentioned that the costs of conducting media outreach and dissemination is a barrier for their projects.

8. CONNECTING THE COMMUNITY WITH YOUTH-FRIENDLY SERVICES

Tier 1B grantees were expected to establish and maintain linkages and referrals to a network of organizations that can provide high-quality, youth-friendly services for youth participants and their families. OPA guidance to grantees (FOA, p. 27) described establishing linkages as involving three components:

- Identifying and recruiting organizations and health care professionals within the community who provide a wide range of high-quality health care services for youth
- Assessing that these organizations and providers are youth-friendly and accessible
- Developing and disseminating a provider referral guide for youth and their families

Grantees were also expected to develop protocols and procedures for grantee and partner staff to refer youth and families to these health care providers; and to train key staff on these processes. This section describes how grantees established linkages, how they defined and assessed youth-friendly services, common referral systems, and barriers to accessing youth-friendly care.

8.1 Common approaches to linkages included resource guides, expanding partnerships, and building capacity for youth-friendly services

As a requirement of the grant, projects developed a resource guide of youth-friendly service providers in the given area to educate youth about the available options. The formats of the guides varied from project to project and can be on paper (a booklet or flier), online (a website or search tool), or part of a mobile phone app. Some respondents also mentioned developing or growing partnerships to expand these linkages—most often this meant partnering with health care providers including school-based clinics. Some projects had not yet defined their approach and were seeking clarity on the appropriate strategy; for others, the options for youth-friendly health care in the community were limited and they were first working to improve the available options.

Some respondents mentioned establishing linkages to other services in addition to reproductive and primary health care, most often related to mental health. Other projects had linkages to services for housing and homelessness, sexual abuse, domestic violence, drug and alcohol services, LGBTQ services, and dental care. While all projects were expected to establish linkages to a full range of youth-friendly services, projects that established linkages beyond reproductive healthcare were most often led by organizations that already provided a range of services to youth or that had already established these linkages through prior efforts, before the start of the grant.

8.2 Youth-friendliness meant providing care that makes youth feel safe and is confidential and accessible

At least some youth-friendly service options existed for the majority of targeted communities. The options that respondents were aware of in their communities ranged from plentiful to sparse. In some cases, just one or two clinics were youth-friendly, and a few reported that youth-friendly options did not exist at all.

Grantees and partners agreed on many of the factors that help define youth-friendliness. The qualities mentioned most often were:

- **Clinic staff who are trained to be supportive of youth.** This includes training on how to work effectively with youth, and providing care in a way that makes youth feel safe and not judged.
- **An environment that facilitates and supports confidentiality.** Many respondents also considered confidentiality to be an important aspect of youth-friendly services.
- **Physical accessibility or transportation to clinics.** It is also very important that a clinic be easy for youth to reach without a car.
- **Generally accessible to teens.** Accessibility includes logistical factors such as the hours a clinic is open, the cost of services, and wait times. Shorter wait times (both the time before one can get an appointment and the wait time once in the office) and offering walk-in appointments are considered to be youth-friendly features. Other factors include the use of targeted advertising, the appearance of the waiting room or set-up of the physical space, and an LGBTQ-inclusive environment.

How Grantees Assessed Youth-Friendliness of Service Providers

- **Assessment tools** with checklists and rating scales for policies, practices, and how the clinic is configured.
- Teen **"secret shoppers"** who call or visit clinics.
- **Interviews with providers** (formal and informal) to assess their policies, practices, and attitudes toward youth.

The secret shopper approach:

"[Teens] make appointments at a clinic and go access services. They provide evaluations to us on [their] experience, how they were treated, what services were offered to them, if they would be comfortable going again ... [We] plan to reach out to clinics with feedback to help with best practices and areas of growth."—Grantee

A grantee explained the important of direct youth perspectives in assessing youth-friendliness:

"We have clinics that say they are youth-friendly, but young people in focus groups have experienced it differently. It's not necessarily that the clinics are lying, but that there is just a disconnect. The message is more powerful when it comes from the youth than from the program, so the clinics need to hear from the young people about their needs."
—Grantee

8.3 Grantees approached referrals in a variety of ways

Project staff described a range of referral strategies, and for some, the approach was in development at the time of the interview.

Most projects focused (or planned to focus) referrals on youth and families participating in EBPs. Most commonly, it was the health educators who made referrals. School staff were also often involved with making referrals, including school social workers or counselors and teachers. In a few communities, schools preferred that EBP staff first refer youth to school counselors who could then make a referral out. In some cases, clinic staff were also involved in the referral process, typically by having a specific referral coordinator responsible for receiving referrals from the health educators.

Referral processes typically entailed one student speaking with one facilitator or teacher for information. However, several projects had implemented a different or more complex process. Multiple projects mentioned using a self-referral form in varying ways. A form allows youth to more comfortably ask for a referral without having to raise their hands or ask the teacher/facilitator in person. Another example is the “envelope system,” in which all students receive an envelope in which to put an information request, regardless of whether they request information (students do not know which of their peers requested information and which returned an empty envelope). Other approaches included using a referral hotline, including a 24-hour text line service.

About half of projects aimed to connect a broader population of youth to youth-friendly health care services, by providing resources publicly rather than through individual contact. Most often, these projects provided information about and connection to youth-friendly health care services to the community as a whole through a website. Some also did so by wide distribution or availability of a paper referral guide.

8.4 Barriers to accessing youth-friendly services

Grantees and partners identified several common barriers that kept youth from accessing youth friendly health care, which form the context in which they are implementing this element of the Tier 1B strategy:

A lack of youth-friendly clinics and other services to which to refer youth. In a small number of Tier 1B communities, there were no or very few youth-friendly health care options available. Rural areas were more likely to have fewer youth-friendly options than urban communities.

“There are not enough safe and supportive, youth-friendly clinics that youth can go to. When youth accessed some health facilities, they were uncomfortable and the feedback was not positive.”—Grantee

“One challenge that has come up is because we have a limited number of services available to young people in our communities, particularly in more rural communities.”—Grantee

Transportation and accessibility, even in urban communities where options were otherwise available. Youth faced multiple challenges in accessing care, but the most common was transportation to services that may be located outside of their immediate community. Many respondents identified poor public transportation or absence of public transportation in their area as a primary barrier to youth-friendly services.

Many youth lacked the skills needed to access health care or are unaware of their options. Youth may not have known what health care services were available. In addition, many respondents said that youth in their communities did not have the knowledge or confidence they needed to call and make an appointment.

Youth were concerned about confidentiality.

Many respondents identified concerns about confidentiality and the fear or stigma associated with accessing health care as major barriers. Confidentiality concerns included not only clinics providing confidential services but also the possibility of being recognized while at the clinic. When discussing the fear or stigma associated with accessing reproductive health care, respondents often mentioned the fear of being judged. This concern was magnified in small or tight-knit communities and when clinics were known to be focused on reproductive health care specifically.

"There is still a stigma [so] that you only go there as a last ditch effort, instead of using health centers for preventive health."—Grantee

Youth may have felt uncomfortable approaching facilitators for advice and referrals. Youth may not have felt comfortable enough with facilitators to make it clear what they need and to receive a referral. In addition, youth may not have had adequate opportunity to comfortably approach facilitators alone. The rapport that facilitators were able to build with youth may have made it easier for youth to approach them for support. The setting itself could sometimes make a difference in either youth comfort level or accessibility of the facilitators after the EBP sessions were over.

"In [a] community center, there is a much smaller group. They are probably able to build rapport with students. Those youth are far more likely to approach one of the facilitators. In a school, it is a little more difficult because they are only there for a class period. There are lower referral numbers because students aren't willing to talk to facilitators."—Grantee

Other barriers to access that respondents mentioned less frequently were closely tied to their understandings of what makes a clinic youth-friendly. These included the hours clinics are open (which may be limited; e.g., the clinic may be closed after school and on weekends), wait times, and issues related to money or insurance requirements. Respondents also identified the languages spoken by providers and the LGBTQ inclusivity of a clinic as potential barriers for youth seeking health care. Youth who were undocumented may also have had trouble accessing health care because they feared people connected to government systems would take notice of them if they did.

In this early phase of implementation, some grantees found it challenging in general to establish linkages and launch a referral process.

“The entire thing is a challenge. ... We’re watching every webinar and trying to get as much feedback as we can from people who have developed it well.”—Grantee

Grantee Strategies for Cultivating Youth-Friendly Options and Increasing Access

Provide training or technical assistance directly to providers or clinics. The training and TA was focused either on general practices for ensuring youth-friendliness or specific areas that need improvement to be more youth-friendly, as identified by an assessment. Typically, these approaches were fairly informal or light-touch, but there were exceptions. One grantee described an elaborate training strategy for health centers:

“There’s six days of face-to-face time over a nine-month period. [We] have 11 health centers who participate in this training, and the idea is that they are learning about family planning guidelines, teen friendliness ... and in between those sessions, they are able to practice and make changes in their process.”
—Grantee

Increase healthcare accessibility and help make youth more aware of and comfortable with accessing healthcare. This included increasing youth familiarity with clinics and health centers (e.g., tours of clinics), providing transportation support for youth (e.g., providing a bus pass), and helping youth gain the necessary skills to access healthcare (e.g., explaining how and when to make an appointment).

At the time of the interviews, some projects had not yet planned whether or how they would increase capacity for youth-friendliness among providers.

9. EARLY SUSTAINABILITY EFFORTS AND PLANNING FOR THE FUTURE

For many grantees, sustainability was a concern before they applied for the OPA grant because they wanted to avoid starting a program that would then end abruptly. Grantees were pursuing or planning a range of strategies to support sustainability following the end of the grant. Whether strategies were in process or merely considered at this stage, sustainability was something that most projects had begun considering.

"My thinking is towards sustainability—what happens after the grant ends—it doesn't mean the problem goes away, so we need to look at sustainability now. We are working to engage people across the spectrum that this is an issue that will probably be with us and we need to continue to look after it."—Partner

The majority of grantees were exploring or developing their plans for sustainability, while about a third had already begun executing plans. Very few grantees had taken concrete action at the time of the interview beyond, in some cases, beginning to train school staff on the EBPs.

Two sustainability strategies were particularly common, with most grantees mentioning one or both:

1. Institutionalizing the EBPs into new systems (typically school systems) to support sustainability; and
2. Exploring new funding mechanisms.

The majority of projects planned or were working to put infrastructure in place in their communities that would integrate programs into regular programming or service delivery systems. For example, a grantee described conducting their own capacity assessment of an implementation site:

"We're looking at how ready the site is to be able to eventually implement some type of sex education on their own without [us]. Do they have resources? Do they have champions? What are opponents saying? Do you have the knowledge? So that tells us what kind of resources [we] have to provide to them if they want to continue since this funding won't be around forever."—Grantee

Most often, this infrastructure involved training school staff to facilitate the EBPs, and/or transferring implementation of EBPs to the schools by making them a part of the regular curriculum without outside facilitation. The few grantees that already had teachers or other school staff as facilitators during the grant period expected that these facilitators would continue to facilitate the EBPs after the grant period ended. Those grantees were working to get as many school-based facilitators as possible trained before the grant funding ran out. Several projects did not use teachers as independent facilitators but did train teachers to co-facilitate with the grantee or implementation partner, or so that they could address questions about the EBPs from partners or other community members. These projects also typically expected the trained teachers to facilitate the EBPs following the end of the grant period. Some respondents said that training, and purchasing the curriculum, was the most expensive part of delivering the EBP; the actual delivery was easier to sustain.

The majority of projects, which had not trained any teachers or other institutional staff in the EBPs in any capacity, were still hopeful that they would be able to integrate the EBPs into school or other systems.

Most grantees that were looking for new funding streams were still exploring the funding landscape.

Multiple grantees expressed concern about potential federal funding cuts due to shifting budget priorities. Grantees were looking for other, related federal grants that may support their projects; exploring foundation dollars; or looking for new partners in their communities who could provide financial support. These new partners may be local government agencies, businesses, or even local health care companies. A few community-based organizations serving as implementation partners asserted that they would continue delivering the EBPs even in the absence of federal grant funding.

Less common sustainability strategies grantees were considering at this early stage were: forming a new coalition or organization that could apply for its own funding, engaging stakeholders and public officials to support the project, and relying on mobilizing the community to build grassroots funding and institutional support. Others were considering how to sustain the YLC and/or the CAG, and empowering those groups to continue the work after the funding ends.

Challenges to Sustainability

Several respondents identified big-picture concerns about securing future funding. These included:

It is initially more practical to focus on scaling up. Some noted that it is difficult to discuss sustainability during the first half of a five-year grant period, while they are still working to establish their project. Several grantees planned to address sustainability during years 3, 4, or 5 of the grant, once the project was solidly off the ground.

Sustainability in the absence of federal funds may not be possible at scale, at least not in all communities. Some noted that, in their communities, programs come and go based on funding availability and support.

Uncertainty around future funding makes sustainability difficult to plan. Respondents noted that unknown federal funding priorities complicate the process of identifying a funding strategy.

The need to show short-term measurable success. Respondents from some projects felt a great deal of pressure to show that their program was successful in order to attract future funding.

Local, context-specific challenges included underfunded school districts without the resources to deliver EBPs, or operating in rural areas that lack potential funders or partners beyond government agencies. A few saw a social context within their communities that was not conducive to building long-term support for teen pregnancy prevention programming.

10. CONCLUSION

The OPA Tier 1B TPP grant program was a large undertaking aimed at supporting community-wide initiatives in high-need communities across the U.S. The program emphasized fitting EBPs to the local context; saturating service delivery systems with EBPs in high-need areas; improving access to youth-friendly services; and amplifying impact by engaging youth, families, community leaders, and organizations with overlapping missions in a shared vision to reduce teen pregnancy.

After the first two years, Tier 1B grantees were in the process of scaling up and fully implementing the multi-component strategy in their unique community contexts. Each faced challenges that they were able to overcome, and their experiences offer insights into what it takes to prepare communities for longer-term successful implementation.

From in-depth interviews with grantees and their partners during the second year of the grant program, it is clear that, while the grant strategy included a set of specific elements with the aim of reducing teen pregnancy and disparities at the community level, the most practical and effective ways to implement them varied substantially based on community resources, needs, history, and culture.

10.1 Implementation approaches varied based on communities' level of readiness

Community readiness for taking EBPs to scale included strong pre-existing networks, influential champions, and partner organizations with capacity to support the planned reach. The broad scope of the multi-component strategy required intensive planning and close coordination with multiple stakeholders to facilitate expansion and build support in the community. Those that needed to form new relationships with key partners, cultivate champions, or build organizational capacity needed more time to lay the groundwork to achieve full implementation of all elements of the strategy. Strong community infrastructure (e.g., pre-existing partnerships and history of collaboration, other TPP-related efforts, and youth-focused non-profits and local government offices) helped grantees facilitate implementation and overcome obstacles to gaining support from the community and specific settings.

The planning year gave all grantees time to train staff and build capacity, solidify and expand agreements and relationships with partners, and establish adult and youth advisory groups before EBP implementation. Communities with higher levels of readiness used this time to build infrastructure for reaching full scale in a way that would be sustainable.

Establishing and maintaining commitments from schools and school districts allowed projects to reach full scale most efficiently. While the Tier 1B program was designed to reach youth across multiple types of settings, schools offered the most opportunities for youth to participate and can help with retention. Projects that started with strong ties to schools or found powerful champions within them were able to implement more readily and with fewer constraints. Many other projects found that building these relationships for the first time required more time and processes than expected.

10.2 Engaging key community members early, continually, and strategically facilitated successful launch of the projects

Gaining substantive engagement by community members and agencies helped projects fully implement each of the interdependent elements of the strategy. This engagement ensured that youth and their communities received appropriate and effective services, that these services were well-received and reinforced, and that the project found open doors when they reached out to communities and schools. Where projects did not yet have this engagement, they faced implementation challenges and delays.

Convening and retaining CAG and YLC members required that projects provide the groups with meaningful roles. Most grantees were able to convene CAGs and YLCs by the second year of the grant, and were working on ways to foster ownership, define meaningful roles, and improve meeting facilitation to keep these groups interested and involved. Many grantees and partners were recruiting and facilitating a youth leadership group for the first time.

10.3 Selecting curricula and strategies that work for the community meant balancing youth needs and local practicalities

Identifying EBPs that were the right fit for the community took time and attention to multiple factors, including which curricula would engage youth and be effective for them, but also which curricula the community and decision-makers would support, and which would be possible to schedule and implement smoothly given time, resources, and retention challenges.

Adaptability to changing environments was essential. While most grantees were able to implement most elements of the strategy as planned, they often had to respond quickly to unexpected challenges. For example, a setting that would no longer allow implementation, a core implementation partner that was not able to provide services as expected, or a coalition dissolving.

10.4 Tier 1B grantees successfully built on prior efforts and expanded EBPs to multiple settings using a community driven, multi-component approach.

For virtually all grantees, the Tier 1B grant was an increase in scale, scope, or both for delivering teen pregnancy prevention interventions and mobilizing their communities. By the second year of the grant, most grantees and their partners had begun to fully implement all elements of the strategy. Many had engaged new stakeholders and community agencies that had not been involved with teen pregnancy prevention efforts before, and had begun to reach more youth than they had previously. At this early stage of implementation, grantees and their partners were continuing to strategize and lay the groundwork for long-term population-level change: raising awareness, building long-term community support, strengthening collaboration across sectors, and integrating EBPs and referral systems into institutions and community settings.

APPENDIX A. TIER 1B LOGIC MODEL

OPA TPP Tier 1B Program Logic Model

