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

Early Implementation of a Multi-Component Approach

OFFICE OF POPULATION AFFAIRS

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BRIEF NO. 1

EVIDENCE-BASED PROGRAMS

In 2010, the U.S. Department of Health and Human Services, Office of Population Affairs (OPA) launched the Teen Pregnancy Prevention (TPP) Program to fund medically accurate and age appropriate programs focused on preventing teen pregnancy and reducing disparities. OPA supports and evaluates evidence-based (Tier 1) and new or innovative (Tier 2) TPP program models. In 2015, OPA awarded a second round of grants, including the "Tier 1B" grant program, which supported 50 organizations in 31 states and the Marshall Islands to replicate evidence-based programs (EBPs) to scale in communities with the greatest need. Projects used a community-wide strategy that integrated EBPs into multiple settings and stages of adolescence, mobilized stakeholders around a shared vision, and increased access to youth-friendly services. While implementation varied, all were required to use a multi-component approach that included four key elements:

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

Community mobilization. Engage the community around a shared vision to increase its ability to prevent teen pregnancy and improve adolescent health. Youth and adult advisory groups inform the effort.

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

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

The Tier 1B implementation study includes a full report, *"Taking Evidence-Based Teen Pregnancy Prevention Programs to Scale in High-Need Communities: Early Implementation of a Multi-Component Approach,"* a brief version of the full report, and a series of four briefs highlighting implementation of the Tier 1B strategy.

This brief describes implementation of evidence-based programs during the first two years of the program.

APPROACHES TO SCALING UP EBPS

Each grantee was required to provide EBPs in at least three types of settings and reach between 700 and 17,550 youth annually (average of 4,899). Grantees used the first year of their project to hire and train staff, select and pilot EBPs, and solidify relationships. They established new and expanded existing partnerships to add capacity, credibility, expertise, and access to settings, with numbers of formal partners ranging from three to 200 (median of 11) per grantee. Purposeful, sustained communication with partners helped grantees manage complex projects and large geographic areas. The added capacity also enabled grantees to:

(1) Expand reach within existing school settings by saturating multiple grade levels within a school, and multiple schools within a district
(2) Reach youth not otherwise in school (or serve the same youth in multiple settings to reinforce message)
(3) Expand to new communities.

EBP IMPLEMENTATION

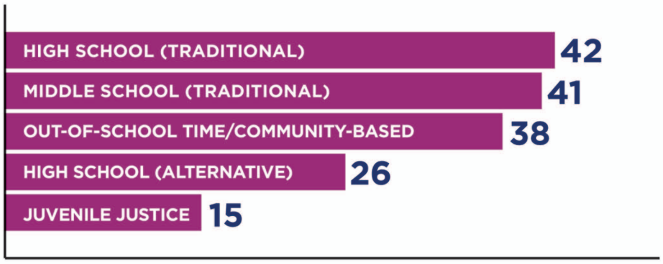
Annual funding per grantee: **$500,000 to $2 million**

Annual reach (planned) per grantee: **700 to 17,550 youth** (average: 4,899)

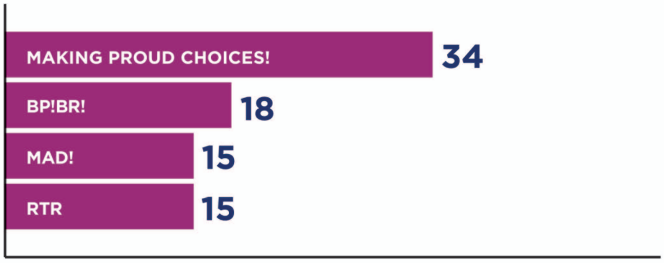
Average teen birth rate (2013) per 1,000 females age 15-19: **Grantees: 51.7 | USA: 26.5**

Ranging from 31.4 to 101.5 per grantee

Most common settings



Most common EBPs



BP!BR!=Be Proud! Be Responsible!; MAD!=Making a Difference!; RtR=Reducing the Risk

4 **Average number of settings** per grantee

28 **Different EBPs** implemented across all grantees

4 **Average number of EBPs** per grantee (Range: 1-11)

In addition to expanding reach, scaling up meant raising community awareness about the importance of preventing teen pregnancy, and ensuring the EBPs fit the community and were implemented with fidelity.

Projects chose settings and EBPs to reach the most youth and meet specific community needs.

Most projects used in-school settings because these allowed them to reach and retain a large number of youth efficiently. Out-of-school time/community-based settings were common complements to school-based settings, and additional setting types allowed projects to reach specific populations of youth (e.g., youth in juvenile detention or in foster care).

Projects chose EBPs based on the fit for the community, population, or settings. Criteria for assessing fit included: compatibility of content with community needs and context, logistical considerations (e.g., length of curriculum), and past success in the community. About a third of projects chose EBPs that grantees or partners had implemented in the past. While grantees usually made the final decision, partners, youth and adult advisory groups, and other stakeholders were often involved in choosing EBPs.

EARLY PROGRESS

Grantees built on prior efforts and expanded EBPs to new settings using community-driven approaches.

By the second year, most projects successfully launched EBPs in their communities across multiple settings. Many were expanding services to new sites within a school district or other community setting in which they had already been working, or to new geographic areas entirely. The planning year gave grantees time to train staff and build capacity, ensure EBPs were a good match, and solidify and expand agreements and relationships with settings to lay the groundwork for full implementation. Some grantees were able to start more quickly than others, often due to existing relationships with schools or community partners.

The Office of Adolescent Health funds the Tier 1B design and implementation study, which includes an implementation study of all 50 grantees, case studies of five grantees, and development of an impact evaluation design. The study is conducted by Abt Associates under contract number HHSP233201500069I.