



Teen Pregnancy Prevention Replication Study: Implementing *Reducing the Risk*

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. These program models were identified through an initial systematic, comprehensive review of the literature on teen pregnancy, STIs, and sexual risk behaviors conducted in 2009 (Kappeler & Farb, 2014).¹

Beyond program funding, OAH set out an ambitious research agenda for the whole effort, encompassing both grantee-led evaluations as well as federally funded impact studies. The office saw an opportunity to support new research that would contribute substantially to existing knowledge. One set of research activities comprised rigorous grantee-led impact and implementation evaluations.² A second set of research activities included evaluation studies 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 settings and populations. Within the overall

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>

evaluation, there are three independent studies, one for each program model and each using data pooled across three replications of that model.⁴

The Implementation Study aims to describe the contexts in which the evidence-based program models were implemented, and explore 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 important and until now largely unanswered 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 lessons are usually delivered in schools with students aged 14-19 years old. Three other grantees were replicating *¡Cuidate!*, 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. Trained health educators deliver the program individually to participants 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 of the three models.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 *RtR*. Two companion reports examine the implementation of *SSI* and *¡Cuidate!*. 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.⁶ All of these site profiles, impact reports and briefs can be accessed from the TPP Replication Study webpage: <https://aspe.hhs.gov/teen-pregnancy-prevention-tpp-replication-study>.

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 excluded because it had already undergone several evaluations.

⁶ The profiles are available at <https://aspe.hhs.gov/teen-pregnancy-prevention-tpp-replication-study>.

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.

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.

2.2 OAH Support for Implementation

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

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.

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.

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

OAH assessed grantee requests to adapt even minor aspects of program implementation, to ensure that adaptations did not affect core program elements.⁷ 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 grantees 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.

⁷ For this first round of grants, every adaptation, however minor, required prior approval. This allowed OAH to understand the broad range of minor modifications that grantees proposed to improve attendance or engagement or fill gaps in the curriculum.

3. The Program Model: *Reducing the Risk*

RtR is a sexual health curriculum developed in the early 1990s to help prevent pregnancy and STI transmission in adolescents. The curriculum focuses on changing four sexual behaviors directly related to this goal: (1) initiation of sexual intercourse; (2) abstinence from sexual intercourse; (3) use of condoms; and; (4) use of contraception. *RtR* is intended for use in high school classrooms with students of all racial/ethnic backgrounds, although program materials suggest it might also be delivered in community settings. Its sixteen 45-minute lessons can be delivered separately or grouped into eight 90-minute sessions, but the 16 lessons must be delivered in the required sequence. The program's objectives for student participants are that they will be able to:

- Evaluate the risks and consequences of becoming a teen parent or becoming infected with an STI;
- Recognize that abstinence or the use of contraception are the only ways to avoid pregnancy;
- Conclude that factual information is essential in order to avoid pregnancy or STIs;
- Demonstrate effective refusal and negotiation skills (Lezin et al, 2010).

The three behavioral theories that provide the basis for *RtR* all hypothesize that, to reduce or avoid risky behavior, people need to learn and personalize relevant information, recognize social pressures and anticipate risky situations, establish norms for positive behaviors, and learn and practice skills so that they can act on the information (Lezin et al., 2010). As a result, although the program includes mini-lectures and worksheet completion, it places great emphasis on practicing skills and problem-solving through group discussions and role plays.

RtR is a highly scripted program that specifies core content and instructional elements in detail. Appendix C shows the core content components of the curriculum, the sessions in which they occur, and the instructional approaches and techniques to be applied. In addition to the instructional elements, the program dictates that implementers ensure that program facilitators are comfortable discussing sexuality, model skills during role plays, give clear directions, and tailor the language they use to connect better to the youth served.

RtR is one of the earliest of the comprehensive sexual health programs, and provided a basis for many later curricular models. It is widely used across the U.S., although it is often used in an abbreviated form when schools are unwilling or unable to accommodate its 16 lessons in their schedules.

Three Replications of *Reducing the Risk*

The three replications of *RtR* included in this study were implemented between 2010 and 2015 by three TPP grantees. Each of the grantee organizations were long-established in their communities and were well-known for the services they provided to youth.

- **Better Family Life.** Better Family Life (BFL) is a non-profit community development agency with deep roots in the St. Louis, MO metropolitan area. Established more than 30 years ago, BFL partners with more than 50 organizations in the region to provide housing, clinical, after-school and education services to more than 50,000 individuals, most of whom are low-income and African American. Prior to the TPP grant, BFL had ten years of experience delivering abstinence education in multi-session programs in schools as part of the regular school day.

- **LifeWorks.** Formed in 1998 as a result of merging four longstanding social service providers in Austin/Travis County, TX, LifeWorks is a non-profit multi-service agency that serves approximately 6,000 youth and their families annually. Its goal is to increase youth self-sufficiency through education, housing, and workforce development programs for youth exiting foster care, pregnant and parenting youth, and homeless and runaway youth. For the TPP grant, LifeWorks partnered with Planned Parenthood of Greater Texas to deliver *RtR*. Planned Parenthood had been providing sexuality education and reproductive health care in the community for many years, including parent workshops, peer educators, and presentations in school classrooms.
- **San Diego Youth Services.** San Diego Youth Services (SDYS) is a non-profit multi-service agency that provides services designed to help young people who are at risk for not achieving self-sufficiency. SDYS provides a spectrum of services, including housing, family-centered counseling and life-skills training for at-risk youth, individual counseling for youth recovering from addiction, and after-school programs, to more than 13,000 youth and families annually at 14 locations across San Diego County. For the TPP grant, SDYS partnered with four multi-service agencies that serve youth and families in different areas of the county.

All three grantees implemented the program in schools in which a majority of students were eligible for free or reduced price lunch. Exhibit 3.1 summarizes the program implemented by each grantee.

Exhibit 3.1: Summary of the *Reducing the Risk* Program and Its Three Replications

Program Model, Grantee	Study Location	Target Population	Participant Characteristics ⁸	Program Duration and Intensity	Program Setting	Program Delivered By
Original Evaluation Study						
<i>Reducing the Risk</i> ⁹	13 high schools in 10 school districts in rural and urban California	27% 9 th grade, 56% 10 th grade, 11% 11 th grade, 6% 12 th grade	62% White, Non-Hispanic; 20% Hispanic; 9% Asian; 2% Black, Non-Hispanic; 2% Native American; 5% Other	15, 45-minute sessions	In-school, high school health education class	Trained teachers; with 3-day training
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.)	9 th graders (small number of 10 th & 11 th 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	9 th grade classes in 6 public high schools	Health Educators hired, trained, and monitored by BFL
LifeWorks	Austin Independent School District (AISD), Austin, TX	9 th & 10 th 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	8 th & 9 th 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	8 th and 9 th grade health classes in 6 public high, middle, or junior high schools	Health educators hired, trained, & monitored by SDYS and partners

⁸ Data for participant characteristics in each of the replication sites comes from the baseline survey of program participants.

⁹ Kirby, D., Barch, R.P., Leland, N., & Fetro, J.V. (1991). *Reducing the Risk: impact of a new curriculum on sexual risk-taking. Family Planning Perspectives, 23(6), 253-263.* This study found no effects after 6 months, but after 18 months, female, but not male, adolescents in the program who were sexually inexperienced at baseline were significantly less likely to report having had unprotected sex. No significant effects were found on sexual initiation, recent sexual activity, or pregnancy.

4. Community Context for the Replications of *Reducing the Risk*

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 and the availability of community resources to support and supplement the work of the program.

4.1 Community Characteristics

The three replications of *Reducing the Risk* were implemented in very different communities in terms of urbanicity, household income, and racial and ethnic mix.

For the purposes of the grant, SDYS and its partners concentrated services in San Diego and communities to the north and south of the city. Although the population of the county is about one-third Hispanic or Latino, the population in the areas of the county served by the partners is closer to two-thirds Hispanic or Latino. Two factors influence the culture of the county: its proximity to Mexico and the large concentration of military installations. Crime rates in San Diego are slightly higher than the national averages but lower than rates for California as a whole and they have fallen steadily over the last five decades, in line with state and national trends. Median household income in 2013 was \$63,456, slightly higher than the state median, and unemployment rates were slightly lower than those for the state.

Although LifeWorks provides services across Travis County, it provided services under the TPP grant in schools within the Austin Independent School District (AISD). Located in Central Texas approximately 80 miles north of San Antonio, Austin is the fourth largest city in the state and one of the fastest growing of the 50 largest US cities, with a population approaching one million.¹⁰ The city is ethnically diverse with no group in the majority; the non-Hispanic white population is less than 50 percent, and more than one-third of the population is Hispanic or Latino residents.¹¹ The proportion of the population that is African-American has declined in recent years. The changes reflect increased gentrification and a resulting move of poorer families out of the city. In 2012, Austin had the second lowest violent crime rate of 33 major cities in the U.S. Median household income in 2014 was \$55,216, higher than the state median, and unemployment was 3.5%, lower than the state unemployment rate.

LifeWorks and SDYS targeted ZIP codes or schools that local health authorities had identified as having high rates of teen pregnancies and teen births, as well as high rates of STIs. These ZIP codes were also likely to have higher rates of poverty and higher crime rates than the county (or city) as a whole.

The communities served by Better Family Life in St. Louis, Missouri represent high-risk communities by many measures. The city of St. Louis, the adjoining small cities in St. Louis County, and the city of East St. Louis across the Mississippi in Claire County, Illinois share many characteristics. Most important may be the continued loss of population in all four areas, as a result of severe job losses. The communities are also predominantly African-American communities, with close to 98 percent of the East St. Louis, IL

¹⁰ Tang, Eric, and Ren, Chunhui, 2014. Outlier: The case of Austin's declining African American Population. *Issue Brief*: The Institute for Urban Policy Research and Analysis, The University of Texas at Austin. Retrieved from: http://liberalarts.utexas.edu/iupra/_files/pdf/Austin%20AA%20pop%20policy%20brief_FINAL.pdf

¹¹ Robinson, Ryan. 2016. Top ten demographic trends in Austin, TX. City of Austin Planning and Zoning Department. Retrieved from: <http://www.austintexas.gov/page/top-ten-demographic-trends-austin-texas>.

population, nearly 90 percent of the Jennings, MO population, and more than two-thirds of the Ferguson, MO population consisting of African American residents. St. Louis itself is somewhat more diverse, with almost equal percentages of White and African American residents and a much smaller population of Hispanic residents (4 percent). East St. Louis is one of the most violent cities in the US, with rates of violent crime ten times higher than for the U.S. as a whole. Rates of violent crime in St. Louis itself are about half those of East St. Louis, but more than five times the national rates.

Median household incomes in the four cities range from a low of \$18,000 in East St. Louis to a high of \$38,000 in Ferguson. Incomes have declined steadily since 2000 except in Ferguson, where they have remained stable. Unemployment rates in East St. Louis, St. Louis, and its neighboring communities are considerably higher than the rates for their states.

4.2 Community Need

Community rates of births to teens varied across the three replication sites.

SDYS proposed to target the communities within San Diego County with the highest teen birth rates. While the teen birth rate for the county in 2008 was 34.4 per 1,000 females, rates in these “hot-spots” ranged from 41.8 to 84.7 per 1,000 females.¹² Similarly, for BFL, St. Louis City’s teen birth rate was 63.9 compared with 45.8 per 1,000 for the state of Missouri. However, among African American teens in the city of St. Louis, the birth rate was 87 per 1,000 females. BFL’s proposal to target predominantly African American youth reflected both this higher risk and the reality that the school population in their service area is overwhelmingly African-American.

LifeWorks focused on high schools within the Austin Independent School District (AISD) with the highest teen birth rates. Though Travis County’s 2010 teen birth rate was 38.8 per 1,000 females compared with 52.2 per 1,000 females for the state of Texas, rates of births to teens differed dramatically across racial and ethnic groups within the county. Teen birth rates for Hispanic teens were more than six times higher than the rate for non-Hispanic White teens in 2010 (50.6 vs. 7.8 per 1,000 females).¹³ The school population in Austin is 70% Hispanic, so it was reasonable to expect a higher teen birth rate than for Travis County as a whole. All but one of the recruited schools served majority economically disadvantaged students, were at high risk for school dropout, and were identified by the district as needing improvement on the basis of their achievement scores.

4.3 Community Resources

In all three replication sites, adolescent health and family planning services were available. However, the three differed substantially in the variety, accessibility, and affordability of these services.

The communities served by the three grantees all offered some level of adolescent health and reproductive health services, but differed in the number of settings and the ease of access to services. San Diego County stands out for both the availability of relevant health services and the ease with which

¹² Rates declined steadily across the board from 2008.

¹³ <http://readyby21dashboardatx.org/socially-and-emotionally-healthy-and-safe/pregnancy-and-births-among-teens.php>.

adolescents could access them. Thirteen clinics offered pregnancy prevention services; another four were adolescent medicine clinics, and 17 clinics specifically offered HIV/AIDs and STI prevention and drug assistance services. Medi-Cal (California's Medicaid program) and Family Pact, a state-funded program for those who do not meet the income requirements for Medi-Cal, facilitate access to services for low-income adolescents and their families.

In Austin, Planned Parenthood of Greater Texas operates three clinics that offer services free or at reduced fees for teens who are income-eligible. In addition, the Center for Adolescent Health provides comprehensive care for low-income, underserved teens. Texas is one of five states with the highest numbers of uninsured individuals that did not adopt Medicaid expansion under the 2010 Affordable Care Act. Medicaid in Texas does not provide funding for reproductive health services. A state-funded program offers family planning services for low-income adult women, but the legislature recently cut funding for the program by 50 percent.

The St. Louis and East St. Louis communities served by Better Family Life have numerous clinics that offer reproductive health and other relevant services for adolescents. Within BFL's service area, there are seven sexual and reproductive health clinics, eleven STI testing sites and four mental health centers. Several hospitals in St. Louis offer adolescent health services, including reproductive health services. While Illinois adopted the Medicaid expansion, providing funds for reproductive health services, Missouri did not; participants in BFL's program had differential access to services, depending on the school location.

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

In all three replications, grantees delivered *RtR* in public school classrooms as part of the regular school day. LifeWorks implemented the program in health classes (mixed 9th and 10th grades with some older students) in five public high schools in Austin. SDYS and its four partners implemented the program in 8th or 9th grade health, physical education, and science classes in six public middle, junior high, and high schools in San Diego County. BFL delivered the program in 9th grade classes (with some older students) in six public high schools in St. Louis City, MO., St. Louis County, MO., and St. Clair County, IL. BFL implemented *RtR* in a wide range of classes, including physical education, ROTC, home economics, health, and home room/guidance.

Although all three grantees included letters of support from schools (or school districts) in their proposals, one experienced some resistance from prospective school partners and expended substantial effort on school recruitment. In-school champions helped ease the process.

Stakeholder support is crucial to implementation. Implementing a sexual health curriculum in school settings requires the approval of a school district, but also acceptance by school principals, who generally have the last word on what programs are delivered in their schools. All three grantees understood this and included letters of support from schools or school districts in their grant applications. However, several factors affected the level of that support, such as school budget cuts, scheduling the curriculum into the school day, and loss of school champions to turnover.

While SDYS and its partners had established relationships with school districts and individual schools, they faced several challenges in recruiting schools. The large San Diego Unified School District (SDUSD) was experiencing cutbacks in state funding that resulted in laying off some health teachers. The remaining health teachers were somewhat resistant to what they saw as replacement of their colleagues by external staff teaching the *RtR* curriculum. School principals were reluctant to add to the troubled atmosphere created by the budget cuts, and it became clear that the partners would need to look elsewhere for schools. They were ultimately able to include one high school and a charter school from SDUSD.

SDYS faced challenges in other districts as well: the 16-lesson classroom-based *RtR* curriculum was new to most schools and hard to accept. Most schools had anticipated an approach similar to that used in an earlier program in which teachers, parents, or social workers would identify youth who needed services and pull them out of class or provide the program in community settings. It took longer to convince them to identify a class that *RtR* could replace for the required eight 90-minute block classes. While school district staff were generally supportive, some principals were initially concerned that some parents might object to the curriculum. Well-placed program champions (a health teacher or a school coach or an assistant principal) helped them get into individual schools.

Prior to submitting the grant proposal, LifeWorks had strong support for the program from the district superintendent, the school board, and school district staff, one of whom had been instrumental in creating

the partnership. With the district’s help, LifeWorks identified four high schools with the highest teen pregnancy rates, all but one of which predominantly served high-risk students from low-income families. The program gained strong support from school leadership and teachers from all four schools. However, after the first full year of implementation, LifeWorks lost its program champions (the principal and cooperating classroom teacher) to turnover in one of the more challenging schools. LifeWorks dropped this school from implementation and subsequently recruited another school to replace it.

Better Family Life experienced little resistance from prospective school partners, in part because of existing strong partnerships with the schools. Before submitting the grant application, agency staff met with school principals from schools in high-need ZIP codes to present results of surveys of high school students showing the need for a comprehensive approach. They used this as an opportunity to provide a detailed briefing on the content and format of *Reducing the Risk*, and the rationale for its use.

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 receive training, monitoring and feedback, and support.

5.2.1 Recruiting Staff

The three grantees used similar criteria for hiring health educators, looking for a blend of relevant experience and personal qualities. They differed in the extent to which they were able to draw from existing staff and combine them with staff hired specifically for the project.

In recruiting and choosing staff to serve as health educators, the three grantees used slightly different strategies and their selection criteria, though similar, had some interesting differences. In Austin, Planned Parenthood’s program manager supervised the work of two full-time health educators who she hired specifically for the project. Requirements for the position included education and training and/or some experience in working with teens and in sexual health. The agency did not want to hire someone with too much or too little experience, arguing that highly experienced staff might not be as receptive to direction but inexperienced staff might be overwhelmed. In particular, the program manager felt that achieving a high level of commitment to implementing the program with fidelity would be difficult with more experienced health educators. Creativity and an engaging manner were desirable characteristics.

In Austin, staff needed to be comfortable working for Planned Parenthood, committed to helping high-risk youth and able to talk in a straightforward way about sex and risk behavior.

In San Diego County, existing staff at each of the partner agencies taught *RtR* during the pilot year. After the pilot year, SDYS retained two of the existing staff and hired two health educators specifically for the project. Partner agencies made the same staffing decision – a mix of existing staff and new hires.¹⁴ One health educator involved in hiring her replacement felt that facilitation skills were most important, combined with the ability to change and to be independent. Another health educator noted that having male and female health educators created a helpful dynamic that youth appreciated.

SDYS's project coordinator felt it was most important that health educators have experience in working with youth and feel comfortable enough in talking about sex to make them feel comfortable; being engaging, outgoing and having a good stage presence were also important.

BFL already had health educators from the previous abstinence education grant who were committed to providing sexual health education to high-risk youth, and had experience facilitating groups and working in high-poverty, high-need schools in their community. Ultimately, the Project Director retained two existing staff and hired two additional health educators who met these requirements and had public health backgrounds. Being able to combine staff who were familiar with the schools and their student population with new staff who may have lacked that familiarity was important from the outset. The existing staff had experience delivering a sexual health curriculum in the study schools and mentored new staff from the moment they were hired.

All health educators had relevant experience for the job. However, in only one replication site did health educators have experience delivering a sexual health curriculum to adolescents in a classroom setting.

All of the health educators in the five partner agencies in San Diego County had worked with high-school-age youth, and one in each pair had some prior experience delivering sexual health information to youth. All had experience working with vulnerable youth (such as youth in alternative schools or foster care), providing mental health services and leading other youth development activities with adolescents.

Planned Parenthood's health educators in Austin had different but relevant experiences, having worked in reproductive health clinics and presented sexual health information to individuals on college campuses. These experiences made them familiar with much of the factual content of *RtR* and provided them with facilitation skills.

BFL health educators had the most directly comparable experience: two of the four educators had been delivering multi-session abstinence-based sexual health curricula in schools in the St. Louis metropolitan area prior to the TPP grant, and a third educator had been working for several years as a classroom teacher in the same area before being hired. Existing staff had a solid understanding of the challenges of working with high school populations, but had to adjust to a comprehensive sexual health curriculum. The project director found the newer health educators in BFL were "better with fidelity" – not needing what one veteran health educator referred to as "reprogramming...not just for me, but also for the schools."

These differences in prior experience provide some insight into what the three grantees believed to be critical skills and experience. For SDYS, an essential element was the ability to work sensitively with vulnerable adolescents; for LifeWorks, an understanding of and comfort with the content of sexual health

¹⁴ The replication in San Diego County had two components: a school-based implementation, which was included in the Replication Study, and a community-based implementation, which was not included. Project staff worked on both components.

programs was very important. BFL emphasized the importance of classroom management experience, especially with high-risk youth populations.

5.2.2 Training health educators

The initial training communicated the philosophy and goals of the curriculum and the importance of implementing it with fidelity. Health educators and their supervisors identified some gaps in the training.

While the health educators had some prior experience that was relevant to the health educator role, none had experience in implementing an evidence-based teen pregnancy prevention program with fidelity. Training was, therefore, a crucial aspect of their preparation for the job.

All three grantees participated in the curriculum developer's introductory training session early in the pilot year. SDYS sent one of the two health educators from each of the five partner organizations to participate in the training, while LifeWorks and BFL sent their project coordinators. In preparation for full implementation, all health educators participated in a training session provided by ETR or by a national training organization (e.g. Healthy Teen Network) focused on understanding the philosophy and core components of *RtR*, and the importance of fidelity of implementation, (i.e. strict adherence to core components).

Health educators praised the hands-on nature of the training. They found practice with facilitating lessons and getting feedback to be particularly helpful. The training also provided nuts-and-bolts information about presentation and facilitation skills, including gestures, body language, classroom management, and maintaining student engagement. Grantee staff did identify some gaps in the training, specifically in the areas of reproductive anatomy and up-to-date information on birth control and STI prevention and treatment.

All three grantees pursued a similar strategy for on-the-job training and coaching individual health educators, using co-facilitation of sessions and shadowing of more experienced health educators to supplement the group training sessions.

Each grantee used similar approaches to training staff on the job. As an illustration, LifeWorks had health educators teach as a team for one cycle, then teach on their own in the following cycle. Later, when a new health educator was hired, she shadowed a veteran health educator, and the veteran would then sit in on the class or team teach for the first few sessions, and then the new health educator would facilitate the session on her own. The veteran health educator prepared a binder for the new health educator with “tips and tricks” for each lesson. The health educators felt very supported, and one veteran health educator explained that, “observing ...is the most beneficial part of the training - observing is best before formal training because [the new health educator] can see exactly what she will be doing.”

All three grantees recognized the need for additional and ongoing training to fill gaps in the initial training, reinforce the messages and strategies of the initial training, and to address important topics not directly related to the curriculum itself.

Although staff of all three grantees found the initial curriculum training sessions effective, all three grantees recognized the need for additional and ongoing training. SDYS felt this need most acutely, because of the importance of ensuring consistent implementation across the large number of partners and staff. In its role as the lead agency, SDYS organized a two-day intensive training in part to fill perceived gaps in the initial training and also to reinforce the messages communicated to the larger group in that

training. SDYS brought in Planned Parenthood to provide supplementary training about reproductive anatomy, birth control methods, and STIs.

SDYS followed this early supplementary training with quarterly training sessions. On average, health educators attended one or two sessions each quarter. Topics for these sessions included: facilitation skills, answering shocking or sensitive questions, cultural competence, working with challenging populations, and issues of bullying, gangs, alcohol and drugs. In addition, SDYS held annual booster training on topics directly related to the curriculum including: maintaining fidelity; acceptable adaptations; curriculum challenges; and updates on STI/HIV and birth control methods. SDYS chose the topics for these training sessions in consultation with partner staff and health educators.

Both LifeWorks and Better Family Life provided similar follow-up training sessions for health educators, covering some of the same topics, but with less intensity than SDYS since they did not face the same challenge of maintaining consistency across multiple partners. For example, in LifeWorks, Planned Parenthood held lunchtime training sessions for their health educators during the first year on a range of topics: birth control methods, STIs, reproductive anatomy, puberty, answering anonymous questions, values training, youth development (physical, emotional, sexual health, the teen brain), LGBTQ youth, helping teens file for child support, and working with parents. The Planned Parenthood supervisor elicited training topics from the health educators and then arranged training, following up to determine which training sessions they found helpful.

Better Family Life in-service training included topics intended to increase the personal skills of front-line staff: classroom management, personal development and leadership, self-care, and boundaries. Other training sessions focused on the needs of their community and students: trauma-informed approaches, child and youth development, CPR/first aid, Afrocentric perspectives, and cultural and community awareness.

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; LGBTQ 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 grantees 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.

5.3 Reaching the Target Population

All three grantees proposed to serve youth in schools in areas where rates of teen births were higher than the national average. All three accomplished this goal, although levels of poverty and of other risk indicators differed across the three replication sites.

There were substantial differences in the racial/ethnic composition of youth served by the three grantees. Youth served by SDYS and its partners were, on average, a year younger than youth in the other two replication sites when they entered the program.

Most (88%) youth served by BFL were African American, reflecting both the racial composition of their neighborhoods and the agency's mission to serve the African American community. By contrast, in SDYS and LifeWorks, the majority were Hispanic youth (68% and 62% respectively). Youth in the SDYS schools were, on average, 13.8 years old, compared to their counterparts in BFL (14.7 years old) and LifeWorks (15.3 years old).

There were significant differences among the grantees in the proportions of youth who were sexually experienced or planned to become sexually active in the following year. Youth in the San Diego sample were much less sexually experienced and many fewer expressed intentions to have oral sex or sexual intercourse in the next year, compared with youth in the other two sites.

Across the three grantees, almost one-third of youth participating in the program had ever been sexually active. BFL had the highest proportions of sexually active youth, where almost half had ever been sexually active, compared with just over one-third of LifeWorks participants, and just over 11 percent of youth served by SDYS and its partners. Less than one-quarter of youth served by SDYS and its partners planned to have sexual intercourse in the following 12 months, compared with approximately half of youth in the other two replication sites.

6. Implementation of *Reducing the Risk* in the Three Replication Sites

In this chapter we address the following questions: how was *RtR* implemented in the three replication sites? Was the program implemented as planned and, 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 participants.

6.1 Implementing the Program Model as Planned

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

Two of the three grantees made approved adaptations to the program model during the pilot phase and all three implemented the program in accordance with the plans submitted at that point.

In all three replication sites, grantees delivered all 16 lessons of the program. One grantee, LifeWorks, requested and received approval to add two additional sessions: one focused on reproductive anatomy and one optional *RtR* session focusing on reinforcing messages covered in other sessions about pregnancy and STI prevention. LifeWorks also requested and received approval to drop the condom demonstration in every school to conform to school district policy, replacing it with a description of the correct use of condoms. BFL requested and received permission to deliver the program separately for male and female students, with instructors of the same gender. To respond to concerns from parents in a single school, the agency requested and received permission to replace the condom demonstration with an acceptable compromise. This was either a video or brief lecture. SDYS and its partners were able to deliver the curriculum without any adaptations.¹⁵

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.

Health educators in all three replication sites strongly supported the program model, although acceptance came more easily to some than others.

¹⁵ Because classes tended to be large in the SDYS replication, the agency requested and received permission to use two co-facilitators. *RtR* assumes a single facilitator, although this is not a core element.

BFL health educators all supported the *RtR* model, but it was initially more difficult for some than others. Shifting gears from an abstinence-based approach or reconciling one's personal beliefs with the curriculum were both challenging. One BFL health educator noted that some of the topics were ones she would have found difficult to discuss with her own children, so "...the separation of mom from educator was hard at first, but now I can put my mom hat back on for the kids as needed."

A different challenge to fully accepting the program was the need to adhere completely to the content and delivery strategy of the program. *RtR* is a highly scripted intervention; early in implementation, supervisory staff needed to remind staff not to stray from the script and not to be creative in ways that could affect core elements.

*"We went from believing in abstinence totally until marriage to comprehensive education. I understand the need for comprehensive education. I believe in abstinence, but it's not realistic. *RtR* is abstinence first – it's not wrong to advocate abstinence, but there's a better way; the kids are not waiting to have sex, even once they get the abstinence education, they aren't waiting."*

BFL health educator

Health educators in Austin were similarly supportive of the curriculum, but recognized that the literacy level of the materials made it challenging for the youth in the schools they were serving – the homework (that is, reading and writing that students had to do independently) "assumes a certain reading comprehension ability, which the students do not always have." Like the BFL health educators, these health educators initially felt overwhelmed by what they termed the rigidity of implementing with fidelity but later found that the structure supported implementation, meaning the emphasis on fidelity helped them learn how to implement this kind of program.

SDYS health educators were passionate about the program and put in extra effort and time to implement it. They were committed to the program, in the face of opposition from some stakeholders who did not believe sexual health education belonged in schools. Some SDYS health educators would have liked more emphasis on alcohol and other drugs, noting that it could go hand in hand with the pregnancy prevention information.

Teachers can support the curriculum by articulating their own enthusiasm for the program or can communicate in subtle and not so subtle ways their lack of support. The extent of classroom teacher support varied across the three grantees.

The strongest support for *RtR* by classroom teachers across the three grantees was in the BFL schools, whose teachers co-facilitated the sessions with the health educators. While the teacher's role was primarily to help manage the group, distribute and collect materials, and help with transitions, these activities communicated to their students that they supported the program. In San Diego County schools, teachers were usually present, though not actively involved in delivery of the program. While the teachers usually maintained a neutral stance, other school staff (coaches, assistant principals) were openly supportive of the program when they talked to students. School staff at LifeWorks' schools were supportive of *RtR* and were present during program delivery to help with classroom management. In one school, the principal and classroom teacher that had championed the program left at the beginning of the first study year. The subsequent administration did not support the health educator or require the teacher to remain in the classroom, which led to LifeWorks dropping the school as an implementation site and replacing it with another.

6.3 Fidelity of Program Implementation

Essential in any rigorous test of program impact is an assessment of the extent to which those who deliver the program adhere to its core elements, which usually involve both the content and the strategies for delivery. The developers of *RtR*, a widely-used curriculum, had a well-articulated process for assessing fidelity of implementation.

The *RtR* training provider, ETR Associates, distributed adaptation and fidelity logs detailing each of the sessions and listing the content to be covered. For each session, the fidelity log listed the content elements and instructional elements with check boxes for the health educator to indicate whether they were covered or used (yes/no) and a space for any remarks.¹⁶ In addition, for each activity, health educators indicated any adaptations made to the activity: what was the adaptation, was it planned, what was the rationale for the adaptation, how effective was it, and any recommendations regarding the adaptation(s) made.

6.3.1 Using the Fidelity Checklists to Monitor Fidelity and Provide Feedback

Health educators across grantees implemented *Reducing the Risk* with high levels of fidelity across the two-year period of intake for the study. However, health educators felt that the scoring and reporting format did not capture the challenges they faced or their response to them.

Fidelity checklists indicated a very high rate of completion for all activities, across grantees and health educators; between 91 percent and 100 percent of all activities were completed in each session. Sometimes health educators noted changes, such as: “youth wrote out the responses and shared them rather than saying them out loud” or, “youth drew numbers to set up groups instead of having facilitator make the groups.”

Aspects of delivery sometimes interfered with the length of time allotted for individual sessions, requiring adjustments to regularly scheduled activities and content. Health educators in San Diego reported that, in addition to having to compensate for time lost to classroom management, they often ran out of time in the discussion of birth control and STIs.¹⁷ In response, they shortened some of the didactic portion of the lessons to allow for longer discussion.

In BFL, classroom management was also a common theme; health educators reported taking time from what was available for activities to manage the class. To mitigate this, health educators gauged the readiness and maturity of the students; on three or four occasions, health educators decided not to do the condom demonstration with a group, substituting approved materials for the demonstration. LifeWorks health educators felt that the literacy burden on their English language learner students made role plays a challenge, so they sometimes reduced the number of role plays. In addition, they reported that critical thinking and writing-intensive activities were not what students expected from their health class, so health educators spent some time adjusting students’ expectations.

¹⁶ See https://www.etr.org/ebi/assets/File/Adaptations/RTR_FidelityLog_041017.pdf

¹⁷ Because of the cuts in state aid noted earlier, schools often collapsed two of the PE classes in which *RtR* was delivered, making the group considerably larger than anticipated. Classes might contain 30 or more students. SDYS and their partners responded by having two health educators co-facilitate the sessions, but this solved only some of the problem. There remained the challenge of trying to ensure that all questions were addressed and that everyone had a chance to participate in role-plays.

IMPLEMENTATION OF *REDUCING THE RISK* IN THE THREE REPLICATION SITES

Health educators had some criticisms of the checklists. Many felt that the checklists were too general, feeling the need for greater specificity. Some wanted the checklists to identify the primary activities for each lesson, as well as the aspects of activities that are essential to the program's success. Several believed that the fidelity checklists failed to capture the special touches that they added to implementation.

Supervisory staff in all three replication sites monitored the performance of health educators, regularly reviewing fidelity logs, attendance data and observation reports. The extent to which staff used the data to provide continuous feedback to health educators differed across the three grantees.

Efforts to supervise health educators were facilitated by the accountability measures required by OAH. Health educators were responsible for completing attendance logs and fidelity checklists; local evaluation staff conducted observations, usually in combination with the project coordinator or other supervisory staff. Supervisory or local evaluator staff summarized and reported the data to OAH every six months.

The accountability data served the additional purposes of self-monitoring and supervisory monitoring, and provided a basis for feedback to health educators, both individually and as a group.

Supervisors for each grantee monitored data from all three sources regularly; however, the extent to which they used the data as a basis for feedback to health educators varied by grantee.

BFL's project coordinator reviewed its online performance database daily to check attendance and session completion, reviewed the fidelity checklists weekly, and then met with the health educators as a group to provide feedback. She also completed a fidelity log during classroom observations to help her see whether the health educators were completing the lesson, with or without changes, and reporting it accurately. She and local evaluator staff together observed about three classes per health educator for each program cycle. During the observation, she watched for youth who were not engaged during the session, and met with the health educator immediately after the class to provide constructive feedback and suggest improvements. Health educators found the feedback helpful and said they would have liked even more one-on-one feedback from the project coordinator.

Accountability measures included: attendance logs to be completed for each session; fidelity checklists to be completed for each session; and observation protocols to be completed for a sample of at least 10% of the sessions facilitated by each health educator in each program cycle.

"...during key lessons, where I see they have the biggest issues, I will pop up during those lessons specifically"

BFL Project Coordinator

"The health educators never skip an activity – if they run out of time they do it in the next class. Reasons for skipping something include: something unexpected happens at school; student behavior; they let the lesson go off track when students are really into it. But it doesn't happen very often. They need to bring the class back around. The facilitators have gotten better at that."

Planned Parenthood Program Manager

SDYS required all health educators to complete fidelity checklists within 24 hours of each session. Supervisors at each partner agency reviewed the checklists weekly and submitted them to the local evaluator. Local evaluator staff, joined at intervals by the SDYS project coordinator, conducted observations of 10% of sessions for each health educator, for each program cycle. The local evaluator used these observations, as well as data from the fidelity checklists, to provide feedback to the entire group of health educators at regular meetings held monthly throughout the grant period.

The SDYS project coordinator met with the health educators that she supervised directly, weekly at first, to make sure everyone was on track, answer questions, and make sure everyone felt supported. Later, the group met monthly to discuss issues that arose and ways of resolving or proactively addressing them in the future. The four partner agencies did not adopt this strategy, relying on the monthly meetings hosted by SDYS and conducted by the local evaluator.

The LifeWorks' project director reviewed fidelity checklists at regular intervals and used them to monitor implementation and provide regular feedback to the health educators. The Planned Parenthood program manager also reviewed the fidelity checklists and had an open-door policy, so that health educators could bring concerns to her if they arose and, in addition, scheduled regular meetings with health educators once or twice per semester to discuss implementation. Local evaluator staff conducted the observations, and they shared the completed observation protocols and notes with the health educators but there was little or no discussion of them.

Although the health educators initially saw the checklists as adding to their burden, they came to view them as aids to self-monitoring.

The checklists also were useful to the health educators as a self-monitoring tool. They provided a consistent framework that the health educators could use to check for themselves that they were doing what they were supposed to be doing, not missing any core elements and not making unplanned modifications. While some health educators felt stifled by the need to adhere so firmly to the curriculum, a health educator in San Diego said that they eventually came to see that the checklists “help us identify which classes we are struggling with, usually because there is too much material to be covered.”

6.4 Challenges to implementation

Challenges encountered in delivering the program in high-risk schools included: classroom management issues, changes and upheaval in the school schedule, and adequacy of the time allocated for program sessions.

As noted previously, school characteristics either supported implementation or posed challenges. In some cases, the challenges proved insurmountable. A LifeWorks health educator commented that overall instability and lack of structure in a school can cause classroom changes, which in turn disrupt the schedule of the session and cuts into learning time. Further, the lack of teacher presence in a classroom undermines discipline.

Structure Matters

“Without the structure of a consistent teacher, it's more difficult to get [the kids] to be accountable for their work.”

LifeWorks Health Educator

Districts and schools also changed their schedules, sometimes unpredictably. In Austin, schools shortened days and scheduled pep rallies, effectively shortening or eliminating some of the 90-minute class sessions in which they planned to deliver two *RtR* sessions; this required the LifeWorks health educators to cover the material in the next session or add a session later in the semester.

BFL encountered this issue when their schools shifted their school calendar to end the semester after the winter holidays instead of before. However, because of the relationship BFL had established with the schools, they were able to negotiate additional dates to make up time that might have been lost. The project director noted, “If you have that buy-in, you can get into the schools an extra time.”

In both Austin and San Diego County, schools used block scheduling. The 90-minute period allowed health educators to achieve some efficiencies; less time was spent in reminding students about the content of the prior session and in bringing the session to a close, since these activities needed to occur only once in each double session. However, in Austin, health educators sometimes found the 90-minute sessions to be unwieldy and had difficulty maintaining youth engagement for the entire period. They tried a 60-minute time frame in some classrooms, but found that it was not feasible to fit two lessons in 60 minutes.

Health educators at both LifeWorks and SDYS commented that students' low reading comprehension levels also meant that they needed more time to make sure students really understood the material, building in time for students to ask questions. BFL and LifeWorks health educators also noted that schools sometimes moved students to different class periods to accommodate their reading levels, changing their schedule in ways that affected their participation in the *RtR* class.

6.5 “Goodness of fit” of the Program Materials and Strategy

As a comprehensive sexual health curriculum that combines the value and importance of abstinence with up-to-date information and skills practice, *RtR* was a good fit for all three replication sites.

Because of its comprehensive approach, *RtR* appeared to be consistent with the curriculum requirements of state and local education authorities and was generally consistent with the values of school staff and parents. Because sexuality education is a sensitive topic, states tend to be prescriptive about content and emphasis. None of the four states in which the study was implemented mandated human sexuality education during the study period. With the exception of California, the other states require that abstinence be presented as the preferred behavior or norm for school-age students; California requires that the curriculum address the value of abstinence. Texas also requires that more time be allocated to discussion of abstinence than to any other topic, and that all school districts set up a School Health Advisory Council to set local standards and review any proposed curriculum.

One factor that smoothed the way for LifeWorks in getting school district approval to implement *RtR* was that it corresponded well with the required testing standards, the Texas Essential Knowledge and Skills (TEKS). Austin schools also appreciated that *RtR* targeted both pregnancy and STI/HIV prevention, that it had a parent component, and that it included homework. At one school, the cooperating health teacher designed ways of fitting *RtR* into the school curriculum by assigning course credit and grades for *RtR* activities and homework, working in quizzes, and figuring out what content from the existing health curriculum could fit into the rest of the semester.

One aspect of the *RtR* curriculum could not be implemented in Austin. Although the superintendent was eager to have comprehensive sex education in the Austin schools, citing teen pregnancy as a priority, the district's policy on condom demonstrations meant that health educators had to eliminate this activity. The developer and OAH approved the adaptation since the developer did not identify this activity as a core element of the curriculum. LifeWorks replaced the demonstration with a “line-up” activity in which participants were asked to place in order the steps in correct condom use.

6.5.1 Parent support

Parents generally accepted the program and, in some cases, expressed approval for one or more aspects of the curriculum.

School principals were concerned at the outset that some parents might complain to school boards about the program and were relieved that this did not occur. At one BFL school a large proportion of the students were Muslim. At the school's request, and with OAH approval, health educators delivered the program in single-gender classes and replaced the condom demonstration with a video or brief lecture. In other BFL schools, health educators could replace the demonstration with a video at their discretion if they felt a particular group was too immature for it. On the other hand, one health educator felt the condom demonstration came too late, since youth were already having sex and that the demonstration should occur earlier. In both BFL and SDYS schools, Muslim parents were the most likely to refuse permission for their children to participate in *RtR*, although the percentage of refusals was generally low, usually less than 10%.

6.5.2 Modifications to fit local context

Health educators had many suggestions about gaps or strategies that might be more effective. Many made minor modifications approved in advance by OAH.

All sites had to add a reproductive anatomy lesson for subsequent pregnancy and STI prevention information to make sense. LifeWorks added an anatomy lesson from Get Real™; made some minor modifications to forms, teaching aids, and presentation boards; and added video clips. Health educators felt there was not enough content dealing with LGBTQ issues, navigating healthy relationships or about learning through technology. Most of the adaptations health educators made to address these issues involved modifying the wording of sentence completions in worksheets.

SDYS did not make any adaptations, but supervisory staff commented that they liked that *RtR* allowed them to add community-specific examples, such as local data on teen pregnancy and STI rates. They made minor modifications to change worksheets into interactive activities.

Grantees made some minor adaptations in response to local constraints. For example, if there was no clinic accessible to students, BFL health educators replaced the homework assignment to visit a clinic with an in-class activity, such as bringing a clinic staff member to the class so that students could ask questions or arranging to call the clinic on speakerphone so that the whole class could hear the conversation. Another common type of modification was to change the wording of the role plays to make them fit the local context better or to include updated topics such as sexting and Facebook harassment for students to practice refusal skills.

Some health educators who implemented the program in schools with block scheduling felt that combining two sessions in one 90-minute class was not effective, because of the intentional repetition of material built into adjacent sessions. For sessions that might be a week apart, this repetition was an important aspect of the program's pedagogical approach. When health educators taught two lessons during the same class session, it felt redundant.

6.5.3 Modifications to outdated material

Health educators felt that the program was showing its age, both in terms of content and strategies.

Across all three grantees, health educators suggested that the curriculum needed updating to be more multicultural, to address issues facing LGBTQ youth, and to update language and content in dialogs, role plays, and videos. *RtR* attempts to reach LGBTQ youth by including a role play whose characters are of indeterminate gender. One health educator pointed out that it did not really address LGBTQ issues and that it would be better to intentionally address LGBTQ issues throughout the course instead of having a single ambiguous role play.

Another content gap was texting/sexting and social media; health educators typically addressed these issues in response to questions from youth. Coercion and consent was another area health educators felt needed to be included. Another health educator would have liked more on the emotional consequences of teenage sex.

Although health educators at all three sites liked the inclusion of role plays, some felt there were too many. All would have liked to have more interactive activities and felt that too much of the curriculum was didactic.

6.5.4 Health educator characteristics

In some cases, program fit may have had less to do with the curriculum than with the use of health educators from an external source, especially those with close ties to the schools and communities they served.

Teachers in two of the sites praised the health educators and *RtR*. They appreciated the candid information and many reported that they thought the students took the health educators seriously because they were coming from outside the school. One principal in St. Louis commented on the rapport the health educator had with youth: “He can relate to them. When the kids say, ‘I’m from this particular area,’ he knows exactly where they’re coming from. He knows what else they’re dealing with.”

One classroom teacher in Austin said, “Having an external health educator also shows students that there are people out in the community that care about them, and that these issues go beyond them and into the community, so they feel less invisible. This helps bring the message home.”

Another teacher in Austin felt that she and her colleagues were under pressure to promote abstinence as the only choice and that the health educators had fewer constraints and could say, “Here’s what to do if you decide to have sex.” In addition, the teacher envied the health educator’s confidence in saying, “I’m not sure” when she did not know the answer and coming back with the answer in the following class. Teachers felt pressure to appear knowledgeable at all times.

“What I like is that the health educator is very unbiased. If there’s a silly question, she doesn’t laugh, says it’s a great question and moves right into the answer. If it was us, we’d be more thinking about the classroom management. This way, I can focus on that and let her teach. It’s very helpful, and the kids respond well to it. There is a different dynamic between the health educator and the kids and us [teachers] and the kids. They trust her. She walks in out of the blue, she’s confident, and she does a great job with it.”

Teacher in Austin

Teachers were also positive about the curriculum's combination of information and strategies: "There's science involved as well as how to communicate, from terminology to how to say no. That social component is nice." They also appreciated the thoroughness of the curriculum, particularly in providing steps to prevent pregnancy. One teacher felt that the students opened up more to the outside person than they would have to him, and another teacher echoed this sentiment: "Students pay more attention to the health educator since she's a stranger coming in, they'll focus on her, and she builds rapport with them. Some kids are sad to see her go."

6.6 Quality of Program Delivery

To supplement the measures of how the intervention was delivered that were included in the fidelity checklists (mainly self-report), OAH provided an observational measure of the quality of program sessions¹⁸, to be completed either 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 Likert scale of 1 to 5 (1 being the lowest score, 5 being the highest) 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 multiple 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, and met or exceeded the sampling target, observing between 10 percent and 15 percent of 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 the 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 understand, given OAH's view of the primary 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.

¹⁸ 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

Given these constraints, the implementation study attempted to use the data to describe areas of strengths and weaknesses identified by the observers, using observation data collected over an 18-month-period, when the program was fully implemented by all three grantees. For this descriptive purpose, the items from the observation scale were collapsed 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. Information from interviews with program staff and our own semi-structured observations (see Appendix E) of group sessions (conducted once in the second year of full implementation, in a small number of sessions) helps 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 itself and the content of the curriculum.

Health educators received their highest scores for knowledge of the program and curriculum content (an average of 4.6 across the three grantees), indicating that their selection and preparation (both prior experience and grant-provided training) were effective. The item in this category with the lowest scores assessed how effectively staff addressed questions and concerns. This probably reflects the time constraints of the class since, in interviews, the health educators emphasized the importance they placed on this aspect of the program. BFL health educators, for example, made themselves available outside the session, providing mobile phone numbers and meeting with youth after sessions. All three grantees’

IMPLEMENTATION OF *REDUCING THE RISK* IN THE THREE REPLICATION SITES

health educators had a system for collecting anonymous questions that could be responded to in the following session, a strategy that would not be captured in an observation.

In spite of their concerns that classroom management issues took away from class time, health educators for all three grantees received high scores for their ability to manage the time available.

Scores for time management were also consistently high, averaging 4.4 across the three grantees. Some health educators, implementing the program in schools with block scheduling, felt 90 minutes was too long for a session (they would combine two RtR sessions in one meeting) because of the built-in overlap between sessions, which felt redundant when the sessions were conducted in the same sitting. None of the frontline staff said that they felt time pressure, perhaps because there are 16 sessions to communicate the core messages.

On average, health educators for all three grantees received high scores for their personal qualities.

Observers rated health educators' personal qualities highly as well, averaging 4.5 across the three grantees. Abt interviewers and observers echoed these findings, reporting high levels of enthusiasm and confidence across grantees. In particular, Abt observers noted that BFL health educators possessed an extraordinary rapport with youth participants, and BFL health educators reported feeling very close to the participants.

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 two-year period.

7. Participant Responsiveness

Abt staff gauged the extent to which participants were responsive to the program using data from several sources. These included: attendance data collected at every session; scores on student engagement drawn from the quality observations described in the last chapter; Abt's own on-site observations of a non-random sample of sessions; and information drawn from focus group sessions with students.

7.1 Attendance

It is important to note that attendance at program sessions is closely tied to school attendance. Any external or internal factor that reduces school attendance will be reflected in attendance rates for the program, because of factors beyond the control of health educators.

Grantees and schools within a replication site varied in their ability to retain students for at least three-quarters of the sessions. Attendance levels varied among grantees and by school, within grantees.

OAH required that attendance logs be completed for every session of the program (or class, in the case of block schedules, where two lessons were delivered during a single class). 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 all three grantees, almost 80 percent of students met the goal (attendance at 75 percent or more sessions). 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. During this period, there was substantial community unrest in areas of St. Louis, which may have resulted in absences from school, not just from the program.

7.2 Engagement

Grantee observers rated levels of student engagement as quite high, although the scores were generally lower than for other observational categories.

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 4.3, not as high as for the ratings of health educators in the other observational categories, but nevertheless still quite high. Health educators noted that longer sessions (such as the 90-minute block sessions) made it difficult to maintain participants' engagement, but they also commented that students started to lose interest when there were too many role plays or too much repeated material.

Health educators, school staff, and students themselves reported that participants were enthusiastic and engaged, although there was some variation in the level of engagement depending on the topic. Larger class sizes affected levels of engagement in San Diego.

As noted earlier, during two-week on-site visits conducted during the second year of full implementation, Abt staff conducted observations of *RtR* 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 D and the protocol for the naturalistic observations can be found in Appendix E.

In BFL schools, Abt observers saw a high level of student engagement and trust. Schools and teachers provided visible support, and health educators demonstrated strong rapport with the students. Health educators made themselves available to students outside class, providing contact information for their offices, and even a cell phone number in case of emergencies. Both female and male health educators elicited respect and trust from students. Health educators' reputations helped them establish credibility for subsequent cycles in the same school: "...that perception of the new students, when they see the other students talking with me, and the ease they have with me, she must be cool...and the kids engage, and when they get engaged in different role plays, 'RtR is fun – yay!' I couldn't complain!"

"In that school, it is encouraged for kids to ask clarifying questions. There, teachers know the kids. It's not just a high school. The teachers were walking through the halls interacting with students by name. In St. Louis Public Schools, you don't always see that."

BFL health educator

LifeWorks health educators did not report the same kind of connection, but the students recognized their dedication. One health educator commented that she felt students opened up to her more because she is a

"They were into the pregnancy and STD scares and finding out about how quickly pregnancy and STDs can occur. They liked me asking them about how they would delay sex. Their attention span wanes with the lectures."

LifeWorks health educator

woman of color (Hispanic) – she knew how to pronounce their names, spoke Spanish and her parents were immigrants. She tried to help students set goals, such as going to college, and felt that their shared experience in the class helped them think about how they could graduate from high school and achieve their goals.

One Austin teacher commented that students, both male and female, would come to her the semester or year after the program to ask for the health educator's contact information; she thought it meant that

they wanted help with something happening in their personal life. In the LifeWorks youth focus groups, students said they felt refusal skills practice was least interesting, but some students argued that not everyone knows how to say no, so maybe the refusal skills practice was important. They were grateful that the health educator made sure to answer all of their questions, even if it meant she had to answer them at a later time. They valued the information from the role plays, some preferring the scripted role plays because they had "better answers" than they could come up with on their own, and others preferring the unscripted ones because they could discuss what others wrote. "Some [role plays] were more like a movie than real life," said one, and "the workbook was too last century," said another.

SDYS' health educators generally agreed that engagement seemed to depend on group size, with the larger classes (over 20 students) having lower levels of engagement than those with around 20 students. SDYS students' favorite lessons were those on birth control and STIs, topics which SDYS health educators had students research and present to each other. Students also enjoyed the unscripted role plays and said those felt real to them; they noted that the health educator checked them to see which refusal skills they used and which they omitted.

8. Lessons Learned

Reducing the Risk is the oldest and possibly one of the most widely used reproductive health curriculum. However, because of the length of the curriculum, many schools across the country choose only a selection of the units. The major challenge for grantees was to persuade schools to accept the curriculum as designed and find ways to incorporate it into the regular school schedule. Below, we summarize what we learned from their experiences.

With appropriate support, it is possible to replicate an evidence-based program model with high levels of fidelity to the core elements of the program.

The three replications of *RtR* demonstrate that, with appropriate levels of training, support and monitoring, it is possible to consistently implement an evidence-based program model with fidelity to its core elements and with minor modifications or additions that respond to the needs of schools and/or participants.

In an earlier study, we had difficulty identifying schools that were implementing the whole program (Kelsey et al., 2010). It is notable that all three grantees were able to negotiate with schools to deliver all 16 lessons required for the program within the school schedules. In these three replications, not only did they deliver all 16 lessons but one grantee added two additional sessions without opposition from district or school administrators.

The infrastructure created by OAH was essential to the establishment and maintenance of fidelity and encouraged high levels of performance. The emphasis on fidelity began with the initial training provided by program developers and distributors, which explained the rationale for strict adherence to the core elements, and carried through to the ongoing training and feedback provided by OAH. The routine use of fidelity logs enabled staff to assess their own performance and, together with the quality observation measures, provided a basis for supervisory feedback on how to improve it. OAH oversaw all adaptations, requiring that each one be pre-approved and not alter the core elements of the program specified by its developer.

Acceptance of this level of performance monitoring and reporting was not automatic; initially grantees articulated some resistance to the rigidity of the infrastructure and perceived level of effort. However, during interviews in the third year of full implementation, supervisory staff and staff who delivered the program emphasized both the importance and usefulness of the performance measures.

Grantees adhered to fidelity of implementation in the face of several external challenges.

Resistance from school staff, disruptions of the school schedule, community instability, and principal, teacher and student mobility, can all affect a grantee's ability to deliver the program and students' ability to take full advantage of it. In some Austin schools, health educators faced disruptions of the school schedule and changes to class schedules and locations, as well as some classroom management issues, which cut into the time available to deliver the curriculum. Block scheduling enabled health educators to make up the time at later sessions, because it reduced the time needed for introductory review of the prior lesson and ending preview of the next lesson.

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. However,

in three schools, unrest in the community affected attendance. There is little that grantees can do, faced with these problems. The schools and students they identify as ones that can benefit most from the programs are likely to have many other challenges in addition to teen pregnancy.

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. However, those with limited experience working with high school students will need support and assistance with classroom management from the classroom teacher.

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 high level of quality.

However students are a challenging group, and can present classroom management issues even for experienced teachers. If a teacher does not take an active role, program managers should try to work with school administration and teachers to encourage an understanding of the important role teachers have in ensuring health educators can deliver the program effectively. In some situations, health educators who do not have classroom experience may need a co-facilitator with the necessary classroom management skills to help keep the session on track and redirect students' attention.

Program material needs to be continually reviewed and revised to identify gaps and to ensure that it is updated and relevant.

Health educators were mostly enthusiastic about *RtR*, but some identified a need for reproductive anatomy information so that students could understand the material dealing with pregnancy and STI prevention. Other identified gaps included more current issues around consent and social media. In addition, the developer needed to update the curriculum to recognize the needs of LGBTQ youth and to revise outdated materials and references.

In situations where the condom demonstration could not be included, grantees were able to identify an equivalent way to illustrate the steps to proper condom use.

The *RtR* curriculum, like others, uses a condom demonstration to show participants the proper way to put on and remove a condom. However, some school districts, such as Austin, may not allow this element of the curriculum in schools. BFL encountered objections from Muslim parents in one school. In these and in other scattered cases, grantee staff had to find an alternative to the demonstration that would meet the developer's requirement to address the topic effectively.

In all cases, they were able to identify an alternative approach: a video, a condom line-up, or an informal verbal presentation of the material. Because this issue almost certainly arises in many other places, it is important to realize that having to eliminate the demonstration need not preclude dealing with the topic in ways that provide the necessary information, even if they are less engaging than the demonstration.

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

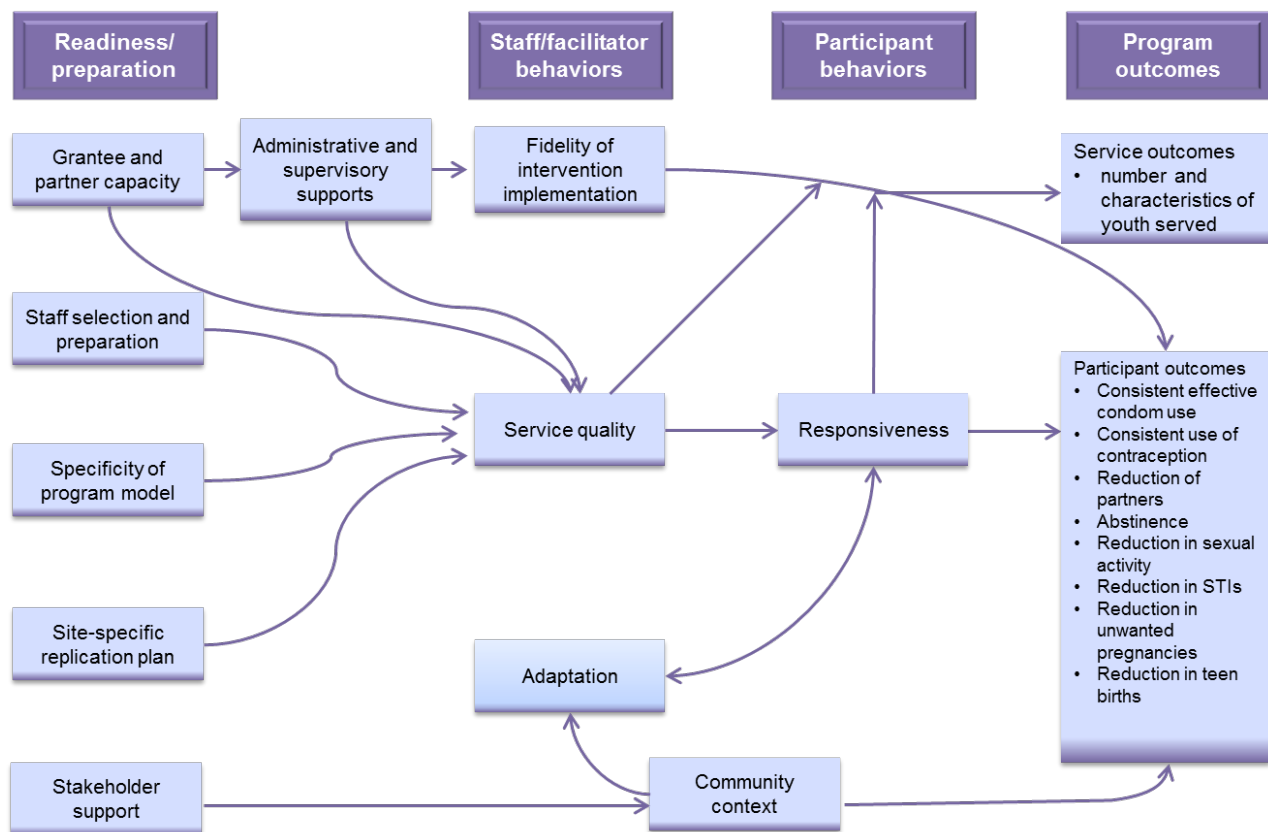
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Appendix A: Conceptual Framework for the Implementation Study

Fidelity to a program model is not the only aspect of implementation that might affect participant outcomes. The framework shown in Exhibit 2.1 builds on the work of Berkel et al. (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, which are 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: abstinence from sexual intercourse or reduction in sexual risk behaviors (i.e. consistent effective condom use, consistent use of contraception, reduction in number of partners, reduction in sexual activity).

Next, Berkel et al. (2011) 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 behavior. 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 staff deliver key program components 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, such as, 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: participant's 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 *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.¹⁹ 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 ***community context*** in which the program operates (e.g., a community, one or more neighborhoods, or a school district) affects the ability to fully implement a program and may also directly influence outcomes.

¹⁹ <http://ctndisseminationlibrary.org/PDF/nirnmonograph.pdf>

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

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 constructs 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 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 study in each replication site, they inevitably touched on challenges the grantees encountered in working with partners, with 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 births to teen mothers.
- **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 and program administrative staff, staff, staff of partner agencies, organizations, and schools. They served to update and expand information drawn from written materials and to provide unique information on the process and challenges of implementing the program from multiple perspectives. We developed interview protocols for:

- Project Director
- Grantee Agency Representative (person listed as contact person on proposal), if different from Project Director
- Project Coordinator
- Frontline Staff (health educators/facilitators)
- Supervisory Staff
- School Staff/School and Community Stakeholders/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 protocols for:

- Small groups of participating youth (non-clinic-based interventions)
- Frontline staff (when individual interviews were not practicable)

Sample protocols are included in Appendix D.

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 the course of the study.

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; while this would have been adequate for the purposes of this portion of the 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 they 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: once, by telephone in 2012 -2013 and again, 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, through weekly telephone contacts, were familiar to grantee staff.

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 E). 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 observation data, since only a small number of sessions could be observed. Study staff observed, taking naturalistic notes, with the observation protocol as a guide, and then wrote up notes using the protocol.

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 “node” (implementation framework subtopic), and analyzed for themes within major implementation topics, checking for triangulation across both extant data sources and interviews within sites, and looking across replication sites for common themes and unique characteristics.

In addressing each topic, we first looked across the replication sites to identify a common theme or finding, and then examined variation among the three. Our descriptive analysis was followed by an evaluative analysis that answered questions such as “How effective were health educators in ensuring participation in interactive components such as role-plays?” As part of the analyses that were conducted after the final follow-up data collection, we used implementation data to provide possible explanations for any variation in program impact that we found.

Appendix C: Topics, Core Components, and Pedagogical Approaches of Reducing the Risk

Exhibit C.1: Reducing the Risk Sessions: Topics and Core Content Components Covered

Core Content Components and Lesson in which Covered	
Core content components	Lesson
Knowledge about:	
Pregnancy risk	1
HIV and other STI prevention, transmission, treatment and consequences	1A, 12
Abstinence	1,2
Birth control methods and effectiveness	7,8
How to access health care information and contraceptives	7,8
Elements of successful relationships	2
Effective refusal skills and delaying tactics	3,6
Attitudes about:	
Abstinence	2
Having sex and unprotected sex	3
Using condoms and contraception	14
HIV risk and consequences	12
pregnancy risk and consequences	1
Skills and Self-efficacy to:	
Refuse sex and unprotected sex	4
Delay sex	16
Use refusal, delay and communication in pressure situations	10
Obtain information and condoms/contraception	7
Negotiation to use condoms/contraceptives	11
Perception of Risk of:	
Pregnancy	1
HIV	13
Being in unprotected "risk crisis"	6
Social/Peer Norms about:	
Sex and abstinence	2, 15
Condom use	9, 15
Values	
Understanding parent/adult values about teen sexual activity	3
Intentions to:	
Use refusal/delaying tactics	5

Core Content Components and Lesson in which Covered	
Core content components	Lesson
Be abstinent	15
Use condoms/contraception	14
Avoid pregnancy	8
Avoid HIV	12
Communication:	
With parents/other adults about teen sexual activity	3,6

Exhibit C.2: *Reducing the Risk Sessions: Pedagogical Approach and Techniques*

Pedagogy and Lesson in which Applied	
Pedagogical Approach and Techniques	Lesson
Create a learning environment by:	
Providing a well-thought out introduction	1
Setting ground rules	1
Summarizing previous lesson	1-16
Reviewing current lesson	1-16
Following detailed steps for each activity	1-16
Facilitate learning activities by using:	
Repetition to reinforce learning	Throughout
Lectures	1,1A,2,3,5,6,7,8
Role plays	1,1A,3,4,5,9,10,11,14,16
Large-group discussion	1A, 2,3,15,16
Brainstorming	2,6,8,15
Guest speakers (as alternative to clinic visit)	8
Worksheets	1,1A,5,6,9,10,11,14,15,16
Homework followed by large-group discussion	3,7,8,12
Traffic light exercises	13
Quizzes	4,5
Address multiple learning styles by:	
Using a variety of teaching methods	Throughout

Appendix D: Data Collection Materials (Samples)

D.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 is inappropriate for the population you are serving? That seems 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 frontline 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?

D.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,?

D.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 E: 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?