

The Teen Pregnancy Prevention Replication Study: Implementing Reducing the Risk

|REPORT SUMMARY|

Overview

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 sexually transmitted infections (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 Replication Study, funded and overseen jointly by OAH and the Office of the Assistant Secretary for Planning and Evaluation (ASPE), was designed to test whether three program models, each previously shown to be effective in a single study, continue to demonstrate effectiveness. The study had two components: an impact evaluation and an implementation study. The overarching goal of the impact evaluation was to estimate the impacts of three program models on adolescent sexual behavior. The implementation study sought to document program delivery, determine the feasibility of consistently replicating evidence-based programs with fidelity and high quality, describe the community contexts in which the program models operated, and explore the challenges faced by grantees. This summary presents highlights from a report[1] on the implementation of *Reducing the Risk, (RtR)*, a widely used curriculum-based sexuality education program usually delivered in schools, by three grantees.

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.

1 The report that accompanies this brief is one in a series that present findings from the TPP Replication Study. Two companion reports describe the implementation of the other two program models evaluated *(SSI and ¡Cuídate!)*. Six earlier reports present findings on the short-term and longer-term impacts of each of the three program models, which can be accessed from the TPP Replication study webpage: https://aspe.hhs.gov/teen-pregnancy-prevention-tpp-replication-study.

EXHIBIT 1: SUMMARY OF THE REDUCING THE RISK PROGRAM AND ITS THREE REPLICATIONS

Program Model, Grantee	Study Location	Target Population	Participant Characteristics[a]	Program Duration and Intensity	Program Setting	Program Delivered By
Grantees Replicating the Program						
Better Family Life Inc. (BFL)	School districts in St. Louis, MO metropolitan area (St. Louis City, MO; St. Louis County, MO., St. Clair County, IL.)	9th graders (small number of 10th & 11th graders)	1.1% White, Non-Hispanic; 2.9% Hispanic; 87.9% Black, Non-Hispanic; 8% Other	16, 45-minute sessions or 8, 90-minute sessions	9th grade classes in 6 public high schools	Health Educators hired, trained, and monitored by BFL
LifeWorks	Austin Independent School District (AISD), Austin, TX	9th & 10th grade students in schools with high teen pregnancy rates	22.2% White, Non-Hispanic; 61.9% Hispanic; 9.3% Black, Non-Hispanic; 6.6% Other	18 sessions, delivered in 9, 90-minute sessions	Health classes in 5 public high schools	Health educators hired, trained, and monitored by Planned Parenthood of Greater Texas
San Diego Youth Services (SDYS)	San Diego County, CA	8th & 9th grade students in schools in high-risk areas of the county	10.7% White, Non-Hispanic; 68% Hispanic; 6.7% Black, Non-Hispanic; 14.7% Other	16, 45-minute sessions	8th and 9th grade health classes in 6 public high, middle, or junior high schools	Health educators hired, trained, & monitored by SDYS and partners

[a] *Data for participant characteristics in each of the replication sites comes from the baseline survey of program participants.*

In this study, three organizations replicated *RtR* between 2010 and 2015. All three delivered the program in schools in which a majority of students were eligible for free or reduced price lunch. Exhibit 1 summarizes the features of the program implemented by each grantee.

Summary of Findings

The three grantees were all well-established in their communities with a record of providing services to families and youth. Two grantees served racially and ethnically diverse communities, with moderate levels of poverty, although their delivery of *RtR* focused on neighborhoods and schools with higher levels of teen pregnancy and births to teens and that were more heavily Hispanic and lower income. The communities served by Better Family Life were majority African-American, with high rates of poverty, unemployment, violent crime and population loss. All three grantees had strong support for their efforts from school district staff; at the outset, Better Family Life was unique in the high level of support the program received from teaching staff as well as school administrators.

Across all three grantees, the program was delivered in public school classrooms during the school day and, as a result, attendance levels were high. Across all three grantees, 80% of participants attended at least 75% of the sessions. Where attendance was lower, events beyond the control of health educators negatively affected program implementation and student participation. There were site-level differences in attendance: SDYS had the highest rate of attendance, with 85% of students attending at least three-quarters of the sessions. LifeWorks was next, with 81% of students attending at least three-quarters of the sessions. BFL's lower rate of 73% was mostly attributable to a single school where less than one-third of the participants attended at least three-quarters of the sessions.

Disruptions of the school schedule, changes to class schedules and locations, and community instability all affected grantees' ability to deliver the program and students' ability to take full advantage of it. In all three replication sites, events beyond the control of the health educators affected program implementation. In some LifeWorks schools, health educators sometimes faced disruptions of the school schedule and changes to class schedules and locations, which cut into the time available to deliver the curriculum. However, block scheduling in this site enabled health educators to make up the lost time in later sessions.

Although some of the BFL schools experienced disruptions, health educators had experience working in those schools and were prepared to deal with the situation and reschedule classes if necessary. In some schools substantial unrest in the community caused absences from school and thus the program.

In SDYS, health educators faced the challenge of greatly increased class sizes, the result of budget shortfalls, which did not affect attendance but did affect engagement. Although the grantee responded by assigning two health educators to each class, larger class sizes (over 20 students) affected students' ability to participate actively in the sessions. The budget shortfall was a particularly acute problem in California during this period, but such budget problems are relatively common, and other grantees may have faced these challenges.

There is little that grantees can do, when faced with such problems. The schools and students they identify as ones that can benefit most from the programs are likely to have many other problems in addition to teen pregnancy that can make implementing programs challenging in these schools.

***Reducing the Risk* was generally a good choice for all three replication sites; its comprehensive approach that combines the importance of abstinence with up-to-date information and skills practice resonated with most stakeholders, including parents.** Community acceptance of the program meant that all three grantees were able to deliver the 16 lessons that the curriculum requires; indeed LifeWorks asked for and received permission from OAH to add two sessions, one on reproductive anatomy and the second an optional *RtR* session reinforcing information about pregnancy and STI prevention. Appropriateness of the curriculum was also evidenced by the small number of requests for adaptations: LifeWorks received approval to drop the condom demonstration and replace it with a comparable activity; BFL requested and received permission to deliver the program separately for male and female youth and to replace the condom demonstration in one school.

While also generally enthusiastic about *RtR*, health educators felt it was showing its age, both in terms of content, language, and teaching strategies. Health educator comments underline the need for continuous review and revision of program material to ensure that it is up-to-date and relevant. Gaps in content that both staff and participants identified include: issues facing LGBTQ youth; multiculturalism; coercion and consent; healthy relationships and sexting. A popular strategy for addressing these and other issues was to ask students to submit questions anonymously at the end of a session, take time to research answers if necessary, and then respond to them at the beginning of the next session. Many health educators also changed the wording of role plays and sentence completion exercises to better fit the local context.

In spite of some challenges, all three replications of *RtR* demonstrated 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 that respond to the local needs of schools and participants. The infrastructure created by OAH was essential to the establishment and maintenance of fidelity to the program model and encouraged high levels of performance among program staff. Offering and supporting staff training throughout the duration of the program, providing measures of program fidelity and quality and requiring regular reporting on them, as well as on attendance, not only ensured accountability but also provided a variety of ways for program staff to obtain feedback on their performance and engage in continuous program improvement.

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