Teen Pregnancy Prevention Replication Study: Implementing *¡Cuídate!*

IMPLEMENTATION REPORT

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1 Introduction

Reducing rates of unplanned teen pregnancy and of sexually transmitted infections (STIs) are priorities for the Department of Health and Human Services (HHS). The federal Teen Pregnancy Prevention (TPP) Program, administered by the Office of Adolescent Health (OAH), includes funding for interventions that address the issues of teenage pregnancy and STIs by: (1) replicating program models that have shown some evidence of effectiveness in reducing rates of both and related behaviors; and (2) testing innovative strategies aimed at producing the same outcomes.

The TPP Program, authorized in 2010 as part of the larger Teen Pregnancy Prevention Initiative, initially included $100 million in annual funding to support programming. Of these funds, $75 million were available annually to support five-year grants for replicating 28 program models that prior rigorous evaluations had shown to be effective. An initial systematic, comprehensive review of the literature on teen pregnancy, STIs, and sexual risk behaviors identified these program models in 2009 (Kappeler & Farb, 2014).[1]

Beyond program funding, OAH set out an ambitious research agenda for the effort, encompassing grantee-led evaluations as well as federally funded impact studies. The office saw an opportunity to support new research that would contribute substantially to the existing knowledge. One set of research activities comprised rigorous grantee-led impact and implementation evaluations.[2] A second set of research activities included evaluation studes managed by the federal government. One federally-led study examined the impacts of innovative strategies and untested approaches for preventing teenage pregnancy conducted as part of ACF's Evaluation of Adolescent Pregnancy Prevention Approaches (PPA).[3] A second federally-led study, the Teen Pregnancy Prevention (TPP) Replication Study, examined the impacts of several widely-used evidence-based program models.

1.1 The TPP Replication Study

Abt Associates, with its subcontractors Belmont Research Associates, Decision Information Resources (DIR), and CiviCore, conducted the TPP Replication Study under contract with OAH and the Office of the Assistant Secretary for Planning and Evaluation (ASPE). The study has two major components: an Impact Study and an Implementation Study. The Impact Study tested whether three program models, each previously shown to be effective in a single study, continue to demonstrate effectiveness when implemented with fidelity (that is, with adherence to the core components of the program) across different

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[1] The initial review was subsequently updated several times to include studies that were released through October 2016, and the number of programs meeting the review criteria for evidence of effectiveness is now 48.

[2] OAH required TPP grantees—both those that received the largest grant amounts to implement evidence-based program models and those that proposed testing innovative interventions— to conduct rigorous evaluations of the programs they implemented.

[3] Additional information about the PPA study can be found at https://www.acf.hhs.gov/fysb/resource/ppa-study

settings and populations. Within the Impact Study, there are three independent studies, one for each program model, each using data pooled across three replications of that model.[4]

The Implementation Study describes the contexts in which the evidence-based program models were implemented, and explores the challenges faced in implementing them. Going beyond the goal of documenting and evaluating the implementation of a single program, the study aims to answer questions about the feasibility of consistently replicating evidence-based programs with fidelity to the core elements of the program model and high-quality service delivery.

1.2 The Three Models Replicated

OAH, in partnership with ASPE, selected three program models from the first round of TPP-funded grants to test and replicate. Three of the nine grantees were replicating *Reducing the Risk (RtR),* a widely used curriculum-based sexuality education program, whose 16 sessions are usually delivered in schools with students aged 14-19 years old. Three other grantees were replicating *¡Cuídate!,* an HIV/AIDS prevention program, culturally tailored to Latino adolescents aged 13-19 years old and delivered over six sessions in small groups that may be either single sex or mixed gender. The third set of grantees were replicating *Safer Sex Intervention (SSI),* a clinic-based intervention to prevent STIs that targets sexually active females aged 14-19 years old. The program is delivered individually to participants by a trained health educator using a motivational interviewing process.

Criteria used to select the program models included the breadth and scale of the proposed replication effort and the number of grantees that proposed to replicate a program model. At least five grantees proposed to replicate each model.[5] In addition, the three models represented a range of targeting and service strategies, as well as some variation in the service delivery settings.

1.3 Focus of This Report

This report focuses on the implementation of *¡Cuidate!*. Two companion reports examine the implementation of *SSI* and *RtR.* The TPP Replication Study also produced reports on the short-term and longer-term impacts of the three program models. In addition, nine site profiles provide an overview of program implementation and descriptive information about the study participants at baseline in each site. All of these site profiles and impact reports and briefs can be accessed from the TPP Replication Study webpage: https://aspe.hhs.gov/teen-pregnancy-prevention-tpp-replication-study.

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[4] The strategy of using pooled data is a unique contribution to the existing research, in that its findings are stronger and more generalizable than the single-site studies. Additional information about the design of the TPP Replication Study impact and design reports can be found at https://aspe.hhs.gov/pdf-report/impact-design-report and https://aspe.hhs.gov/pdf-report/implementation-study-design-report.

[5] Of the 28 program models in the TPP Program eligible for funding in 2010, the *Teen Outreach Program (TOP)* was the most frequently replicated. Seven independent evaluations of TOP were conducted as a condition of those grants. For this reason, it was excluded from consideration for the TPP Replication Study. *Becoming a Responsible Teen (BART)*, another widely used model, was also excluded because it had already undergone several evaluations.

2 The Implementation Study

Across the replications of the three program models, a common set of questions shaped the design of the implementation study, the types of data needed to answer the questions, the strategy and measures used to collect the data, and our approach to analyzing the data.

> The Implementation Study…
>
> - **Describes** how the replications were implemented, the contexts in which they were implemented, and the implementation challenges encountered;
> - **Evaluates** the extent to which program models were replicated with fidelity and met quality and performance standards; and
> - **Identifies** lessons for future implementation efforts.

2.1 Research Questions

Six questions address the feasibility of high-quality replication of evidence-based program models. They are as follows:

1. ***To what extent was the program model implemented as planned in the replication sites?***
2. ***To what extent was the program model implemented with fidelity in the replication sites?***
3. ***What challenges or barriers to implementation did grantees encounter and how did they deal with them?***
4. ***To what extent were the services provided under each program model of high quality?***
5. ***To what extent were program participants engaged in and responsive to the program?***
6. ***To what extent were grantees and partners ready to support high quality implementation of the selected model?***

Appendix A describes the conceptual framework for the study. Appendix B describes the data needs, sources, data collection methods, and analysis strategy. Appendix C includes sample data collection protocols.

2.2 OAH Support for Implementation

OAH created an infrastructure to support and sustain implementation (or replication) of program models selected by grantees. Throughout the grant period, the agency provided training sessions at annual grantee meetings. These were supplemented by periodic regional training sessions and webinars. This infrastructure would ensure that program models were implemented as intended by the developer and tested in its earlier evaluation, to the greatest extent possible.

> To support fidelity of implementation, OAH:
>
> - Worked with program developers to create fidelity logs (when they did not already exist)
> - Ensured that initial and ongoing training included an emphasis on fidelity
> - Stipulated completion of fidelity logs for every program session
> - Required reporting of data from the logs every six months as part of performance measure reporting

To monitor fidelity, OAH required that fidelity logs be completed after each session, and summary data be submitted every six months. To monitor implementation quality, OAH created a protocol for observers (e.g., local evaluators or grantee supervisory staff) to assess, record, and report on the quality of a sample of 10 percent of program sessions for each health educator.

OAH assessed grantee requests to adapt even minor aspects of program implementation, to ensure that adaptations did not affect core program elements.[6] Finally, OAH required that grantees record attendance at every program session and report it on the same schedule as other performance measure data. In addition to providing accountability, these measures taken together ensured that, in all cases, it would be possible to define exactly what was implemented.

OAH's fidelity and performance measurement requirements standardized the program models to the greatest extent possible, and reduced variation in both fidelity and strength of implementation.

[6] For the 2010 cohort of grants, every adaptation, however minor, required prior approval. This allowed OAH to understand the broad range of minor modifications that were intended to improve attendance or engagement or fill gaps in the curriculum.

3 The Program Model: *¡Cuídate!*

¡Cuidate! is an HIV/STI risk reduction curriculum adapted from the *Be Proud! Be Responsible!* curriculum and culturally tailored for Latino youth. It aims to reduce the risk of STIs, in particular HIV, by affecting sexual behaviors such as sexual intercourse, number of sexual partners, and condom use. Six 60-minute modules are delivered in small groups of six to 10 youth, led by a trained adult facilitator who is bilingual in English and Spanish, although the program is delivered in English only.

¡Cuídate! was originally tested in an after-school setting on consecutive weekends, but it can be delivered in other settings and on different schedules (Villaruel, Jemmott, & Jemmott, 2005). The curriculum modules are delivered in participatory, interactive sessions. Each session weaves in the theme of "taking care," whether it is taking care of oneself, one's partner, family, or community. The materials used in the sessions emphasize core Latino values and feelings, and link them to safer sexual behavior. The facilitator demonstrates correct condom use and teaches negotiation and refusal skills. Youth are exposed to information about HIV/STI transmission and prevention. Through active participation in discussions, sharing ideas and feelings, and role-playing situations in which they may be pressured to have unwanted or unsafe sex, participants increase their understanding of sexual risks and safe sexual practices and motivation to delay childbearing. Repeated role-playing activities support the acquisition of skills they need to deal with unwanted pressures and risky situations, refuse unsafe sex and negotiate safer sex, and use condoms correctly (See Appendix D for complete list of topics and core elements).

Changes in skills are hypothesized to mediate the behavioral outcomes that the program seeks to achieve: abstinence from sex, delay in initiating sex, reduced sexual activity, and correct and consistent use of condoms and birth control for those who are sexually active. Prevention of or reduction in sexually risky behavior is ultimately expected to result in reduction in the rates of STIs among teens as well as reduction in pregnancy rates (See Appendix D for the program logic model).[7]

3.1 Three Replications of *¡Cuídate!*

The replications of *¡Cuídate!* were implemented between 2010 and 2015 by three organizations:

- **Community Action Partnership of San Luis Obispo County.** Community Action Partnership, a non-profit agency founded in 1965 and based in San Luis Obispo, California, provides a wide variety of programs and services to residents of San Luis Obispo County and 10 other California counties. Since 1977, the agency has provided comprehensive sexual health education programming in schools for youth ages 10–18. The agency also has its own reproductive health clinics, including teen-designed and peer-staffed teen clinics.
- **La Alianza Hispaña.** Founded in 1970 and based in Boston, Massachusetts, La Alianza is a non-profit advocacy and service organization whose core programs address family mental health, public health, and workforce education. The agency has worked with the Boston Housing Authority to provide information about HIV/AIDs and STI prevention and pregnancy prevention to young Latina women. In addition, La Alianza has partnered with other members of the Adolescent Medicine Trials

[7] In 2012, the curriculum was revised to include material on pregnancy prevention. However, the grantees whose projects were funded in 2010 were trained on the original curriculum and implemented it, supplementing it with additional sessions on pregnancy prevention or weaving that theme into existing sessions.

network (a collaborative of community-based organizations and health care providers based at Boston Children's Hospital) to reduce HIV infection rates among adolescents.

- **Touchstone Health Services.** This non-profit organization has more than 30 years of experience providing behavioral and mental health prevention and treatment programs and services to youth across the Greater Phoenix, Arizona area. The agency has focused its prevention work on the Maryvale community, which has a predominantly Hispanic population. Before receiving the TPP grant, Touchstone had implemented a substance abuse prevention program and some limited sexual health programming in schools in this community.

Exhibit 3.1 summarizes the program as implemented by each grantee.

Exhibit 3.1: Summary of the *¡Cuídate!* Program and Its Three Replications

Program Model, Grantee	Study Location	Target Population	Participant Characteristics[b]	Program Duration and Intensity	Program Setting	Program Delivered By
Original Program Evaluation[a]						
¡Cuídate!	Saturday program serving neighborhoods in northeast Philadelphia	Adolescents age 13–18, mixed gender	81% Hispanic[c]/Latino	Eight 50-minute sessions	After-school program	Facilitators trained by the developers
Grantees Replicating the Program						
Community Action Partnership of San Luis Obispo County (Community Action Partnership)	School districts in San Luis Obispo County, CA	10th-graders	• 29–47% Hispanic, 47–64% non-Hispanic White, 1–3% non-Hispanic Black • 35–50% free/reduced-price lunch	• OAH-approved adaptation added two sessions on STIs and pregnancy prevention. • Eight sessions over eight weeks	Pullout sessions during school day in three high schools	Facilitators hired and trained by Community Action Partnership
La Alianza Hispaña (La Alianza)	School districts in Greater Boston, MA	ninth-graders (some 10th- and 11th-graders)	• 62–78% Hispanic, 9–20% non-Hispanic White, 4–25% non-Hispanic Black • 68–88% free/reduced-price lunch	• Six sessions with schedules varying by school: from nine 45-minute sessions over three weeks to three 2-hour sessions in one week	Non-core classes in two high schools; after-school program in one high school; 2 community-based program settings	Facilitators hired and trained by La Alianza
Touchstone Health Sevices[d] (Touchstone)	School districts in Greater Phoenix, AZ	eighth-graders	• 61% Hispanic, 29% non-Hispanic White, 7% non-Hispanic Black • 18.5% below federal poverty level	• OAH-approved adaptation added one session on pregnancy prevention. • Seven modules delivered over three weeks	Non-core classes in 10 elementary or intermediate schools, grades K–8	Facilitators hired and trained by Touchstone

[a] As described by developers Villarruel, Jemmott, and Jemmott (2006).
[b] Data for participant characteristics in each of the replication sites comes from the baseline survey of program participants.
[c] In the original program evaluation, *¡Cuídate!* was delivered to mixed groups of Hispanic and non-Hispanic youth, but non-Hispanic youth were excluded from the impact analyses. Of Hispanic youth, 85% were Puerto Rican.
[d] During the time of the study, the agency was called Touchstone Behavioral Health.

4 Community Context for the Replications of ¡Cuídate!

To understand the challenges that organizations face as they attempt to put in place a strong intervention that adheres to the core elements of the program model, we need an understanding of the nature of the communities in which it is delivered, the extent to which teen pregnancy and sexual risk behaviors are seen as important issues, and the availability of reproductive health resources to support and supplement the work of the program.

4.1 Community Characteristics

The three replications of *¡Cuídate!* were implemented in communities that differed in terms of the proportion of Hispanic residents in the population.

Community Action Partnership implemented the program in high schools in three communities spread across San Luis Obispo County, California. Paso Robles, the largest city in the county, is a mix of suburban and rural areas. Arroyo Grande is a small coastal town. Nipomo, in the southern part of the county, is a small rural community. The populations of all three are primarily White, with varying proportions of Hispanics residents (almost entirely of Mexican origin); Hispanic residents comprise 35 percent of the population of Paso Robles, 26 percent of Arroyo Grande, and 40 percent of Nipomo.

Touchstone Health Services implemented the program in the Pendergast Elementary School District, which includes communities in Glendale and Avondale (suburbs of Phoenix) as well as the Maryvale community in West Phoenix, Arizona. An older, inner-ring suburb, Maryvale is suffering some urban decline as Phoenix continues to grow and move outwards. Its low housing costs have made it a magnet for large numbers of immigrants from Mexico and other Latin American countries. About two-thirds of the Maryvale population is Hispanic and about one-third was born outside the United States. The proportion of Hispanics is slightly smaller in the other two communities (Avondale and Glendale); 50 percent and 36 percent respectively.

La Alianza originally focused its implementation of *¡Cuídate!* in Boston neighborhoods with large Hispanic populations but expanded beyond the Boston area to include Chelsea and Greater Lawrence, Massachusetts, both heavily Hispanic and highly urban communities. The Hispanic population in Roxbury, the area of Boston served by La Alianza, is about 28 percent, whereas the city as a whole has a Hispanic population of less than 20 percent. Chelsea, a city across the Mystic River from Boston, is the smallest in area and the second most densely populated in the state. Almost two-thirds of Chelsea's population is Hispanic, most of whom are recent immigrants from Central America. Greater Lawrence encompasses Lawrence, Methuen, and North Andover, which are all industrial cities north of Boston on the Merrimack River. Almost three-quarters of the population in Greater Lawrence is Hispanic, primarily of Dominican origin.

4.2 Community Need

Community rates of teen pregnancy varied across the three replication sites, but in all of the communities, rates for Hispanic teens were higher than rates for non-Hispanic teens.

Birth rates for Hispanic teens in the La Alianza communities ranged from 32 per 1,000 females in Boston to 57 per 1,000 females in Chelsea, compared with the state rate for all teens of 12 per 1,000 females (Massachusetts DPH, 2014). In Phoenix, which is served by Touchstone, the birth rate for Hispanic teens

was 48 per 1,000 females compared with the rate of 30 per 1,000 for all female teens (Maricopa County DPH, 2012). Teen pregnancy appears to be less of a problem in the Community Action Partnership locations, where teen birth rates have, for a decade, been well below those for California as a whole. However, in these communities, as in the other replication sites, birth rates for Hispanic teens are substantially higher than for non-Hispanic teens. In San Luis Obispo County, rates of births to Hispanic teens in 2011 were about twice as high as the rate for all teens: almost 40 per 1,000 Hispanic females vs. 20 per 1,000 females (Public Health Institute, 2012).

Teen pregnancy and births to teens were not seen as the most pressing issues in these communities.

In all three replication sites, schools recognize the problem of teen pregnancy, although it is seen as less of a priority than other issues such as bullying, academic failure, truancy, and dropout rates. None of the study communities views teen pregnancy or births to teen mothers as the primary issue facing it. Given the high crime rates in the La Alianza communities, school and community agency staff there believe that gang violence, trauma related to violence, and school dropout rates were more salient concerns. In Greater Lawrence and Chelsea, with large numbers of recent immigrants, issues of immigration, poverty, and lack of affordable housing were key concerns. Program staff reported that parents who were recent immigrants were less likely than other parents to see teen pregnancy as a problem. School and community agency staff also noted the challenge of poor academic performance.

> *"If you want to eradicate a problem, you need to get rid of the problems all around it. You need three things—health, education, and work."*
>
> La Alianza health educator

In San Luis Obispo County, drugs and alcohol were primary community concerns. In the areas served by Touchstone, community concerns focused on school issues such as aggressive behavior, bullying, attendance problems, as well as non-sexual risky behaviors outside school such as marijuana use; perhaps this was because students were on average a year younger than students in the other replication sites.

In all three replication sites, school staff reported that substantial numbers of parents held conservative views on sex education; that is, either they were unwilling to have the subject discussed in school or they preferred an abstinence-based approach. Agency and school staff believed that these parents were uncomfortable or unable to talk about sexual risk behavior and its consequences with their children, perhaps reflecting parents' own lack of knowledge about STIs and how to have a conversation on sexual topics.

4.3 Community Resources

Reproductive health services for youth were available in all three replication sites but varied in the extent to which they were accessible and used.

The three replication sites varied in the extent to which reproductive health services and other relevant services were accessible to young people. In Community Action Partnership's implementation, all three communities have accessible public health clinics. In perhaps the most conservative of these communities, the public health clinic was located just over a mile from the high school and closer to the downtown area. In each of the other two communities, Community Action Partnership runs a Center for Health and Prevention that is close to the high school. Students make use of the clinics and they provide

guest speakers for the schools on a range of health topics, including STIs and birth control (topics that California law dictates must be addressed in the health curriculum).

The Greater Boston communities served by La Alianza are relatively service-rich environments. Roxbury and Chelsea both have adolescent health clinics. In Greater Lawrence, the Family Health Center is located on the school campus and offers free condoms and birth control. It is open for the full school day and is frequently used by students. In addition, the Center provides speakers for school health classes.

In Phoenix, Touchstone staff and school staff believed that most students learn about sex from television and the Internet. The school district has avoided formally adopting a sex education curriculum. It offers an older curriculum for middle school students, consisting of six hours of videotapes, although it is rarely used. In all of the schools served by Touchstone, counselors offer help for students but are also overwhelmed by the combination of academic and family issues faced by students. There are many public health clinics in the communities served by the schools where Touchstone was implementing *¡Cuídate!*.

The three grantees were all established and well-known in their communities, and two of them had established strong links to school districts and schools that facilitated acceptance of the program.

All three grantee agencies are established and well-known in their communities; all have provided services to community families for more than 30 years. All three offer a wide variety of services for both adults and youth, but Touchstone and Community Action Partnership differ from La Alianza in the extent to which services focus on children and youth and in the linkages they have established with community partners, especially local schools.

In Maryvale, a predominantly Hispanic community in Greater Phoenix, Touchstone has provided a range of programming for youth over the 10 years preceding the grant. Specifically, they have offered in-school programs to reduce and prevent drug use, violence, depression, and emotional problems, as well as limited sexual health programming.

Touchstone focuses squarely on behavioral and mental health issues affecting youth, although its programming includes services for parents and guardians. The agency works closely with a 30-member advisory committee, whose members are all committed to preventing health problems in youth. Although the Community Action Partnership's service focus is broader and includes early care and education, housing, energy and homeless assistance for families, and family support services, the agency has worked closely with a network of service providers and advocacy groups to support teen pregnancy prevention efforts in San Luis Obispo County. It operates its own reproductive health clinics, including two designed specifically for teens, and it maintains close working relationships with the Community Health Center Network. The youth populations served by Community Action Partnership are more ethnically diverse than those served by Touchstone, including substantial proportions of White and Hispanic youth and smaller numbers of Asian and Black youth.

Almost since its inception,Community Action Partnership has provided sexual health education in schools in the county, supported by local, state, and federal funding.

By contrast, La Alianza programs and services reflect the needs of the Hispanic population it was founded to serve. The agency offers many programs that address the challenges of recent immigrants including English as a Second Language, citizenship, and high school GED classes; assistance to parents as they try to navigate the public school system; and, to a lesser extent, outpatient mental health and elder care services. With local partners, the agency has provided free STI and general health screenings at annual

health fairs. A key partner has been the Boston Housing Authority; a state grant allowed the agency to provide information about HIV/STI and pregnancy prevention to Hispanic female youth living in Boston public housing.

> The only one of the three replications with prior experience with *¡Cuídate!*, La Alianza implemented the program on a small scale (12 program cycles), with groups of girls in after-school settings in Boston public schools.

The agency is a member of the Adolescent Medical Trials Network for HIV/AIDS, a collaborative of community organizations and health care providers based at Boston Children's Hospital.[8] La Alianza had offered the *¡Cuídate!* program prior to the current OAH grant. However, there was no emphasis on implementing the program with fidelity, and the agency had few linkages to the public school system.

[8] The network was established to link young people age 12 to 24 years old living with HIV/AIDS in the Boston area to medical services, including access to clinical trials.

5 Putting the Program into Place

This chapter describes the steps taken by each of the grantees in advance of full implementation of the program; these included: cementing the agreements made with school partners (and, in some cases, finding new partners); establishing schedules for delivering the curriculum; hiring, training and supporting staff to deliver the program, and recruiting the target population.

5.1 Choosing Settings and Establishing Schedules

To a great extent, the selection of settings determines the schedule for program delivery (e.g., whether it can be delivered as part of the regular school schedule), which in turn is likely to affect attendance.

All three grantees established agreements with school partners to deliver the program in school, during the school day. One grantee had community as well as school partners and, as a result, more varied schedules. In addition, one school would agree to delivery of the program only as an after-school activity.

Both Touchstone and Community Action Partnership proposed from the outset to replicate *¡Cuídate!* in school settings, and they were successful in doing so, although the process of recruiting schools was not without challenges. Both grantees had successfully completed their recruitment of schools by the end of the pilot year and thus were able to implement the program fully in the fall semester of 2011.

Touchstone initially planned to implement the program in a high school district in Greater Phoenix where it had been working as part of an earlier project and where the superintendent was supportive. As a result of a sudden change in the district's leadership, the school district decided to revisit the selection of curricula and subsequently chose not to implement *¡Cuídate!*. This meant that Touchstone had to look beyond the high schools and instead partner with a group of 11 Greater Phoenix elementary schools (grades K–8). Touchstone had tested delivering *¡Cuídate!* as an after-school program during the pilot year and had experienced difficulty with attendance despite offering incentives to participants. As a result, staff concluded that the program should be delivered during the regular school day and negotiated with the school district and individual schools on that basis.

Touchstone devised an interesting strategy to implement *¡Cuídate!* during the school day. Regular classes on the days the program was delivered were shortened to make room in the schedule for a 60-minute *¡Cuídate!* session. An alternative program was provided for those students who were part of the evaluation but assigned to the control group, as well as for those students whose parents refused permission for them to participate in the study.[9] Drawing on its expertise in behavioral health, Touchstone quickly proposed an age-appropriate health class, using a "healthy lifestyle" curriculum that covered topics such as diet and exercise as well as decision-making. Touchstone proposed, and the district accepted, that the program be delivered to eighth-graders. Given the age of the students (13 years old), the district also required that the program be delivered to single-gender groups. These proposed modifications were reviewed by the program developer and OAH staff and approved.

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[9] Although this is a contingency that always needs to be planned for, a very small number of parents refused permission for their children to participate in the study.

Community Action Partnership also proposed to implement *¡Cuídate!* in school settings, and it too experienced some initial difficulties in recruiting schools. Previously, its work in schools had involved providing counseling and other services to students whom teachers identified as at-risk and needing help. These students were pulled out of their classes, where they might sometimes have been a disruptive element, to meet with agency staff, who could provide counseling as well as referrals or links to other services. This program was valued by school principals and teachers. Originally, the agency proposed using this same strategy to identify Hispanic students who could benefit from participation in a risk prevention program. In this case, ethical concerns (denying an intervention to the control group who had been identified as potentially in need of services) as well as the needs of the evaluation dictated a broader, less targeted approach (it would probably have been impossible to achieve the required sample sizes). Agency staff went back to schools with a proposal to deliver the program to tenth-grade students weekly over eight weeks, in a non-core class.

Schools had some problems with Community Action Partnership's approach. Some schools were concerned about the feasibility of implementing the program before school or after school, unwilling to contemplate displacing a regular class for the number of periods required to deliver the program. Finally, Community Action Partnership was able to convince three high schools, in three communities across San Luis Obispo County, to implement the program (and the study) in 10th grade physical education classes. Students whose parents gave permission for them to participate in the study and who were assigned to *¡Cuídate!* were pulled out to meet with a health educator in another area of the school. Students assigned to the control group or whose parents refused permission stayed in the physical education class. Although there was some intial opposition from teachers whose classes were affected (namely teachers resented students being taken out of their regular class), the agency was able to implement the program successfully over the two-year period.

La Alianza struggled to find partners and settings for the program and was still recruiting them after the pilot year had ended. Initially, La Alianza proposed to implement the program in public housing settings, in partnership with the Boston Housing Authority. This plan broke down in the pilot year, when the Housing Authority objected to the idea of targeting Hispanic youth; there were already tensions among ethnic groups in public housing projects, and it believed a targeted program could exacerbate them. Next, the project coordinator worked hard to forge a partnership with the Boston Public Schools, with public schools in Chelsea, and with some charter schools in both cities. These efforts faced resistance on several grounds, including opposition to the conditions of a rigorous evaluation from schools that would otherwise have welcomed the program, as well as reluctance to implement a program that targets a specific ethnic group. The bureaucratic processes for approving research studies in the Boston Public Schools were slow and unresponsive, much like those of many large urban school authorities.

> As Touchstone discovered during the pilot phase, implementing the intervention as an after-school program presents challenges that are not easy to overcome. La Alianza staff discovered that many youth enrolled in the program but then had difficulty attending the sessions consistently. Some had after-school jobs with schedules that conflicted with the program, others had family responsibilities, such as caring for younger siblings, that were not necessarily on a regular schedule.

Ultimately, La Alianza abandoned the hope of partnership with the Boston Public Schools and instead (as the program coordinator had urged for some time) expanded the proposed service area to Lawrence, an old city in the Greater Boston area with a large Hispanic population. Working closely with in-school champions for the program, the program coordinator was able to recruit a large high school and persuade

its staff to allow implementation of *¡Cuídate!* in ninth and twelfth grade physical education classes. In another school, La Alianza was able to arrange to deliver the program during the regular school day during ninth grade health class. In another high school, administrators and teachers were unwilling to give up instructional time, regardless of the subject, so the program was implemented as an after-school program.

La Alianza was successful in recruiting two community organizations to host the program during a summer youth employment program and at a youth sports program. In both cases, participants assigned to *¡Cuídate!* were pulled out of their regular class/session. In spite of the struggles to identify partners, the mix of settings in which La Alianza ultimately implemented the program provided useful information about the challenges of implementing a program outside the regular school day and in settings other than schools.

The program's flexibility about the scheduling of sessions allowed grantees to be responsive to the needs of their school and community partners. As a result, the duration of the program varied substantially, not always to good effect.

The guidance provided by *¡Cuídate!*'s developer and distributor offers a good deal of flexibility, in terms of both settings for the program and a schedule for its delivery. The program as originally tested was delivered intensively over two days; but there is no evidence that this approach is more or less effective than when the program is delivered once a week for six weeks, and the developer's guidance is neutral about a desirable schedule. In some settings, such as juvenile justice detention centers, a compressed schedule may be necessary to avoid losing participants. In other settings, what this flexible approach means is that school or community agency staff can opt for a schedule that works for them.

In all three replications, grantee staff worked with school and community partners to develop a schedule that created the least upheaval for the partners. Touchstone delivered the program in each of 11 elementary (K–8) schools on a similar schedule; that is, in eight sessions, each just under one hour, three days a week over a three-week period. Community Action Partnership negotiated a schedule with three high schools in which the program was delivered in 60-minute sessions once a week for eight weeks.

In La Alianza, schedules varied depending on the setting: in one high school, the program was delivered in eight sessions (to ensure a total of at least six hours, as class periods were considerably shorter than the hour-long session), three times a week for ninth-graders and five times a week for higher grades, so that the program was completed in two to three weeks. In the other high school, the program was delivered after school three days a week for two weeks. In the third school, a public charter school, the health teacher agreed to allocate six 1-hour class periods over six consecutive school days. The summer youth employment program built *¡Cuídate!* into its regular schedule, offering La Alianza time on Fridays, when youth attended "enrichment" activities. The program was delivered in one 4-hour session and one 2-hour session on two consecutive Fridays.

Although the program model was originally delivered over two days in two long sessions, both health educators and students found the longer sessions (two hours or more) challenging. Although it was easier to fit all the material into longer sessions (less time was needed for ice-breakers and review), both health educators and students reported that participants became bored and restless. The repetition of themes and material seemed inappropriate to them when delivery is condensed into two or three long sessions.

Finally, at the youth sports program, La Alianza scheduled three 2-hour sessions on three practice nights over a two-week period at the end of the regularly scheduled sports season. Like the employment program, the sports program initially had proposed to incorporate *¡Cuídate!* into its regular program, but it had encountered opposition from parents who did not want sex education as part of the sports program for their children. Because attendance at the practice sessions is voluntary, this compromise satisfied parents' objections, but it meant inconsistent attendance. As we will see later in the report, incorporating *¡Cuídate!* into the school schedule or as an integral part of a program, ensures many fewer attendance problems which, in turn, helps to ensure a high dose of the program and a strong test of the program's effectiveness.

5.2 Recruiting, Training, and Supporting Staff

Staff who deliver the program are one of the "drivers" of implementation. While their background and skills are especially important for addressing sensitive topics with vulnerable young people, their success also depends on the extent to which they are receive training, monitoring and feedback, and support.

5.2.1 Recruiting Staff

Across the three replications, basic hiring requirements for health educators were that they be bilingual and have prior experience working with youth. Project directors also looked for individuals who could communicate well with young people, were comfortable answering questions on sensitive topics, and could manage the dynamics of a group of teens. They looked for passion and energy, recognizing that young people can be challenging to work with effectively. In some cases, they were recruited from existing staff; in others, the grantee advertised.

All three grantees hired staff who combined familiarity with their communities, experience in and comfort with working with young people on sensitive topics, and the ability to manage groups of teens.

The selection and hiring of staff was the responsibility of the project director at each site, usually assisted by the program coordinator. The project directors at two of the three replications were well qualified to conduct the selection process; they were experienced and skilled individuals who combined an understanding of adolescent risk behavior, familiarity with their communities and potential program settings, and management skills. An interesting strategy used by the Community Action Partnership as part of the interview and screening process was to ask applicants to do a presentation on sexuality for agency staff.

> *"I was looking for people who were able to have an open mind and implement the curriculum without prejudice… people with a passion for helping young people with their issues."*
>
> A project director

La Alianza had a succession of project directors, none of whose credentials were a good match with the focus of the program;[10] with the help of a highly motivated program

> Over the first two full years of implementation, there was little or no turnover of front-line staff in two of the three replications.

[10] The first two were mental health specialists with no prior experience in the field of sexual health or adolescence. Later, a management consultant and a senior member of the La Alianza board both briefly filled the post.

coordinator, however, the agency was able to select staff to deliver the program who met its requirements.

Ultimately, the staff selected in each of the three replications had, in addition to the required skills, a variety of backgrounds. They included mental health and case management, HIV/AIDS outreach, youth development, community organizing, secondary school teaching, in-school tutoring of at-risk youth, work in reproductive health clinics, rape crisis counseling, dating violence and sexual assault prevention, and advocacy. Staff retention in La Alianza was a challenge, because of frequent leadership changes. In the third year of the grant, the project coordinator was promoted to project director, ensuring continuity in direction and leadership.

5.2.2 Training health educators

Though the staff selected to deliver the program all had prior experience that was in some way relevant to the roles they were asked to play, almost none had experience in implementing an evidence-based teen pregnancy prevention program in group settings with young people. Training was, therefore, a crucial aspect of their preparation and ongoing support for their job. In this respect, they were well served by the program developer, OAH, and their agency supervisors.

Staff training was intensive, comprehensive, and ongoing. In addition to purchasing the official training provided by the program distributor, OAH and the grantees themselves invested heavily in staff training and development.

The training provided by *¡Cuídate!*'s developer and distributor focused specifically on the unique aspects and core components of the program and the need to adhere strictly to them. It was designed to ensure that health educators understood the meaning and importance of the core components and that they made a commitment to implementing them with fidelity. Health educators and their supervisors attended these initial trainings, reporting that they were very effective in communicating these messages. For many, it was the first time they had encountered this emphasis on fidelity.

Nevertheless, there remained substantial gaps in training that were filled by program directors and by local organizations. At Touchstone, facilitators and their supervisor researched topics in comprehensive sex education or birth control to update information and then shared the information with their colleagues. Constant updates on medical accuracy were provided on the iPads that all the facilitators used; the ipads contained the curriculum content and facilitators used them to document any issues that arose after each session.

OAH offered two days of workshops at the annual grantee conference, as well as regional training sessions and webinars throughout the grant period. Topics for the workshops and webinars included classroom management, LGBTQ and diversity issues, time management, cultural diversity, engaging youth, and working with students with special needs.

At La Alianza, the local evaluator provided training in cultural competency, mandatory reporting, and STIs and HIV/AIDS. The facilitators themselves requested a refresher training to deal with sexual anatomy and physiology questions raised by students. They reported that they needed more training on how to address difficult or sensitive issues with teens and on how to help teens resist peer pressure. Staff at the Community Action Partnership attended 11 additional sessions offered by state and local agencies on topics ranging from adolescent health and sexuality to classroom presentations and public speaking.

In all three replications, supervisory staff were proactive in identifying training topics that would help staff do their job better. In particular, supervisors at the Community Action Partnership and Touchstone viewed training as an essential part of a staff development strategy that would help retain staff and keep them interested.

All three grantees felt that OAH played an essential role in the training and professional development of grantee staff. Throughout the grant period, OAH invested heavily in training, using annual conferences, regional training sessions, webinars and other strategies to cover topics of importance to all.

Toward the end of the pilot year, OAH held a grantee conference that included two days of workshops on a wide variety of topics such as awareness of cultural, racial, and ethnic issues, understanding how populations shift, understanding LGBTQ concerns and issues, and more information about fidelity, conducting observations, and adaptations. These grantee conferences continued annually throughout the grant period. One aspect of the OAH conference training sessions that grantees appreciated was that they could learn about different interventions, contexts, challenges, and strategies for overcoming barriers to implementation.

OAH supplemented the annual conferences with regional training sessions and webinars throughout the grant period. Topics covered included: classroom management; LGBT and diversity issues; time management; engaging youth; and working with youth with special needs. Because not all health educators could attend every conference or regional training session, project coordinators at all three grantee sites used a teach-back strategy, in which staff who attended a workshop provided training on the topic to other staff when they returned from the training.

5.2.3 Monitoring and feedback

In all three replications, supervisory staff monitored the performance of health educators and provided feedback. In two of the replications, the feedback was more systematic, but in all three, health educators reported feeling supported by their supervisors.

All three replications were fortunate to have as project director or project coordinator a highly trained and energetic individual who remained through the pilot year and the first two years of full implementation. For two of the three grantees, the key project leader remained in place throughout the five years of the grant. Their approach to monitoring and feedback differed somewhat.

Two of the three grantees had a systematic and tiered approach to monitoring and support. At Touchstone and Community Action Partnership, supervisory staff, sometimes in parternship with their local evaluator, regularly observed delivery of the program by health educators. They provided feedback one-on-one, either immediately after the observation or at regularly scheduled monthly meetings. At both agencies, more general issues such as time management or classroom management were discussed at group meetings, held weekly (Community Action Partnership) or monthly (Touchstone). With new staff, supervisors sometimes co-facilitated sessions, paired new staff with veteran staff, and made sure they observed the first sessions that newcomers conducted by themselves.

At La Alianza, the local evaluator observed health educators to monitor fidelity to the model and raised issues at monthly team meetings. The project coordinator visited groups almost every day; issues identified were discussed at weekly team meetings. Individual health educators were encouraged to take the initiative and consult with the project coordinator, if they encountered a problem. There was no

regularly scheduled one-on-one feedback; however, health educators reported feeling very supported by the project coordinator and completely comfortable in seeking her help.

In two of the three replications, the project coordinator or director received consistent support from the agency's administrative staff. This was not the case at La Alianza, where the agency itself was in some turmoil throughout the implementation period, with repeated changes in administrative and supervisory staff and some financial instability that contributed to staff turnover at all levels. In all three agencies program staff were involved in activities that were external but related to *¡Cuídate!*, but at La Alianza program staff were repeatedly called on to support outreach efforts to make the work of the agency more visible.

5.3 Reaching the Target Population

Given the focus of the program on Latino culture and values, the expectation was that the overwhelming majority of the youth served would be Hispanic and at higher risk for teen pregnancy than their non-Hispanic counterparts. Resistance to targeting Hispanic youth in school settings meant that in one site, the more diverse racial/ethnic composition of the population recruited by the program did not reflect the grantee's initial goals to serve mostly Hispanic youth. For the most part, the other two grantees were able to reach the proportion of Hispanic youth they proposed to serve.

In their grant proposals, all three grantees had proposed to serve primarily Hispanic youth, although each acknowledged the ethnic diversity of their communities. Both the Community Action Partnership and Touchstone proposed identifying at-risk Hispanic students and pulling them out of class to participate in the program. This was unacceptable to some prospective school partners (and possibly a violation of school policy, in that it identified students by ethnicity rather than academic performance or social-emotional problems). In response, both agencies decided to recruit all students, regardless of ethnicity, assuming that primarily Hispanic students would choose to enroll.

> Community Action Partnership, faced with a selection and recruitment strategy radically different from what it had proposed, recruited a considerably more ethnically diverse population than it had planned. La Alianza, after a number of false steps, succeeded in recruiting a heavily Hispanic population.

La Alianza faced a similar problem in the pilot year, when the agency realized that the various public housing projects it considered partnering with were considerably more ethnically diverse than staff had believed. The agency encountered similar obstacles in the Boston Public Schools, where the Hispanic population (approximately 40 percent) is comparable to that in the public housing projects administered by the Boston Housing Authority. It was difficult to promote a program during the school day that was seemingly relevant to only one cultural group.

To address these challenges, La Alianza developed a multi-pronged solution. The agency opted to broaden the geographic scope of the program to include communities in Greater Boston that were more heavily Hispanic (Chelsea 85% Hispanic; Lawrence 94%); to accept the fallback solution of an after-school implementation of the program; and to move forward with community partners outside schools that supported the program.

Participants in *¡Cuídate!* were quite young; on average, they were 14.5 years old when they entered the program. There were substantial differences among sites in student age. Youth in the Touchstone sample

were, on average, approximately two years younger than those in the La Alianza and Community Action Partnership samples. La Alianza had the broadest age range because their population included juniors and seniors in high school. This age difference was reflected in significant differences in the proportions of youth who were sexually experienced at baseline: youth in Touchstone were much less sexually experienced compared with youth served by La Alianza and the Community Action Partnership.

6 Implementation of *¡Cuídate!* in the Three Replication Sites

In this chapter we address the following questions: How was *¡Cuídate!* implemented in the three replication sites? Was the program implemented as planned? If not, what were the reasons for change or modification? What challenges did staff encounter, and how did they respond? To answer these questions we describe: the program model as it was implemented in each site; the extent to which program staff were able to implement the core elements of the program; and the extent to which they were able to retain and engage participant.

6.1 Implementing the Program Model as Planned

For each of the TPP grantees, the first year of the grant was considered a pilot year. One purpose of this pilot year was to allow grantees to assess how realistic their original replication plans were and to allow for more detailed implementation plans. For this reason, our assessment of their ability to implement the model as planned was anchored in the decisions made at the end of the pilot year.

After minor adaptations made during the initial pilot phase, all three grantees implemented the program model in accordance with the plans submitted at that point.

After the pilot year, all three grantees implemented the program in accordance with their revised plans. At that point, almost all the adaptations that grantees needed had been requested and approved as part of their revised plan. None affected the core components of the model. There were small variations in program design across the three replications, primarily in response to gaps in the program model content.

The "light touch" on pregnancy and on STIs other than HIV required grantees to add one or more sessions to fill the gap or to incorporate additional topics into existing sessions, in order to address the goals of the grant program.

Because the program's original focus was on HIV/AIDS infection and transmission, the version available to grantees from the developer/distributor in 2010 had little information about birth control methods other than condoms and it did not have updated material on STIs. [11] A challenge faced by all three grantees was how to ensure that*¡Cuídate!*, designed as an HIV/AIDS prevention program, addressed the primary goals of the TPP Program, namely to reduce rates of pregnancy and births to teens as well as STIs. In California, the Community Action Partnership determined that the program did not meet the state's curriculum requirements for sex education and, for that reason, had to add sessions on preventing pregnancy as well as on STIs other than HIV to comply with the state standards. Agency staff developed both sessions, and OAH reviewed them for medical accuracy before giving its approval. One session dealt with contraception and contraceptive methods; a second dealt with STIs other than HIV. For the second of these modules, the agency created a slide to review reproductive anatomy, which, all three grantees agreed, was an area in which participants lacked sufficient knowledge to understand the risks, transmission pathways, and prevention strategies addressed in the curriculum.

[11] Coverage of pregnancy prevention, missing in the original *¡Cuídate!* curriculum, was bolstered in a later version, published after the 2010 grantees had purchased the curriculum and training.

While not required to do so to meet state health standards, Touchstone chose to add a session on pregnancy prevention, using a module taken from another evidence-based program, reviewed for medical accuracy and approved by OAH.

La Alianza added a brief review of reproductive anatomy, to ensure that participants were aware of the correct names for body parts. It chose not to add a module on contraceptive methods, however, believing that it could undermine the program's emphasis on consistent condom use.

Finally, although the model guidance suggests the program be delivered in small groups (six to 10 participants), Touchstone requested and received permission to deliver the program in larger groups of 20 students, with two health educators rather than one leading each group. The grantee added an eighth session to ensure that students in these larger groups had opportunities to have questions answered and to engage in role plays.

6.2 Support for Implementing the Program

An important element in strong implementation is the extent to which the staff delivering the curriculum, as well as classroom teachers, support and believe in the curriculum.

Enthusiasm for *¡Cuídate!* among school staff varied, especially at first, when principals and teachers worried about parents' reactions. Over time, and with the absence of negative feedback from parents, school staff generally supported the program.

Because *¡Cuídate!* was replicated in schools by all three grantees, the attitudes of school staff were important, and to some extent were influenced by their concern about parents' reactions. School principals and staff supported the program with varying degrees of enthusiasm. Initially, some principals, though supportive, were concerned about possible adverse reactions from parents (which did not materialize).

In the Touchstone schools, principals and assistant principals who observed some sessions were impressed by the maturity and seriousness of the student participants and their use of appropriate terminology without embarrassment. A school counselor explained that, as a religious conservative, she had initially expressed some opposition to the program but had quickly moved to active support; she helped to facilitate and encourage role-play and other activities. A (male) coach at one of the schools, who was responsible for delivering some of the standard health classes, was a champion of the program, recognizing his own inability to address the topic adequately.

6.3 Fidelity of Program Implementation

The critical elements of program models typically fall into two categories: content (*what* is being taught) and pedagogy (*how* the content is taught). *¡Cuídate!*, defines the *how* in its six "core elements:" (1) the "take care" theme of the program must be incorporated into every session; (2) Latino cultural values must be linked to safer sex practices; (3) activities must be designed to increase knowledge about, positive attitudes toward, and self-efficacy with respect to sexual risk-reduction behaviors; (4) effective use of condoms must be modeled and practiced; (5) activities must build problem-solving, negotiation, and refusal skills; and (6) all sessions must be highly interactive (see Exhibit 3.1 shown earlier).

The *¡Cuídate!* developer provided fidelity checklists (or logs) for each of the sessions, listing the content to be covered and the strategy to be used.[12] For each activity, health educators were asked whether the activity was conducted (yes/no); and whether it was conducted according to the directions in the manual (yes/no)? The form provided space to comment on how the activity was changed (if it was). Health educators were required to complete a fidelity log after each class or session. Appendix E shows a sample fidelity checklist for the first of the program's six modules.

6.3.1 Using the Fidelity Checklists to Monitor Fidelity

All three grantees implemented *¡Cuídate!* with high levels of fidelity throughout the two-year period of intake for the evaluation. But the scoring did not reflect some of the changes implemented by health educators.

All three grantees that implemented *¡Cuídate!* adhered to the core elements of the model, as defined by the developer. The fidelity scores reported to OAH, based on checklists completed by health educators for every session, were uniformly high across grantees (ranging from 97 percent to 100 percent) and changed little over time.

Despite the high fidelity scores, health educators noted they occasionally had to make changes to activities. Health educators used the space allowed for notes to explain why an activity was omitted; often the reason was a scheduling change made by the school, and the activity was added to the next session. The most common activity missed was the final talking circle (usually due to time constraints). Sometimes health educators chose to omit unscripted role-plays or a game (*La Lotería*) in order to preserve the opportunity for each participant to say something at the end of the session.

6.3.2 Using the Fidelity Checklists for Continuous Improvement

After some initial resistance, both health educators and their supervisors found the fidelity logs useful for self-monitoring and for individual and group discussions aimed at improving time management.

Initially, the requirement that, throughout the grant period, health educators complete fidelity logs for every session seemed onerous and was met with some resistance. However, in interviews, health educators and their supervisors both reported that the checklists proved helpful to them. For the health educators, the checklists helped them improve time management and reminded them about topics or activities they believed were inadequately covered because of time constraints. Because this issue of insufficient time was raised by almost everyone, supervisors who read the notes from each session could focus individual and group feedback meetings on strategies to manage the sessions more effectively.

> Health educators at Community Action Partnership and Touchstone provided details about each session, including how they felt individual students were responding to the material, how effective they felt different techniques had been for conveying the desired information, and strategies for improving their performance in future sessions.

[12] Program content is covered in more detail in the Facilitator's Curriculum, provided during training.

In Community Action Partnership and Touchstone, front-line staff moved beyond issues of time management, writing extensive notes that indicated a high level of reflective practice. Some used the Notes section to point out areas or topics where youth seemed less engaged or confused. Others noted important and interesting questions raised during discussions or submitted by individual students anonymously. In both of these sites, health educators also reported to us that their supervisor (the project coordinator) reviewed these notes and used them as the basis for feedback, coaching, and group discussion (when appropriate; for example, when the whole group shared a challenge or when an individual educator had found an effective strategy or technique). Group meetings were used to develop strategies to make the material more engaging or to make sure that all the health educators were prepared to answer challenging and unexpected questions. Health educators reported finding these sessions valuable and motivating, encouraging them to continue to record detailed reflections on the fidelity checklists.

> *"The curriculum needs more information about [STIs] and oral sex. The curriculum mentions that oral sex is a risky behavior but doesn't explain why it can be risky."*
> Health educator

At La Alianza, in contrast, health educators rarely wrote any comments at all; when they did, notes were limited to comments such as "Ran out of time so was not able to complete this activity." The coordinator at La Alianza did not use these notes in her feedback or for performance reviews, and the staff were not directed or motivated to write detailed notes.

6.4 Challenges to Implementation

Although health educators delivered *¡Cuídate!* with high levels of fidelity, and they were enthusiastic about it, they faced a number of challenges related to the adequacy, relevance, and appropriateness of some of the curriculum content.

In all three replications, health educators and their supervisors struggled to incorporate essential material that was not in the curriculum, to adapt Hispanic cultural references for non-Hispanic youth, to explain them for Hispanic students unfamiliar with those references, and to explain or replace outdated material.

Gaps in the curriculum content. We noted earlier that grantees identified gaps in the content of the *¡Cuídate!* curriculum that needed to be filled, primarily the absence of material on pregnancy prevention and methods of contraception other than condoms. Also the curriculum provided sparse information on STIs beyond HIV/AIDS (in the case of one grantee, the coverage of STIs in the curriculum did not meet state standards for sexual health education). These gaps were filled by adding sessions on these topics or by incorporating approved material into existing sessions. Like staff of other grantees, health educators struggled to ensure that the information they provided was as up-to-date as possible and also medically accurate. These gaps were addressed to a greater or lesser extent before full implementation. In the course of delivering the curriculum, program staff discovered that many participants lacked a basic understanding of reproductive anatomy. The curriculum assumes a familiarity with body parts and their functions, without which much of the content is hard to understand. Grantees solved this in different ways, usually adding an explanation of

> *"The curriculum talks a lot about negotiation and refusal skills but not about how to negotiate a healthy relationship once you are sexually active."*
> Community Action Partnership health educator

reproductive anatomy before introducing material that required this knowledge, and sometimes adding a poster to illustrate the relevant anatomical parts.

> *"There should be more information on birth control methods, since it is being funded and used to reduce teen pregnancy. We struggled with how to include information on pregnancy in the curriculum."*
> La Alianza health educator

Meeting the needs of non-Hispanic participants. All three grantees delivered the program to non-Hispanic as well as Hispanic youth, as did the developer in her test of the program model. The developer explained to grantees that because *¡Cuídate!* is an adaptation of a more generally targeted program (*Be Proud, Be Responsible*), it delivers messages that are relevant and appropriate across cultures and ethnicities. However, the training provided with the curriculum did not offer help in translating some of the Hispanic cultural references for youth of other cultures (e.g., for Haitian youth in Boston, for Asian American, non-Hispanic White, or non-Hispanic Black youth in California). Faced with the challenge, health educators developed their own ways, often by asking teen participants to work with them to develop analogous cultural references when, as was frequently the case, they themselves did not know any.

Explaining unfamiliar cultural references. For reasons that are not entirely clear, a number of Hispanic participants did not understand cultural references such as "marianismo"[13](although most participants, Hispanic and non-Hispanic, understood "machismo") which has become mainstream American usage. This meant that health educators had to spend time explaining concepts that the developer had assumed Hispanic youth would understand. Generally, the assumption of a shared Hispanic culture was not borne out in the three replications, either because parents had not transmitted those particular values and concepts to their children or because parents themselves had different cultural values or used different terminology.

Health educators often enjoyed these challenges, but they also recognized that the unanticipated demands encroached on the time available for some of the program sessions: "It was a struggle to make sure we covered everything," more than one health educator said. Just about every health educator explained in the Notes section of the fidelity checklists that some activities were only partially completed, or that only some participants were able to engage in the role-plays. The theme of insufficient time was consistent across grantees and was a major focus of discussions with supervisors.

6.5 "Goodness of Fit" of the Program Materials and Strategy

Because *¡Cuídate!* was replicated in schools by all three grantees, the attitudes of school staff were important, and to some extent were influenced by their concern about parents' reactions. Initially, some principals, though supportive, were concerned about possible adverse reactions from parents (which, for the most part, did not materialize).

The program's emphasis on family and community cultural values helped generate some parental support for the program. In the La Alianza communities, however, opinion was divided, with some parents and community members supporting the Latino cultural emphasis and others believing that an intervention

[13] Marianismo: A strong or exaggerated sense of traditional femininity, especially in some Latin American cultures, placing great value on forbearance, self-sacrifice, nurturance, and the limiting of sex to marriage.

should serve students from all ethnic groups. In those same communities, there was some opposition to the program from religious groups that wanted to see abstinence education, arguing that the program encouraged sex by emphasizing the need to use condoms. The prospect of the condom demonstration, which was explained as part of the consent process, alarmed a small number of parents and accounted for some of the initial refusals to let their children participate.

6.6 Quality of Program Delivery

To supplement the measures of how the program was delivered, OAH provided an observational tool to measure the quality of program sessions.[14] Observations were conducted by a local evaluator, where one existed, or by a member of the grantee staff not directly involved in program delivery. Unlike the fidelity measures, which were model specific, the quality measures assessed aspects of program delivery common to most curriculum-based interventions. Each of ten items was rated on a scale of 1 to 5 (1 being the lowest score, 5 being the highest score) and an overall rating of the quality of the session was scored in the same way.

OAH required that these measures be completed based on observations of at least 10 percent of all program sessions; each health educator and each session was to be observed at least once a year. For grantees implementing the program in many different settings, strict adherence to these requirements proved challenging. Nevertheless, the three grantees were able to schedule observations of all health educators and most program sessions each year. Observers (local evaluators and project coordinators) were not required to nor did they observe a **representative** sample of settings or facilitators. Decisions about which sessions to observe were based on convenience and feasibility, given the need to meet the requirements.

It is important to understand the intended use of these observations. OAH required that grantees report observational findings on a regular basis as one of several accountability measures. Understandably, this requirement caused some anxiety among grantees, who were concerned that OAH might use the data to make comparisons among them; OAH was careful to reassure them that this was not their purpose. In reality, observation data do not support comparisons, given the extent of preparation for the use of the observation tool. Beyond an overview of the measure itself, OAH provided no formal training in its use. While the highest and lowest points on the five point scales have descriptive anchors, the other points are not defined, allowing for subjectivity in the rating. More importantly, there was no attempt to establish inter-rater reliability across grantees, in order to standardize ratings across observers.

These omissions are easy to explain if we understand OAH's primary view of the purpose of the observations: as a tool for continuous program improvement. For this purpose, objective observers (external evaluators) or supervisors could use the observations to identify individual health educators who could benefit from feedback and/or additional training or to identify specific areas where all staff needed the same kind of support.

Given these constraints, we approached the use of the data with great caution, hoping that they could be used to describe areas of strengths and weaknesses identified by the observers. For this purpose, we drew on observation data collected over a two-year-period, when the program was fully implemented by all

[14] The measure can be accessed at: https://www.hhs.gov/ash/oah/sites/default/files/ash/oah/oah-initiatives/assets/tpp-grantee-orientation/tpp_program_observation_form_pdf.

three grantees. Also, for this descriptive purpose, we collapsed the items from the observation scale into four categories, namely: the health educator's demonstrated knowledge of the program and curriculum content; the health educator's time management; personal qualities of the health educator (comfort with curriculum content, ability to engage students) related to effective curriculum delivery; and the responsiveness of youth participants. Exhibit 6.1 shows the items that constitute each of the categories. Below, we report on three of the four categories; the fourth category (participants' responsiveness and engagement) is discussed in the section that follows. Where helpful, we use information from interviews with program staff and Abt's own semi-structured observations of group sessions (conducted once over an 18-month period, in a small number of sessions) to shed additional light on the findings.

Exhibit 6.1 Observation Items and Conceptual Categories

Item Number	Item Content	Conceptual Category
1	In general, how **clear** were the program implementer's **explanations of activities**?	(1) Knowledge of program and content area
6a	(implementer's) **Knowledge of the program**	
6e	(implementer) **Effectively addressed questions/concerns**	
2	To what extent did the implementer **keep track of time** during the session and activities?	(2) Facilitator's time management
3	To what extent did the **presentation** of materials **seem rushed or hurried**? (reverse-scored: 1=very rushed, 5=not rushed)	
6b	(implementer's) **Level of enthusiasm**	(3) Personal qualities of facilitator
6c	(implementer's) **Poise and confidence**	
6d	(implementer's) **Rapport and communication with participants**	
4	To what extent did **participants** appear to **understand material**?	(4) Participant responsiveness and engagement
5	How **actively** did the group members **participate in discussions and activities**? (active group participation)	

Health educators for all three grantees received high scores for their knowledge of the program and the content of the curriculum.

Health educators received almost perfect scores (an average of 4.9 across the three grantees) on the observation measure for their knowledge of the program (reflecting effective training). Within the category of "knowledge," they were rated as being slightly less effective in addressing questions. In interviews, health educators expressed some frustration about their ability to address questions adequately, given the time constraints of the sessions. In addition, participants had important questions about reproductive anatomy and transmission of some STIs that were not addressed in the program content but that health educators felt were critically important.

In spite of health educators' concerns about feeling rushed at times, they received high scores for their ability to manage the available time.

The average score for time management (keeping track of time, presentation not hurried) was also high (4.6). However, in interviews and in their fidelity log notes, health educators voiced their concern that there was not sufficient time for all the activities included in each session and that they felt rushed. Grantee observers rated health educators' personal qualities very highly, averaging 4.8 across the three

replications. Abt interviewers and observers echoed these findings, reporting high levels of enthusiasm and confidence across grantees.

After their initial hesitation and concerns, grantees found conducting the observations, and providing feedback to health educators based on the observations, to be useful. They were probably most varied and most useful in the period of early implementation; certainly the high ratings they gave staff once the program was fully implemented were supported by the limited observations and interviews conducted by Abt staff over the same period.

7 Participant Responsiveness

We gauged the extent to which participants were responsive to the *¡Cuídate!* program using data from several sources: attendance data records; scores on "participant responsiveness and engagement" drawn from supervisors' observations of the quality of program sessions. Abt's own on-site observations of a sample of sessions, and information drawn from focus group sessions with students.

7.1 Attendance

OAH required attendance logs for every program session. The agency set an attendance goal for participants of 75 percent or more of sessions offered and grantees were required to report the percentage of participants who achieved that goal.

Across the three grantees, average participant attendance was high; however, one site's average was lowered by poor attendance in its community-based and after-school settings.

Across the three grantees, an average of 86 percent of participants attended at least 75 percent of the sessions (i.e., five of six sessions or six of eight sessions). Levels of attendance varied by grantee and by setting within a replication.

Averaged across the Touchstone settings (10 elementary schools teaching kindergarten through eighth grade; one intermediate school teaching sixth through eighth grade), 96 percent of participants attended at least 75 percent of the sessions. Across the 11 schools, between 86 percent and 100 percent of participants achieved this level of attendance. In the three high schools that were the setting for the Community Action Partnership's replication, 88 percent of participants attended at least 75 percent of the sessions, with little variation across the schools (ranging from 85 to 92 percent).

La Alianza experienced the greatest variation in participant attendance; depending on the setting, the percentage of participants who attended at least 75 percent of the sessions ranged from an average of 43 percent in community-based settings to 93 percent in a high school setting. However, because the largest number of program participants (69 percent) came from a single large high school, their attendance drives the site average; overall, a majority (73 percent) of participants attended 75 percent or more of the sessions. Exhibit 7.1 shows attendance by grantee.

Exhibit 7.1: Percentage of Participants Who Attended at Least 75% of Sessions, by Type of Setting and Enrollment

Grantee	Type of Setting (number of settings)	Average Enrollment	Percentage of Participants Who Attended at Least 75% of Sessions
La Alianza	During school day, high school (1)	285	93%
	During school day, charter school (1)	26	42%
	Outside school day, high school (1)	46	37%
	Community-based organizations (2)	55	43%
Community Action Partnership	During school day, high school (3)	104	88%
Touchstone	During school day, K-8 elementary school or intermediate school (11)	50	95%

7.2 Participant Engagement

The fourth category of the OAH quality observation forms encompasses two items for which the observer was required to gauge youth responses to the health educator and the material, to assess whether they understood it and the extent to which they participated actively. The average score for the category was 4.7, not as high as for the ratings of health educators in the other observational categories, but nevertheless still quite high

As noted earlier, during two-week on-site visits conducted during the second year of full implementation, Abt staff conducted observations of *¡Cuídate!* sessions in a small number of classrooms. In addition, they conducted a small number (3-4) of focus groups with participants recruited by the grantees before the visits. The focus group guide can be found in Appendix C and the protocols for observations can be found in Appendix F.

The systematic observations of program quality conducted by program supervisors (discussed in Section 6.6) offer supplementary information about the extent to which participants were actively engaged. Scores for participant responsiveness (appear to understand material, active group participation) were high (ranging from 4.4 to 5.0 on the five-point scale).

In the Touchstone replication, where the group sessions had twice as many participants as recommended, youth were somewhat less likely to actively participate in activities than were youth in the other two replications. This suggests that, even with two health educators instead of the recommended one, it was a challenge to ensure everyone's active participation, perhaps most obviously in role-playing activities. Typically, one pair of students act out the roles while all the rest watch, and the facilitator asks questions of the group and of the active pair. Even with two facilitators, if every student had a chance to participate, a group of 20 would mean 10 pairs doing role-plays in the same time allotted for three to five pairs in a typical group of six to 10 participants.

Beyond the observational score, we were interested in some factors that may have influenced student responsiveness: how health educators engaged participants, whether and how they made connections between the content and participants' lives, how they handled students' questions, and what aspects of the sessions participants responded to most positively. Information from the naturalistic observations by Abt staff provided some insight into these questions.

Health educators used questions, games, hands-on practice, and role-plays to ensure participants were actively engaged.

The *¡Cuídate!* curriculum itself includes many activities intended to engage participants: a version of the game *La Lotería* that involves facts about HIV/AIDS; role-plays to practice refusal and negotiation skills; and practice putting a condom on a penis model and taking it off. These activities involve small groups or pairs of students working collaboratively. In one of the replications, health educators began each session by eliciting ideas or examples from participants, sometimes by asking questions designed to help review material covered in the prior session, but sometimes by asking questions about life experiences or about material not yet covered. Participants responded readily to the questions, and the responses served to jump-start the session. In Abt's limited observations of classes, across sites and settings, *¡Cuídate!* health educators actively worked to draw out participants and encouraged interaction among them.

Health educators linked curriculum content to participants' lives, acknowledging different beliefs and practices while stressing the common values underlying them.

In part, health educators linked curriculum content to students' lives by encouraging students to offer examples from their own life experience, avoiding singling out individuals and allowing participants to make the connections and identify common values. They also acknowledged the diversity within the participants in each session and potential sources of conflicting beliefs. When they introduced information about the Latino cultural beliefs and values as articulated in the *¡Cuídate!* curriculum, they linked them to beliefs and values in cultures represented by non-Latino participants, without reference to any individual.

Similarly, they acknowledged that, for some participants, their religious beliefs might conflict with the curriculum content. One health educator noted that some religious beliefs might oppose teen sexual activity and the use of condoms to avoid its potential consequences, but pointed out that the information provided was intended to enable youth to make smart decisions about their behavior.

Health educators were well prepared to answer questions and also devised effective strategies to ensure that all questions were answered, while protecting participants' privacy.

As the grantees' own observations of program quality showed, across all three replications, health educators were well prepared to answer students' questions, partly as a result of the initial and ongoing training and partly as a result of the debriefing and feedback that local evaluators and supervisors provided. In all three grantee sites, health educators made the program sessions feel like a safe place, within which participants could ask questions and get answers. What educators often lacked was the time to answer all the questions asked of them. To address this challenge and also recognizing that not all students would be equally comfortable raising questions (and exposing their ignorance) in front of their peers, health educators devised supplementary strategies. One strategy was shared across grantees: at the beginning of each session, health educators distributed strips of paper, to be collected at the end of each session. Students who had a question could write it on the slip of paper; if not, they handed in a blank strip of paper. Health educators reviewed the questions and responded at the beginning of the next session. Because the questions most often arose from material presented in the prior session, this strategy served as a natural way to review the prior session as well as ensuring that all questions received an answer and that all participants felt comfortable about raising questions.

> *"Before, I thought I knew how to protect myself, but talking about sex was scary. Now I'm not afraid to talk about it…. I can be more open."*
>
> Student participant

Students enjoyed *¡Cuídate!'s* activity-based approach and, for the most part, participated with enthusiasm in role-plays, demonstrations, and games.

Participants were very engaged by the condom demonstration, probably because of its novelty, and had many questions (e.g., whether spermicide would be irritating, how to roll a condom). Other activities, while more familiar, still preserved the novelty of moving out of their seats, working in pairs, playing card games, and so on. We were fortunate, in one site, to observe two groups, one at the beginning of the cycle of eight sessions, the other at the end. The difference in the level of comfort and enthusiasm during

> *"It's a good year to be learning this because we have to know it when we are freshmen…in high school a lot of guys will convince you… freshman girls are easily tricked. In high school, girls are getting pregnant."*
>
> Student participant

role-plays was striking: early in the cycle, students needed lots of encouragement and prompting to participate in the role-play. Sessions in this school were segregated by gender so that, in an all-boys class, one member of the role-play pair had to assume the female role. The male health educators encouraged participation by modeling the role-play, taking on the female role themselves with a student partner.

8 Lessons Learned

The program was originally tested in a community-based setting with almost entirely Latino youth of Puerto Rican descent.[15] The three grantees replicating this program faced the challenge of offering a program developed for Latino youth in schools that serve a variety of ethnicities, without appearing to target a single ethnic group. In these replications, grantee staff struggled to adapt language and materials to fit the needs of a diverse school population with limited success. The one grantee who attempted to implement it as an after-school program faced difficulties in recruiting and retaining participants. Below we summarize what we learned from their experiences.

Given appropriate support, it is possible to mount replications of an evidence-based program model with fidelity to the original model.

The three replications of *¡Cuídate!* demonstrate that, with appropriate training, support, and monitoring, it is possible to consistently replicate a program model with fidelity to its core elements while incorporating minor modifications or additions responsive to the local needs of schools and participants. The infrastructure created by OAH to ensure fidelity to the program model and encourage high levels of performance provided early and ongoing support to staff who delivered the program and to their supervisors. The emphasis on fidelity began with the initial training provided by the program developer and distributor, which explained the rationale for strict adherence to the core elements. That emphasis carried through to the ongoing training and feedback provided by OAH and grantees' supervisory staff. The routine use of fidelity logs enabled staff to assess their own performance. Together, the logs and the observation measures of program quality provided a basis for feeback on how to improve that performance. OAH restricted adaptations, requiring that each one be approved before its implementation, and maintaining the position that no adaptation would be approved that altered or modified the core elements of the program as specified by its developer. The reporting requirements imposed by OAH ensured that supervisory staff were continuously aware of gaps in performance, such as poor participant attendance, and could attempt corrections (not necessarily successfully, but with full awareness of the shortfall).

Acceptance of this level of performance monitoring and reporting was not automatic; initially, grantees expressed some resistance to the rigidity and required level of effort. However, during interviews in the first and second years of full implementation, both supervisory staff and front-line staff emphasized both the importance and usefulness of the performance measures.

Individuals with a variety of prior experiences and qualifications can deliver high-quality services with fidelity to the program model, given appropriate levels of training and supervision.

The health educators who delivered the program sessions brought a range of prior experiences, qualifications, and skills to the task. With initial and ongoing training, monitoring, and feedback, they were able to deliver the program with fidelity, and to ensure that the three replications achieved a uniformly high level of quality.

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[17] Villarruel, A. M., Jemmott, J. B., & Jemmott, L. S. A randomized controlled trial testing an HIV prevention intervention for Latino youth. (2006). *Archives of Pediatrics & Adolescent Medicine, 160*(8), 772–777

Gaps in readiness may not affect the ability of program staff to deliver services with fidelity, but they can delay program implementation, affect the strength of program implementation, and create stress for program staff.

Even though one of the grantees, La Alianza, was less well prepared in terms of prior experience with programs for youth or school partnerships, it was able to deliver *¡Cuídate!* with fidelity. However, La Alianza's experience suggests that a solid understanding of the "goodness of fit" of the program with its community (the demographic mix, the political and social context, the issues that are seen as pressing, and the existence and strength of partnerships with schools and community agencies) is necessary. Without it, potential implementers will experience difficulty getting the program off the ground, which may, in turn, create uncertainties that result in staff turnover.

A program such as *¡Cuídate!* that targets a specific ethnic group faces implementation challenges in any environment that is not overwhelmingly composed of members of the group targeted.

Although there are communities in which the population consists of members of a single ethnic group, in practice these are hard to identify. In many communities there are institutions such as churches whose members belong to a single ethnic group. Such institutions or agencies could probably house a targeted intervention (although below we discuss the challenges of implementing a program in non-school settings).

¡Cuídate! is often not a perfect fit for school settings, where it is not acceptable to recruit from a specific ethnic group. Even when the majority of the school population is Hispanic, there are likely to be non-trivial numbers of non-Hispanic students, some of whom (or their parents) wish to participate and who cannot be excluded. Indeed, the developer faced the same challenge in implementing the program in Philadelphia for the original program evaluation (Villarruel et al. 2006). The developer included non-Hispanics in the program (though not in the analyses conducted for the study), arguing that the program messages had universal application. Even if this is true, *¡Cuídate!*'s very specific Hispanic cultural references need to be translated to make them relevant for non-Hispanics participants, increasing substantially the time needed to deliver the program sessions. This challenge was not addressed either in the training provided or in the program manual and materials; health educators or their supervisors will need to develop their own solutions to the problem, as they did in each of the replications examined here.

Program materials need to be continually reviewed and revised to identify gaps and to ensure they are up-to-date and relevant.

OAH ensured that all curriculum materials and any supplementary materials were medically accurate. At the same time, health educators and their supervisors grappled with issues of missing content they considered essential; with outdated materials; and with students' unfamiliarity with cultural references that the developer had assumed were universal among Hispanic populations. It is difficult to know whether the lack of familiarity is attributable to assimilation into a more universal youth culture, change in the cultural values and assumptions of the Hispanic population generally or variation in cultural values across the many different Hispanic groups in the U.S.

These gaps and issues were not clear to the grantees when they chose a program model in 2010; but it is also true that if they desired to address specifically the higher rates of HIV infection and births to Hispanic teens, there weren't a lot of program choices. Since 2010, however, additional programs

developed for Latino youth that demonstrate evidence of effectiveness have been identified, providing future implementers with wider choices.

It is challenging to retain youth when a program is implemented in community-based settings or outside the regular school day.

Settings are an important consideration. It can be desirable to move beyond school settings, especially in situations where high-risk youth have dropped out of school (less likely in eighth or ninth grade) or in order to capture a targeted ethnic group. However, many factors beyond lack of interest constrain the ability of youth to participate in non-school settings (e.g., family responsibilities, after-school jobs, transportation).

Non-school settings also provide an opportunity to have a less hurried schedule, as they are not governed by a school schedule and class periods that are often shorter than the hour that is recommended for *¡Cuídate!* sessions. However, unless participation can be mandated (e.g., in a diversion program, as a condition of participation in a sought-after activity such as sports), the program is likely to face challenges in recruiting and retaining youth.

The uniformity, fidelity, and high quality of the three replications have positive implications for the study of program impacts but may limit our ability to explain variations in impacts.

The high levels of fidelity and of program quality across the three replications have positive implications for the assessment of *¡Cuídate!*'s impact. First, they make it possible to characterize what was actually delivered to participants. Second, the uniformity of implementation supports the pooling of outcome data from the three replications. And finally, these features of the implementation make it possible to assert that what was delivered came as close as possible to what the program developer intended. However, the uniformly high quality of the replications makes it difficult to explain findings from the Impact Study in this aspect of implementation.

Finally, the fidelity and quality of the replications, achieved in spite of the challenges faced by all three grantees, are a testament to the commitment of grantee staff and of the OAH agency staff who guided, supported, and monitored them. Their efforts resulted in strong replications that accurately reflected the essential elements of the *¡Cuídate!* program model and provided a strong test of its effectiveness.

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Villarruel, A. M., Jemmott, J. B., & Jemmott, L. S. (2006). A randomized controlled trial testing an HIV prevention intervention for Latino youth. *Archives of Pediatrics & Adolescent Medicine, 160*(8), 772-777.

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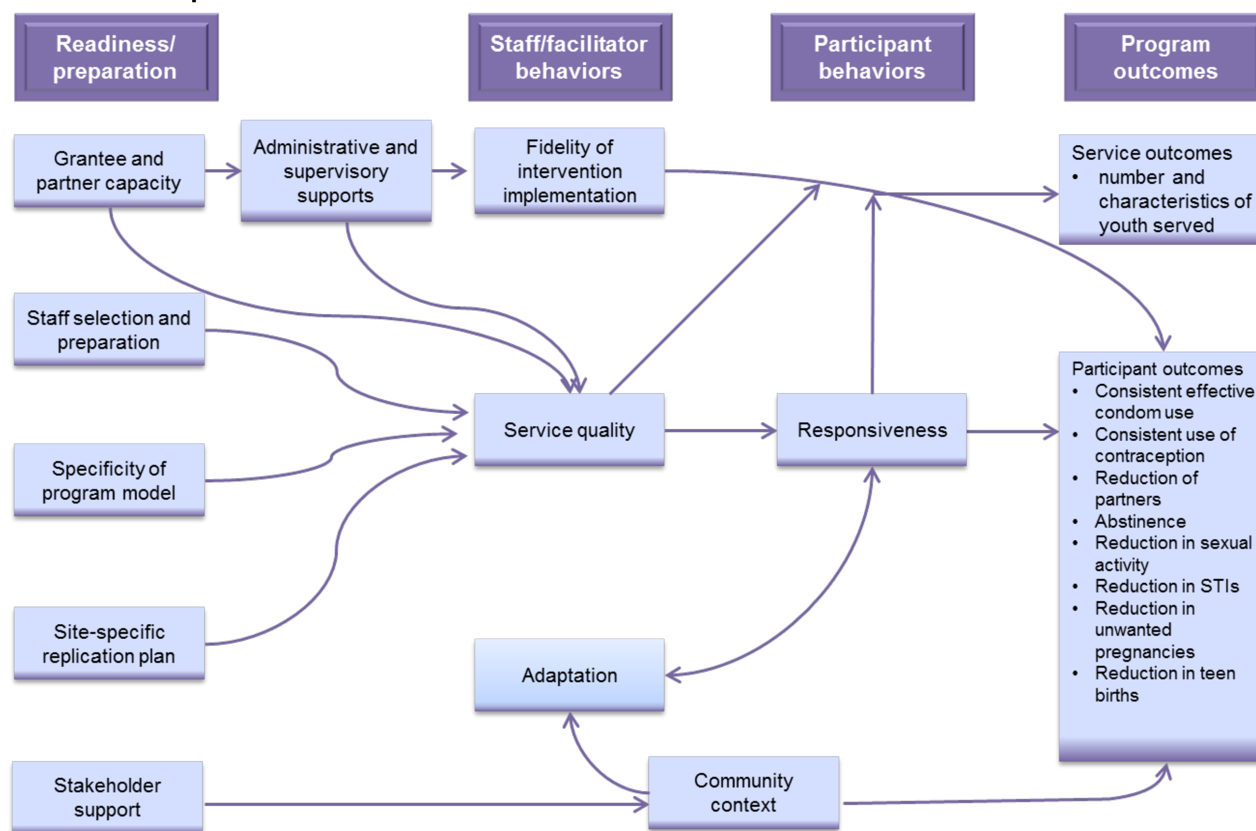
Appendix A: Implementation Framework Elements, Constructs, and Data Elements

Fidelity to a program model is not the only aspect of implementation that might affect participant outcomes. The framework shown in Exhibit A.1 builds on the work of Berkel and her colleagues (2011) and others to identify aspects of implementation that have been shown to affect program outcomes, as well as the factors, internal and external to the grantee, that affect implementation. ***Readiness***, both of the grantee and partners and of the program model itself; the ***context*** in which the program is implemented; and the extent to which ***supervisory staff*** monitor and support staff who deliver the program may all affect the ***fidelity*** and ***quality*** of program implementation and force ***adaptations*** that strengthen or weaken the program. In turn, the strength and quality of program implementation influence its ability to attract and retain participants and their ***responsiveness*** to the program's messages—critical antecedents of program impact.

Exhibit A.1: Implementation Framework



Beginning from the right-hand side of the diagram, the participant outcomes shown are a set of behavioral outcomes that are necessary precursors of reductions in STIs, teen pregnancies, and teen births. They are: abstention from sexual intercourse or reduction in sexual risk behaviors (i.e. consistent effective condom use, consistent use of contraception, reduction in number of partners, reduced sexual activity).

Next, Berkel and her colleagues propose four behavioral mediators linked to participant outcomes in reviews of prior research (e.g., Dane & Schneider, 1998; Durlak & DuPre, 2008; Dusenbury et al., 2003).

Three are in the category of staff behaviors; one is participant behaviors. The three staff behaviors are fidelity, service quality, and adaptation. The participant mediating behavior is responsiveness.

Fidelity of intervention implementation is the extent to which key program components are delivered as prescribed by the program developer, in terms of content, delivery methods, and the amount of time spent on each component. ***Service Quality*** refers to the instructional approach and the skill with which facilitators or health educators deliver program material and interact with participants. ***Adaptation*** refers to changes made to the program as planned; for example, changing recruitment and retention strategies, adding materials that are relevant to participants' lives or that fill a gap in the existing curriculum. ***Responsiveness*** is indicated by: participants' attendance at program sessions, active participation and engagement in program activities, and satisfaction with the program. Participant responsiveness and quality of service interact with fidelity to produce the desired outcomes, in terms of both *service outcomes* (the number and characteristics of youth served) and *participant outcomes* (reduction in STIs, teen pregnancy, and teen births).

The actions and processes that program administrators put in place to support the work of front-line staff are crucial to successful implementation. The ***administrative and supervisory supports*** that foster positive staff behaviors include: decision-making and problem-solving processes that involve front-line staff; clear rules and performance standards; in-service training, consultation, and coaching that is responsive to staff needs; fidelity and performance monitoring; regular feedback to improve performance; and effective work with external systems and agencies to ensure needed support for the program.

Although ***readiness and preparation*** are not always part of the discussion of implementation, they are crucial to the ability of organizations to implement the program as planned.[16] Indeed, the requirements of the funding opportunity announcement and the provision of a planning and pilot year for all grantees made it clear that OAH also perceived the importance of these precursors of implementation.

Finally, the external ***community context*** in which the program is operating (e.g., a community, one or more neighborhoods, a school district) affects the ability to fully implement a program and may also directly influence outcomes.

[16] http://ctndisseminationlibrary.org/PDF/nirnmonograph.pdf

Appendix B: Data Needs, Sources, Data Collection Methods, and Analysis

The conceptual framework for the Implementation Study guided our identification of the information needed to address the study's research questions and to identify the challenges. We grouped the information needed under four major elements drawn from the framework: *readiness, implementation, community context,* and *participant responsiveness.* Within each of these categories we identified a number of topics (constructs). Then within the contructs we grouped the data elements needed to build them and assessed the extent to which existing materials and documents could provide the data needed. For the many gaps left, we developed measures and a strategy for data collection. Below we describe these steps in more detail.

Data Sources

For some of the information needed, ***existing materials and documents*** constituted a rich resource. These fall into six categories:

- **Materials prepared by the grantee.** These included: the original grant proposal and revisions to it; semi-annual reports; adaptation and modification requests made in writing to OAH; and materials developed to publicize the program and explain its purpose to community members and potential participants. These provided background information on the grantee, its partners and the community context, as well as the original plan for program implementation and subsequent revisions.
- **Materials developed and provided by OAH.** These included: guidance on adaptation and modification; fidelity checklists, attendance logs, and quality observation protocols, with guidance for their use and reporting. These provided information about OAH's strategy for shaping and controlling changes to the original program model, as well as an understanding of the agency's plans for recording and monitoring the strength, fidelity, and quality of the program implementation in a systematic way.
- **Information collected by Abt staff as part of the recruitment site visits and subsequent weekly calls to grantees.** Although the principal focus of these conversations was the TPP Replication Study itself and the progress of the evaluation in each replication site, they inevitably touched on challenges the grantees encountered in working with partners, school districts, and individual schools, in reaching out to parents and community members to explain and justify the program; and modifications they needed to make to their original plans.
- **Extant data on community and population characteristics.** Existing national, state, and local databases provided information on community demographics, crime statistics, and teen births.
- **Data collected by grantees and reported to OAH.** As we noted earlier, OAH required grantees to record and report data drawn from the fidelity checklists, quality observations, and attendance logs. These data, specifically for the two-year period when grantees were recruiting and serving study participants, provided systematic and comprehensive information on the strength, fidelity, and quality of program implementation.
- **Data from the Impact Study baseline survey.** The initial survey conducted for the Impact Study provided demographic and other information on program participants that allowed us to characterize the population served by the program.

Although these resources provided essential information, there were substantial gaps that dictated the need to create ***new measures*** specifically for the study. These included:

- **Interview topic guides.** These were intended for use with agency, program, partner, and school staff as well as stakeholders. Interviews served to update and expand on information drawn from written materials and to provide unique information on the process and challenges of implementing the program from multiple perspectives. We developed individual interview protocols for six roles:
  - Project director;
  - Grantee agency representative (person listed as contact person on proposal), if different from project director;
  - Program Manager;
  - Front-line staff (health educators/facilitators);
  - Supervisory staff; and
  - School, school/community stakeholder, and partner staff.

Focus group and group interview guides. These were intended for use with program participants and for health educators (if they were interviewed in a group rather than, or in addition to, individually). For teens who participated in the program, the guides probed reactions to the program in terms of the appeal of its content and activities, information that was new and important to them, misconceptions corrected, and changes in attitudes or intentions. For health educators, the guides gathered information similar to that gathered in individual interviews, but in a more informal way. We developed group interview protocols for:

- Participating youth (non-clinic-based interventions); and
- Front-line staff (when individual interviews were not practicable).

Sample protocols are included in Appendix B.

B.1 Data Collection Strategy

The strategy for amassing data from these sources differed, depending on the type of information. Information from materials prepared by the grantees or by OAH was extracted at intervals as it became available. Information from extant databases was extracted early in the study and updated over its course.

The issue of how and for what period to obtain performance data (attendance, fidelity, and quality) was not simple to resolve. Although all of it was reported to OAH, there were problems with accessing the data from that source. For example, attendance data were reported in aggregate form to OAH; though this would have been adequate for the purposes of the Implementation Study, the Impact Study required attendance data linked to individual participants. In addition, grantees reported performance measure data on all the participants served; some grantees provided services to participants in locations not included in the study. For these reasons, we opted to have grantees download performance data directly to a secure Abt website, on the same schedule as data were reported to OAH, and for the three reporting points (May 2013, November 2013, and May 2014) when grantees were recruiting and serving study participants.

Information from agency and program staff was collected twice during the period of full program implementation: by telephone in 2012-13 and face-to-face during site visits in 2014. Both telephone and

in-person interviews were conducted by two-person teams, composed of study staff members who were familiar to grantee staff through their weekly telephone calls.

Information from partner and school staff and other community members, as well as from program participants, was collected once during the same site visits.

Finally, during the same site visits, Abt staff observed a sample of program sessions, using semi-structured observation protocols for a naturalistic observation (see Appendix C). The use of these measures was intended to structure and focus the observations conducted by Abt staff, rather than to provide additional information for the grantees' own use, as only a small number of sessions could be observed. Staff observers took naturalistic notes, with the observation protocol as a guide, and then wrote up notes using the protocol.

B.2 Analysis Strategy

Because the data gathered for the study came from multiple sources, the information collected on-site and by telephone was not summarized in a traditional single-site report. Rather, the interview notes and other data were coded and entered into an electronic database, using NVivo, a software package designed for this purpose. The software allows, among other things, search and retrieval of information by code (i.e., topic or question), so that we were able to extract information from all sources to address, for example, questions such as "How appropriate/relevant was the curriculum for the population served? What gaps, if any, were identified?" We generated reports for each implementation framework subtopic ("node") and then analyzed for themes within major implementation topics, checking for triangulation across both extant data sources and interviews within sites. We also looked across replication sites for common themes and unique characteristics.

In addressing each topic, we first looked across a program model's three replications to identify a common theme or finding, and then examined variation among them. We followed our descriptive analysis by an evaluative analysis that answered questions such as "How successful were health educators in dealing with the challenge of delivering a program to multi-ethnic groups?" As part of the impact analyses that were conducted after the final follow-up data collection, we used the implementation data to provide possible explanations for any variations in program impact that were found.

Appendix C: Data Collection Materials (samples)

C.1 Discussion Guide for Use with Program/Project Director (telephone interview)

(person responsible for overseeing the implementation of the program model)

A: READINESS/PREPARATION: PROJECT DIRECTOR BACKGROUND AND SPONSORING AGENCY READINESS

A1. Education and experience of project director

Probes: Can you tell me about yourself – how long you have been with the agency, what you were doing before you came here? What aspects of your education and experience do you see as helpful for this job? Experience with youth programs? Sexual health services or interventions? Social services?

A2. Grantee agency position and role in the community.

Probes: What is your perception of how the agency is viewed in the community – in terms of its mission, the accessibility of its programs and services, its ability to reach and serve needy populations? Is it seen as a leader in the community or one of many? Is there opposition to (or support for) the agency or to agency programs such as this one? Which community institutions support the agency and how is their support shown? Where does opposition arise and how does it manifest itself (news items, columns, letters to the editor, direct communication with the agency)?

A3. Agency's prior experience with programming for youth, with sexual health programming

Probes: Are you familiar with the agency's earlier experience with youth programming, sexual health programming? How successful were these earlier efforts in terms of attracting and retaining the target population, ability to implement the intervention as planned, any outcomes measured? Any adverse reactions/opposition from community members?

A4. Selection of program model for replication

Probes: Were you involved in the selection of the program model that you are replicating? If not, who can talk to us about this? If you were, what information did you use in determining the need for the program (problems in community, statistics on teen pregnancy, births, STIs)? Who did your needs assessment? Did you seek advice from others in the community or involve others in the choice of the program? What were your considerations in selecting (name of program model)? In what ways did it appear appropriate to the needs you identified? Did you foresee any challenges in implementing this program model – if so what were your concerns (agency policies, community opposition, school district concerns about aspects of the program)? What was your vision for the program and what it might accomplish or lead to?

A5. External support for the program

Probes: Thinking about planning for implementation of the program, what resources, if any, did you feel you would need, outside the services your agency provides? Did you feel you might need, for example, sexual health services, youth programs as sources for referral into the program or sources for additional services? Were there organizations or individuals in the community, outside your partner

agencies, you felt you could count on to support the program (school district or school staff, local government agencies, private agencies)? Have those expectations been realized? Did the individuals and organizations you counted on to provide resources or support, in fact provide them? Are there organizations that see your agency as a competitor for youth services, that are hostile or unwilling to help you?

B. READINESS/PREPARATION: STAFFING

B1. Structure of program staffing

Probes: Can you help me understand how the project works, how the program is staffed, who you report to, who reports to you, the lines of supervision and accountability? In your view, is the staff configuration and number appropriate to mount a strong implementation of the program. If not, what additional staff do you think would make the program stronger – numbers and type of staff?

B2. Recruitment and selection of staff for the program

*Probes**:** How involved were you in planning the staffing of the project? If you were involved, what was your plan for staffing the program (supervisory vs. front-line staff)**?** Was your plan to use existing staff to implement the program or to recruit staff specifically for this program? Advantages vs. disadvantages of the decision? If decision was to use existing staff, how did you select them, what were criteria for selection? If decision was to hire new staff, how did you recruit them, what qualifications, skills were you looking for? Who, ultimately, makes staffing decisions?*

B3. Staff training for implementation

Note: we are not talking here about training to deliver the program.

*Probes: What amount and kind of training did you feel it was necessary for staff to have? What type and amount of training did they receive before the program began? Who provided the training? If the developer provided training, who attended? **For each kind of training (i.e., OAH-provided, developer-provided, grantee-provided), ask:** Did you participate in the training? Did you feel it was adequate? Were staff required to do any other type of preparation? In retrospect, are there areas where staff needed more or different training? Who trains new hires and what does the training focus on? Is it as intensive as the initial training? If not, why not?*

B4. Staff commitment

Probes: How committed are staff to this specific program model? Do you think they believe in the program model's goals? Feel the activities and content are appropriate for the youth population they are working with? (If staff are very committed: how do they demonstrate their commitment? What is the basis for your judgment? How do you keep them motivated?) Did their feelings about the program change as a result of the pilot? In what ways?

C. READINESS/PREPARATION: SUPPORT FOR IMPLEMENTATION OF THE MODEL

C1. Adequacy of materials and support for implementation of the model

Probes: Do you feel that the materials provided for training and reference met your needs and those of your staff? If not, in what ways were they not adequate – what would have been helpful? Did you receive prompt and helpful support when you had questions about the program? Who provided that support?

D. READINESS/PREPARATION: SITE-SPECIFIC REPLICATION PLAN

D1. Approved changes/adaptations to the program model

Probes: Did you make any subsequent changes to the plan with OAH approval? What were the reasons for the change(s)? Were there changes you made that didn't require formal approval (like adding a staff member, assigning responsibilities differently)? Which changes were made early (before the pilot test)?

D2. *How useful was the pilot test? What did you learn? Were any changes to your plan made as a result?*

E. IMPLEMENTATION: PUTTING THE PROGRAM IN PLACE

(Note: We are referring to first year of full implementation, before the study started –we will ask about this current year on our site visit next year)

E1. Settings for the program

Probes: Looking back at last year, were you able to implement the program in the number and type of schools that you planned? What obstacles did you encounter? Were you able to overcome them? How? If the obstacle remained, what changes did you make in your strategy for implementing the program? How did this affect the implementation of the program, your ability to recruit and retain youth, other aspects of the program?

E2. Staffing the program

Probes: Did you make any changes in program staffing as a result of the first implementation year (i.e., last year)? What were they? What is the workload (case flow) for front-line staff? Is it more or less than you expected? What are the reasons for the difference? Have you lost any of your original staff? How many and over what period? What were their reasons for leaving the program? How do you think that staff changes affect the intervention?

E3. Target population

Probes: Are you serving the youth you planned to serve, in terms of numbers, characteristics, risk factors? If not, what barriers to your original plan did you encounter? What outreach strategies have you developed to recruit participants? How do you recruit youth for the program? Are there things you would do in terms of recruiting, if you had more resources (money and/or staff)? Have you encountered problems with retention? What strategies have you developed to improve retention?

E4. Schedule for program activities

Probes: How is the program delivered? In how many sessions, of what length, and over what period of time? What challenges to scheduling the program did you encounter? How does scheduling affect retention? How does it affect your ability to deliver the program?

E5. Program components/activities

Probes: have you been able to implement all the components/activities required by the program model (as adapted for the replication)? If not, which ones have you had to drop or modify? What were the reasons for the change?

E6. Gaps in /problems with program content/length and number of sessions

Probes: Are there activities or program content that are inappropriate for the population you are serving? That seem out of date? Are there gaps in content, information that your youth population needs that is not part of the program? Are the sessions long enough and are there enough of them to meet the needs of the youth you serve? If not, how would you change the length and/or number of sessions? How have you dealt with these issues?

E7. Satisfaction with program model

Probes: Overall, do you feel that the program model you are replicating is the correct choice for the youth population you are serving? If not, in what ways is it less than ideal? In retrospect, would you choose a different program model to replicate? Which one (or what characteristics would be important)?

E8. Response of participants

Probes: How engaged are youth in the activities/content of the program? What aspects of the program/activities/content are they most/least responsive to? Have you had any feedback from them about the program? What kinds of comments do they make about the program? Have you made any changes as a result of these comments? What kinds of changes did you make?

F. IMPLEMENTATION: ADMINISTRATIVE AND SUPERVISORY PROCESSES

F1. Working with partners (these could be agencies that help implement the program, schools that signed on at the proposal stage, others).

Probes: Were you able to work productively with the partners you originally proposed? What problems or barriers did you encounter? What roles did the partners play in implementing the program? Which partnerships were most effective?

F2. Decision-making and problem-solving processes and strategies

Probes: Who is involved in making decisions about the program, solving problems that arise? Do you bring front-line staff (health educators, facilitators) into the process? How?

F3. Maintaining school and community support

Probes: Have you been involved in maintaining support for the program in schools (or community agencies)? What difficulties have you encountered?

G. Support for Staff Performance

G1. In-service training for staff

Probes: Do you provide in-service training for your front-line staff? What type and amount do you provide? Who does the training? Do you get feedback from staff about the relevance and effectiveness of the training? Have you changed the training in response to feedback from staff/ How? What about new staff … how are they trained?

G2. Consultation and coaching

Probes: In addition to any in-service training, who can front-line staff go to for advice, consultation? Does this happen as a regularly scheduled activity, or as needed?

G3. Monitoring, evaluation and feedback

Probes: Who is responsible for monitoring staff performance, in particular monitoring fidelity to the program model and effectiveness of delivery? How is that information used, in addition to reporting it to OAH? Is it used to provide feedback to front-line staff? Who provides the feedback and on what schedule? What has been staff reaction to the monitoring tools and any feedback? Do they find it helpful? Do they believe that the monitoring tools assess performance accurately? What are the areas in which achieving fidelity has been challenging? Why do you think that is? What did you do to address weaknesses in those areas? Have you had challenges in achieving high-quality services? What were they? Has improving fidelity/quality of services affected levels of participation or engagement?

G4. Staff workload

Probes: What is the workload of your front-line staff (number of clients/number of sessions or groups per week)? Is that too much, too little or just right, in your view? How could it be improved?

C.2 Site Visit Discussion Guide for Use with Program Director

E. IMPLEMENTATION: THE PAST YEAR

(Note: let's make it clear here that we are talking about the past year.)

E1. Settings for the program

Probes: Looking back at the last year, were you able to implement the program in the number and type of schools that you planned? ***Did you have any difficulty recruiting schools? Was support for the program uniform across schools or were there differences? Let's talk through each of the schools and how implementation went in each one?*** *What obstacles did you encounter (**classrooms set aside for RtR, scheduling, teacher attitudes, class sizes compared with prior years, classroom management issues**). Were you able to overcome them? How? If the obstacle remained, what changes did you make in your strategy for implementing the program? How did this affect the implementation of the program, your ability to recruit and retain youth, other aspects of the program?* ***What, if anything would you do differently?***

E2. Staffing the program

Probes: Did you make any changes in program staffing since we talked last December? What were they? What is the workload (case flow) for your front-line staff? Is it more than it was the year before? What are the reasons for the difference? ***What are the implications for staff of implementing the program in two schools simultaneously?***

E3. Target population

Probes: Are you serving the youth you planned to serve, in terms of numbers, characteristics, risk factors? If not, what barriers to your original plan did you encounter? ***Let's talk about each of the schools you are in – are there differences in risk level among them? Are they different in this respect from the schools you began with in the pilot year?*** *How do you recruit youth for the program? Are there things you would do in terms of recruiting, if you had more resources (money and/or staff)? Have you encountered problems with retention? What strategies have you developed to improve retention?*

E4. Schedule for program activities

Probes: ***Thinking about each of the schools you are in, what challenges to scheduling the program did you encounter?*** *How does scheduling affect retention? How does it affect your ability to deliver the program?*

E5. Program components/activities

Probes: have you been able to implement all the components/activities required by the program model (as adapted for the replication)? If not, which ones have you had to drop or modify? What were the reasons for the change? ***How successful were you in getting students to complete homework assignments like visiting clinics, shopping for condoms? What barriers did they encounter? Were these positive experiences for students who completed them? What could be done to improve the completion of these assignments/the quality of the experience?***

E6. Gaps in /problems with program content/length and number of sessions

Probes: ***Is RtR generally appropriate for the students you are serving? How about when you have a mix of ages in the class****? Are there activities or curriculum content that are inappropriate? That seem out of date? Are there gaps in content, information that your youth population needs that is not part of the curriculum? Are the sessions long enough and are there enough of them to meet the needs of the youth you serve? If not, how would you change the length and/or number of sessions? How have you dealt with these issues?*

E7. Maintaining fidelity/meeting performance standards

Probes: How adequate do you feel the fidelity measures are in reflecting the core elements of the program? Are there important elements that the fidelity measures can't capture? What are they? Do you use the data you collect on fidelity for your own purposes, ***for monitoring and improving staff performance, for instance?*** *How do you use the data* ***(ask about both the fidelity logs and the observations****)? How much time do you (or other staff) spend collecting and reporting fidelity and performance measure data? (We want to be able to explain exactly what it takes to implement a program with fidelity). Do you think the requirements are too burdensome or not sufficiently demanding, or not focused on the right things/ How would you change them if you were designing a system to ensure fidelity to a model?*

H. COMMUNITY CONTEXT

H1. External events that affected program implementation (**legislation, negative publicity about Planned Parenthood, school district budget cuts)**

H2. Community attitudes toward the problem of teen pregnancy

Probes: What are the prevailing attitudes towards adolescent sexual and other risk behaviors? What are the beliefs about teen pregnancy (i.e. a large problem, a manageable problem)? Are teen sexual behavior and pregnancy perceived as problems by members of community? ***How important is the teen pregnancy problem compared with other youth issues in the community?***

H3. Visibility of the program and community response

Probes: Is this program (highly) visible in the community? What is the level of community support for and/or opposition to the program from schools/school supervisors/community leaders? What are the sources of support for and/or opposition to the program from schools/schools supervisors/community leaders? Have you received any positive or negative messages about your program? Are there particular components of the program that are perceived positively or negatively by the community?

H4. Sustainability of the program

Probes: Are you hoping to sustain the program within this community? How do you think it might look five years from now? Who would sponsor it, how would it be staffed, how would it be funded, would it serve the same population or a broader/narrower population? Do you think there is a continuing need to monitor and support fidelity of implementation?

Wrap Up

Thank you for taking time to talk to me. Before we end this interview, this is a final opportunity for you to reflect on the experience of the last three years and distill from it some important lessons to share with future implementers. What would you like to share—suggestions about working with schools, staffing, program adaptations and implementation, building community support, external influences on your ability to implement the program, ………?

C.3 Focus Group Discussion Guide for Use with Program Participants

Instructions: Program participants may not participate in the focus group if the assent/consent form is not signed and submitted. Study participants already have parent consent to participate. Confirm ahead of time that recruits are in the study. Assent forms will be collected and stored, but identifying information on participants will not be collected during the focus group discussion. Introduce yourself, explain your role, purpose of the focus group, ground rules for discussion, and review information (e.g., risks & benefits, confidentiality) contained in the Consent Form.

Icebreaker/introductions:

A: Understanding the goals of the program

Let's talk about *Reducing the Risk*--what you think it is trying to do and how you feel about it.
Probes: What do you think ***Reducing the Risk*** *is trying to do in their work with you and others like you? What are the messages you take away from the program? What are they hoping to teach you?**?***

B: Program activities

Probes: In a typical session, what happens? About how much time is there to have discussions, ask questions and have them answered? What are the kinds of questions that don't get answered? What things would you like to have heard about that weren't covered? Are there any activities that you have especially liked? What are they? Are there any activities that you have not liked or that made you feel uncomfortable? What are they?

C. Program content

Probes: What kinds of things do you talk about in the program sessions? Do you discuss pregnancy prevention? What kinds of topics tend to get a lot of attention? Are there things you discuss that you feel everyone already knows? Are there things you wish you could discuss as a group? Topics that aren't covered that you would like to talk about?

D. Participation

Probes: Who talks more, you and the others in the group or the adult leading the session? How would you describe the sessions? Interesting? Boring? Somewhere in between? What kinds of things does s/he/they do that you like or dislike? Do you feel really involved in the program?

E. Response to message

Probes: You don't need to be specific, but has anything you did or heard in this program helped you to make a decision about how to lead your life or how to act in certain situations? What was it that had that effect on you?

F. Overall experience

Probes: Overall, are you glad that you have been involved in this program? Why or why not? Would you do it again if you had the choice? Why or why not? Lastly, if you could change one thing about the program, what would it be?

Appendix D: *¡Cuídate!* Sessions

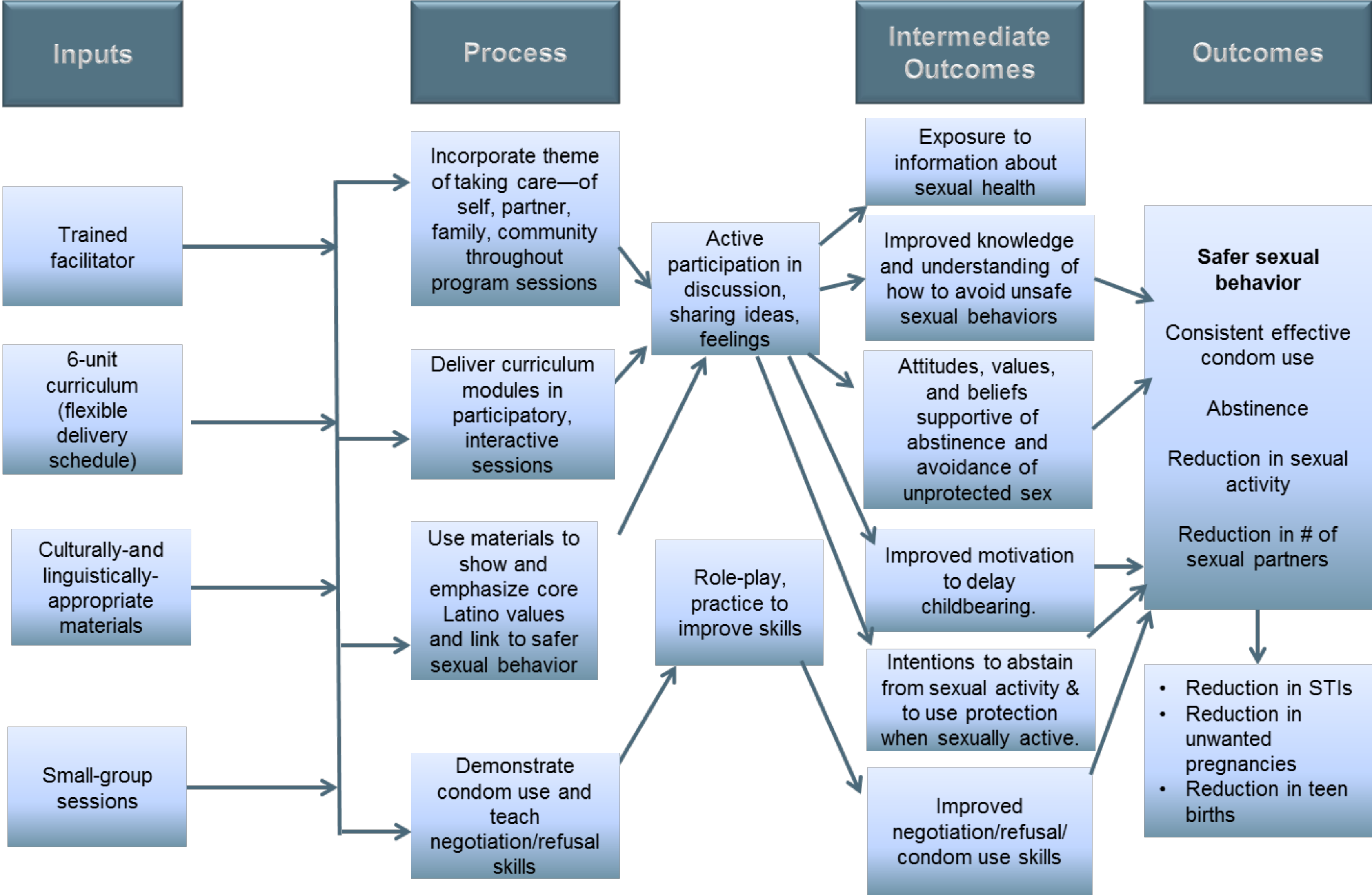
¡Cuídate! Modules, Topics, and Core Element(s)

Module	Topic/Activities	Core Elements Addressed[a]
Introduction and Overview	• Getting to Know You • Talking Circle • Creating Group Rules • HIV/AIDS • What It Means to Be Latino/Latina • Cultural Values • What Latinos Think About HIV/AIDS and Safer Sex	1, 2, 3, 6
Building HIV Knowledge	• View *¡Cuídate!* Video • Myths and Facts	1, 2, 3, 6
Understanding Vulnerability to HIV Infection	• Acknowledging the Threat of HIV/AIDS • Latino Cultural Values and HIV • "A Romance" (role play) • La Lotería • Talking Circle	1, 2, 3, 5, 6
Attitudes and Beliefs about HIV/AIDS	• Welcome and Talking Circle • Music and Discussion • Quién es más macho? Quién es más mujer? • Adolescent Vulnerability to HIV • La Zona Peligrosa	1, 2, 3, 6
Building Condom Skills	• Discussing Condoms • Condom-Use Skills • Overcoming Barriers to Condom Use • What Gets in the Way of Caring Behavior? • Condom Line-Up	1, 3, 4, 5, 6
Building Negotiation and Refusal Skills	• No Hay Razon • How to Use the S.W.A.T. Technique and Scripted Role Plays • AIDS Jeopardy Game • Talking Circle	1, 2, 3, 5, 6

Source: ¡Cuídate! Starter Kit

[a] Core elements: (1) Incorporating the theme of "taking care" of oneself and one's partner, family, and community throughout the program. (2) Using culturally and linguistically appropriate materials and activities to show and emphasize core Latino cultural values, specifically familialism and gender roles and how those are consistent with safer sex behavior. (3) Incorporating activities that increase knowledge and influence positive attitudes, beliefs, and self-efficacy regarding HIV sexual risk-reduction behaviors. (4) Modeling and practicing the effective use of condoms. (5) Building participants' skills in problem solving, negotiation of safe sex, and refusal of unsafe sex. (6) Delivering sessions in highly participatory, interactive small groups.

***¡Cuídate!* Logic Model**



Appendix E: *¡Cuídate!* Activities and Core Elements[*]

¡Cuídate! has six core elements, and each is numbered for inclusion in the sample fidelity checklist.

1) Incorporating the theme of *¡Cuídate!*—taking care of oneself and one's partner, family, and community—throughout the program.
2) Using culturally and linguistically appropriate materials and activities to show and emphasize core Latino cultural values, specifically *familialism* and gender roles, and how those are consistent with safer sex behavior.
3) Incorporating activities that increase knowledge and influence positive attitudes, beliefs, and self-efficacy regarding HIV sexual risk-reduction behaviors.
4) Modeling and practicing the effective use of condoms.
5) Building participants' skills in problem solving, negotiation of safe sex, and refusal of unsafe sex.
6) Delivering sessions in highly participatory, interactive small groups.

[*] Adapted from the *¡Cuídate!* Monitoring and Evaluation Field Guide

SAMPLE FIDELITY CHECKLIST FOR *¡CUÍDATE!*

Facilitator____

Checklist Completed By____

Date Checklist Completed____

Module 1: Introduction and Overview

Activity	Corresponding Core Element(s)[a]	Was Activity Carried Out? Y=YES N=NO	Was Activity Carried Out According to Directions in the Facilitator's Curriculum? Y=YES N=NO (describe) changes in next column)	In Which Ways (If Any) Was Activity Changed?
Conocimiento (Getting to Know You)	6			
Talking Circle	1, 6			
Creating Group Rules	6			
Discussing HIV and AIDS	1, 3			
What It Means to Be Latino/Latina Overview	1, 2			
Cultural Values	1, 2,3			
What Latinos Think about HIV/AIDS and Safer Sex	1, 2, 3			

[a] Core Elements: 1=Incorporating the theme of *¡Cuídate!* throughout the program; 2=Using culturally and linguistically appropriate materials & activities; 3=Incorporating activities that increase knowledge and influence positive attitudes, beliefs, and self-efficacy regarding HIV sexual risk-reduction behaviors; 4=Modeling and practicing the effective use of condoms; 5=Building participants' skills in problem solving, negotiation of safe sex, and refusal of unsafe sex; 6=Delivering sessions in highly participatory, interactive small groups.

Appendix F: Program Observation Forms

OAH Program Observation Form for TPP Grantees

Grantee: Location:	Program Implementer(s):
Observer: Observation Date:	Session Number/Name: Duration of Session: # of Participants:

Program Observation Form for TPP Grantees

Introduction: The purpose of the observation form is to measure the fidelity and quality of implementation of the program delivery. Please use the guidelines below when completing the observation form and *do not* change the scoring provided; for example, do not circle multiple answers or score a 1.5 rather than a 1 or a 2.

You should complete the observation form *after viewing the entire session*, but you should read through the questions prior to the observation. It is also helpful to take notes during your viewing; for example, for Question 1, each time an implementer gives explanations, place a checkmark next to the appropriate rating.

Instructions: The following questions assess the overall quality of the program session and delivery of the information. Use your best judgment and do not circle more than one response.

1. In general, how clear were the program implementer's explanations of activities?

1	2	3	4	5
Not clear		Somewhat clear		Very clear

1 - Most participants do not understand instructions and cannot proceed; many questions asked.
3 - About half of the group understands, while the other half ask questions for clarification.
5 - 90-100% of the participants begin and complete the activity/discussion with no hesitation and no questions.

2. To what extent did the implementer keep track of time during the session and activities?

1	2	3	4	5
Not on time		Some loss of time		Well on time

1- Implementer does not have time to complete the material (particularly at the end of the session); regularly allows discussions to drag on (e.g., participants seem bored or begin discussing non-related issues in small groups).
3 - Misses a few points; sometimes allows discussions to drag on.
5 - Completes all content of the session; completes activities and discussions in a timely manner (using the suggested time limitations in the program manual, if available).

3. To what extent did the presentation of materials seem rushed or hurried?

1	2	3	4	5
Very rushed		Somewhat rushed		Not rushed

1- Implementer doesn't allow time for discussion; doesn't have time for examples; tells participants they are in a hurry; body language suggests stress or hurry.
3 - Some deletion of discussion/activities; sometimes states but does not explain material.
5 - Does not rush participants or speech but still completes all the materials; appears relaxed.

4. To what extent did the participants appear to understand the material?

1	2	3	4	5
Little understanding		Some understanding		Good understanding

Use your best judgment based on participant conversations and feedback.
Roughly: 1 - Less than 25% seem to understand; 3 - About half; 5 - 75-100% understand.

5. How actively did the group members participate in discussions and activities?

1	2	3	4	5
Little participation		Some participation		Active participation

Use your best judgment based on listening to the discussions and feedback.
Roughly, 1 - Less than 25% participate; 3 - About half participate. 5 - 75-100% participate

6. On the following scale, rate the implementer on the following qualities:

a) Knowledge of the program

1	2	3	4	5
Poor		Average		Excellent

1 - Cannot answer questions, mispronounces names; reads from the manual. 5 - Provides information above and beyond what's in the manual; seems very familiar with the concepts and answers questions with ease.

b) Level of enthusiasm

1	2	3	4	5
Poor		Average		Excellent

1 - Presents information in a dry and boring way; lacks personal connection to material; appears "burned out."
5 - Makes clear that the program is a great opportunity; gets participants talking and excited; outgoing.

c) Poise and confidence

1	2	3	4	5
Poor		Average		Excellent

1 - Appears nervous or hurried; does not have good eye contact.
5 - Does not hesitate in addressing concerns. Well organized, not nervous.

d) Rapport and communication with participants

1	2	3	4	5
Poor		Average		Excellent

1 – Doesn't remember names; does not "connect" with participants; acts distant or unfriendly.
5 - Gets participants talking and excited; very friendly; uses people's names when appropriate; seems to understand the community and its needs.

e) Effectively addressed questions/concerns

1	2	3	4	5
Poor		Average		Excellent

1 - Engages in "power struggles"; responds negatively to comments; gives inaccurate information; doesn't direct participants elsewhere for further info.
5 - Answers questions of fact with information, questions of value with validation; if doesn't know the answer, is honest about it and directs them elsewhere.

7. Rate the overall quality of the program session.

1	2	3	4	5
Poor		Average		Excellent

Summary measure of all the preceding questions. Assesses both the extent of material covered and the performance of the implementer.

Excellent sessions looks like:

- Participants are doing rather than talking about activities
- Non-judgmental responses to questions
- Answering questions of fact with information, questions of value with validation
- Good time management and well organized
- Adequate pacing—not too fast and did not drag
- Using effective checks for understanding.

Poor sessions look like:

- Lecture-style of presenting the content
- Reading the content from the notebook
- Stumbling along with the content and failing to make connections to what has been discussed previously or what participants are contributing.
- Uninvolved participants
- Getting into power struggles with participants about the content.
- Judgmental responses
- Flat affect and boring style
- Unorganized and random
- Loses track of time.

Note: The following questions (8, 9, and 10) are for grantee's internal use only for program improvement purposes. These questions are optional and will not be reported to OAH or ACYF for performance measurement purposes.

8. Briefly describe any implementation problems you noticed, including any major changes to the content or delivery of the material; time wasted in getting the session started or finished, etc.:

____
____
____
____

9. Please note at least one major strength of the session and/or facilitator's delivery of the material:

____
____
____
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10. Other Comments: Use the space below for additional comments regarding strengths or weaknesses of the session, particularly if there is anything that affected your ratings above.

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Naturalistic Observation Protocol

[SITE NAME] Observation [##] Protocol

Goal(s) of the session: (Take from curriculum)

Timing and Location: Describe the setting and how the room was arranged. What is on the walls? On a blackboard or wallboard? Is the setting crowded or comfortable?

[DATE] of observation, [TIME] of observation.

Activity Leader: Any co-presenters or helpers – what do they do? In classrooms, was the teacher present?

Participants: Number, age, gender

Activities: For each activity, what was the activity, who presented? How were students grouped for the activity?

Health educator/facilitator strategies: Presentation of material, dealing with questions, refocusing, re-engaging, group management. How effective were the strategies?

Health educator/facilitator sensitivity: acceptance of other perspectives, responses to questions.

Participant engagement: Were the participants engaged in the activities? Some more than others? Some activities more engaging than others?

Any other comments, observations?